Hello
my name is
Making Introductions,
Leaving Lasting Impressions

CIS Self-Study Lesson Plan
TASS Prevention:
Processing of Intraocular Surgical Instruments

CRCST Self-Study Lesson Plan
Regulations, Voluntary Standards and Recommended Practices
In the US, healthcare-associated infections account for an estimated 1.7 million infections and 99,000 associated deaths each year. A great majority of these infections are present on non-surgical surfaces. HAIs can be acquired anywhere in a medical facility, whether it be from a scope, a surgical instrument or even a telephone. Ruhof's ATP Complete® Contamination Monitoring System now makes it possible to measure any surface inside your hospital for microbial contamination in just 15 seconds. Quick, reliable test results allow you to immediately clean any contaminated surface, helping to lower the risk of HAIs to patients and staff.

ATP Complete® provides reliable results each time with our Hand-Held Monitoring Device, medical-grade Test® Swab and Test® Instrusponge™. In addition, the ATP Complete® System includes easy-to-use database Monitoring Software for tracking ATP hygiene monitoring results. It allows facilities to increase productivity, quickly identify problem areas and track results.

For More Information call 1-800-537-8463 or visit www.ruhof.com

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IAHCSMM Conference & Expo
Booth 523
April 29-May 2, 2012
Albuquerque Convention Center
Biofilm, an antimicrobial-resistant organism, can develop on surgical instruments and scopes as a result of constant exposure to wet and dry phases during usage and reprocessing. Residual biofilm left on an instrument or scope after cleaning is impervious to high level disinfectants and can lead to infection of patients.

Once biofilm is formed, getting rid of it is almost impossible. Biofilm anchors itself to a surface creating a protective environment for microorganisms to grow.

RUHOF’S BIO-CLEAN TECHNOLOGY is a unique multi-tiered enzymatic detergent designed to target the insoluble extracellular polymeric layer that encases the bacteria in biofilm. Dissolving this polysaccharide layer exposes the bacteria allowing for the complete elimination of all bioburden and biofilm on semi-critical and critical medical devices by high level disinfectants or liquid chemical sterilants.

• The only enzymatic detergent on the market clinically tested to pass ISO 15883 Annex F*.
• Solubilizes polysaccharides during the cleaning process allowing for high level disinfectants to kill and remove biofilm.
• Proprietary blend of enzymes designed to remove all bioburden - blood, carbohydrates, protein, polysaccharides, fats, oils, uric acid and other nitrogenous compounds
• Cleans the inanimate surfaces where biofilm, germs, allergens or microorganisms can hide, thrive, and grow
• Advanced Proteolytic Action - Increased protein enzyme activity

For Generous Free Samples call 1-800-537-8463 or visit www.ruhof.com

ENDOZIME® BIOCLEAN multi-tiered enzymatic detergent designed to target and dissolve polysaccharides on medical devices allowing for the complete remove all bioburden and biofilm by high level disinfectants or liquid chemical sterilants.

PREPZYMÉ® now with Bio-Clean Technology, pre-cleans inanimate surfaces where biofilm can hide, thrive, and grow. Prevents adhesion of bioburden to surgical instruments and scopes.

ENDOZIME® SPONGE – Now with Bio-Clean Technology, pre-cleans scope surface enabling high level disinfectant to kill and remove biofilm.

ENDOZIME® SLR PHASE ONE Endoscopy Bedside Care Kit now with Bio-Clean Technology, removes synthetic lipids while pre-cleaning scope surface and internal channels enabling high level disinfectant to kill and remove biofilm.
**WE DEFINITELY CLEAN...**

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ON SALE!

**Baron & Frazier Suction Tube Brushes**
- Made with anti-microbial nylon bristles and stainless steel twisted wire shafts
- Color-coded for easy identification
- 3 per package

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FROM JUST $12.12
PER Pkg!

**Twisted Wire Cleaning Brushes**
- Perfect for laparoscopic instruments
- Made with anti-microbial nylon bristles and stainless steel twisted wire shafts
- Color-coded for easy identification
- 3 per package

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FROM JUST $12.72
PER Pkg!

**Nylon Bristle Double-Ended Cleaning Brush**
- Rigid, white, medical-grade nylon bristles
- 7" length
- Perfect for Laparoscopic instruments and Kerrison Rongeurs
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Copiously flush with less labor

**H2O MEASURING**
Enables technicians to know exact volume

**CHEMICAL MEASURING**
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**DEEP SINK SOLUTION**
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Stop getting showered with the faucet hose! The flushing pump exceeds 30 psi minimum and 20 second flushing parameters.

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The cycle for clogged tubular devices allows the technician to attach the device to Pure Station and walk away to keep up with other trays.

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The 500 ml container gives the technician a visual of how much fluid is flushing through the device. Clean and dirty solutions are kept separate.

**BRUSH HOLSTER**
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Booth 830 at IAHCSMM

For more information on the Pure Station surgical devices pre-cleaning system, call:
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Making Introductions, Leaving Lasting Impressions

IAHCSMM’s media relations initiatives have prompted some big – and positive – developments that are giving the Association and the CSSD profession the public attention both deserve.

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TBJ Sinks Offer Work Surface Height Adjustment & Processing Fixture Solutions

Our Stainless Steel Decontam Work Sinks are ergonomically designed to provide human comforts during the critical pre-treatment and reprocessing of instruments. All of the accessories we offer, including height adjustment and custom processing fixtures, are specifically engineered to equip your staff with the tools they need to safely, comfortably and effectively prepare instruments and devices for the next step in the decontamination process.

TBJ Decontam Work Sinks are available with one, two or three sink bowls with varying bowl sizes and depths. Our large 28” x 16” sink bowl is designed to accommodate oversized bariatric instrument trays.

Exceptional optional accessories can be added, such as our unique built-in Multi-Enzymatic Foaming Spray System that is specifically designed to create a thick foaming enzymatic spray, quickly breaking down bio-burden and allowing the operator to clean faster and more efficiently. The system is completely integrated into the work sink and includes an enzymatic cleanser storage area, ON / OFF controls and spray gun applicator.

Additional Work Sink Options Include:

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Confidence. Pass it on.
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BY NOW, YOU PROBABLY HAVE NOTICED that the Communiqué in your hands has undergone a bit of a makeover. While the “nuts and bolts” that have made it the go-to publication for IAHCSMM members remain, you’ll find some noticeable design changes – and even some new features (welcome, Rose Seavey – our newest columnist!), which we believe will make Communiqué even more insightful and eye-catching.

What began as a trusty newsletter has since blossomed into a full-fledged professional magazine, brimming with educational content and a host of other features that reflect the true state (and stature) of our challenging, yet rewarding, profession. It’s our hope that this level of professionalism will be reflected on each and every page of Communiqué’s glossy stock.

Of course, Communiqué isn’t the only notable development of late, and it’s certainly not the only publication focusing on CSSD-related issues. As you’re likely aware, the CSSD profession – and IAHCSMM – has been in the media spotlight lately (NBC, if you recall), and has also been fodder for two back-to-back articles from The Center for Public Integrity – and more media-related opportunities have since presented themselves in recent weeks as a direct result of this publicity. While I won’t go into detail on those reports here (you’ll find more on this subject and other exciting media relations developments in this issue’s “Professional Perspectives” and “Hot Topics” columns), I will say this: the general community has been made aware of the importance of the CSSD and its role in delivering clean, sterile, and otherwise safe and well-functioning devices to the operating room. And it’s about time!

IN PURSUIT OF PROFESSIONALISM

No question, these developments have underscored what each of us quality- and safety-focused CSSD professionals already know: that ongoing education, professional advancement and, yes, even certification, all play a critical role in our ability to perform our various roles and responsibilities well.

It goes without saying that our profession is not an easy one. It’s forever in flux, with ever-evolving technologies and procedures a perpetual reality…and the need to stay abreast of frequently changing standards, processes and procedures are an undeniable must. And let’s not forget that many of us must do all this with limited facility resources at our disposal!

Unfortunately, what the recent media reports failed to show was how many of us possess an unwavering commitment to patient safety and quality, exemplary customer service and, above all, doing “what’s right” each and every time, regardless of time pressures and demands from our customers to turn instruments around more quickly than is reasonable or prudent. Even though we don’t always get the credit or respect we deserve (I do believe that is changing for the better, though!), we are bona fide instrumentation and sterilization experts. We are professionals through and through, and it shows in the service we routinely deliver.

With the IAHCSMM Annual Conference & Expo upon us, I’m reminded again just how deep CSSD professionals’ commitment to the profession, their facility, their hospital customers, and their patients, runs. Hundreds of attendees from all over the world have descended upon Albuquerque, NM, all with the same honorable goal: to advance their knowledge, skill sets and professionalism, so they can return to their hospitals and apply their newly-acquired knowledge in a way that drives quality practices and positive outcomes even further. I, along with my IAHCSMM peers, are also keenly aware that many tap into vacation time and personal savings to attend, and for that, we are both impressed and grateful – and your healthcare organizations and customers should be, too.

I’m confident that each of us will continue our quest for quality and professional excellence, whether it’s through actively participating in the multitude of educational offerings available at the IAHCSMM Annual Conference & Expo, attending local or regional IAHCSMM Chapter meetings, challenging our knowledge through lesson plans, inservices and other continuing education opportunities, and – for those who haven’t done so already – making 2012 the year to become certified.

Now that the world is aware of what we do, it’s time to show them just how great we do it!

Bruce Bird
President
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Davina Cowlard, RN BSN CRCST CIS CHL
Clinical Services Manager
Sterile Processing Department

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  - $11-100 = $5
  - $101-250 = $15
  - $251-500 = $25
  - $501 & up = $50
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- 3 Day Select = $15 + Ground 2nd Day Air Equals $25 + Ground Next Day Air Equals $50 + Ground
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- ❑ My check, money order, or bank draft is enclosed, made payable to IAHCSMM
- ❑ My credit card is to be charged, and I have supplied ALL requested information below.

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MEDIA REPORTS PUSH CSSD, IAHCSMM IN PUBLIC EYE

The Central Sterile Supply profession found itself in the national spotlight February 22, 2012, with the airing of an NBC TODAY show segment that addressed the dangers of contaminated surgical instruments and concluded with co-anchor Ann Curry and Dr. Nancy Snyderman discussing the need for adequate training and certification of CSSD technicians. One day later, the segment was rerun on NBC Nightly News, this time with Dr. Snyderman discussing instrument reprocessing-related challenges with anchor Brian Williams. No question, the reports provided a very big platform for educating the public on the profession, why those who reprocess instruments are so important, and, yes, how the negative outcomes that can arise if dirty, non-sterile instruments make their way into a physician’s hands.

The segment – partially filmed at BON SECOURS-Mary Immaculate Hospital in Newport News, VA, and featuring an interview with IAHCSMM President-Elect Sharon Greene-Golden, CRCST, FCS, who serves as SPD manager at the hospital -- stemmed from an investigative report by The Center for Public Integrity. The Washington-based news organization first contacted IAHCSMM last September to learn more about the CSSD profession, the challenges they face, and their vital role in the delivery of safe, high-quality patient care. Greene-Golden, IAHCSMM Educational Director Natalie Lind and IAHCSMM Government Affairs Director Josephine Colacci, JD, all contributed information that helped frame the report’s development. While the news reports underscored the role that instruments can play in hospital-acquired infections and highlighted the dangers patients face if hospitals fail to allocate sufficient attention and resources to those responsible for instrument processing, the reports also highlighted that CSSD technicians are among the hardest-working, yet often least appreciated and understood contributors to infection prevention and the delivery of quality patient care.

“CSSD professionals often lack the respect they deserve, and that’s something that IAHCSMM is working hard to change,” said Lind. She stressed that while many factors may contribute to infections and other negative surgical outcomes, many of which were not explored in the recent media reports, there’s no question that education and certification is critical for driving quality and professionalism in the department, and keeping technicians abreast of the latest standards and technological advancements.

The Center for Public Integrity also published a follow-up article that directly addressed the CSSD certification issue, and IAHCSMM’s legislative initiatives. Colacci, who was interviewed for the article, said national media coverage provided by IAHCSMM and other outlets that educate the public on the CSSD’s critical role could also have a favorable impact on certification legislation at the state level.

“Any forum that promotes education and meaningful discussion amongst the public and state-elected officials could go a long way toward driving further progress on the push for certification.” New Jersey is currently the sole state in the nation to require certification, but significant progress is being made in other states. This month, New York introduced certification legislation and bills are also pending in Ohio and Pennsylvania. Numerous other states are actively educating state-elected officials on the CSSD’s role in patient safety and infection prevention, and about the benefits of certification and ongoing education.

“We are definitely making positive strides,” Colacci continued. “The next state to pass legislation will likely be the tipping point for many others to follow. This is why education and awareness is so critical.”
IAHCSMM-VENDOR PARTNERSHIPS ADVANCE EDUCATIONAL INITIATIVES

IAHCSMM has long relied on vendor partnerships to support the development of a wide range of educational offerings and knowledge-building resources for the Central Sterile Supply profession. It’s because of this mutual commitment to advancing the profession that IAHCSMM is able to provide the most innovative, relevant and valuable educational offerings to its more than 18,000 members.

The most recent partnership is the IAHCSMM/3M International Sister CSSD Educational Exchange Program, which will promote the global exchange of CSSD best practices in hospitals worldwide. The program will pair three CSSDs from the U.S. with another three CSSDs across the Asia Pacific, Latin America or Central Eastern Europe/Middle East/Africa regions. Under the program, “Ambassadors” will participate in monthly teleconferences to discuss critical issues and solutions, as well as standards in their regions. Additionally, participating CSSD managers will engage in a week-long shadowing experience in their sister hospital facility, hosted by the counterpart facility in a different country.

The types of IAHCSMM-vendor partnerships implemented in recent years have been as unique and varied as the vendors themselves. Some other recent examples of these partnerships include: Spectrum Surgical Instrument Corp.’s sponsorship of Central Source, IAHCSMM’s monthly e-newsletter, and the sponsorship of the IAHCSMM video “Central Sterile Supply Department: It All Starts Here” by Spectrum Surgical, 3M Healthcare, Kimberly-Clark, Ecolab, SPSmedical Supply Corp., Key Surgical, and STERIS Corp.

IAHCSMM will continue to explore new, exciting and innovative partnerships that will further benefit its members and advance the profession through education, professional development and awareness.

For more information about the IAHCSMM/3M International Sister CSSD Educational Exchange Program, visit www.iahcsmm.org and click on the “IAHCSMM News” link on the home page.

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EASTERN PENNSYLVANIA ASSOCIATION OF CENTRAL SERVICE
The April EPACS meeting was held Thursday, April 12, 2012, at the Starlite Diner in Allentown, PA. After a great meal, EPACS President Georgina Long opened the meeting. Bob Kline of Bloomsburg Hospital introduced guest speaker Justin Poulin, sales representative for Spectrum Surgical. Poulin spoke on “The How’s and Why’s of Manufacturing, Testing and Using Surgical Instruments.” During the presentation, he reviewed the following topics: manufacturing; inspection; testing; assembly; and proper use of surgical instruments.

After the presentation, a short business meeting was conducted. Reminder: Dues are due for 2012.

The May and June EPACS meeting will again be held at the Starlite Diner in Allentown, PA. The May EPACS meeting will be hosted by Tonya Zehner of Geisinger Community Medical Center. The June EPACS meeting will be hosted by Jim McDonald of Lehigh Valley Hospital.

Our Chapter meets the second Thursday of the month from March through November. Our meetings are held at the Starlite Diner on Route 100 near Allentown, PA. Dinner is at 5 pm and the speaker starts at 6 pm, and a short business meeting follows. Contact hours are always provided. You may contact our chapter at EPACS2011@yahoo.com.

For address changes, dues and newsletter information, please contact Debi Batcsics at 484.223.2880, ext. 144, or by email at batcsics@yahoo.com.

CENTRAL INDIANA CHAPTER
The Central Indiana Chapter had a nice turnout for its Regional Symposium held Saturday, March 10, 2012. Participant evaluation comments were great, with some stating that this one was of the best seminars they had ever attended.

The day began with a timely presentation on “Biofilms” by Lynne Thomas from IMS. Healthmark’s Mary Legan presented the session “Using Peel Pouches.” Other speakers included Lana Phillips of IU Health and Ronald Runyon of St. Vincent Hospital. Runyon’s presentation centered around an audience response game, which participants enjoyed. Twelve vendors participated in the exhibits. The chapter would like to introduce two new members, J. Green and D. Steward, and one new renewal, R. Brewer.

The Central Indiana Chapter’s bi-monthly meeting will be held Wednesday, June 6, 2012, at IU Health University. The meeting will begin at 4:30 pm and our host will be Mollye Banks.

The Central Indiana Chapter will be hosting its next seminar Friday, October 12, 2012. This is a great opportunity to accrue continuing education points to send in to IAHCSCMM. For more information, contact Lana Phillips at 317.962.8925; e-mail: lphillips@iuhealth.org, or Dave Mathis at 317.217.3457; e-mail: dmathis@iuhealth.org. Chapter information may also be found on IAHCSCMM’s website.

HEART OF OHIO CHAPTER
The Heart of Ohio Chapter is again joining forces with the Mid Ohio Central Service Professionals Chapter, the Buckeye Central Service Association, and the NW Ohio Central Service Association in presenting the 4th annual “All Ohio” conference of Central Service professionals, October 12-14, with the theme “Central Service Investigators.”

The seminar is the fourth event to be sponsored by the newly-formed Ohio Sterile Processing Association (OSPA). The 2.5-day IAHCSCMM-approved seminar features a faculty of the best educators, industry leaders and professionals who will treat the attendees to a combined 12 continuing education credits. Featured speakers for this event include: Matt Rudolph; Dr. Rod Parker; Nancy Chobin; Mary Ellen Fortenbury; Lorrie Calabrese; Charles Ciullo; Cynthia Spry; Deb Penner; Dennis Murphy; Rod Chamberlin; and our OSPA President, Rafael Fernandez.

The meeting last October was attended by more than 100 professionals and this year’s attendance is expected to exceed 150. Meetings and presentations will begin at 4 pm Friday, October 12 and will go into early evening. Matt Rudolph of Spectrum Surgical will be discussing flexible scope processing and repairs. Saturday will feature notable topics on orthopedic instrument technology and reprocessing within the central service department with Dr. Rod Parker, sponsored by Stryker. Later in the afternoon, a 40-booth vendor fair with a lunch will be provided. The price of the seminar will include both meals and breaks. Sunday will be kicked off by AAMI notable Cynthia Spry as she motivates the audience on the importance of preventing patient infections with standardization and adherence to best practices.

