Capital Health

Flash Sterilization Record

Date: (yyyy/mm/dd) _____

Autoclave Location and Number: _____

Site: HI, DGH, VG1O, VG11, Hants, Ophthalmology (circle one)

Reasons Item(s) Flashed
Booking = B
Contaminated in OR = C
Damaged wrap = D
Lack of instruments = L
Biological Testing = BI
Maintenance Testing = M
Other = O

Initials _____ **& Signature** _____
Initials _____ **& Signature** _____
Initials _____ **& Signature** _____
Initials _____ **& Signature** _____
Initials _____ **& Signature** _____
Initials _____ **& Signature** _____

Instructions: Complete a new record daily for each flash sterilizer.
Sterilizer print outs/graphs are to be attached to this record daily, reviewed by the SPD Supervisor or delegate and retained for a period of 7 years.

Decontaminated by: (initials)	Daily Load #	Load Contents Item & Quantity	Patient name (Place Pt label on back of this record)	Reason Item(s) Flashed See Codes above	Chemical Integrator or Indicator Used (Check)	Temp 270°F 134°C	Exposure Time (minutes)	Dry Time (min) or N/A	OR #	Operator In & Time (initials)	Operator Out & Time (initials)	Biological Indicator (BI) results (+/-) Or N/A (initial)	Flash Pak (#) or Open Pan (OP) Method

Place Patient Label here: