

The Puck is Passed! IPAC Lapses in the Community Setting

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Still Too Early In The Game

No conflicts to declare





Goal! For Our Session

To review the Niagara approach to IPAC lapse investigations

 To discuss protocols that govern IPAC lapse investigations in Ontario

 To outline the education and resources that are preparing our IPAC Team

 To identify common IPAC lapses in Regulated Health Care Facilities & Personal Service Settings thestar.com (

Life · Health & Wellness

Hepatitis C outbreaks at three Toronto colonoscopy clinics kept secret

Toronto Public Health, which revealed the outbreaks when pressed by the Star, said 11 patients were infected and tainted sedative injections were the "possible" cause in all cases.



NEWS

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SEARCH

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Home / News / Local /Five People Infected With Hepatitis C In...

Five people infected with hepatitis C in outbreak in Kitchener colonoscopy clinic



Life · Health & Wellness

Ontario health minister orders data on clinics made public

Eric Hoskins is demanding more transparency and has told province's regulatory colleges and public health units he wants investigations and inspections made public.

titis C after having colonoscopies at the Tri-City Colonoscopy

ing the hepatitis C outbreak — the first in the region — and

aid inspections by public health officials found no evidence of ing Road clinic continues to perform colonoscopies.

v, there's risk," Nolan said.

n since the clinic opened has not identified other cases linked

tient transmission due to a lapse in infection prevention and le 13 people who had procedures that day, five were found to

noscopies was ruled out as the outbreak's source, Nolan said.

outbreaks in colonoscopy clinics in North America and while to infection control lapses with medication vials or flushing



TOP STORIES



BUSINESS Sep 18, 2017

⊕ EMPLOYMENT LAW: Doughnut shop facing 'hole' lot of trouble

LOCAL Sep 17, 2017



Niagara - Our Arena

Grimsby to Fort Erie

• Physician Offices – 160 offices

Personal Service Settings - 720





Playbooks

Ministry of Health and Long-Term Care

Infection Prevention and Control Complaint Protocol, 2018

Population and Public Health Division, Ministry of Health and Long-Term Care

Effective: January 1, 2018

Ministry of Health and Long-Term Care

Infection Prevention and Control Disclosure Protocol, 2018

Population and Public Health Division, Ministry of Health and Long-Term Care

Effective: January 1, 2018



IPAC Lapse

Is defined as a failure to follow IPAC practice standards resulting in the transmission of infectious diseases to clients, attendees or staff through:

- exposure to blood
- body fluids
- secretions, excretions
- mucous membranes
- non-intact skin
- contaminated equipment and soiled linens

Source: MOHLTC Infection Prevention and Control Disclosure Protocol, 2018

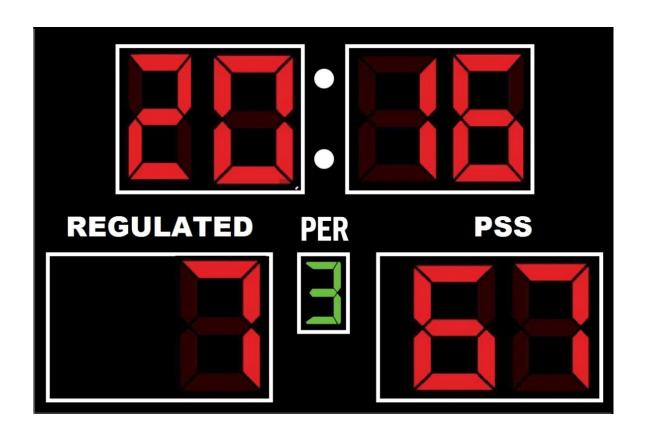


Lapses Can Be Triggered By

- An IPAC complaint from a member of the public made directly to the local PHU
- Referral from a regulatory college (i.e. CPSO, RCDSO) notifies Public Health
- Alternate sources- other Public Health Units, Public Health Ontario or the MOHLTC
- Communicable disease surveillance