The ongoing purpose of the Sterile Processing Association is to promote patient safety, education of Central Service professionals in Ohio and certification in the state of Ohio. Our elected officers include: Rafael Fernandez, President, Kay Huston, Treasurer, David Narance, Secretary, Kathy Ly and John Best, Educational Committee, Marie Long and David Narance, Conference Committee, and Rod Chamblin, Vendor Committee. Rod Chamblin is also our “inside” man, helping the Association with state certification efforts as he
works with Senator Shannon Jones and IAHCSMM Government Affairs Committee member David Narance.

Please join your peers and fellow professionals at the October Ohio meeting as we celebrate International CSSD Week in Ohio!

KEYSTONE STATE ASSOCIATION OF STERILE PROCESSING PROFESSIONALS

The Keystone State Association of Sterile Processing Professionals will host the 6th Annual KASPP Educational Seminar at Lancaster General Hospital in Lancaster, PA, Saturday, September 29, 2012. Again this year, we are planning a variety of speakers and topics throughout the day-long event. Vendors will again be on hand to answer questions and show new products that are on the market. Our attendees include sterile processing professionals from New York, New Jersey, Delaware, Pennsylvania, and Maryland. Join us for a great opportunity to network with others in your profession. Updated information will be posted in future issues of Communiqué and online at www.IAHCSMM.org.

In the first quarter of 2012, we have seen a variety of presentations. In January, STERIS Corp. provided an in-depth and personal view of multidrug resistant organisms; February brought a dramatic session on bariatric surgery; and March brought a hands-on workshop from Spectrum Surgical Instruments. As you can see, we provide education on a wide range of subjects in a variety of avenues. For these monthly sessions, KASPP offers 1 Contact Hour.

The sessions are held at our regularly-scheduled monthly meetings the second Tuesday of the month. Each meeting begins at 6 pm, with the one-hour educational session, and is then followed by the business meeting of the chapter. Membership is $25 annually. If you are not a member, educational sessions can still be attended for a $10 fee.

We invite you to join our monthly educational opportunities and ask that you save the date of September 29, 2012, for our 6th Annual Educational Seminar in Lancaster, PA. If you would like more information about our chapter or would like to be added to our mailing list, please contact Susan Dickel, KASPP President, at sfdicke@ghealth.org, or call 717.544.4854.

MARYLAND ASSOCIATION OF STERILE PROCESSING PROFESSIONALS

The Maryland Chapter held its Spring Seminar on March 31, 2012, at the Greater Baltimore Medical Center. Several speakers were on hand to discuss Air Flows in Central Sterile Departments, LEAN strategies for improvement, and a presentation (as well as breakout sessions) related to the segment from the TODAY Show on dirty surgical instruments and the difficulty in cleaning and sterilizing them.

The Maryland Chapter continues its involvement in the grassroots stages regarding state certification of CSSD professionals. Information has been passed on to our state delegates and we are making efforts to schedule meetings with these delegates.

Our Maryland Chapter continues to network with CSSD managers across the state. We just held our last meeting in March at Franklin Square Hospital. We discussed several topics that focused on our upcoming seminar planning, development and improvement ideas for our chapter website, and discussed strategies to improve vendor/loaner instrument processes across the state. This serves as a vehicle to improve communication and support for each other. If there are CSSD managers/directors not currently attending these meetings, we ask that you please get involved so that your department staff can be well informed of what is happening with our profession in the State of Maryland. Ask your manager/director to contact Steve Adams at sjadams@gbmc.org.

Lastly, our Chapter has published its website. The website is still in its infancy and will be improved as we enter more functional capabilities. The domain name for this site is www.maspp.net, so be sure to check it out.

MINNESOTA HEALTHCARE CENTRAL SERVICE MEMBERS ASSOCIATION

Spring is here and those of us in Minnesota feel that winter never arrived! MHCSMA’s February Chapter Meeting was a huge success. Hosted by 3M, the topic “Monitoring the Efficacy of Manual Cleaning” drew a very large crowd – 65 attendees!

Because flexible endoscopes are a concern for everyone, we addressed the topic at our April meeting. The presentation “Infection Prevention – Flexible Endoscopes” was provided by ASP at Hennepin County Medical Center in Minneapolis April 3, 2012. Our MHCSMA Board is working on a project to create a position statement to use as a Minnesota standard for loaner trays. Loaner trays are often delivered late leaving the SPD little time to prepare them for surgery. In addition, weight limits and containment will be addressed.

For more information about our chapter, please visit www.mhcsma.org, or email Thomas Stang at thomas.stang@homed.org.

WESTERN WISCONSIN CHAPTER OF IAHCSMM

The Western Wisconsin Chapter held its February meeting at the Marshfield Clinic-Eau Claire, WI Center. Our education for the evening was “Cost of Instrument Tray Process-
ing,” presented by Bill Germscheid of Kimberly Clark. We were given handouts to guide us in determining the costs involved in tray processing. We learned that we would need to figure in not only employee wages, detergents, water, electric, and wrappers, but also depreciation of washers and other processing equipment, and so on.

We were also given a tour of the Sterile Processing Department there in Eau Claire. We do enjoy seeing others facilities as it gives us a chance to see where we could make changes in our own areas – and also to appreciate what we do have in our own departments.

Our new President, Dawn Rooney, had the opportunity to run her first chapter meeting – and she did a terrific job. The different committees also provided their reports. Our nominations committee is hard at work as this is the season for elections. We voted on a Treasurer, President Elect and one Board Member March 31; those results will be presented in the next Communique. The workshop committee, as always, has been hard at work, too, preparing for our Spring Workshop (held March 31). Please make note that the 2013 workshop will be held in LaCrosse, WI, in April, 2013 (exact dates still to be announced).

Upcoming meetings: June 11, 2012 – St. Joseph Hospital, Marshfield, WI; August 14, 2012 – Gunderson Luther, LaCrosse, WI; October 2012 – Date/location to be announced; December 13, 2012 – St. Claire Hospital, Weston, WI.

Be sure to check us out on Facebook (type “Western Wisconsin Chapter of IAHC-SMM” in the search bar and click “like” to follow).

Contact: Western Wisconsin Chapter President Dawn Rooney at dawn.rooney@ministryhealth.org.
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The Importance of Water Quality in Instrument Processing

The reprocessing of surgical instrumentation is a complex, multi-faceted process. Failure to perform all of the steps correctly can have serious consequences for our patients. Contaminated instrumentation can result in the transmission of pathogenic organisms from one individual to another, which could lead to post-operative complications.¹

One of the most important – and often forgotten – elements in the sterilization process is water.

Healthcare facilities get their water from a municipal water supply, which collects water from rivers, lakes or streams. It can take the form of liquid, solid or gas, and is often referred to as the universal solvent. As source water (untreated water) travels over land or underground, it picks up and dissolves materials, such as bacteria and viruses, pesticides, radioactive material, and metals, such as copper and lead.² Water treatment plants (Fig. 1) significantly reduce the level of these substances through filtration, aeration and disinfection to render the water potable (safe to drink).

Some contaminants that remain in tap water can be harmful to instruments, equipment and patients; therefore, further purification is required for instrument processing.

**Purification Systems**

There are many ways that water can be purified, depending on the level of purity required. Table 1 shows the types of water, methods of purification and uses in instrument reprocessing.

**Water Quality and the Cleaning Process**

Water is a fundamental component in the instrument cleaning process. Poor water quality can not only affect the sterility of an item, it can also affect its functionality. The Association for the Advancement of Medical Instrumentation (AAMI) recommends that healthcare facilities monitor their water's pH, hardness, ionic contami-
nants, temperature, microbial counts, and endotoxin levels.\(^3\)

- **pH** – Water for instrument cleaning should have a neutral pH so that it does not interfere with the efficacy of detergent and enzymes. Cleaning agents are formulated to work best at a certain pH. If water is outside of the neutral range, it can render the cleaning agents ineffective.

- **Hardness and ionic contaminants** – The dissolved solids commonly found in tap water can cause damage to costly instruments and equipment. Chlorides will corrode stainless steel instruments, which can cause the instrument to malfunction during a procedure. Silicates, calcium and magnesium will stain instruments. The harder the water, the more damaging it can be to instruments and equipment.\(^4\) For this reason, it is imperative that the final rinse water be either deionized or reverse osmosis water.

- **Temperature** – Water temperatures above 113° F will coagulate protein (blood is a water soluble protein), making it difficult to rinse away, while temperatures above 140° F will inactivate the enzymes in the cleaning products.\(^5\) The detergent manufacturer’s written instructions for use must be carefully followed. Failure to properly clean an instrument may result in a sterilization process failure.

## STEAM STERILIZATION

Water quality can impact both steam quality and steam purity. Steam quality refers to the dryness of the steam.\(^6\) Steam is comprised of steam vapor, liquid water and a small amount of non-condensable gases (NCGs). AAMI recommends that steam quality be between 97% and 100% (no more than 3% liquid water) for opti-

### TABLE 1

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<tr>
<th>TYPE OF WATER</th>
<th>TREATMENT</th>
<th>USES IN REPROCESSING</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Source Water</td>
<td>Untreated water from surface or an underground source</td>
<td>N/A</td>
<td>Contains bacteria, minerals, pollutants</td>
</tr>
<tr>
<td>Tap (potable)</td>
<td>Source water that has been treated by aeration, filtration and disinfection, and is deemed safe to drink by EPA standards. (Not safe for immuno-compromised patients.)</td>
<td>Pre-cleaning and cleaning of critical devices (if chelating agents are added to detergents)</td>
<td>Contains minerals, salts, bacteria, and viruses</td>
</tr>
<tr>
<td>Softened</td>
<td>Water has been processed to exchange most of the CA and Mg with sodium</td>
<td>Pre-cleaning and cleaning. Makes soaps and detergents more effective.</td>
<td>Only calcium and magnesium are removed</td>
</tr>
<tr>
<td>Deionized Water</td>
<td>Water that has had ions (particles containing an electrical charge) removed from the water</td>
<td>Ideal for final rinse</td>
<td>Does not remove bacteria or viruses</td>
</tr>
<tr>
<td>Reverse Osmosis Water</td>
<td>Water that has forced through a permeable membrane, which removes most solids and dissolved minerals</td>
<td>May be used for final rinse</td>
<td>Removes bacteria, viruses and endotoxins, but not dissolved gases. If used for sterilization, requires designated boiler and all stainless pipes.</td>
</tr>
<tr>
<td>Distilled Water</td>
<td>Water is heated into steam, which is condensed back into water and collected in a purer form</td>
<td>Used in cooling and heating therapy devices</td>
<td>Very pure. If used for sterilization (rare), requires designated boiler and all stainless pipes. Primarily used in medical device and pharmaceutical industry.</td>
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</tbody>
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mum sterilization. Steam that is not in the 97-100% range may compromise sterility. If the steam contains too much moisture, the load will not dry. Conversely, dry steam (super-heated steam) is an ineffective sterilant and can damage instrumentation and packaging.

NCGs are present in small amounts in the feed water and cannot be liquefied during the sterilization process. When the water turns to vapor, the gases are carried along with the steam. When the steam condenses and collapses, these gases can settle on the instruments and form a barrier to the steam. Any barrier to the steam can cause a process failure. NCGs can be controlled through deaeration and treatment of the boiler feed water.

STEAM PURITY
Steam purity refers to the amount of contaminants in the steam. To generate steam, most hospitals use potable water that is passed through a filter. Some contaminants, such as minerals, prions, bacteria, and viruses, may be small enough to pass through these filters. Although the temperature of the steam is sufficient to kill any pathogens, it may not be lethal to bacterial by-products, such as endotoxins. Endotoxins are complex polysaccharide molecules that can cause fever and impaired resistance to bacterial infections. Endotoxins occur in the outer membrane of certain gram-negative bacteria, and are released when the cells are destroyed, as in sterilization.7

Mineral contaminants may also compromise sterility. Laboratory studies have shown that B. stearothermophilus spores are able to survive steam sterilization when encased in calcium or iron crystals, which are common to hard water.8 Such potential sterilization failures can be avoided by using deionized water for the final rinse and by doing a visual inspection for any signs of residue. Instruments with hard water deposits should not be used in invasive procedures and should be reprocessed using proper water conditions.9 If water chemistry in the boiler is not adjusted frequently, dissolved solids in potable water can cause scale deposits inside the pipes, boilers and valves, which can restrict water flow, thereby reducing the sterilizer's efficacy and decreasing the life of the sterilizer.10

LOW TEMPERATURE STERILIZATION
The increase in minimally invasive surgical techniques has resulted in the manufacture of highly complex and delicate medical instrumentation. Many endoscopic instruments must be processed with a high level disinfectant or a low temperature sterilization process because they cannot withstand high heat methods.11

In one commonly used system, (STER- is System 1) the diluent water and rinse water is extensively treated potable water that has been filtered. Newer models (1E) expose the filtered water to ultraviolet rays.12 Although the tap water is filtered to 0.1 micron, smaller contaminants, such as viruses (.01 to .25 microns) may pass freely thru the filters. Furthermore, bacterial filters are not foolproof. There have been reports of filter failures after only a few uses permitting the passage of bacteria, causing instruments to become re-contaminated.13

Multiple cases of patient infection linked to contaminated rinse water have been reported.14

Low temperature sterilization processes filters do not remove salts, calcium, minerals, and bio-burden beyond the size of the filter(s). Contaminates in potable water may potentially adhere to instrument as scale, lime deposits or hard water deposits, under which corrosion may occur.15

IN CONCLUSION
Water is a vital component of every phase of instrument reprocessing. High quality water can reduce the incidence of stained instruments, wet packs, super-heated loads, and exposure to endotoxins. It can also prevent sediment and biofilm build-up in the boiler, on the pipes and in the sterilizer.

Proper monitoring of healthcare water systems will not only help keep our patients safe from pathogenic microorganisms, it may also extend the life of costly surgical instrumentation and sterilization equipment.6

REFERENCES
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WHAT IS TASS?
Toxic anterior segment syndrome (TASS) is an inflammatory reaction of the anterior segment of the eye. It is caused by the introduction of a foreign substance into the anterior chamber, which is located between the lens and the cornea. In other words, it is the area in which cataract surgeries (phacoemulsifications) are performed. These surgeries involve breaking cataracts with ultrasound, followed by irrigation and suctioning procedures. When substances inadvertently get into the eye's anterior chamber, they can cause a toxic inflammatory reaction, which could lead to blindness. TASS is often linked to the failure to follow the instrument manufacturers' instructions for use (IFU) and published standards and recommendations from professional organizations.

reduce the risk of TASS
TASS prevention requires many steps – from medication and solution preparation to instrument reprocessing – and, therefore, a team approach is necessary to prevent the syndrome. In addition to the surgeons, the team should consist of anyone who prepares the medication or solutions used in anterior segment surgery, and the staff members responsible for cleaning and maintaining instruments, autoclaves and ultrasonic baths.

CIS Self-Study Lesson Plan
Lesson No. CIS 231 (Instrument Continuing Education - ICE)

Sponsored by:

CERTIFIED INSTRUMENT SPECIALIST (CIS) TECHNICIANS MUST know many details about a wide variety of instruments to fulfill their job responsibilities. Background information about and knowledge of specialty instruments used for specific surgical procedures can give them an appreciation of their role in helping that ensure surgical interventions will be successful. This lesson will discuss toxic anterior segment syndrome (TASS), with an emphasis on required instrument processing procedures.

LEARNING OBJECTIVES
1. Define and explain the causes of Toxic Anterior Segment Syndrome (TASS).
2. Describe procedures to reduce the risk of TASS.
3. Explain reprocessing recommendations for ophthalmic instruments.
4. Review documentation requirements for ophthalmic instruments.
5. Discuss equipment maintenance and training concerns related to ophthalmic instruments.

Instrument Continuing Education (ICE) lessons provide members with ongoing education in the complex and ever-changing area of surgical instrument care and handling. These lessons are designed for CIS technicians, but can be of value to any CRCST technician who works with surgical instrumentation.

You can use these lessons as an in-service with your staff, or visit www.iahcsmm.org for online grading at a nominal fee.

Each lesson plan graded online with a passing score of 70% or higher is worth two points (2 contact hours). You can use these points toward your recertification of CRCST (12 points) or CIS (6 points).

Mailed submissions to IAHCSMM will not be graded and will not be granted a point value (paper/pencil grading of the ICE Lesson Plans is not available through IAHCSMM or Purdue University; IAHCSMM accepts only online subscriptions).

www.iahcsmm.org
surgery. No matter where the procedure is performed, special precautions are required to process eye instruments because of their complex and delicate nature, and the sensitivity of the eye.

Many ophthalmic instruments are processed manually using procedures that are less controlled than automated cleaning methods. To ensure patient safety, it is critical that the cleaning and sterilization procedures stated in the instrument manufacturer’s instructions for use (IFU) are consistently and closely followed. As well, it is essential to comply with published recommendations from professional organizations such as the Association of periOperative Registered Nurses (AORN), the Association for the Advancement of Medical Instrumentation (AAMI), and the American Society of Cataract and Refractive Surgery (ASCRS).

A sufficient inventory of intraocular instruments should be provided to allow for proper decontamination and sterilization between cases. Unfortunately, time constraints may sometimes create a disincentive for personnel to follow decontamination details. To ensure effective cleaning and sterilization, adequate time should be provided for processing instruments according to the specific instrument manufacturer’s IFU.

All manufacturers’ current written IFU for cleaning and sterilization should be readily available and reviewed by all staff responsible for processing the ophthalmic instruments. Frequent auditing of the processes will help ensure that the reprocessing procedures comply with the IFU.

**PROCESSING RECOMMENDATIONS**

To reduce the potential for cross-contamination, intraocular instruments should not be processed with general surgical instruments. In addition, a designated cleaning area and designated cleaning equipment should be used solely to clean eye instruments. As well, single-use cannulae should be used whenever possible.

Solutions and OVDs can dry onto instruments very quickly. Therefore, instruments should be wiped clean with sterile water and a lint-free sponge during the surgical procedure. Biofilm adheres to the surfaces of instruments and is very difficult to remove, so the soiled instruments should be immersed in sterile water immediately following the procedure. To prevent material build-up inside the phacoemulsification handpiece, the irrigation and aspiration ports of the handpiece, and the tips and tubing should be flushed with sterile distilled water or other solution recommended by the manufacturer before disconnecting the handpiece from the unit. Gross debris should be removed immediately following the procedure. If reusable cannulae are used, the lumens should be flushed with sterile water immediately following the procedure. The instruments should be kept moist (using water, not saline) to prevent the drying of debris.

To prevent exposure to bloodborne pathogens, personnel who clean and process instruments should wear appropriate personal protective equipment (PPE), which includes general-purpose utility gloves and a liquid-resistant covering with sleeves (for example, a backless gown, jumpsuit, or surgical gown). Because of the risk of splash or splatter, the PPE should also include a fluid-resistant face mask and eye protection. PPE used to protect the eyes from splash could include goggles, full-length face shields or other devices that prevent exposure to splash from all angles.

Ophthalmic instruments should be cleaned as soon as possible after use. Instruments should only be brushed and flushed under water to avoid creating aerosols, which can contaminate processing equipment and work surfaces, and expose staff to aerosolized microorganisms.

Care should be taken when cleaning intraocular lens injectors/inserters. Deposits left in the injector can be inserted into the eye chamber and cause
Cleaning and sterilization equipment, boilers and water filtration systems should be properly maintained to avoid foreign material deposits, including endotoxins, heavy metals, or chemical contaminants or impurities on instruments during processing.

- **Cleaning Agents.** To ensure effective cleaning and compatibility with the instruments, only appropriate cleaning agents recommended by the specific instrument manufacturer should be used. Detergents and enzymatic solutions should be diluted according to the cleaning agent manufacturers’ written IFU. Some of these IFU require the use of deionized or distilled water for diluting but, preferably, after each use. An ultrasonic unit designated for cleaning of medical instruments should be used.

- **Disinfection and Inspection.** To disinfect instruments and make them safe to handle after manual or ultrasonic cleaning, ophthalmic instruments should be wiped with alcohol unless contradicted by the manufacturer’s IFU. After cleaning and disinfection, instruments contacting viscoelastic material or OVDs should be inspected for residue under magnification.

- **Rinsing.** Ophthalmic instruments should be thoroughly rinsed with copious amounts of free-flowing sterile, distilled or deionized water. After cleaning, lumens should be thoroughly flushed with sterile water (expel the liquid into a drain, not into the rinse water) and dried with filtered, oil-free compressed air. The water used to clean or rinse instruments should not be reused.

- **Ultrasonic Cleaners.** Ultrasonic cleaning is particularly effective in removing soil deposits from hard-to-reach areas. If the instruments are processed in an ultrasonic cleaner, it should be emptied, cleaned, rinsed, and dried at least daily to detect any residual material. If not cleaned satisfactorily, it should be returned to decontamination for reprocessing.

- **Cleaning Tools.** To prevent reintroduction of contaminants to the next instrument, syringes, brushes and other cleaning implements should be discarded after each use (if designed for single use). Alternatively, they should be cleaned, decontaminated or sterilized following all recommended precautions.

- **Sterilization.** Eye instruments should be sterilized using the methods and conditions recommended in the specific instrument manufacturer’s written IFU. Any discrepancies between the sterilizer manufacturer’s written IFU, the facility’s sterilization processing equipment, and the instrument manufacturer’s written IFU should be resolved by contacting the instrument manufacturer. The sterilization process should be effective, monitored and documented.

Immediately Use Steam Sterilization (IUSS), formerly known as flash sterilization, should not be used as a substitute for an adequate quantity of instruments. IUSS may create an additional risk of infection to patients because of time pressures placed on personnel to rush the cleaning and sterilization process which, in turn, could lead to skipping necessary steps. If IUSS is necessary due to an emergency situation, the instruments must still be subjected to the same decontamination process as those that receive terminal sterilization. Instruments subjected to IUSS should be placed in rigid sterilization containers designed for flash cycles to reduce the risk of contamination. Doing so will also protect the instruments during transport, and facilitate the ease of presentation to the sterile field.

**DOCUMENTATION REQUIREMENTS**

Sterilizer loads should be documented to ensure that cycle parameters have been met and to establish accountability.

For each sterilization cycle the following information should be recorded and maintained:

- **Cleaning and sterilization equipment, boilers and water filtration systems should be properly maintained to avoid foreign material deposits, including endotoxins, heavy metals, or chemical contaminants or impurities on instruments during processing.**

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CIS Self-Study Lesson Plan

a. lot number;
b. specific contents of the lot or load,
c. exposure time and temperature, if not provided on the sterilizer recording chart;
d. name or initials of the operator;
e. results of biological testing, if applicable;
f. results of Bowie-Dick testing, if applicable;
g. response of the CI placed in the PCD (BI challenge test pack, BI challenge test tray, or CI challenge test pack), if applicable; and
h. any reports of inconclusive or nonresponsive CIs found later in the load.

The time and temperature recording chart, printer or tape should also be dated. Each cycle on the chart should be reviewed and signed by the operator. The sterilization records can be in a paper or electronic log or filed as individual documentation records.

Records of all cleaning methods, detergent solutions and lot numbers of cleaning solutions used on ophthalmic instruments are helpful to facilitate investigations of any suspected or confirmed cases of TASS.

Healthcare facilities are responsible for determining the record retention policy based on state and local regulations, legal considerations, such as the time limitation for lawsuits, and its individual situation. Sterilization records should be retained according to the policy and procedure established by the individual healthcare facility.

TWO FINAL TASS CONCERNS
Cleaning and sterilization equipment, boilers and water filtration systems should be properly maintained to avoid foreign material deposits, including endotoxins, heavy metals, or chemical contaminants or impurities on instruments during processing. Facilities should consult the equipment manufacturer’s operating manual to learn the required frequency and type of maintenance activities. These activities should be performed by qualified personnel and should be documented.

TRAINING
Policies and procedures for reprocessing ophthalmic instruments should be clearly written and outline the important steps in instrument cleaning and sterilization. Processing personnel should follow the appropriate processing procedures, and maintain knowledge of practices that could have an impact on the efficacy of cleaning and sterilization. Each surgical center or other healthcare facility should have at least one person responsible for remaining current with recommendations for processing intraocular surgical instruments.

Training should include verifying the efficacy of training and continued competency in instrument processing procedures. Periodic observation of cleaning and sterilization practices by training personnel, and periodic audits of the cleanliness of processed instruments are critical for reducing the risk of TASS.

IN CONCLUSION
Many substances can elicit a TASS response if they are inadvertently introduced into the anterior chamber of a patient’s eye. Therefore, the need to ensure use of the proper intraocular surgical instrument processing procedures cannot be over-emphasized. Convenience or economics should never trump patient safety, and that is why CIS technicians know and consistently follow the IFU for this and all other equipment.

REFERENCES AND RESOURCES

ROSE SEAVEY MBA, BS, RN, CNOR, CRCST, CSPDT is the President/CEO of Seavey Healthcare Consulting, LLC, and formerly the Director of the Sterile Processing Department at The Children’s Hospital of Denver. Ms Seavey served on the Association of periOperative Registered Nurses (AORN) Board of Directors from 2008-2010. She was honored with AORN’s award for Outstanding Achievement in Mentorship in 2012 and the Outstanding Achievement in Clinical Nurse Education in 2001.
1. TASS is caused by the introduction of a foreign substance into the ________ chamber of the eye.
   a. Posterior
   b. Anterior
   c. Medial
   d. Lateral

2. TASS is not an infection; instead, it is a toxic inflammatory reaction that can lead to blindness.
   a. True
   b. False

3. Cases of TASS may be caused by:
   a. Solutions, ointment, or medications used during surgery
   b. Enzymes or detergents used to clean instruments
   c. Heat-stable endotoxins from sources involved in reprocessing instruments
   d. Cleaning solutions not completely rinsed after cleaning
   e. All of the above

4. Special precautions are needed when reprocessing eye instruments because:
   a. The instruments are owned by the surgeon
   b. The instruments are complex and delicate
   c. The eye is very sensitive
   d. B and C above
   e. All of the above

5. All ophthalmic instruments should be processed:
   a. Manually
   b. In an automatic washer
   c. In an ultrasonic cleaner
   d. According to the instrument manufacturer's IFU

6. To allow for appropriate decontamination and sterilization between cases, healthcare facilities should:
   a. Have sufficient inventory of intraocular instruments
   b. Provide adequate time to properly reprocess the instruments
   c. Routinely use immediate use steam sterilization (otherwise known as flash)
   d. A and B above
   e. All the above

7. Ophthalmic instruments should be routinely processed with general surgery instruments.
   a. True
   b. False

8. Single-use cannulae should be used in cataract surgeries whenever possible.
   a. True
   b. False

9. When cleaning ophthalmic instruments, personnel staff should wear PPE which includes:
   a. General-purpose utility gloves
   b. Long sleeve liquid-resistant covering
   c. Fluid-resistant face mask
   d. Eye protection
   e. All of the above

10. To ensure effective cleaning and compatibility with ophthalmic instruments:
    a. Only use appropriate cleaning agents recommended by the instrument manufacturer's IFU
    b. Dilute detergents according to the cleaning agent manufacturer's IFU
    c. Always use enzymatic detergents
    d. Rinse with copious amounts of free flowing sterile, distilled or deionized water
    e. All but C above

11. Immediate use steam sterilization (IUSS) should not be used as a substitute for an adequate quantity of instruments.
    a. True
    b. False

12. Which is not part of the documentation requirements for sterilizer loads?
    a. The lot number
    b. The specific contents of the load
    c. The name and initial of the supervisor
    d. The results of sterilization monitors

13. Each facility should have a records retention policy based on:
    a. State and local regulations
    b. Legal considerations
    c. Their physical storage space
    d. A and B above

14. Maintenance and repair of cleaning and sterilization equipment should be completed by qualified personnel and documented.
    a. True
    b. False

15. Which is not recommended to help reduce the risk of TASS?
    a. Specific written policies and procedures
    b. Remaining current on intraocular surgical instrument processing recommendations
    c. Training, including documented competency and periodic audits of the cleaning processes
    d. All of the above are recommended.
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There are four key principles that must be implemented to build an integrated team. Two of those principles, teamwork and communication, have already been discussed in the previous lesson.

This lesson begins with a discussion of workplace diversity because departments with a multi-cultural management team have built-in benefits that form the foundation for a coordinated team working together to attain CSSD goals. The lesson then provides information about the remaining two principles important for an integrated team: commitment/accountability and visibility.

LEARNING OBJECTIVES
1. Review the benefits of workplace diversity for the Central Sterile Supply Department.
2. Explain how high levels of commitment and accountability enable Central Sterile Supply Department managers to increase their contributions to their stakeholders.
3. Describe how a manager’s visibility in the Central Sterile Supply Department can help create a positive role model for the staff.

WORKPLACE DIVERSITY
One definition of diversity identifies the entire population according to six characteristics: age, gender, mental/physical abilities, sexual orientation, race, and ethnic heritage. In other words, the definition addresses a range of human characteristics and dimensions. This definition includes all managers and other employees, and it celebrates the contributions every member of the team can make to the CSSD.

A strong business case can be made for the benefits of diversity. The advantages include:
• A welcoming and rewarding work environment that encourages all employees to perform to the best of their abilities.
• An organizational culture of understanding, respect and cooperation that encourages teamwork with all of its benefits.
• Persons with diverse backgrounds are likely to generate more creative alternatives when decisions are made and problems must be resolved.
• Entry-level technicians with different backgrounds can see evidence of advancement opportunities within their department and facility as they are led by culturally diverse leaders. This supports the welcoming culture of the work environment and may encourage employees to maximize their contributions to the department.

However, a diversity-valuing environment does not just happen because top-level administrative officials require it, because human resource specialists...
request it, or because a CSSD manager desires it. It requires a significant organizational culture change with an ongoing commitment from the parties just noted. There must also be buy-in from employees in the CSSD. In fact, there is no quick-fix diversity implementation plan; it often requires a change in the attitudes of the managers and employees, and this can be difficult and time-consuming to achieve.

Those who value diversity have some basic beliefs:

- Diversity cannot occur unless it is supported by the facility's organizational culture.
- An emphasis on diversity must transcend the entire healthcare facility; it cannot be an “option” for interested departments. The top-level support drives the cultural change within departments.
- Efforts to implement diversity should include every staff member with an interest in doing so.
- The values of diversity accrue to the facility, in general, and its employees, more specifically.
- Changes in organizational culture are difficult and are generally very time-consuming to make.

Some CSSD managers may think that affirmative action programs are the same as diversity-valuing efforts. This is not true. Affirmative action programs are implemented to address the several types of discrimination that are forbidden by equal employment opportunity laws. These programs address the prevention and/or correction of employment practices that discriminate against individuals for reasons including age, color, disability, national origin, race, religion, and gender. A goal of affirmative action programs is to close gaps by establishing targets and time frames to modify race and gender profiles in organizations.

In contrast, healthcare facilities that implement diversity-valuing efforts move beyond race, gender, and related concerns in an attempt to provide an environment that is welcoming and rewarding for every staff member. The goal is to move beyond satisfying legal requirements to addressing workplace environment concerns, improving productivity, and increasing employee morale. In other words, these facilities attempt to create an organizational culture in which diversity is desired because it yields the full utilization of the diverse talents of every staff member.

Changes in organizational culture take time. Those supporting diversity believe that all staff members want to be recognized for who they are and appreciated for what they do. Employees want to feel comfortable while they are at work.

When the CSSD management team is comprised of culturally diverse managers, the numerous benefits of integrative management are multiplied. Managers with different ideas and perspectives can focus their creative thoughts on improving the department so it can better serve patients and other stakeholders. To ensure that it is fully integrated, diversity is an important characteristic of a CSSD management team.

CSSD managers must be committed to the department’s goals, and they must be held accountable for their actions. They must focus on the concerns of the entire CSSD rather than just the interests of their work sections or their own personal issues.

Commitment relates to each CSSD manager’s interest in developing and implementing quality management systems for their area of responsibility and continually improving their area’s effectiveness. Commitment also requires a genuine desire to attain assigned goals, to help department employees find pride and joy in the workplace, and to maximize the usefulness of the resources under their control.

Management accountability in the CSSD involves a sense of responsibility for the quality, quantity and timeliness of the team’s performance. Managers must also ensure that their subordinates meet productivity standards, control costs and help address the requirements of their “customers” who are responsible for meeting patients’ needs.

CSSD managers must be committed to the department’s goals, and they must be held accountable for their actions. They must focus on the concerns of the entire CSSD rather than just the interests of their work sections or their own personal issues. To do this, CSSD directors must help their managers create goals and implement plans that help attain the department’s mission. This tactic will, in turn, help the healthcare facility move towards attainment of its broader mission.

Like all goals, those of CSSD managers and their teams must be measurable, and they must be accepted by the employees who are responsible for attaining them. Progress toward goals should be reviewed at least annually, ideally at each manager’s performance appraisal session. This is an excellent time to formally document any needed changes to plans that can help employees better attain performance and departmental goals.

It is important that each CSSD manager have input to the development of his or
her goals that relate to financial performance, patient and other stakeholder services, and other goals, such as those relating to professional development that help the department address its own concerns. As this occurs, the CSSD managers will become more committed to goal attainment, and a more effective department will result.

Performance appraisal sessions, for CSSD managers can consider historical activities to attain goals (were previous goals met?), current activities (are managers presently involved in activities helpful in attaining goals?), and the future (what are the best uses of each manager’s talents to help the CSSD?).

Incentives and rewards for attaining mutually-developed goals are very important. Gestures as simple as a sincere “thank you” and ongoing acknowledgement of a manager’s achievements are a good start. A plaque given at a departmental meeting, a featured write-up in the CSSD newsletter (see Part I in this series), and a “news round-up” on the employee bulletin board are other possibilities.

CSSD leaders are committed to education. They understand its role in helping all CSSD employees more effectively complete their daily operational responsibilities. Leaders also know that education contributes to better planning and implementation of tactics that help the CSSD achieve its mission. Educational opportunities sponsored by the International Association of Healthcare Central Service Material Management (IAHCSMM) are among the numerous opportunities that are increasingly available to CSSD managers.

The attainment of challenging goals, ongoing and focused feedback from the CSSD director, and an emphasis on professional development can yield a solid foundation for each manager’s commitment and accountability to the department. These efforts also build trust and provide evidence that each manager is respected and is a contributing member of the CSSD management team.

**VISIBILITY**

CSSD leaders know that they are always “on stage.” Managers and all others in the department observe what the leader says and does, and they often compare this to what the leader says should be done. There must be a close correlation between a leader’s words and his or her actions. If they match, there is a great chance for the team’s success; if not, there is little chance that the department’s goals can be attained.

The best CSSD leaders and managers model desired attitudes and behaviors for those whom they supervise because they know that doing so impacts the performance of their subordinates. Some CSSD leaders may not realize that they act as a role model whether they do it consciously or not! They can exhibit the desired behavior and be a positive role model, or they can “do what I say, not what I do,” and exhibit undesirable traits that make them a negative role model.

There are two things that every CSSD leader can do in an effort to be a positive role model:

- **Lead by example** – everything that exemplary CSSD leaders do is some thing that their subordinates should also do. They express concern for the patients and do whatever is reasonably possible to help those in the surgical suites who use their products and services. They also treat their employees the same way they want to be treated by their own bosses.
- **Follow the rules** – the best CSSD leaders do not take “short-cuts” because they are the boss and have a right to do so because they are in a hurry. They know all applicable policies and standard operating procedures, and they follow them to the letter all of the time. They seek out good ideas from their employees, implement them when possible, and praise them for the contributions they make to the CSSD.

CSSD leaders “manage by walking around” and, as they do so, they have opportunities to coach, encourage, thank, and learn from their other managers. In exactly the same way, managers should expand their definitions of employee supervision to include these opportunities to interact with and obtain ideas from those whom they supervise. Leaders who treat others the way they would like to be treated by their own boss are teaching others great lessons about how to help employees be successful. These actions will not go unnoticed by the employees. They may inspire team members to help each other in expanded ways, which could result in a more integrated team that can achieve loftier goals that might appear unattainable for less integrated departments.

These activities are likely to provide valuable feedback of many types that will help the department improve. The old saying that “none of us knows as much as all of us,” is relevant here. As teams of managers apply their diverse knowledge and skills with a can-do attitude, it will create significant force to move the CSSD towards success.

**IN CONCLUSION**

CSSD leaders who desire to implement an integrated management approach within their departments can start with an understanding that the CSSD management team and its teams have a significant amount of collective knowledge, experience and creativity. Tactics that make use of these resources in ways that benefit a department’s patients and staff, and the department itself, are very important. CSSD leaders cannot be successful unless their department attains its goals, and doing so requires the participation of all managers and other employees with the department, and the thoughtful application of teamwork, communication, accountability, and visibility by department leaders.
CHL Self-Study Lesson Plan Quiz -
Integrative Leadership for Central Sterile Supply
Departments: Part II
Lesson No. CHL 331 (Supervisory Continuing Education - SCE)

1. The concept of workplace diversity celebrates the contribution that every member of the team can make to the CSSD.
   a. True
   b. False

2. Which is not a benefit of diversity?
   a. Persons with diverse backgrounds can generate more creative alternatives when decisions are made.
   b. Entry-level technicians with different backgrounds can see evidence of advancement opportunities.
   c. A welcoming and rewarding work environment will encourage all employees to perform to the best of their abilities.
   d. All of the above are benefits of diversity.

3. The best way to implement a diversity-valuing effort is for top-level administrative officials to require it.
   a. True
   b. False

4. Affirmative action programs are basically the same as diversity-valuing efforts.
   a. True
   b. False

5. Which of the following is the primary goal of affirmative action programs?
   a. Improved productivity
   b. Increased employee morale
   c. Satisfy legal requirements
   d. All of the above

6. Management commitment to developing and implementing quality management systems is not necessary if they are held accountable for doing so.
   a. True
   b. False

7. Which is not true about goals established by CSSD managers?
   a. They must be measurable
   b. Employees should provide input to them
   c. Good managers can plan their goals without input from others
   d. Progress toward goals should be reviewed at least annually

8. Performance appraisal sessions can consider the success of what kind of activities to attain goals?
   a. Historical
   b. Current
   c. Future
   d. A and B above
   e. All the above

9. Incentives for attaining mutually-developed goals are not necessary if a manager is committed to them.
   a. True
   b. False

10. Attainment of challenging goals builds a solid foundation for each manager’s commitment to the CSS department.
    a. True
    b. False

11. CSSD leaders should only act as role models when they want to.
    a. True
    b. False

12. How can CSSD leaders be positive role models?
    a. They can coach, thank and learn
    b. They can follow the rules
    c. They can exhibit desired attitudes
    d. A and B above
    e. All the above

13. Leaders should generally treat others the way they would like to be treated by their own bosses.
    a. True
    b. False

14. The primary reason that CSSD leaders “manage by walking around” is to catch employees doing something wrong so the actions can be corrected.
    a. True
    b. False

15. The best place to start when implementing an integrative management approach is to:
    a. Recognize that its main purpose is to delegate responsibility to entry-level employees
    b. Delegate responsibilities to reduce the CSSD leader’s work load
    c. Recognize and utilize the knowledge, experience and creativity of all employees
    d. Minimize requirements imposed by affirmative action programs

Supervisory Continuing Education (SCE) lessons provide members with ongoing education focusing on supervisory or management issues. These lessons are designed for CHL re-certification, but can be of value to any CRCST in a management or supervisory role.

You can use these lessons as an in-service with your staff, or visit www.iahcsmmm.org for online grading at a nominal fee.
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Monday, April 30
Keynote Address: Amy Roloff

Tuesday, May 1
Exhibit – Balloon Gondola and Learning Annex
Exhibit Hall Box Lunches
Concurrent Session: Around the World in 80 Slides: Focus on CSSD

About Keynote Speaker Amy Roloff
Probably best known as the star of hit TV show “Little People, Big World,” Amy Roloff is also a business woman, farm owner, philanthropist, author and mom. She will speak about life as a little person, overcoming challenges and making a difference in other peoples’ lives.
REGULATIONS ARE MANDATORY LAWS OR RULES, AND MANY HAVE a major impact on the daily activities of Central Sterile Supply Department (CSSD) personnel. Several professional associations develop and promote voluntary standards and recommended practices that provide a foundation for the procedures and protocols used by CSSD personnel. These mandatory regulations, voluntary standards and recommended practices are reviewed in this lesson.

OBJECTIVE 1: DISCUSS REQUIREMENTS OF THE U.S. FOOD AND DRUG ADMINISTRATION (FDA) AFFECTING CENTRAL STERILE SUPPLY DEPARTMENTS.

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FDA-regulated medical devices include the instrumentation, packaging, sterilizers, scopes, quality monitors, and implants processed daily in CSSDs; the level of regulation and monitoring depends upon the medical device classification.

FDA’s policy requires that labeling not contain references to specific diseases or specific microorganisms, unless product lethality has been proven effective by clinical trials. Users should be able to infer the microbiocidal efficacy of a product by examining its FDA-cleared claims for use in sterilization or high-level disinfection.

FDA-regulated medical devices include the instrumentation, packaging, sterilizers, scopes, quality monitors, and implants processed daily in CSSDs; the level of regulation and monitoring depends upon the medical device classification. FDA’s pre- and post-market requirements, including a 510(k) approval for each type of item. Use of a third party reprocessor is also acceptable (with 510(k) clearance).

**Objective 2: Review Occupational Safety and Health Administration (OSHA) Regulations Impacting Central Sterile Supply Departments.** The Occupational Safety and Health Administration (OSHA) protects employees by ensuring a safe work environment. Any substantiated or proven violation of its regulations can yield fines and penalties for the employer. OSHA representatives visiting a facility for a specific reason have the right and obligation to investigate any violation they find.

OSHA has established occupational exposure limits for several agents in chemical sterilants and disinfectants. Employers must ensure compliance with these limits by implementing engineering controls, defining procedures for safe employee work practices, establishing medical surveillance programs, employing methods for monitoring for occupational exposure, providing worker protection, and taking other OSHA-specified measures.

Product manufacturers might be subjected to certain labeling requirements. State and local health agencies also regulate certain aspects of chemical sterilant use and disposal. These regulations must be as stringent as federal requirements, and they are sometimes more stringent. Healthcare personnel should know their state and local obligations regarding storage, use and disposal of these products.

OSHA mandates that manufacturers provide material safety data sheets (MSDSs) for the chemicals they produce, and employers must make them available to employees. The MSDSs provide information about:

- Identification
- Hazard(s) identification
- Ingredient composition
- Containers
- Safe handling
- Exposure controls
- Personal protective equipment
- First aid
- Spill cleanup
- Disposal
- Hazardous waste identification
- Emergency and fire-fighting procedures
- Regulatory information
- Legal information

These MSDSs will clarify the product and its intended purpose and use, the product’s potential health effects and hazards, and the steps that must be taken to protect employees from exposure to the chemical.

OSHA regulations require that employers provide employees with access to MSDSs. Employers are also required to implement training programs, ensure that employees receive and retain copies of MSDSs, and maintain an employee exposure logbook.

Healthcare personnel should be aware of state and local obligations regarding storage, use and disposal of these products. Additionally, they should be familiar with the OSHA regulations for handling and disposing of hazardous materials, as well as the requirements for providing MSDSs to employees.

**Note:** The information provided is for general educational purposes only and should not be used as a substitute for professional medical advice. Always consult with a qualified healthcare provider for specific advice regarding your medical condition.
First-aid measures
Fire-fighting measures
Accidental release measures
Handling and storage
Exposure controls/personal protection
Physical and chemical properties
Stability and reactivity

Toxicological, ecological, disposal, transport, regulatory, and other information is also provided on the MSDS. OSHA requires environmental monitoring of Ethylene Oxide (EtO) and other chemicals. It sets permissible exposure levels for these chemicals, and it specifies record keeping, protective clothing, signage, first aid, and other employee safety requirements. Health care professionals, including those in the CSSD, must also adhere to the OSHA Bloodborne Pathogen Standard, a comprehensive guideline for employee safety in all areas of a health care facility. The Bloodborne Pathogen Standard mandates that employees working in the decontamination room wear appropriate personal protective equipment to protect against exposure to infectious materials.

OBJECTIVE 3: DISCUSS U.S. ENVIRONMENTAL PROTECTION AGENCY (EPA) REGULATIONS OF CONCERN TO CENTRAL STERILE SUPPLY DEPARTMENTS.

The EPA protects human health and the environment. The agency’s goal is to ensure that:

• all Americans are protected from significant risks to human health and the environment where they live, learn, and work;
• national efforts to reduce environmental risks are based on the best available scientific information; and
• federal laws protecting human health and the environment are enforced fairly and effectively.

The EPA implements environmental laws by developing regulations. Often, it establishes national standards that states then enforce with their own regulations. CSSD professionals must be aware that the EPA also regulates ethylene oxide (EtO) under the Federal Insecticide, Fungicide, and Rodenticide Act. One change, effective January 1, 2010, that affected CSSDs was the required phase-out of Oxyfume 2002. Oxyfume 2000, an alternate mixture of Oxyfume, can be used until January 1, 2015, at which time it will also be phased-out (discontinued).

In 2008, the EPA completed a Reregistration Eligibility Decision (RED) for EtO. It permits the continued use of EtO, provided users adopt new risk mitigation measures indicated on EtO labels. Two specific restrictions exist for healthcare facility usage of EtO:

• Sterilization/fumigation with EtO must be performed only in vacuum or gas tight chambers designed for use with EtO.
• After February 28, 2010, a single chamber process is required for EtO treatment (sterilization and aeration are to occur in the same chamber) in hospitals and healthcare facilities.1

The EPA regulates disinfectants used on environmental (housekeeping and clinical contact) surfaces. Manufacturers must test formulations with accepted methods for microbicidal activity, stability and toxicity to animals and humans, and these data must be submitted to EPA with proposed labeling. If EPA concludes a product does not cause unreasonable adverse effects, the product and its labeling receive an EPA registration number. The manufacturer may then sell and distribute the product in the United States.

The following statement appears on all EPA-registered product labels under the Directions for Use heading: “It is a violation of federal law to use this product inconsistent with its labeling.” This means that users must follow the safety precautions and use directions on the labeling of each registered product. The product is considered to be misused if specified dilutions, contact times, method of application, or any other conditions of use are not followed.

OBJECTIVE 4: REVIEW REQUIREMENTS OF TWO OTHER FEDERAL AGENCIES THAT IMPACT CENTRAL STERILE SUPPLY DEPARTMENTS.

The Department of Transportation (DOT) requires formal training of all persons who are involved in the shipping process, including anyone who prepares hazardous items for shipment or prepares shipping documents. Several levels of training are specified, ranging from “general awareness” to “function-specific.” The required training must include safety issues and must be documented. If training records are not complete, the shipper is subject to significant penalties.

The U.S. Centers for Disease Control and Prevention (CDC) promotes the health and quality of life by preventing and controlling disease, injury and disability, and by responding to health emergencies. The CDC collaborates to create the expertise, information and tools required by people and communities to protect their health. CDC personnel accomplish this through health promotion, prevention of disease, injury, and disability, and by responding to new health threats. The CDC develops non-regulatory guidelines based on research and science.

OBJECTIVE 5: DEMONSTRATE HOW VOLUNTARY STANDARDS AND RECOMMENDED PRACTICES INFLUENCE WORK PRACTICES IN CENTRAL STERILE SUPPLY DEPARTMENTS.

The following three voluntary organizations develop protocols that are used by CSSDs:

THE JOINT COMMISSION

The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 19,000 healthcare organizations and programs in the United States. The Commission is accredited by the Commission on Accreditation of Healthcare Organizations (CAHO), a Trombly Systems, Inc. subsidiary.
ASSOCIATION OF PERIOPERATIVE REGISTERED NURSES (AORN)
The Perioperative Standards and Recommended Practices contains the AORN-approved standards, recommended practices, guidelines, and guidance statements. These comprehensive documents reflect the scope of professional responsibility for perioperative registered nurses and provide essential information for the delivery of safe patient care and a safe work environment. They guide perioperative nursing practice, while allowing for flexibility and adoptability in all settings where surgical and other invasive procedures are performed.

IN CONCLUSION
CSSD personnel refer to mandates issued by governmental agencies, and by standards and recommended practices issued by voluntary organizations when policies are developed. These impact the daily work practices in place to provide patients with safe and effective products used in their care.

SUSAN KLACIK, BS, CRCST, serves as the IAHCSMM Representative to the Association for the Advancement of Medical Instrumentation (AAMI), and co-chairs the AAMI Process Challenge Device (PCD) committee. She has more than 30 years experience managing Central Sterile Supply Departments, and currently serves as CSS Manager and CRCST Instructor and Course Director for St. Elizabeth Health Center in Youngstown, OH. Klacik is also a consultant, international speaker and widely published author on sterilization-related subject matter.

ADDITIONAL READING
Association for the Advancement of Medical Instrumentation. Comprehensive guide to steam sterilization and sterility assurance in health care facilities. ANSI/AAMI ST79: 2010

Association for the Advancement of Medical Instrumentation. Chemical sterilization and high-level disinfection in health care facilities. ANSI/AAMI ST58:2005


IAHCSMM acknowledges the assistance of the following two CSSD professionals who reviewed this quiz:

LISA HUBER, BA, CRCST, ACE, FCS; Sterile Processing Manager, Anderson Hospital, Maryville, IL

PAULA VADIVER, CRCST, CIS, CS Technician; Orthopedic Specialist, Anderson Hospital, Maryville, IL

Instrument Continuing Education (ICE) lessons provide members with ongoing education in the complex and ever-changing area of surgical instrument care and handling. These lessons are designed for CIS technicians, but can be of value to any CRCST technician who works with surgical instrumentation. You can use these lessons as an in-service with your staff, or visit www.iahcsmm.org for online grading at a nominal fee. Each lesson plan graded online with a passing score of 70% or higher is worth two points (2 contact hours). You can use these points toward either your recertification of CRCST (12 points) or CIS (6 points).

Mailed submissions to IAHCSMM will not be graded and will not be granted a point value (paper/pencil grading of the ICE Lesson Plans is not available through IAHCSMM or Purdue University; IAHCSMM accepts only online submissions).
1. Regulations are laws or rules that are
   a. mandatory
   b. don’t matter
   c. not enforced
   d. inconsequential

2. Medical devices require ____________ before being marketed.
   a. EPA approval
   b. FDA clearance
   c. OSHA guidance
   d. CDC approval

3. Which government agency regulates high-level disinfectants?
   a. DOT
   b. AAMI
   c. AORN
   d. FDA

4. Which term is not a Spaulding classification?
   a. Critical
   b. Non-critical
   c. Very-critical
   d. Semi-critical

5. The FDA regulates
   a. instrumentation
   b. low-level disinfectants
   c. medical licenses
   d. employee safety

OBJECTIVE 2
6. The purpose of OSHA is to protect
   a. patients
   b. visitors
   c. employees
   d. the environment

7. OSHA has established occupational exposure limits for
   a. agents used in sterilants and disinfectants
   b. sterilization temperatures
   c. employee exposure to stress
   d. sterile storage temperatures

8. The purpose of material safety data sheets (MSDS) is to provide:
   a. information about chemicals used by employees
   b. operating instructions for medical devices
   c. cleaning instructions for medical devices
   d. set assembly instructions for endoscopes

OBJECTIVE 3
9. Ethylene oxide is regulated by which government agencies?
   a. AAMI and FDA
   b. OSHA and AORN
   c. EPA and OSHA
   d. AORN and DOT

10. OSHA requires _______ to protect employees from blood borne pathogens
    a. scrub attire
    b. lead aprons
    c. PPE
    d. respirators

11. The EPA requires EtO aeration to occur
    a. in the sterilizer’s chamber
    b. in the sterilizer’s external room
    c. at an elevated temperature
    d. at a lower temperature

12. The EPA regulates which of the following?
    a. Instrumentation sterilization
    b. Disinfectants for environmental surfaces
    c. Disposable packaging
    d. High-level disinfectants for endoscopes

13. If EPA concludes a product may be used without causing unreasonable adverse effects, the product and its labeling are given ___ before they can be sold.
    a. An EPA registration number
    b. a sales tax code
    c. a license with approval code
    d. two-year testing approval

OBJECTIVE 4
14. The CDC’s role is to
    a. regulate operating procedures for CSSDs
    b. create expertise, information and tools to protect public health
    c. set standard levels for sterilization of medical instrumentation
    d. provide data to meet The Joint Commission requirements

15. Should a Joint Commission survey show failure to meet standards, the hospital can lose accreditation by federal and state governments resulting in
    a. failure to receive required state licenses
    b. increases in facility operating costs
    c. loss of Medicare and Medicaid payments
    d. revocation of physicians’ surgery licenses

16. AAMI develops standards and recommended practices which are the basis of
    a. good practices
    b. revenue enhancements
    c. licensure regulations
    d. surgical procedures

17. The AAMI standards and recommended practices include:
    a. expense reports
    b. implant tracking
    c. regulatory requirements
    d. budgetary concerns

18. AAMI standards are based on
    a. political decisions
    b. costs and technology
    c. current technology, science and consensus
    d. none of the above

19. Which is not an AAMI document for CSSD?
    a. Comprehensive guide to steam sterilization and sterility assurance in health care facilities
    b. Chemical sterilization and high-level disinfection in health care facilities
    c. Ethylene oxide sterilization in health care facilities: safety and effectiveness
    d. Supply forecasts based on standard and planned reimbursements

20. The Perioperative Standards and Recommended Practices contains
    a. AORN approved standards, recommended practices, guidelines, and guidance statements
    b. nursing staffing patterns for normal surgical procedures in the United States
    c. AORN expense practices for allocating patient costs between facility departments
    d. AORN guidelines for manufacture of surgical instrumentation

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Making Introductions, Leaving Lasting Impressions
When I assumed the Media Relations Director position in 2009, I was excited about the many opportunities that would unfold to help spread the word about the Central Sterile Supply profession and IAHCSMM’s leading role in CSSD education, certification and support. I had many ideas on how best to make that happen – yet, despite my enthusiasm, I knew that it would take some time to gain momentum and start reaping the rewards in an obvious and meaningful way.

While it may be true that all good things come to those who wait, I must say that IAHCSMM, its thousands of members and those who comprise the collective CSSD discipline have been fortunate in that it hasn’t taken too long to see marked – and, in some cases, monumental – progress. Some of this progress points to the general public finally becoming aware of the inner workings of the CSSD. The latest media reports, including the February television segments that ran on NBC, have made it clear that the CSSD’s many roles and responsibilities are anything but easy. They also sparked the discussion about why less critical professions require licensure or certification, while similar requirements are absent for those who clean, sterilize, store, distribute, and otherwise manage surgical instrumentation.

Already, these reports – in which IAHCSMM played a key role – have prompted a flurry of follow-up activity. In March, the Center for Public Integrity released a second report to address certification-related activities and legislative initiatives being spearheaded by IAHCSMM, under the leadership of Governmental Affairs Director Josephine Colacci, JD. Even more recently, IAHCSMM was contacted by the editor of Same Day Surgery, and asked to participate in an article on how those in the outpatient surgery setting can achieve and maintain effective instrumentation processing, and promote quality, practice consistency and professional integrity. And, at the time of this writing, IAHCSMM is preparing for an interview with Men’s Health to discuss certification and legislative initiatives, and core responsibilities of CSSD professionals.

