Hamilton Public Health Services

Infection Prevention and Control (IPAC) Lapse Report

<table>
<tr><td colspan="2">Final IPAC Investigation Report</td></tr>
<tr><td colspan="2">Premise/Facility under Investigation (name & address)
The Mayer Institute, 20 Railway Street, Hamilton, L8R 2R3</td></tr>
<tr><td colspan="2">Type of Premise/Facility
Diabetic Foot & Wound Care Clinic</td></tr>
<tr><td>Date of Final Report Posting

October 31, 2019</td><td>Date of Final Report update(s) if applicable
Not applicable</td></tr>
<tr><td colspan="2">Brief Description of Corrective Measures Taken

Hamilton Public Health Services (PHS) has verified, based on the information collected during re-inspections of the premises that corrective measures have been implemented.</td></tr>
<tr><td>Date all corrective measures were confirmed to have been completed

October 25, 2019</td><td>Date and list of any order(s) or directive(s) that were issued to the owner/operator (if applicable)
Not applicable</td></tr>
<tr><td colspan="2">If you have any further questions, please contact:
Infectious Diseases Program, Hamilton Public Health Services
905-546-2063 or infectious.disease@hamilton.ca</td></tr>
<tr><td>Date of Initial Report Posting
October 9, 2019</td><td>Date of Initial Report update(s) if applicable
Not applicable</td></tr>
<tr><td colspan="2">How Board of Health became aware of potential IPAC lapse?

Complaint received on September 17, 2019.</td></tr>
<tr><td colspan="2">Summary Description of IPAC Lapse

During an inspection conducted by Hamilton Public Health Services on September 30, 2019, the following IPAC lapses were identified:
• Improper practices related to reprocessing of medical equipment/devices.
• Reprocessed, sterile items not being stored and maintained sterile until point of use.
• Insufficient cleaning of non-critical surfaces and equipment.
• Inappropriate hand hygiene.</td></tr>
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IPAC Lapse Investigation	Yes	No	N/A	Details
Did the IPAC lapse involve a member of a regulatory college?	☒	☐	☐	College of Physicians and Surgeons of Ontario (CPSO)
If yes, was the issue referred to the regulatory college?	☒	☐	☐	Notified CPSO on October 2, 2019.

Corrective measures recommended and/or implemented

The following corrective measures were recommended based on current evidence and best practice documents:

- Critical and semi-critical devices which are reprocessed must be stored in sterile packaging and maintained sterile until point of use;
- Records for verification of sterilization parameters are to be available on site;
- All touched surfaces and equipment in the treatment areas must be cleaned and disinfected between clients using a hospital-grade disinfectant wipe with either a 1 minute or 3 minute contact time. Allow for adequate contact time; follow the product monograph for appropriate use;
- Provide and consistently use the above hospital-grade disinfectant wipe in the reprocessing area. Allow for adequate contact time; follow the product monograph for appropriate use;
- An alcohol-based hand rub with a minimum of 70% alcohol must be located for consistent use in the reprocessing area;
- All staff must follow proper hand hygiene;
- Ensure all personal protective equipment is selected and used appropriately based on risk assessment; and
- Ensure that applicable sterile supplies, including PPE are readily **available and used where appropriate as per manufacturer's** instructions.

Date and list of any order(s) or directive(s) that were issued to the owner/operator (if applicable)

N/A

Additional Comments:

An inspection report was given to the premise/facility noting corrective measures. Information and resources was provided. Re-inspections were conducted on October 1, 2019 and October 25, 2019 which verified the corrective measures had been implemented.