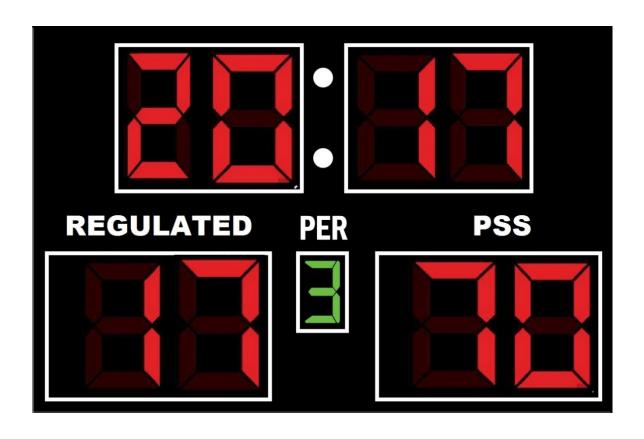


2016 IPAC Investigations



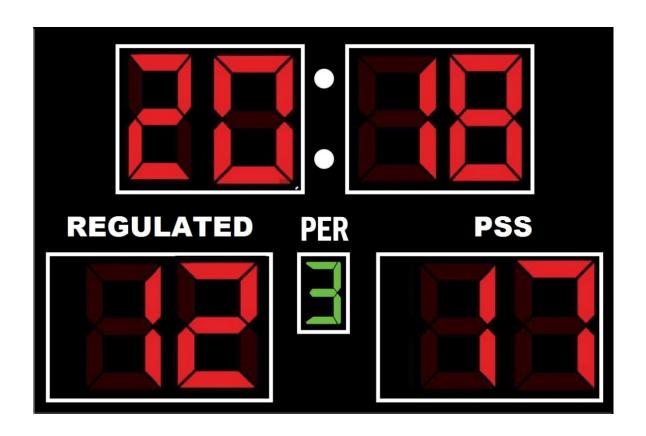


2017 IPAC Investigations





2018 IPAC Investigations











✓ Manager (Infectious Disease Program)

✓ IPAC Supervisor (Infectious Disease Program)





Preparing Our IPAC Team

- IPAC Canada Infection Control courses (Queens University & Centennial College) preparing for CBIC exam
- Medical Device Reprocessing Course (MDRAO)
- PHO modules (Core Competencies & Reprocessing)
- On-line subscription to the Canadian Standards Association
- On-line subscription to APIC



Provincial Infectious Disease Advisory Committee (PIDAC)-Resources







Infection Prevention and Control for Clinical Office Practice

Published: June 2013 1st revision: April 2015



Best Practices for Cleaning,
Disinfection and Sterilization of
Medical Equipment/Devices

In All Health Care Settings, 3rd edition

Provincial Infectious Diseases Advisory Committee (PIDAC)

Published: April 2007 Second Revision: February 2010 Third Revision: May 2013



Routine Practices and Additional Precautions

In All Health Care Settings, 3rd edition

Provincial Infectious Diseases Advisory Committee (PIDAC)

Published: August 2009 Second Revision: July 2011 Third Revision: November 201



Best Practices for Environmental Cleaning for Prevention and Control of Infections

In All Health Care Settings - 2nd edition

Provincial Infectious Diseases Advisory Committee (PIDAC)

First Published: December 2009 Revised: May 2012











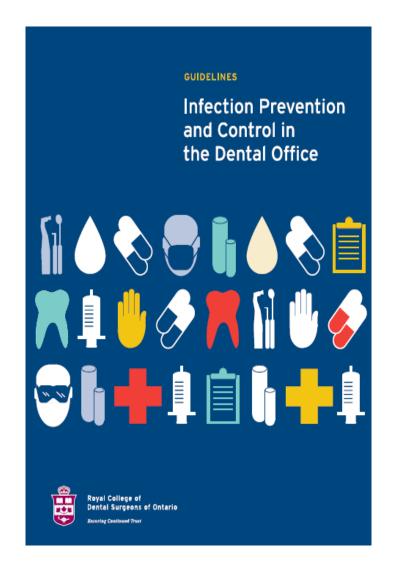




Other IPAC Guidelines



User Handbook for Medical Device Reprocessing in Community Health Care Settings





Preparing To Be An IPAC Champion

- Monthly Health Care Provider Newsletter- select IPAC issues
- CME Health Care Provider In-Service (September 2017) and "friendly" consultation was an option
- Niagara Dental Hygienist Presentation
- Dental In-Service (January 2018)

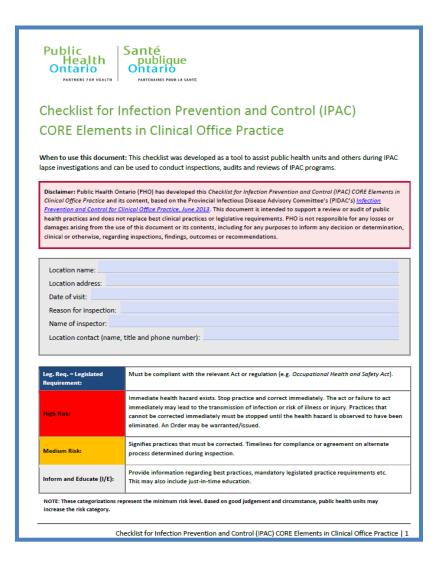


Regulated Care Providers

- Investigations conducted by a Public Health Nurse and Public Health Inspector
- Investigations conducted within 24 hours after initial complaint
- Site visits are unannounced
- Public Health is required to report complaints to the regulatory college(s) (e.g. CPSO, RCDSO)
- Public Health may be accompanied by the regulatory college on the site visit



PHO Checklists-Medical



PARTNERS FOR HEALTH	PARTENAIRES POUR LA SANTÉ
Checklist for	Reprocessing of Medical
Equipment/	Devices in Clinical Office Practice
	nt: This checklist was developed as a tool to assist public health units and others during IPAC an be used to conduct inspections, audits and reviews of IPAC programs.
Disclaimer: Public Health Ontario (PHO) has developed this Checklist for Reprocessing of Medical Equipment/Devices in Clinical Office Practice and its content, based on the Provincial Infectious Disease Advisory Committee's (PIDAC's) infection Prevention and Control for Clinical Office Practice, June 2013. This document is intended to support a review or audit of public health practices and does not replace best clinical practices or legislative requirements. PHO is not responsible for any losses or damages arising from the use of this document or its contents, including for any purposes to inform any decision or determination, clinical or otherwise, regarding inspections, findings, outcomes or recommendations.	
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Location address: Date of visit: Reason for inspection: Name of inspector:	, title and phone numbers):
Location address: Date of visit: Reason for inspection: Name of inspector:	title and phone numbers): Must be compliant with the relevant Act or regulation (e.g. Occupational Health and Safety Act).
Location address: Date of visit: Reason for inspection: Name of inspector: Location contacts (name	
Location address: Date of visit: Reason for inspection: Name of inspector: Location contacts (name Leg. Req. = Legislated Requirement:	Must be compliant with the relevant Act or regulation (e.g. Occupational Health and Safety Act). Immediate health hazard exists. Stop practice and correct immediately. The act or failure to act immediately may lead to the transmission of infection or risk of illness or injury. Practices that cannot be corrected immediately must be stopped until the health hazard is observed to have beer
Location address: Date of visit: Reason for inspection: Name of inspector: Location contacts (name Leg. Req. = Legislated Requirement:	Must be compliant with the relevant Act or regulation (e.g. Occupational Health and Safety Act). Immediate health hazard exists. Stop practice and correct immediately. The act or failure to act immediately may lead to the transmission of infection or risk of illness or injury. Practices that cannot be corrected immediately must be stopped until the health hazard is observed to have beer eliminated. An Order may be warranted/issued. Signifies practices that must be corrected. Timelines for compliance or agreement on alternate



PHO Checklist- CORE Elements

- 1. Lack of IPAC policy and procedures
- 2. Medication preparation counter shared with instrument cleaning/disinfection
- 3. Non-critical items not being cleaned and disinfected between patient use (e.g., blood pressure cuff, stethoscope)
- 4. No safety engineered needles