Spreading the “Good” Word
It’s important to point out, though, that IAHCSMM and the CSSD had been capturing some much-deserved spotlight long before The Center for Public Integrity and NBC programs ran their reports. Last fall, ECRI Institute, the independent nonprofit that researches best approaches to improving patient care, contacted IAHCSMM to gather expert input for an article on Immediate Use Steam Sterilization. Beyond that, IAHCSMM was also sought to participate in a number of magazine articles, including some published in Healthcare Purchasing News, Infection Control Today, OR Today, and AORN Journal, among others.

This is worthy of mention for a couple reasons: While IAHCSMM has long had a voice in many of these publications, the difference is that we are no longer the only ones spreading the news about the CSSD. Certainly, IAHCSMM’s monthly columns and articles have gone a long way toward promoting the profession and the value of those who comprise it, but the tables are now beginning to turn in an equally important way: others are seeking our knowledge and expertise, and are interested in learning more about the roles, responsibilities, challenges, and successes of the CSSD.
It’s true that contaminated instruments can lead to serious consequences, including morbidity and mortality, but such occurrences are few and far between thanks to dedication from professionals like you – and also because of the strong educational focus and support (not to mention, legislative efforts) being led by IAHCSMM.

Our Media Relations efforts are certainly picking up steam, and I am confident what we’ve seen is really only the tip of the iceberg. Our social media presence is beginning to take off now that we’ve stepped up our Facebook presence, and we’ll be adding Twitter to the mix at the 2012 IAHCSMM Annual Conference. I also smile knowing that the New York Times, Washington Post, Wall Street Journal, Los Angeles Times, Chicago Tribune, and other news giants now have IAHCSMM’s Media Guide on their editors’ desks, so when the next big story makes national news, they’ll know to contact us for quotes or pertinent background information.

The tide is shifting and, so far, it’s been one exhilarating ride!

JULIE WILLIAMSON serves as IAHCSMM’s Media Relations Director and has held the role of IAHCSMM Editor since 1999. She has 16 years of experience writing on topics related to Central Sterile Supply, surgical services, infection prevention, materials management, and healthcare technology for various healthcare trade publications and journals.
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Soon after I watched the February 22, 2012, TODAY Show segment that was prompted by The Center for Public Integrity report “Filthy Surgical Instruments: The hidden threats in America’s Operating Rooms, I had two reactions. First, I thought, “It’s about time. Those of us in the field have been saying this for how many years?” My second reaction was a fear that our profession would no longer be trusted and people may even put off having necessary surgery due to this negative press. My friends and family even said to me, “We aren’t going to have surgery unless we know you have sterilized our instruments.” Of course, I assured them that these stories are the exception and not the rule. I explained that millions of surgeries are performed annually across the nation without incident or resulting infection.

While scrubbing and circulating in the OR, I had many firsthand complaints about our Central Sterile Supply Department. My manager said, “If you have better ideas, why don’t you manage that department?” I took that challenge because I wanted to “fix” the surgical instrument reprocessing problems at my facility. I quickly realized that the problems were not “people problems,” but systems problems related to a lack of resources -- and respect. This was in 1988.

Today, these issues are bigger than ever. We no longer are just reprocessing knives, forks and spoons (as I like to call basic instruments), but very sophisticated devices with multiple parts and long, narrow lumens. Due to the technology explosion, medical devices reprocessed today are much more complicated than ever before, making them almost impossible to clean. We know if it can’t be clean, it can’t be sterilized – period.

As an independent consultant today, I see these same concerns nationally in all types of facilities where medical devices are reprocessed, including CSSDs, traditional operating rooms, ambulatory surgery centers, endoscopy suites, dental offices, physician’s offices, and various other clinics. In my opinion, the real issues are the lack of necessary resources (financial and human), the lack of respect for the responsibilities associated with reprocessing reusable medical devices efficiently and effectively, and poorly designed devices. We need to acknowledge the very important role these professionals have in safe patient care. We must ensure that all the necessary resources are available (including education and training budgets), that compensation matches the responsibilities, and that instrumentation can be easily cleaned.

Seeing the Positives in the (Seeming) Negatives

The adage “every cloud has a silver lining” means every bad situation has some positive points. I have always tried to find the positive when I hear negative things. Personally and professionally, I am glad that this story hit the media and put much-needed attention on these issues.

Reprocessing reusable devices in healthcare facilities has been in the spotlight for the last few years for multiple reasons. There is a national emphasis on reducing healthcare-acquired infections (HAIs) and, in particular, surgical site infections (SSIs). The Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) have recently updated their sterilization guidelines. The Food and Drug Administration (FDA) has sent equipment warning letters to manufacturers.

These spotlights and headlines have spurred a couple of national reprocessing summits. The FDA has put out new draft guidance on device changes that warrant a stricter premarket review. These stories headlined the healthcare world; however, the “Filthy Instruments” investigative report and the follow-up television segments called national attention to
the issues and concerns regarding the cleanliness of surgical instruments. Now that spotlight is much larger and the light is white-hot.

This white-hot attention can be the silver lining to help “fix” the complicated and multifaceted issues that contribute to instrument reprocessing problems. The phrase “first do no harm” from the Hippocratic Oath should be the mantra for every healthcare provider, whether you are a physician, nurse, technician, or administrator. Therefore, we must put emphasis and resources toward the efforts to reprocess efficiently and effectively. We need leaders with autonomy and authority, and who motivate, educate and ensure competency. We also need adequate compensation and respect for the responsibility of reprocessing.

If you are fortunate enough to attend the IAHCSMM Annual Conference and Expo in Albuquerque, I urge you to soak in all the knowledge you can, look for any new technologies that will help make reprocessing safer, and talk to your peers about their successes and efforts toward reducing HAIs and SSIs. You now have the white-hot attention of every perioperative professional, infection preventionist, risk manager, safety officer, and administrator. Use this silver lining to get the resources you need at your facility.

When you return home from the IAHCSMM Annual Conference, I challenge you to share the information and education you learned – not just with your coworkers, but also with your peers in the OR, your infection preventionist, risk manager, and administration. After all, we all own a part of infection prevention.

ROSE SEAVEY MBA, BS, RN, CNOR, CRCST, CSPDT is the President/CEO of Seavey Healthcare Consulting, LLC, and formerly the Director of the Sterile Processing Department at The Children’s Hospital of Denver. Ms. Seavey served on the Association of periOperative Registered Nurses (AORN) Board of Directors from 2008-2010. She was honored with AORN’s award for Outstanding Achievement in Mentorship in 2012 and the Outstanding Achievement in Clinical Nurse Education in 2001.
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In his opening speech at the 12th Congress of the World Forum for Hospital Sterile Supply (WFHSS), Wim Renders, President, said that the Portuguese conquerors were the first to have crossed the oceans, thus paving the way for exchange between continents. On this occasion, the WFHSS continued this exchange in Portugal itself, welcoming some 800 delegates.

Training – A Vital Foundation

Elaine Pina reported on the first training initiatives in Portugal. Medical device reprocessing has, in the meantime, emerged into the light and is now certified. Gillian Sills, who had helped conduct the first course in Portugal in the mid-1990s, reported on her many years’ experience and advocated that endoscope reprocessing should also be performed by specialist staff in the sterile supply department. She asked whether in principle reprocessing had to be carried out by nurses. After all, reprocessing calls for a vast amount of technical knowledge.

Valeska Stempliuk, hygiene specialist at the Panamerican Health Organization (PAHO), spoke about the challenges posed by reprocessing in the 21st century. The quality and safety of reprocessing varies greatly from one country to another, and even within the same country very different conditions prevail. Stempliuk stated that this made it difficult to observe national and international standards and recommendations. In a study conducted some years ago in 67 hospitals in seven countries, PAHO had noted that 88% did not fully comply with the recommendations. Shortcomings were found, especially with regard to control activities and preventive equipment maintenance. The standard of staff training is also by no means uniform.

Ana Paula Cotinho elaborated further on the topic of reprocessing with limited resources, asking at the outset what factors were really essential for reprocessing. There is often an imbalance between the technical fittings and essential requirements because what use are the best machines if, for example, there is no running water. In principle, the safety of patients has to be assured from start to finish of a procedure, and that applies in poor as well as rich countries. Hence, staff training is essential and also has to be tailored to the respective conditions to assure the reprocessing quality.

Cleaning – Manual, Automated

Anke Carter from Germany reported on the current stage of drafting of a guideline for standardized manual reprocessing. The aims of the working group were as follows: to provide documentary materials for formulation of user-specific SOPs and issue recommendations for validation of manual working steps.

One point that is often overlooked is the time investment needed for manual cleaning and its verification, if it is to be properly done.

Carter gave an overview of the investigations conducted so far, which showed that, inter alia, the cleaning results were markedly better when using ultrasound. That was so was demonstrated by Robert Mettin of Germany in his talk on the secret life of (ultrasound) bubbles. To use ultrasound for reprocessing, it is necessary to know and appreciate some of the fundamental effects of ultrasound, so as to be able to derive optimal benefit and avoid impeding its action. Mettin explained that, because of the difficult reproducibility and manifold nature of effects unfolding in an ultrasonic basin, it was virtually impossible to achieve standardization.

Christine Denis from France reported on her experiences of the effects of detergents on the material polyoxymethylene (POM), which was used e.g. in numerous instruments in orthopaedic surgery. In view of the new French regulations for dealing with prions, various alkaline detergents were tested and the reprocessing cycle adapted to the new provisions. Following this, white residues appeared on instruments made of POM. It was revealed that approximately three to four weeks later the POM contained in instruments from various loaned sets had been destroyed by the new reprocessing method. An investigation revealed that the interaction between detergents, acidic neutralization agent and the heat generated when drying had triggered material destruction. Further tests and clear specifications – as well as, if possible, replacement of such materials – are needed.

Lumens and Other Challenges

Diana Bijl from the Netherlands outlined the difficulties encountered when reprocessing MIS instruments. Such instruments are characterized by their delicate nature and presence of several lumens,
joints, cables, and similar components that are difficult to reprocess. When using special MIS trolleys for washer-disinfectors (WDs), the loading patterns used at the time of validation have to be observed. Otherwise, adequate flow cannot be guaranteed. Additional manual pre-cleaning is needed for instruments of intricate design. Bijl stated that the results could be improved by brushing and using ultrasound. There are major differences in how cleanliness is defined in various countries. Bijl went on to say that uniform definitions and test procedures were urgently needed.

Hervé Ney from Geneva, Switzerland, described his investigations into lumened instruments, in this case, needles used for liposuction. These had been contaminated with a test soil and after undergoing various cleaning steps, the lumens were checked with a device used to inspect optics and cold-light cables. It was revealed that none of the methods used to clean the needles was able to do so without leaving residues. Hence, the needles investigated did not lend themselves to reprocessing and should be replaced by disposable products.

**TRACKING SYSTEMS – REDUCING THE ERROR RATE**

In a session on the topic of tracking, Christina Rato reported on her experiences. Modern tracking systems make it easier to keep sight of things and deal with quality management since all instruments and reprocessing steps can be tracked and visualized via the system. Details of orders and repairs can be stored here. It also makes it easier to provide information updates to staff, which can be made accessible to everyone via the system.

Christophe Lambert from France demonstrated how tracking could be used in an individual case. Lambert stressed that the automation achieved thanks to tracking systems helps reduce error rates, since the influences of the human factor are minimized. Lambert explained the features of various marking systems (engraving, laser). A study of the legibility of codes demonstrated that this legibility was not equally good or equally durable in all marking systems.

**HOW AND FOR HOW LONG DOES STERILE REMAIN STERILE?**

Several lectures focused on the ambient conditions prevailing in a reprocessing unit and on storage of sterilized supplies. Manuela Cano spoke about controlling environmental factors. She outlined how a sampling policy could be devised and adapted to specific requirements. These requirements had to be stipulated on the basis of risk analysis. Microbiology testing of particularly critical points ought to be integrated into routine tests.

Terry McAuley from Australia devoted her talk to temperature and humidity specifications for medical device stores. In the case of extreme temperatures, some air conditioning systems are not able to meet the specified conditions. A high burden of microorganisms, in general, also poses a higher risk of contamination of packaging. Humidity is conducive to entry of microorganisms. It has to be observed that major temperature differences within a short period of time (e.g. on switching off air conditioning systems at night) leads to condensation. The ambient pressure is also important because packaging “breathes.” Greater differences in pressure can arise during transport (e.g., in an elevator).

It is difficult to make evidence-based statements about packaging, and different approaches are used in different countries. In any case, daily checks and recording of conditions are recommended.

**NEW STERILIZATION METHODS**

Alberto Bertucco from Italy reported on investigations into a novel sterilization method using supercritical carbon dioxide (CO2). This CO2 can penetrate into the cell wall of microorganisms and reduce viable forms by > 6 log levels. The exact mechanisms of action have not yet been fully elucidated. Bertucco said that on its own, supercritical CO2 was not enough for sterilization since it did not kill spores. But in any case, it could potentiate the action of hydrogen peroxide (H2O2).

**PSYCHOSOCIAL RISK FACTORS**

Marisa Salanova, a psychologist from Spain, described stress factors in the workplace. Not only excessive work demands, but also boredom and lack of challenge, can create problems. In a reprocessing department, the confined spatial conditions and lack of professional recognition can also become an issue. Salanova described strategies for coping with such stress factors. Employees’ self-confidence had to be reinforced, and attention paid to achieving a harmonious work-life balance, she noted.

In his lively talk, João Leite, a psychologist from Portugal, spoke about training methods. He gave an insightful portrayal of the possible forms of interactions between trainer and audience. It is important to impress upon participants why continuing professional development (CPD) is needed. This CPD should be tailored to existing problems and the...
latter converted into requirements that can be met. Accentuating employees’ skills was, thus, as important as ensuring their involvement in the training process because, to cite Leite, “The more I try to teach, the less they learn.”

AIR MOVEMENT – IMPLICATIONS FOR CONTAMINATION

In the final session of the congress, Berit Reinmüller and Bengt Ljungqvist from Sweden spoke about airborne contamination. Distribution of such contamination depends on the magnitude of the source and on the room volume. The latter factor is decisive because with a smaller room the concentration can be essentially higher despite using similar air exchange rates. Microorganisms eventually spread throughout the entire room and are not confined to “arm’s length.” Besides turbulence and obstacles (persons) which can cause reversal of the direction of flow, body heat also plays a role, causing the air – with its microbial burden – to rise upward.

Doors represent a problem in the everyday setting, especially if the OR opens immediately onto a corridor, where there is also a temperature difference. Opening of the door can then cause turbulence and significantly increase the microbial burden.

Reinmüller elaborated in greater detail on the role of clothing. The ability of different materials to prevent microbial release varies. Textile clothing, which continues to be widely used in Sweden, in a new state releases only around 1.7 colony forming units (cfu) per second, and that figure rises after 50 washes to 29 cfu per second. Very good values are achieved only with OR clothing that covers the entire body, including protective overshoes.

This year, the WFHSS will meet in Osaka, Japan, where the next world congress is scheduled to take place November 21-24, 2012.

For the full article, please contact zentrsteril@mhp-verlag.de

DR. GUDRUN WESTERMANN serves as Production Editor for the German journal Zentralsterilisation Central Service.
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AFTER YEARS OF SPECULATION and controversy, we now have a concrete, well-defined definition of Immediate Use Steam Sterilization (IUSS). For years, the term “flashing” has been overused and misused by CSSD personnel, O.R. staff and sales representatives, and this new term better describes and defines the intended use of the process.

As consultant Rose Seavey, MBA, BS, RN, CNOR, CRCST, CSPDT, noted, “the process of IUSS is efficacious, if and only if all of the critical steps of cleaning, decontaminating and aseptic transportation accompanying the sterilization cycle.”

We must also have written instructions from the instrument manufacturer that not only instruct us on how to disassemble, clean and reassemble the device, but also state that IUSS may be utilized in the sterilization process.

No agency or organization has instructed us to stop the practice of immediate use sterilization. Instead, we have been instructed to follow the manufacturers’ Instructions for Use (IFU). We have further been tasked with reducing our dependence on and inappropriate overuse of IUSS.

DRIVING BETTER PRACTICES
Reducing IUSS improves quality and safety, and reduces risk to the patient. Many people claim it is not possible to reduce IUSS and some say they would like to limit its use, but staff won’t cooperate. But the good news is we all can make it happen. It has been and is being done. I have personally seen a 30% decrease in my own facility this year alone.

How do you make it happen in your own facility? First, the CSSD and O.R. managers must both be mutually supportive and committed to the mission of decreasing the use of IUSS. We must send the right message to our staff and to the O.R. staff. We must ensure that our message was received and then clarify any inconsistencies that may arise. It is essential that everyone understand the process and the reason for change. We must have a common understanding of the vision of process improvement, and all staff must be driven to make this cultural change if we are to be successful.

INVEST IN SUCCESS
A successful IUSS reduction strategy begins with the CSSD staff, but then directly includes the O.R. staff, as well. CSSD staff must all be able to thoroughly understand and explain the need for this process change. If the CSSD staff are not all on board, it will be difficult, if not impossible, to be successful with surgeons and other O.R. staff.

Engaging the workforce is a vital step. We can’t just tell them that there is going to be a process change and expect it to be greeted with open arms and active participation. Instead, we must explain, in detail, the science behind the sterilization process – and this must not be a one-time discussion. Success will require repeated exposure to the information. Use every tool at your disposal to get the information to sink in; for visual learners, use posters and “cheat sheets,” for example. For auditory learners, consider using mini lectures or short presentations during staff meetings. Whichever approach is taken, don’t confuse them with jargon or overwhelm them with too much information at once. Take your time and feed them slowly and frequently. This will allow your staff to digest and process the information, and formulate questions, if necessary. They will get it and you will have a successful process improvement as a result.

It’s also important to teach what goes on inside the autoclaves. This means describing the differences in IUSS and the use of a standard sterilization cycle, and making sure they understand the requirement to strictly adhere to the manufacturers’ IFUs. Once staff is on board with the new process, the next step is training.
the sales representatives and surgeons. Be sure to notify all sales reps that the practice of “forgetting” to drop off “just these two instruments that Dr. X has got to have” has ended. When they tell you to “Just flash this for me, it’s only one instrument,” you should introduce your new process and explain that your facility will no longer be able to accommodate their “flashing” requests. Explain that IUSS is truly for emergencies only and forgetting to bring in an instrument on time does not constitute an emergency. Let them explain to the surgeon why there will be a delay in their case while the “forgotten” instrument is properly processed and sterilized. It will amaze you how quickly this practice will cease when you refuse – and when the sales reps are required to explain their ineptitude to the surgeons.

