

November 12, 2007

**To:** Chief Executive Officers of Member Institutions

**Re: Flash Sterilization of Instruments**

The Provincial Infectious Diseases Advisory Committee (PIDAC) was established by the Ministry of Health and Long-Term Care (MOHLTC) to be a single standing source of expert advice on infectious diseases for Ontario.

Since 2006, the MOHLTC and the Ontario Hospital Association (OHA) have worked together to facilitate awareness and uptake of PIDAC's Best Practice documents. We have jointly held webcasts and issued bulletins on a variety of PIDAC's Best Practice documents.

The purpose of this communication is to turn hospitals' attention to *PIDAC's Best Practices Manual on Cleaning, Sterilization and Disinfection*, revised April 2006.

According to PIDAC, the manual is intended for health care providers to ensure that the critical elements and methods of decontamination, disinfection and sterilization are incorporated into health care facility procedures. The best practices for reprocessing medical equipment set out in the manual should be practiced in all settings where care is provided, across the continuum of health care. This includes settings where emergency care is provided, hospitals, long term care homes, outpatient clinics, community health centres and clinics, physician offices, dental offices, offices of allied health professionals, public health and home health care.

We would like to bring to your attention, one specific portion of the manual. Section 13.8, page 29, which provides guidance on *Flash Sterilization*.

According to PIDAC, **flash sterilization should only be used in emergency situations** and must never be used for implantable equipment/devices.

PIDAC reminds hospitals that sterilization is a process, not an event. Effective sterilization is impaired if all the necessary parameters of the process are not met.

Where instruments are flash sterilized, hospitals are advised to maintain a record for each piece of equipment/device being subjected to flash sterilization. This record should include:

- the name of the patient;
- the procedure;
- the physician/practitioner; and
- the equipment/device used.

Hospitals are advised to have a procedure for notification of this patient in the event of a recall. In addition, these records should be reviewed on a regular basis to ensure that flash sterilization is not being overused.

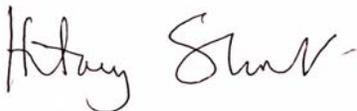
Hospitals are advised to review the *PIDAC Best Practices Manual on Cleaning, Sterilization and Disinfection*, particularly to the section on flash sterilization and incorporate these recommendations into their hospital's policies and procedures.

To provide further guidance on this issue, the OHA and the MOHLTC will jointly hold a videoconference on Wednesday November 28, 2007 (copy of flyer attached). Hospitals are encouraged to register and view this webcast.

For further information about flash sterilization or any of the PIDAC's Best Practices documents, please contact Cassandra Lofranco, Manager, Infectious Disease Research & Policy, MOHLTC at [Cassandra.LoFranco@ontario.ca](mailto:Cassandra.LoFranco@ontario.ca).

For further information about this letter, please contact Sudha Kutty, OHA at [skutty@oha.com](mailto:skutty@oha.com).

Sincerely,



Hilary Short  
President and Chief Executive Officer

Sincerely,

*"Original Signed By"*

Ron Sapsford  
Deputy Minister  
Ministry of Health and Long-Term Care