PHO Checklist- CORE Elements

5. Multi-dose vials – past expiration date (B12, Lidocaine)

6. Furniture – absorbent material; torn

PHO Checklist - Reprocessing

1. Lack of training/education in reprocessing area

2. Lack of policies and procedures

3. Missing or incomplete Biological &/or Chemical Indicators

4. No records for physical parameters



PHO Checklist-Reprocessing

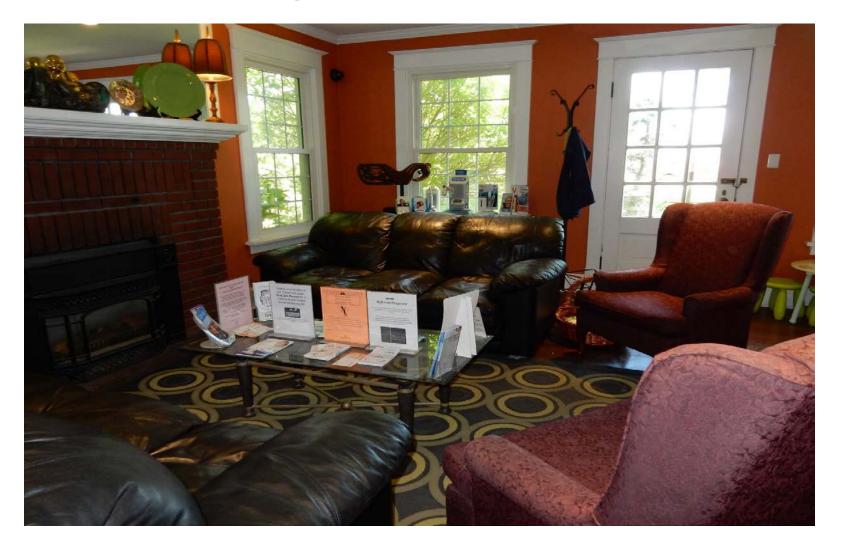
5. Instruments/items not packaged appropriately (e.g., hinged devices in closed position, too many tools in package)

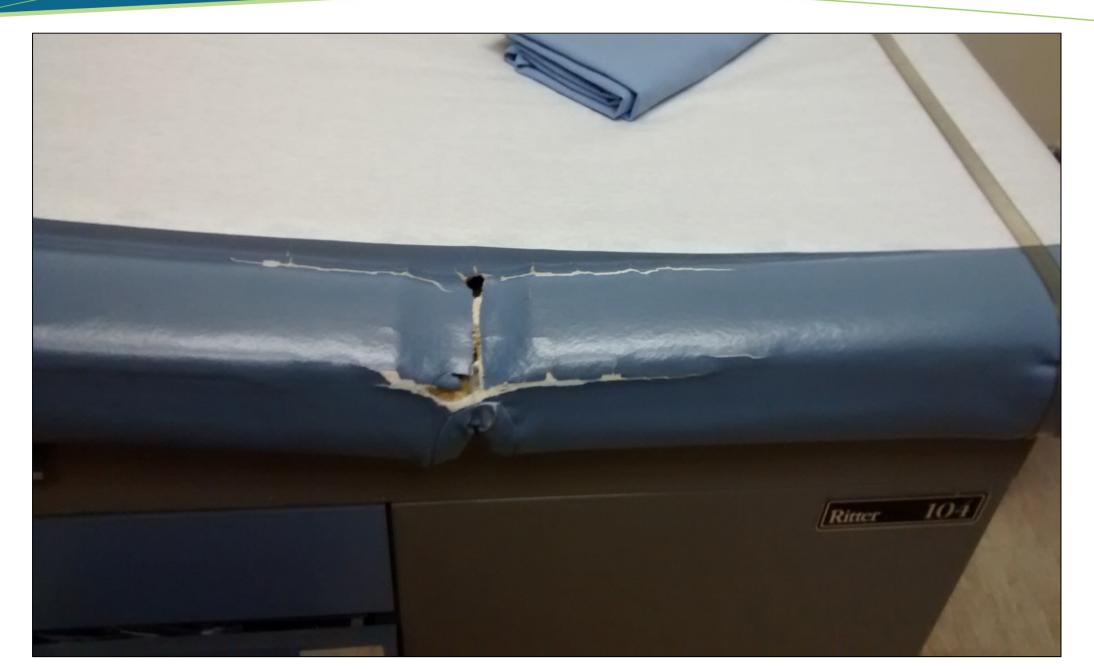
6. No alcohol based hand rub or dedicated hand washing sink in reprocessing area