And don’t forget to involve the surgeons in the change, either. When they understand how IUSS affects patient safety and infection risk, they will cooperate with your efforts to provide a safe and quality product. Don’t expect them to jump on board quickly when you inform them that their turnaround times are going to increase or that their cases may be delayed, however. This might take time. Educate them on the need to stop the routine use of IUSS and the science behind your decision. Notify them in writing or face-to-face, but inform them! You need them on your team. They want to do what is right for the patients under their care and they do not want to put them at unnecessary risk. Ultimately, they will appreciate your efforts to protect their patients.

Once you have educated CSSD staff, O.R. staff, sales representatives, and surgeons, set your start date to effect the process improvement. If needed, reprogram your autoclaves to restrict the available cycles for use. Stick to your start date and stick to your guns. You will be challenged and tested, but don’t give in – not even once. Believe in your decision to make this process change and stand your ground. Then sit back and watch your IUSS rates plummet and take pride in knowing that you have made a process improvement that positively affects the quality of the healthcare your facility provides for its patients.

REFERENCES

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**Q** We are looking to purchase an instrument demagnetizer but are having difficulty finding one. Can you help?

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**Q** Why are small facilities held to the same sterilization standards as large facilities? Small facilities often do not have the resources to meet those standards.

**A:** I would follow up this question by asking, “Should patients expect a different standard of care in a smaller facility than in a larger one?” Sterilization is a science and it does not change depending upon the location where it is performed.

I do understand that changes can be difficult, especially when they require resources (financial and human) that are not easily approved in today’s budget-conscious environment. Be sure to keep your administration informed of changes in requirements that will require changes in your work areas and work practices. Share documents and articles and invite administrators to observe your work area and work practices to help them understand changing needs. Their support should help you overcome many of the challenges you will face in regard to evolving standards.

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THE ASSOCIATION FOR THE Advancement for Medical Instrumentation (AAMI) has released a new update to the Technical Information Report (TIR) 30: compendium of processes, materials, test methods, and acceptance criteria for cleaning reusable medical devices. This manufacturer document discusses the validation of cleaning processes for medical devices that are intended and labeled by the manufacturer for reprocessing and reuse.

UPDATES ON 2011 AAMI/FDA SUMMITS ON REPROCESSING OF MEDICAL DEVICES
In 2011, AAMI and the US Food and Drug Administration (FDA) held summits on the reprocessing of medical devices to ascertain the issues facing healthcare facilities. Through these summits some solutions were identified to resolve the problems encountered in healthcare facilities. On February 14 through 16, 2012, AAMI held task group meetings to begin these resolutions. The goal of these new working groups is to develop new TIRs for Standardizing Instructions for Use (IFU), Processing of Flexible and Semi-Rigid Scopes, and Human Factors for Device Reprocessing. These groups assembled to begin working on the new documents. This work will continue during regular upcoming committee meetings. These documents are briefly described below:

STANDARDIZED INSTRUCTIONS FOR USE (IFU) FOR MEDICAL DEVICES
This TIR is to provide standardized cleaning processes that manufacturers can use in their IFU for medical devices. These standardized IFUs will be consistent with the recommended practices in ANSI/AAMI ST79: Comprehensive guide to steam sterilization and sterility assurance in health care facilities and will be consistent with the practices utilized in healthcare facilities to enable Central Sterile Service Departments (CSSD) to standardize their processes.

Currently, there are several different manufacturers of the same basic instrument pattern, each with different IFUs. Instruments may be in sets, which may contain from one to 100 instruments. Another problem is that some IFUs are confusing and have very narrow processing parameters, which results in an unmanageable process. Manufacturers are not familiar with the processes in the CSSD and, therefore, the IFU they develop are not consistent with ANSI/AAMI ST79, which reflects the practices in CSSD. The purpose of this New Work Proposal is to provide standardized cleaning guidelines for basic instrumentation, so that the manufacturers’ IFUs are consistent with the practices in CSSD.

PROCESSING OF FLEXIBLE AND SEMI-RIGID SCOPES
This document will address both flexible and rigid endoscopes. It will provide guidance on all phases of endoscope processing – from transporting used and clean scopes to their cleaning, high level disinfection and/or sterilization. Specific information will be included on the design and function of these devices, as well as a quality system for processing. Flexible and semi-rigid scopes have been the focus of numerous nosocomial infections (which have been well documented in the literature). These devices are very expensive and difficult to clean. This document will provide an excellent resource to healthcare professionals processing these scopes. This document will be directed to Perioperative Services Managers, Ambulatory Care Managers, GI Lab Managers, and CSSD Managers.

HUMAN FACTORS FOR DEVICE REPRESSING
The Human Factors for Device Reprocessing document is being developed to provide guidance for reusable medical device manufacturers’ Instructions for Use.
This document will address the information that manufacturers should provide to those healthcare personnel responsible for cleaning reusable devices – to ensure that they have the instructions needed to clean the reusable medical devices in a safe, effective and timely manner.

Comments from the AAMI/FDA Reprocessing Summits included the fact that poor IFUs frequently lead the user to perform unnecessary time-consuming and repetitive steps that may possibly be skipped or avoided, thereby, leading to incomplete cleaning of the device. Cleaning reusable devices is a very important first step in reprocessing medical devices. Improperly cleaned reusable devices compromise the disinfection or sterilization of the reusable device.

This document will address environmental and personnel considerations, equipment availability, learning modalities, user capabilities/age/experience, as well as impacts of physical limitations, such as PPEs, training materials, instructions, validation in different settings, and best practices for presenting instructions in multiple languages.

SUSAN KLACIK, BS, CRCST, serves as the IAHCSMM Representative to the Association for the Advancement of Medical Instrumentation (AAMI), and co-chairs the AAMI Process Challenge Device (PCD) committee. She has more than 30 years experience managing Central Sterile Supply Departments, and currently serves as CSS Manager and CRCST Instructor and Course Director for St. Elizabeth Health Center in Youngstown, OH. Klacik is also a consultant, international speaker and widely published author on sterilization-related subject matter.
You mentioned in a previous column that you would be adding some new legislative tools to the website. Have those tools been added yet? If so, what are they – and how will we benefit from them?

A: Yes, the new tools have been added to the website! Here’s how to find them: From the IAHCSMM home page, click on the “Government Affairs” drop down menu and then click on legislative tools. Under Certification Resources, I added an example of a memo of support that we are using for our certification bill in New York. It demonstrates how we are explaining the certification issue to legislators.

Another newly-added document is How a Bill Becomes Law in the States. This time, instead of trying to explain it in words, I used pictures. As you will see, there are many steps that a bill must pass before it becomes law. I’m sure this pictorial will bring back memories of your high school government/civics class.

Additionally, I created a Grassroots Handbook for members. This handbook discusses what grassroots is, how a bill becomes law, the steps we are taking for our certification efforts, an example of an action alert email that includes screen shots of an actual action alert, and do’s and don’ts when meeting with elected officials. It is my hope that this handbook will provide members with a user-friendly guide of how we are approaching the certification issue. Please take a moment to review the document.

I hope that you will find these tools helpful as we move along in introducing certification legislation across the country.
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I DISCOVERED SOMETHING INTERESTING when I first started writing fiction. The more I developed a character, the more he would develop a mind of his own about what he would or would not do. Many times, a direction I initially imagined the character would take was no longer possible based on the character’s values. If I tried to force it, it would seem contrived, and the reader would no longer find my character believable.

When that happens, I either have to rework my character or change the direction of my plot. If I don’t, my reader will lose interest and put down the book. And that is the last thing I want.

Later on in life, I was shocked to learn there was something else creating the motivation for my characters—my subconscious.

Sometimes a writer’s stories are guided by his deepest unsatisfied needs. I’m not talking about the fact that most first novels are biographical and written from an author’s own experience and knowledge. I’m talking about how his unresolved issues, ones that hark back to his childhood, will emerge as traits in his characters. What shocked me when I recently revisited some of my earliest writings was that I, too, had done this.

I first read about this in the book, “The Body Never Lies: The Lingering Effects of Hurtful Parenting,” by psychotherapist Alice Miller. She writes of how the pain and suffering parents inflict on their children is retained in the psyche of the individual into adulthood. When the adult continues to repress the trauma he or she received, it causes illness. She illustrates this point by comparing the lives and work of several famous writers. She notes that, despite these writers’ attempts to suppress their memories of being abused, the need to address their suffering and deal with it tends to emerge somewhere in their writing.

According to Miller, most people feel bound by the commandment to “Honor thy mother and father,” despite how badly they were treated by their parents. Many of us, because of the love and caring we also received from our parents, suppress the memories of their mistreatment. Suppressing those memories causes stress to our bodies, and stress eventually causes illness.

According to David Eagleman, a neuroscientist and author of “Incognito: The Secret Lives of the Brain,” your brain does not like to keep things secret. He says your brain also does not like stress hormones. When you keep something secret, it increases the level of stress hormones in the body. The stress is created by the infighting between the part of your brain that wants to keep the secret, and the part that wants to reveal it. If you tell the secret—even by writing it in a private journal or sharing it in privileged conversation with a doctor or lawyer—it relieves its burden on your brain.

After reading those two books, I went back and reread an unpublished novel I
wrote in my twenties. I recognized that the traits I gave to the main character’s father resembled those of my mother. As a child, I was alternately abused or engulfed by my mother.

As adults, my sister and I have joked that we never understood the proverb, “Don’t cry over spilt milk” because, as children, we literally always cried over it because my mother would punish us severely for even accidentally spilling some on her clean floor. Subsequently, the father character in my book would beat his teenage son and scream at him for the mildest of infractions or accidents.

As a teenager, I found that I was enamored of my friend’s mother. She was always gentle and calm. Even though she had five boisterous kids, she never lost her temper. I enjoyed hanging out at my friend’s house instead of mine because of the fear-free environment created by that woman. In my teenage opinion, she was the ideal mother – the one I wished I had. My mother’s name was Barbara, so I would refer to my friend’s mom as the Anti-Barbara.

In my novel, an abused teenager found a replacement father-figure in a boy three years older than himself who never bullied him and always treated him with respect. When I re-read my book, I recognized my friend’s mom.

After my divorce, I went into therapy to understand the roots of my depression, which seemed to go beyond losing my spouse. I learned that many of my issues were fallout from the abuse I suffered as a child. With that knowledge, I believe I can now go back to that novel I wrote so many years ago and rework the traits of my characters to make them more believable.

In revisiting my early work, I realized that in writing it, I was motivated by unresolved issues in my past. I was unconsciously expressing the effect my childhood trauma had on my life. What unresolved issues are unconsciously motivating your actions and directing your life?

ROBERT EVANS WILSON, JR., is an author, humorist and innovation consultant. He works with companies that want to be more competitive and with people who want to think like innovators. For more information on Robert, please visit http://www.jumpstartyourmeeting.com.
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86 Communiqué MAY / JUNE 2012 www.iahcsmm.org
How Can a Small Card Work the Same as a Large Bowie-Dick Test Pack?

Scientific technology has allowed many products, for example, computers, cameras and Bowie-Dick test packs to be reduced in size yet function better than the preceding products. The original Bowie-Dick pack consisted of cloth towels stacked 11-inches high. Disposable Bowie-Dick packs made of paper were invented in the early 1980’s. They were 2% the size of the original towel packs. The new “Green Card” by SteriTec is the next step in the evolution. It is about 1% the size of current disposable Bowie-Dick packs.

10 Bowie-Dick Packs

Save Money. Save Space. Save the Planet.

1 Towel Pack

One tree = approximately 100 pounds of paper
One Bowie-Dick Pack = .25 pounds of paper
One year supply of Bowie-Dick Packs = 90 pounds of paper
One year supply of Bowie-Dick cards = 1.32 pounds of paper

Switching to The Green Card will save approximately one tree per year of usage.

30 Green Cards

Scan the Tag for a Video Demonstration
Get the free mobile app: getscanlife.com

SteriTec ♦ info@steritecproducts.com ♦ www.steritecproducts.com ♦ 1-866-480-0255
The following are New CRCST, CHL, CIS, CCSVP, Provisional CRCST and
New Members from 1/1/2012 to 2/29/2012 (information current as of 3/1/2012, as submitted on application)

**ALASKA**

**NEW CRCST**

- Joel Del Mundo, CS Tech - Providence Alaska Medical Center
- Thyda Lor, CS Tech - Providence Alaska Medical Center
- Xien Mai, CS Tech - Providence Alaska Medical Center
- Sokheng Phal Meas, CS Tech - Providence Alaska Medical Center

**NEW CHL**

- Tina Matthews, Coordinator - St. Vincent Infirmary Medical Center

**NEW CRCST**

- Megan Abrams, Team Leader - Mobile Infirmary Medical Center
- Timothy Gosdin, CS Tech - Surgical Solutions, LLC
- Tyler Kirkland, CS Tech - Surgical Solutions, LLC

**NEW CHL**

- Donald Turner, RN - Provisional Certification

**NEW CHL**

- Stanley Landrum, Supervisor - Southern Hills Hospital
- James Navarro, CS Tech - Banner Estrella Medical Center

**NEW CRCST**

- Keith Jennings, CS Tech - Banner Estrella Medical Center
- Mark McCay, CS Tech - Carondelet St. Joseph’s Hospital
- Phelan Parker, CS Tech - Flagstaff Medical Center
- Loreinne Romero Adame, CS Tech - Mayo Clinic Arizona
- Kristena Schenkel, CS Tech - St. Joseph’s Hospital & Medical Center
- Brandon Waggle, CS Tech - Scottsdale Healthcare - Shea Medical Center

**NEW MEMBER**

- Terre Simons, CS Tech - Western Arizona Regional Medical Center

**CALIFORNIA**

**NEW CIS**

- Jamael Abily, SPD Tech - Clovis Community Medical Center
- Abigail Araiza, CS Tech - San Joaquin General Hospital
- Jerrod Cox, CS Tech - Tri-City Medical Center
- Jenny Fernandez, CS Tech - Community Medical Centers
- Michael Munetta, CS Tech - Children’s Hospital Central California

**NEW CRCST**

- Sukhpal Aguilar, CS Tech - St. Mary Medical Center
- John Alba, CS Tech - Scripps Health - Mercy SD
- Jacqueline Baker, CS Tech - Kaiser Downey Medical Center
- Kayla Bangs, Supervisor - Providence Tarzana Medical Center
- Alexander Bareng, CS Tech - El Camino Surgery Center
- Timothy Barragan, CS Tech - St. Jude Medical Center
- Emily Bayot, CS Tech - Scripps Health - Mercy SD
- Benigna Canta, CS Tech II - Kaiser Foundation Hospital–San Francisco
- Brian Chao, CS Tech - Kaiser Permanente Hospital
- Lisette Contreras, CS Tech - Riverside Community Hospital
- Eric Davidson, CS Tech - Scripps Memorial Hospital La Jolla
- Efren De La Rosa, CS Tech - Scripps Health - Mercy SD
- Charles Elsberry, CS Tech - Sutter General Hospital
- Anishia Finley, CS Tech - Children’s Hospital & Research Center Oakland
- Walter Flores, CS Tech - Children’s Hospital-Los Angeles
- Ulrike Fosselman, CS Tech - Scripps Memorial Hospital La Jolla
- Lydia Garcia, Aide - Marion Medical Center
- Rodel Geronimo, CS Tech - Scripps Memorial Hospital La Jolla
- Dana Gould, CS Tech - St. Joseph’s Medical Center
- Brittany Grace, CS Tech - Aspen Surgery Center
- Jennifer Hollowell, CS Tech - Scripps Memorial Hospital La Jolla
- Roger Holmes, Equipment Tech II - John Muir Health
- Jan Idos, CS Tech - Scripps Memorial Hospital La Jolla
- Christian Jacot, CS Tech - Sutter Delta Medical Center
- Christian Jana, CS Tech - Scripps Health - Mercy SD
- Ysidro Jeanopolous, CS Tech - Scripps Health - Mercy SD
- Virendra Jetalpuria, CS Tech - St. Joseph Hospital
- Antony Joseph, CS Tech - Sutter General Hospital
- Anthony Kahana, CS Tech - Department of Veterans Affairs - Long Beach
- Katherine Kelly, CS Tech - Scripps Memorial Hospital La Jolla
- Mark Kennedy, CS Tech - Scripps Memorial Hospital La Jolla
- Eino Kvisto, CS Tech - Fresno Heart & Surgical Hospital
- Tresia Klug, CS Tech - Surgical Center of San Diego
- Benedick Malonzo, Coordinator / Ortho Tech - Hoag Orthopedic Institute
- Lindsey Matheson, CS Tech - Alta-Bates Summit Medical Center
- Hana Mekonnen, CS Tech - City of Hope
- Marjorie Meyer, CS Tech - Valley Surgery Center
- Maria Navarro, CS Tech - Rady Children’s Hospital
- Rebeca Olivas, CS Tech - Children’s Hospital-Los Angeles
- Anton Pearson, CS Tech - Hacienda Surgery Center
- Thalia Pesquera, CS Tech - Scripps Health - Mercy SD
- Larry Price, Asst. Chief - Department of Veterans Affairs - Mather
- Jose Racela Jr., CS Tech - Department of Veterans Affairs - Long Beach
- Juan Ramirez, CS Tech - Scripps Memorial Hospital La Jolla
- Silvia Ramos, CS Tech - St. Joseph Hospital
- Laura Ray, CS Tech - Riverside Community Hospital
- Naomi Rogers, CS Tech - Bakersfield Memorial Hospital
- Joseph Russo, CS Tech - Verdugo Hills Hospital
- Stephen Seufert, CS Tech - Kaiser Permanente
- Bernice Syss, CS Tech - Aspen Surgery Center
- Danieca Sykes, CS Tech - Scripps Memorial Hospital La Jolla
- Jessie Tenorio, CS Tech, Kaiser Foundation Hospital - San Diego
- Christopher Terry, CS Tech - Olympia Medical Center
- Betty Tyler, CS Tech - Kaiser Foundation Hospital - South San Francisco
- Marcela Vesely, CS Tech - Providence Holy Cross Medical Center
- Marlon Vinluan, Data Specialist - Stanford Hospital & Clinics
- Veulah Wafer, CS Tech - North Point Surgery Center
- Nicole Watson, CS Tech - Scripps Health - Mercy SD
- Alexander Wori, CS Tech - Aspen Surgery Center