7. No personal protective equipment available or worn during reprocessing

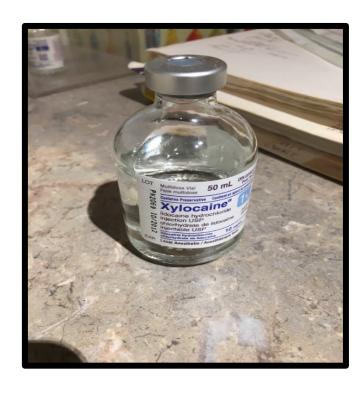


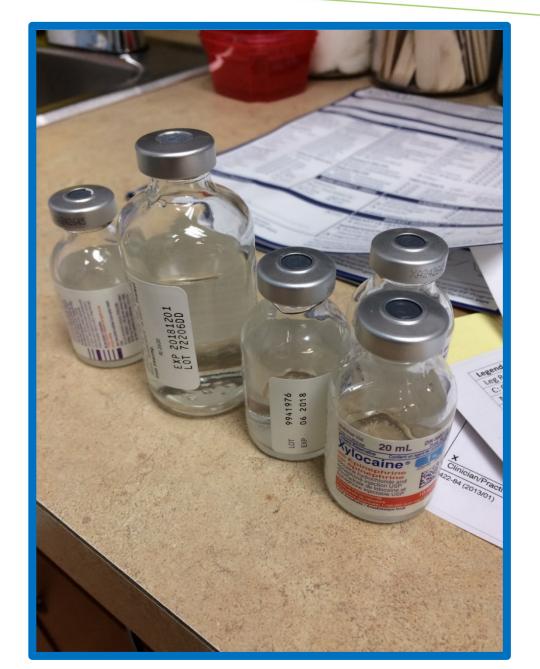
Reception/Waiting Area





Multi-dose Vials





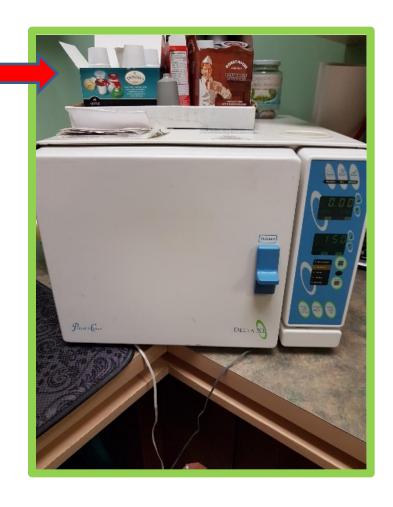


Glucometer-Lancing Devices





Reprocessing Area

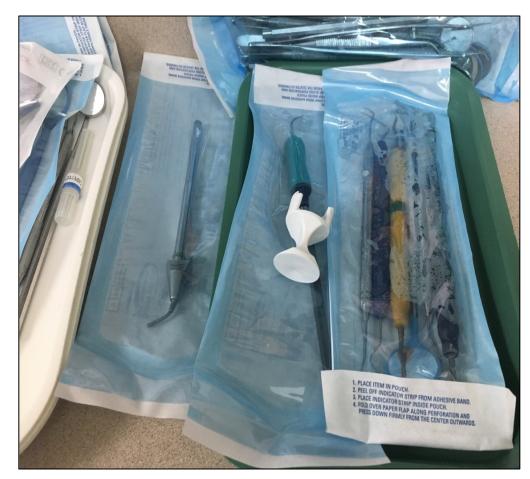






What's Wrong In This Picture?