**NEW MEMBERS**

- Sukhpal Aguilar, CS Tech - St. Mary Medical Center
- John Alba, CS Tech - Scripps Health - Mercy SD
- Jacqueline Baker, CS Tech - Kaiser Downey Medical Center
- Kayla Bangs, Supervisor - Providence Tarzana Medical Center
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- Eric Davidson, CS Tech - Scripps Memorial Hospital La Jolla
- Efren De La Rosa, CS Tech - Scripps Health - Mercy SD
- Charles Elsberry, CS Tech - Sutter General Hospital
NEW CERTIFICATION AND MEMBER LISTINGS

NEW PROVISIONAL CRCST
Elpidio Asuncion Jr., CS Tech - Provisional Certification
Noe Diaz, Student - Provisional Certification
Julia Duran, Student - Provisional Certification
David Enkhorn, Student - Provisional Certification
Gina Guaracha, Student - Provisional Certification
Richard Heine, CS Tech - Provisional Certification
Maria Humdon, Student - Provisional Certification
Thea Johnson, CS Tech - Provisional Certification
Maria Teresa Liwanag, Student - Provisional Certification
Stephany Medeiros, Student - Provisional Certification
Moses Osaghae, Student - Provisional Certification
Francisco Pozo, Student - Provisional Certification
Marian Redondo, Student - Provisional Certification
Cynthia Ticsay, Student - Provisional Certification
Ryan Walters, Student - Provisional Certification
Vasanthi Wijetunge, Student - Provisional Certification

COLORADO
NEW CIS
Tara Grosboll, CS Tech - Medical Center of the Rockies

NEW CRCST
Matthew Berndt, CS Tech - Prowers Medical Center
Kimberly King, CS Tech - Memorial Health System
Julian Long, CS Tech - Kaiser Antioch Medical Center
Maria Manzanares, CS Tech - Penrose Hospital
Felicia Rodriguez, CS Tech - Not Currently in a CS Department
Vincent Tischler, Instrument Tech - Exempla Saint Joseph Hospital
Gloria Werner, CS Tech - Summit View Surger Center

NEW MEMBER
Karen Homrich, Instrument Tech - Kaiser Permanente
Josh Townsend, CS Tech - Gunnison Valley Hospital

CONNECTICUT
NEW CRCST
Maria Bastos, CS Tech - Waterbury Hospital
Matthew Baxter, CS Tech - UMASS Memorial
Luis Gonzalez, CS Tech - Waterbury Hospital
Arisa Hardy, CS Tech - Hospital of St. Raphael
Timothy Holmes II, CS Tech II - Lawrence & Memorial Hospital
John Riccio, CS Tech - Waterbury Hospital
Evelyn Torres, CS Tech - Waterbury Hospital

NEW MEMBER
Jacque Barker, Clinical Coordinator - Lawrence & Memorial Hospital
Robin Groux, Nurse Manager - Lawrence & Memorial Hospital

DISTRICT OF COLUMBIA
NEW CRCST
Jesse Morris, Sanitation Assistant - Children’s National Medical Center

DELEWARE
NEW CHL
Franklin Lindsay, CS Tech - Alfred I. Dupont Hospital for Children

NEW MEMBER
Betty Warren, Instrument Tech - Delaware Outpatient Center for Surgery

NEW PROVISIONAL CRCST
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Richard Hudson, Instrument Specialist - Miami Children’s Hospital
Pedro Infantes, CS Tech - Villages Regional Hospital
James Jones, Lead Tech - Mayo Clinic-Jacksonville
David Kain, CS Tech - Outpatient Center at The Sanctuary, The
Gary Kish, Instrument Tech - Gulf Coast Hospital
Fredrick Llenares, CS Tech - University Community Hospital
Latoya Portee, CS Tech - Sarasota Memorial Hospital
Stephanie Swain, Med Supply Tech - Department of Veterans Affairs - Pensacola
William Wootten, CS Tech II - Tampa General Hospital

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David Jones, Sterile Processing Coordinator - West Florida Hospital
Dale Knight, Educator, Sterile Processing - Tampa General Hospital
Jacqueline Walker, Intern - Department of Veterans Affairs - Bay Pines

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Selinthia McKine, CS Tech - Memorial University Medical Center
Cynthia Peek, Supervisor - Hamilton Medical Center
Barbara Richardson, CS Tech - Memorial University Medical Center
Vernon Woodall, CS Tech - Medical Center of Central Georgia, The

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NEW PROVISIONAL CRCST
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HAWAII
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IDAHO
NEW CRCST
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NEW MEMBER
Lana Hendrick, CS Tech - Mountain View Hospital

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Jose Cruz, CS Tech - Northwestern Memorial Hospital - Feinberg and Galter Pavilions
Daniel Dennis, CS Tech - Springfield Clinic
Gina Fiori, SP Aide - St. Mary’s Hospital
Troy Grisom, Lead Tech - Decatur Memorial Hospital
Michelle Key, CS Tech - Proctor Hospital
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Sandra McMullen, CS Tech - St. Mary’s Hospital
Julia Roeske, CS Tech - St. Francis Medical Center
William Skinner, CS Tech - Crossroads Community Hospital

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Jeff Wallace, SP Manager - Rockford Memorial

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Donnie Horn, Supervisor - Great River Medical Center

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Gary Cooper, Sales & Contract Manager - Mobile Instrument Service and Repair, Inc.
Jo Dee Witty, Director of Surgical Services - LaBelle County Medical Center

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NEW CRCST
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Matthew Nevezer, CS Tech - Surgical Solutions, LLC
Robert Parker, CS Tech - Baptist Hospital East

LOUISIANA
NEW MEMBER
Randy Broussard, Director, Surgical Services - Jennings American Legion Hospital

MAINE
NEW CRCST
Lawrence Krebs, CS Tech - Exeter Hospital

MARYLAND
NEW CIS
Roger Prather, CS Tech - Anne Arundel Medical Center
Shanelle Reed, CS Tech - St. Joseph’s Medical

NEW CRCST
Keith Burton, CS Tech - Greater Baltimore Medical Center
Rustom Rubia, CS Tech - Greater Baltimore Medical Center
Hughgill Simpson, Supervisor - Georgetown University Hospital
Ruhil Sultan, CS Tech - Walter Reed Army Medical Center
Darlene White, CS Tech - Harbor Hospital Center
Peter Paul George Yatco, CS Tech - Sinai Hospital of Baltimore

NEW MEMBER
Shirley Allen, Director, Central Materials Services - University of Maryland School of Denistry
Catherine Chance, Clinical Director - Delaware Outpatient Center for Surgery
Guy St. Louis, Senior Clinical Staff Nurse, SPD - Walter Reed Army Medical Center
Steven Turtl, Scientific Reviewer - Food and Drug Administration

MASSACHUSETTS
NEW CIS
Eric Tremblay, CS Tech - Cape Cod Hospital

NEW CRCST
Van Castillo, CS Tech - Massachusetts General Hospital
Anthony Golston, CS Tech II - Boston Medical Center
Renée Harmon, CS Tech - Boston Medical Center
Lisa McGoff, CS Tech - Salem Hospital
Anna Napolitano, CS Tech II - Bay State Medical
Shawn Roe, CS Tech - Tufts Medical Center
John Salah Jr, CS Tech - Salem Hospital
Emma Singleton, CS Tech - Tufts Medical Center
Karla Starkenberg, CS Tech - Salem Hospital
Kimberly Wood, CS Tech - UMass Memorial

NEW PROVISIONAL CRCST
Susan Boyce-Lesse, Student - Provisional Certification
Maxime Georges, Student - Provisional Certification

Kervens Guirand, Student - Provisional Certification
Tseten Gyurmee, Student - Provisional Certification
John Hirshon, Student - Provisional Certification
Darrell MacLean, Student - Provisional Certification
Rashanna McKenzie, Student - Provisional Certification
Hongzi Zhang, Student - Provisional Certification

MICHIGAN
NEW CRCST
Carol Cellebs, Supervisor - Henry Ford Macomb Hospital - Warren
Joshua Harville, CS Tech - Henry Ford Macomb Hospital
David Kassab, CS Tech - Oakwood Hospital and Medical Center
Tera Lawhead-Jones, CS Tech - Port Huron Hospital
Shannon Listy, CS Tech - Henry Ford Macomb Hospital
Gloria Napper, CS Tech - DMC Sinai-Grace Hospital

NEW MEMBER
Janet Comtois, SP CNS - Aleda E. Lutz VAMC
Deborah Crilli, CS Manager - St. John Hospital - Macomb Center
Cherie Trippy, Director of Clinical Education - Midbrook Medical, Inc.
Robert Ziegler, Corporate Director, Material Management - Botsford General Hospital

NEW PROVISIONAL CRCST
Elton Henley, CS Tech - Provisional Certification

MINNESOTA
NEW CRCST
Valentina Brikova, Instrument Specialist - Mercy Hospital
Kathy Fredrickson, Instrument Specialist - Mercy Hospital
Janice Janda, Aide - Immanuel St. Joseph’s Hospital - Mayo Health Systems
Angela Jeremiason, CS Tech - Mercy Hospital
Kese Johnson, Instrument Specialist - Mercy Hospital
Shelly Jollymore, CS Tech - Unity Hospital
Kimberle Liebelt, Surg Tech - Fairview Maple Grove Surgery Center
Carol Peterson, CS Tech - Unity Hospital
Rose Schmidt, Instrument Specialist - Mercy Hospital
Ioana Trosyak, Instrument Specialist - Mercy Hospital
Mariya Ureke, Instrument Specialist - Mercy Hospital

NEW MEMBER
Sarah Bauer, CST Instructor - Anthem College
Ryan Hennessy, Student - Regions Hospital
Erik Hromatka, Director, National Accounts - Key Surgical
Max Jahraus, Sales Representative - Key Surgical
Lindsay Johnson, Sales Representative - Key Surgical
Nicole Lundgren, CPC Ad - Fairview Medical System
Michele Moss, CS Tech - Fairview Health Systems
Mark Peabody, Regional Service Lead - Prezio Health
Marlynn Thompson, CPD Tech II - Hennepin County Medical Center
Phillip Van Gorp, CPD Supervisor - Hennepin County Medical Center
Barbara Wilker, Account Manager - Advanced Sterilization Products
Qiosha Blythe, SIPT - Fairview Health Systems

NEW PROVISIONAL CRCST
Tasha Lind, Env. Services - Provisional Certification

MISSOURI
NEW CRCST
Terri Hemmerling, Assistant Chief of SPS - Department of Veterans Affairs - Leavenworth
Raema Howell, Team Leader/Manager - St. Mary’s Health Center
Thuy-Tien Huynh, CS Tech - St. Mary’s Health Center
Joseph Wardrip, CS Tech - Liberty Hospital
MISSISSIPPI
NEW CRCST
Kellie Colburn, CS Tech - North Mississippi Medical Center
Lily Ellis, CS Tech - Regional Medical Center of Memphis
Mario Judge, CS Tech - University of Mississippi Medical Center
Vanessa Manning, SPD Chief - Department of Veterans Affairs - Jackson

NEW MEMBER
Courtenay Veglia, Surgical Technologist/Central Supply Tech - Hancock Medical Center

MONTANA
NEW CRCST
Heather Franzel, CS Tech - St. Vincent's Hospital
Suzanne Peters, CS Tech - Bozeman Deaconess Hospital
Jerry Taylor, Supervisor - Bozeman Deaconess Hospital

NEBRASKA
NEW NEW PROVISIONAL CRCST
Sara Boyer, CS Tech - Provisional Certification

NEVADA
NEW CRCST
Marilou Botelho, CS Tech - Carson Tahoe Hospital
Lesly Garcia-Vallecillo, CS Tech - Sierra Surgery Hospital

NEW MEMBER
Davita Leaks, Student - Nevada Career Institute

NEW JERSEY
NEW CIS
Reshma Bhatt, Case Cart Technician - Jersey Shore University Medical Center
Davina Coward, Manager - Jersey Shore University Medical Center

NEW CRCST
Yamin Anderson, CS Tech - Trinitas Hospital
Filomena Barcellona, CS Tech - Dover Business College
Remzi Demo, CS Tech - Dover Business College
Tammy Glover, CS Tech - St. Peter's University Hospital
Wacking Horace, CS Tech - Robert Wood Johnson University Hospital
Natayla Khodov, CS Tech - Staten Island University Hospital North
Shiry Loor, CS Tech - St. Barnabas Medical Center
David Pieters, CS Tech - Hunterdon Medical Center
Janeris Rodriguez, CS Tech - Dover Business College
Giovanni Santos, CS Tech - Dover Business College
Kevin Sharpe, CS Tech - Methodist Hospital
Nedra Simpson, CS Tech - Dover Business College
Ronette Singletery, CS Tech - Bartan Bay Medical Center
Edward Vance Jr, CS Tech - Dover Business College
Michelle Waddy, CS Tech - Christ Hospital

NEW MEMBER
Sakina Askew, Surgical Technician - University Medical Center at Princeton

NEW PROVISIONAL CRCST
Emmanuel Asare, Student - Provisional Certification
Wilhena Benn, Student - Provisional Certification
Margaret Benson, Student - Provisional Certification
Nicole Covin, Student - Provisional Certification
Soney Mathew, Student - Provisional Certification
David Santiago, CS Tech - Provisional Certification
Danny Simms, Student - Provisional Certification

NEW MEXICO
NEW CRCST
Edward Espinosa, Medical Supply Tech - Department of Veterans Affairs - Albuquerque

NEW YORK
NEW CCSVP
Cynthia Blodgett, Corporate Accounts Representative - SPSmedical Supply Corporation

NEW CHL
Anthony Oliver, SP Tech - NYU Langone Medical Center
Lizbeth Weiss, Associate Director of Patient Nursing Services - Department of Veterans Affairs - Buffalo

NEW CIS
Shedrac Alenkhe, CS Tech - Bellevue Hospital Center
Stephen Dwamena, CS Tech - NYU Langone Medical Center
Rebecca Essel, CS Tech - North Shore Long Island Jewish Hospital
Alex Picard, OR Attendant II - Montefiore Medical Center
Gilbert Rodriguez, Supervisor - Hospital For Special Surgery
Vida Toku, CS Tech - Korno Akye Teaching Hospital

NEW CRCST
Calisto Altamirano, CS Tech - St. Francis Hospital Heart Center
Karen Carbone, CS Tech - John T. Mather Memorial Hospital
David Castro, Supervisor - Long Island Jewish Medical Center
Fatou Ceesay, CS Tech - Bellevue Hospital Center
Tyrone Fields, CS Tech - Lenox Hill Hospital
Denese Gentiles, CS Tech - St. John's Episcopal Hospital
Jean Joseph, CS Tech - New York Hospital Queens
Kelmah Liverpool, CS Tech - Department of Veterans Affairs - Buffalo
Deborah Maile, Infection Control Nurse - John T. Mather Memorial Hospital
Kim Mooney, CS Tech - St Joseph Hospital
William Morrison, CS Tech - Southside Hospital
Dwane Narcis, CS Tech - Island Eye Surgicenter
Alfred Okoh Addo, CS Tech - New York-Presbyterian/Weill Cornell Medical Center
Cheriyann Oommen, CS Tech - Flushing Hospital Medical Center
Lorinda Poku Davies, CS Tech - Lincoln Medical and Mental Health Center
Mary Ellen Rasulo, CS Tech - John T. Mather Memorial Hospital
Michael Roacher, CS Tech - Long Island Jewish Medical Center
Salvatore Savoina, Aide - John T. Mather Memorial Hospital
Joseph Scala, CS Tech - Bassett Health Care
Stanley Smith, CS Tech - Island Eye Surgicenter
Saul Urena, CS Tech - Hospital For Special Surgery
Cherrymae Watkins, Patient Care Associate
Marc Wiener, Aide - John T. Mather Memorial Hospital

NEW MEMBER
Melissa Austin, SPD Supervisor - United Health Services
Carol Corso, CST Educator-Adult Education Instructor - OCM BOCES - Central Service Technician Program
Barbara Lindsay, Director, Nursing Quality - Cleveland Clinic Abu Dhabi
Kathi Mullaney, Associate Executive Director - Metropolitan Hospital Center
Alice Schiro, Assistant Material Coordinator - St. Catherine's of Siena Medical Center
Mary Cate Sinkus, SPD Intern - Department of Veterans Affairs - Northport
Sonja Ward-Dough, CS Supervisor - Samaritan Medical Center

NEW PROVISIONAL CRCST
Annita Abbey, Student - Provisional Certification
Augustine Acheampong, Student - Provisional Certification
Oliver Adjei-Twum, Student - Provisional Certification
Jennifer Aftul, Student - Provisional Certification
Gibrilla Allamu, Student - Provisional Certification
Samuel Appiah, Student - Provisional Certification
Nana Arthur, Student - Provisional Certification
Idowu Bakare, Student - Provisional Certification
Soraya Brioso, Student - Provisional Certification
NEW CERTIFICATION AND MEMBER LISTINGS

Betzaida Cajigas, Student - Provisional Certification
Nafisa Carmana, Student - Provisional Certification
Diana Essuman, Student - Provisional Certification
Natalia Fredericks, Student - Provisional Certification
John Guevarra, Student - Provisional Certification
Saturday Idernucia, Student - Provisional Certification
Aisha Kannez, CS Tech - Provisional Certification
Solomane Kante, Mat-Handler - Provisional Certification
Marilou Lescoulair, Student - Provisional Certification
James Mtoranan, Student - Provisional Certification
Cleoville McKoy, Student - Provisional Certification
Annette McPherson, Student - Provisional Certification
Brian Miller, Student - Provisional Certification
Bright Opoku, Student - Provisional Certification
Kofi Osei, Student - Provisional Certification
Evelyn Owusu, Student - Provisional Certification
Lourdes Owusu, Student - Provisional Certification
Valerie Perez, Student - Provisional Certification
Rhoda Paniun, Student - Provisional Certification
Vivianne Printson, Student - Provisional Certification
George Spears, Student - Provisional Certification
Jonathan Thompson, Environmental Tech - Provisional Certification
Dania Townsend, Nursing Assistant - Provisional Certification
Samuel Vasquez, Student - Provisional Certification
Sherre Walters, Student - Provisional Certification
Ayishetu Yidana, Student - Provisional Certification

NORTH CAROLINA
NEW CRCST
Michele Dragoslis, Instrument Coordinator - Rex Hospital
Joshua Hardee, CS Tech - CarolinaEast Medical Center

NEW MEMBER
Pamela Alexander, RME Coordinator - Department of Veterans Affairs - Asheville
Rhonda Edwards, Sterile Processing Coordinator - Carolina Eye Associates

NORTH DAKOTA
NEW CRCST
Kyle Medenwald, CS Tech - Sanford Health - Fargo Medical Center

NEW MEMBER
Lyn Haring, CS Tech - Oakes Community Hospital

OHIO
NEW CIS
John Belz, CS Tech II - Cincinnati Children’s Hospital Medical Center
Gary Moore, Coordinator - St. Elizabeth Health Center

NEW CRCST
Carey Anderson, CS Tech - Mercy Hospital-Western Hills
Yolanda Clemons, CS Tech - Mercy Hospital of Fairfield
Diane Coleman, CS Tech - Department of Veterans Affairs - Dayton
Dora Dobbs, CS Tech - Mercy Hospital-Anderson
LaTrisha Fail, CS Tech - Mercy Hospital of Fairfield
Andre Gamble, CS Tech - Cincinnati Children’s Hospital Medical Center
Aaron Haig, Supervisor - Mercy Hospital of Fairfield
Darian Hughes, Supervisor - Nationwide Children’s Hospital
Cemecko Kenney, CS Tech - Nationwide Children’s Hospital
Dana Lackey, CS Tech - Jewish Hospital
John Lewis, CS Tech - Mercy Hospital-Western Hills
Scott Meredith, CS Tech - Ohio State University Hospital East
Heather Ralston, Med Supply Tech - Department of Veterans Affairs - Cincinnati
Susan Scholz, Sterile Processing Manager - Mount Carmel East Hospital
Jonda Shafner, CS Tech - Dayton Eye Surgery Center
Karen Smith, CS Tech - Knox Community Hospital
Laura Tyson, CS Tech - Knox Community Hospital
Mary Walsh, CS Tech - Ohio State University Medical Center, The
Amanda Weber, CS Tech - Mercy Hospital-Western Hills
Richard Wilson, Med Supply Tech - Department of Veterans Affairs - Dayton

NEW MEMBER
Janet Berry, Manager - Nationwide Children’s Hospital
Karen Moon, Manager - Dayton Children’s Medical Center

OKLAHOMA
NEW CRCST
Steven Cileyus, CS Tech - Department of Veterans Affairs - Oklahoma City
Ramon Flores, CS Tech - Department of Veterans Affairs - Oklahoma City
Marsha Harris, RME Coordinator / Educator - Department of Veterans Affairs - Oklahoma City

NEW MEMBER
Joseph Daniel, CST - McAlester Reg Hospital

OREGON
NEW CIS
Pamela Sauer, CS Tech - Good Samaritan Regional Medical Center

NEW CRCST
Art Pila, CS Tech - Bay Area Hospital
Maryrose Rea, CS Tech - Carondelet St. Joseph’s Hospital

NEW MEMBER
Brent Conger, Head Sterile Processing Tech - Cornell Surgery Center

PENNSYLVANIA
NEW CIS
Justin Poulin, Sales Representative - Spectrum Surgical Instruments

NEW CHL
Tara Fischer, CS Tech - Wilkes-Barre General Hospital
Varkey Koshy, Supervisor - Abington Memorial Hospital
James Nisula, Supervisor - Abington Memorial Hospital

NEW CIS
Joanne Fenstermaker, CS Tech - Lehigh Valley Hospital & Health Network
Lori King, Educator - Rockingham Memorial Hospital

NEW CRCST
Toni Amorine, CS Tech - Geisinger - Community Medical Center
Tyra Bolton, CS Tech - Suburban General Hospital
Lennelle Calhoun, CS Tech - Albert Einstein Medical Center
Marc Diana, CS Tech - Nazareth Hospital
Vicki Gutai, SPD Tech II - Lehigh Valley Hospital & Health Network
Taylor Hovan, CS Tech - Lehigh Valley Hospital & Health Network
Meghan Kauriga, CS Tech - Albert Einstein Medical Center
Kamal Khalidy, CS Tech - North Philadelphia Health System
Terry Kiefer, CS Tech - Lehigh Valley Hospital & Health Network
Deanna Maddrey, CS Tech - Coordinated Health - Allentown Campus
Jeffrey Moyer, CS Tech - Geisinger Medical Center
Sue Myers, CS Tech - The Physicians Surgery Center Lancaster General
James Newpher Jr, CS Tech - Geisinger Medical Center
Jennifer Pearsall, CS Tech - Nazareth Hospital
Shelly Peleil, Lead Tech - Advanced Surgical Hospital
Carole Selway, CS Tech - Advanced Surgical Hospital
Gregory Shuttleworth, CS Tech - Meadville Medical Center
James Small, Supervisor - Thomas Jefferson University Hospital - Center City Campus
Kenneth Szajdek, Supervisor Thomas Jefferson University Hospital - Center City Campus
Robert Waitz, CS Tech - Nazareth Hospital
Gregory Wippel, CS Tech - Lehigh Valley Hospital & Health Network
NEW MEMBER
Ruth Campbell, Coordinator, Surgical Processing - University of Pittsburgh Medical Center
Mary Beth Freda, Clinical Education Specialist - Magee-Women’s Hospital of UPMC
NEW PROVISIONAL CRCST
Ajlen Sakir, Student - Provisional Certification
RHODE ISLAND
NEW MEMBER
Kathleen Gales, CS Tech - Milford Regional Hospital
SOUTH CAROLINA
NEW PROVISIONAL CRCST
Brock Gibson, Surgical Attendant - Provisional Certification
NEW CRCST
Nicholas Cerny, CS Tech - Middle Tennessee Medical Center
NEW MEMBER
Pam Arnold, OR Supply Cost Manager - Parallon Business Solutions
Kelly Johnson, Surgical Technology Program Director - Miller-Motte Technical College
TENNESSEE
NEW CRCST
NEW MEMBER
Kenneth Misajet, Lead Tech - Parkland Health & Hospital System
NEW CRCST
Luis Aguero, CS Tech - University of Texas MD Anderson Cancer Center
Aaron Anderson, OR Director - Harris Methodist Hospital Southlake
Jessie Caffey III, Night Supervisor - University of Texas Medical Branch
Larry Flores Jr, Med Supply Tech - Valley Coastal Bend Ambulatory Surgery Center
Ricardo Garcia, Lead Tech - Valley Coastal Bend Ambulatory Surgery Center
Gay Glover, Lead Tech - East Texas Medical Center Jacksonville
Drusilla McCarley, Program Manager, Sterile Processing - University of Texas Medical Branch
Guillermo Mújares, CS Tech - Denton Regional Medical Center
Kaanna Montgomery, CS Tech II - Ben Taub General Hospital
Chibuzo Onubogu, CS Tech - UT Southwestern University Hospital - Zale Lipshy Shamese Reece, CS Tech - HCA Woman’s Hospital of Texas
Tony Sanders Jr, CS Tech - Parkland Health & Hospital System
Paul Yelle, CS Tech - Medical Center of Lewisville
Americo Zepeda, CS Tech II - University of Texas Medical Branch
NEW MEMBER
Cairo Caldera, Materials Manager - Platinum Surgery Center
Cheryl Green, CS Tech - Memorial Medical Center of East Texas
Toni Hardin, Director of Hospital Operations - Memorial Hermann Hospital Southwest
Barbara Inkel, Accounts Director - Pryce Consultants
Jesus Lopez, CS Tech - Platinum Surgery Center
Gayla Marien, Educator - Department of Veterans Affairs - Dallas
Corey Stewart, SPD Supervisor - SRI Surgical
Stephanie Strickland, Director - North Hills Hospital
Orlando Wilson, Supervisor Sterile Processing - SRI Surgical
NEW PROVISIONAL CRCST
Kaeor Arnett, Student - Provisional Certification
Anna Castillo, Student - Provisional Certification
Lonet D’hui, Student - Provisional Certification
Curtis Dunigan, Student - Provisional Certification
Frank Rizzo, Student - Provisional Certification
Joe Ruiz, CS Tech - Provisional Certification
Porche Turner, Student - Provisional Certification
UTAH
NEW CRCST
Jennifer Anderson, Coordinator - Intermountain Riverton Hospital
Shari Baird, CS Tech - Ogden McKay-Dee Hospital Center
Brittney Bankhead, CS Tech - Ogden McKay-Dee Hospital Center
Katie Beardall, CS Tech - Utah Valley Regional Medical Center
Seryn Hendrickson, CS Tech - Utah Valley Regional Medical Center
Robert Housley, CS Tech - University of Utah Medical Center
Gabriella Johnson, CS Tech - Intermountain Medical Center
Angela Jones, CS Tech - Dixie Regional Medical Center
Helen Manning, CS Tech - Utah Valley Regional Medical Center
Heather Mastricola, CS Tech - Primary Children’s Medical Center
Bryce Nielsen, Supervisor - LDS Hospital
Katie Richardson, CS Tech - Dixie Regional Medical Center
Mauri Voorhees, CS Tech - Ogden McKay-Dee Hospital Center
Patricia Walker, CS Tech - Utah Valley Regional Medical Center
Tyler Witzel, CS Tech - Intermountain Medical Center
NEW MEMBER
Alishia Clausing, Materials Management Facilitator/CS Supervisor - University of Utah Orthopaedic Center
Virginia
NEW CHL
Carolyn Sink, CS Tech - Virginia-Maryland Regional College of Veterinary Medicine - Veterinary Teaching Hospital
NEW CIS
Karen Hardy, Manager - Inova Mount Vernon Hospital
NEW CRCST
Tommy Barrios, CS Tech - Mary Washington Hospital
Lance Beanum, CS Tech - Mary Washington Hospital
Denise Brathwaite-Ukawua, CS Tech - Kadcyla Medical Center
Catherine Carter, CS Tech - Mary Washington Hospital
Vasudev Channaih, CS Tech - Medical College of Virginia (VCU)
Jessica Douthat, CS Tech - Virginia-Maryland Regional College of Veterinary Medicine - Veterinary Teaching Hospital
Kelli Faust, CS Tech - Inova Loudoun Hospital
Betty Maddrey, CS Tech, Southampton Memorial Hospital
Bernice Manker, CS Tech, Virginia Hospital Center Arlington GI Unit
Melissa Perez, CS Tech - Mary Washington Hospital
Raquel Taboada, CS Tech - Inova Fair Oaks Hospital
Tornika Vaughan, CS Tech II - Sentara Norfolk General Hospital
Brandy Williams, CS Tech II - Sentara Norfolk General Hospital
William Williford, CS Tech - Inova Fair Oaks Hospital
Marinko Zecevic, CS Tech - Kosovska Mitrovica Hospital
NEW MEMBER
Margaret Cox, Manager Central Sterile Processing - Virginia Commonwealth University Medical Center
Terry Hubbard, Perioperative Nurse Educator - Bon Secours
Tairre Massenburg, CS Tech - Provisional Certification
NEW PROVISIONAL CRCST
Enock Ansah, Student - Provisional Certification
Henok Mulugeta, Student - Provisional Certification
Henry Nosar, CS Tech - Provisional Certification
VERMONT
NEW CHL
Michael Janesik, CS Tech - Fletcher Allen Health Care
NEW CIS
Michael Janesik, CS Tech - Fletcher Allen Health Care
Diana Lopez, CS Tech - Northeastern Vermont Regional Hospital
NEW MEMBER
Nicholas Cerny, CS Tech - Middle Tennessee Medical Center
NEW CRCST
Brock Gibson, Surgical Attendant - Provisional Certification
NEW PROVISIONAL CRCST
Erokk D’haïti, Student - Provisional Certification
Curtis Dunigan, Student - Provisional Certification
Frank Rizzo, Student - Provisional Certification
Joe Ruiz, CS Tech - Provisional Certification
Porche Turner, Student - Provisional Certification
NEW CERTIFICATION AND MEMBER LISTINGS

NEW CRCST
Daniel Harris, Supervisor - Cheshire Medical Center

NEW PROVISIONAL CRCST
Wendy Corrow, Surgical Tech - Provisional Certification

WASHINGTON
NEW CHL
Joseph LeBouef, Regional Sterile Processing Educator - Kaiser Foundation Northwest

NEW CIS
Maria Asuncion Rones, CS Tech - Swedish Medical Center - First Hill Campus

NEW CRCST
Shawna Boutu, Assistant Chief - Department of Veterans Affairs - Spokane
Florina Felipe, CS Tech - Harborview Medical Center
Merly Guerrero, CS Tech - Swedish Medical Center - First Hill Campus
Melinda Guo, CS Tech - Overlake Medical Center
John Kangethe, CS Tech - Swedish Medical Center - First Hill Campus
Edilberto Molina, CS Tech - Virginia Mason Medical Center
Gloria Rones, CS Tech - Swedish Medical Center - First Hill Campus
Marilou Trask, CS Tech - Virginia Mason Medical Center

NEW MEMBER
Elaine France, Supervisor - Overlake Medical Center
Krista Grinstead, Account Executive - Kimberly-Clark Corporation
Tami Poole, CS/SP - Clover Park Technical College
William Salisbury, CS Tech - Naval Hospital

NEW PROVISIONAL CRCST
Alan Sims Jr, Student - Provisional Certification

WEST VIRGINIA
NEW CHL
Patricia Driver, Supervisor - West Virginia University Healthcare

NEW CRCST
Jack Bryant, Med Supply Tech - Department of Veterans Affairs - Beckley
Sheila Robinson, CS Tech - Logan General Hospital

WISCONSIN
NEW CRCST
Nicholas Pfund, CS Tech - Sacred Heart Hospital
Darwin Portz, CS Tech - Waukesha Memorial Hospital
Lynn Taylor, CS Tech - Sacred Heart Hospital
Jill Wolfe, Distribution Coordinator - Waukesha Memorial Hospital

NEW MEMBER
Gretchen Gilliss, CS Tech - St. Mary's Hospital Medical Center
Gwynne Roberts, Program Manager/Chief SPS - Department of Veterans Affairs - Milwaukee

NEW PROVISIONAL CRCST
Ruth Collis, CS Tech - Provisional Certification
Christine North, CS Tech - Provisional Certification

WYOMING
NEW CRCST
Karen Lundgren, CS Tech - South Lincoln Medical Center
Zachary Pound, CS Tech - Wyoming Medical Center

CANADA
NEW CRCST
Pinky Abella, CS Tech - Foothills Medical Centre
Mysert Belishaku, CS Tech - Rockyview General Hospital
Joshua Callaway, CS Tech - Sturgeon Community Hospital Lei Chen, CS Tech - Foothills Medical Centre
Cristina Darnayla, CS Tech - Rockyview General Hospital
Daniel Dejene, CS Tech - Foothills Medical Centre
Diana Durmic, CS Tech - Foothills Medical Centre
Fekerte Haile, CS Tech - Foothills Medical Centre
Esther Lam, CS Tech - Rockyview General Hospital
Sheila Lee, CS Tech - Rockyview General Hospital
Teresa Quinn, CS Tech - Alberta Children's Hospital
Krystle Raymond, CS Tech - Foothills Medical Centre
Getenet Tafesse, CS Tech - Peter Lougheed Center
Cristyan Turnadce, Surgical Processor - Rockyview General Hospital

NEW MEMBER
Mark Drescher, Supervisor - Foothills Medical Centre
Debbie Layden, Supervisor Medical Device Reprocessing - Red Deer Regional Hospital
Kathy Thompson, Surgical Reprocessor - OR Core - Red Deer Regional Hospital
Julia Cristobal, Territory Manager - Trudell Medical Marketing Limited
Jimmy Trieu, Director Central Processing Department, Huron Perth Healthcare Alliance
Bhindi Sharma, Supervisor - Sunnybrook Health Sciences Centre

CHINA
NEW CRCST
Kwok Kin Ng, CS Tech - United Christian Hospital

NEW CHL
Katherine Slaggett, Business Development Associate - Surgical Innovations

GERMANY
NEW CRCST
Monika King, CS Tech - Landstuhl Regional Medical Center

SAUDI ARABIA
NEW MEMBER
Jenny Faustino, CSSD Technician - Al Mashfa Hospital

NEW CHL
Perfecto Ramos, CS Tech - King Abdullah Medical City (National Guard Hospital)

NEW CIS
Deogenes Bardon, CS Tech II - King Abdullah Medical City (National Guard Hospital)
Romeo Nillo, CS Tech - King Abdullah Medical City (National Guard Hospital)
Alicia Tubao, CS Tech - King Abdullah Medical City (National Guard Hospital)
Amer Yu, CS Tech - King Abdullah Medical City (National Guard Hospital)

NEW CRCST
Mohammed Al-Magbool, CS Tech - Dhahran Health Center
Annellin Caro, CSSD Tech 2 - King Abdullah (National Guard Hospital)
Joel De Guzman, CS Tech II - King Abdullah Medical City (National Guard Hospital)
Oscar Gomez, CSSD Tech I - King Abdullah (National Guard Hospital)
Sheila Mendoza, CS Tech II - King Abdullah Medical City (National Guard Hospital)
Akhbar Qureshi, CS Tech - Dhahran Health Center
Elizabeth Reyes, CS Tech II - King Abdullah Medical City (National Guard Hospital)

SINGAPORE
NEW MEMBER
Wendy Kueh, Market Development Manager - 3M Singapore Pte Ltd

UNITED ARAB EMIRATES
NEW MEMBER
Lara Mohammad, CS Aide - Al-Ain Hospital
Ferdinand Awa, CS Tech - NMC Specialty Hospital
Rovil Argana, Warehouse Tech - American Hospital Dubai
Sajid Kaldane, CS Tech - American Hospital Dubai
Monowara Mohammed, CS Tech - Al-Ain Hospital
Nenita Te, CS Tech - Al-Ain Hospital

UNITED STATES ARMED FORCES EUROPE
NEW MEMBER
Julie Conrardy, Department Head MOR and CSR - Naval Hospital

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We would like to thank all our partners for their continued support of IAHCSMM

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- AESCULAP
- B.Braun
- Kaysurgical
- Kimberly-Clark
- Spectrum
- SPS Medical
- Steris

### Premium Partners

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- Case Medical
- Censitrac
- Certol International
- ChemDAQ
- Cygnus Medical
- Ecolab
- Getinge Group
- IMS
- Karl Storz — Endoskope
- Medisafe
- Mobile Instrument Service & Repair Inc.
- Ruhof
- Skytron
- SteriTec

### Professional Partners

- Batrik
- Best Practice Professionals
- Bioseal
- Capsa Solutions
- General Hospital Supply
- InstruMedics LLC
- Microsystems
- Nuell
- Prezio Health
- Richard Wolf
- Televflex
- Thermo Diagnostics
- Ultra Clean Systems, Inc.
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