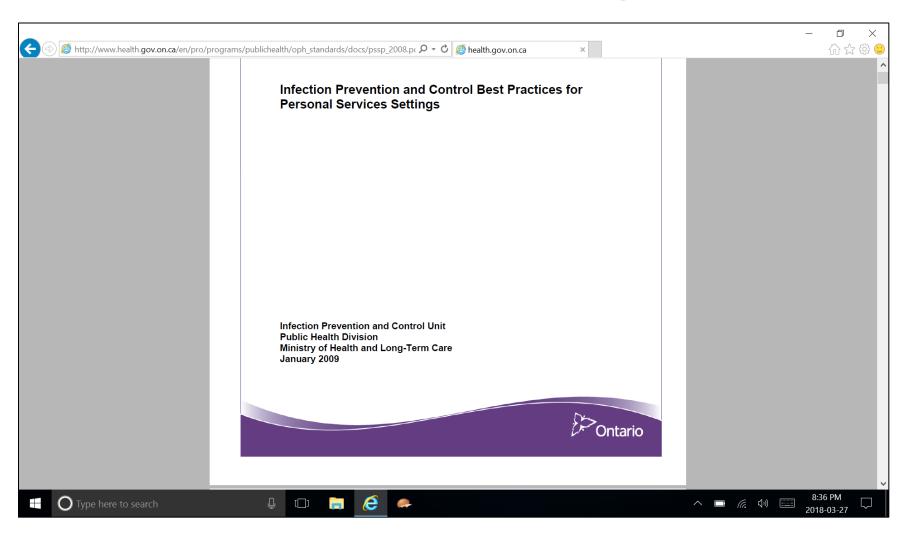


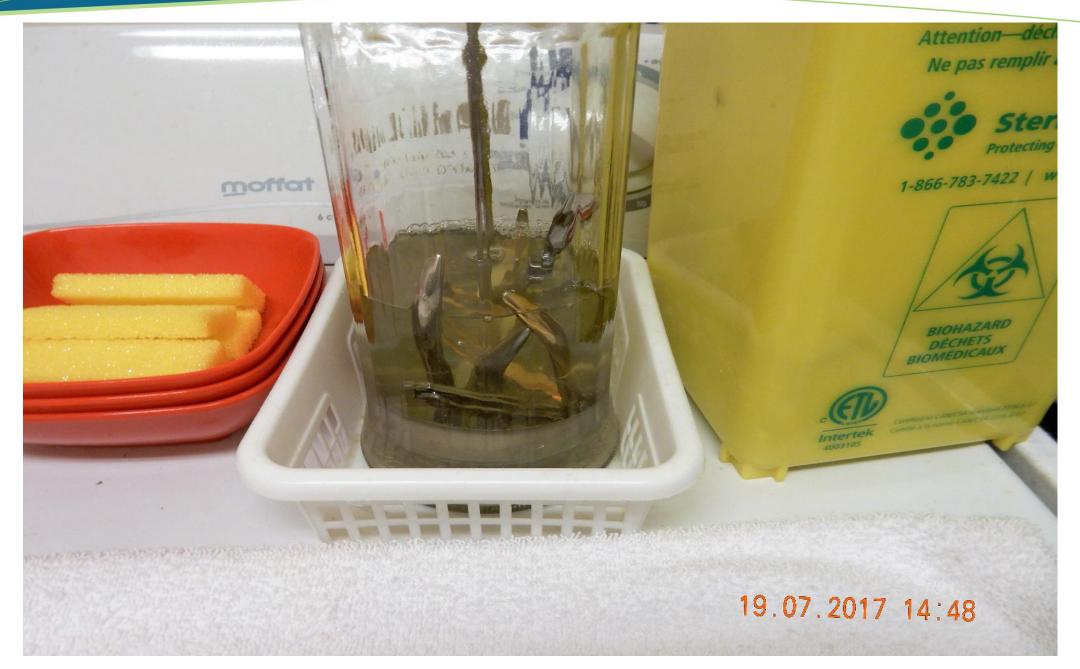




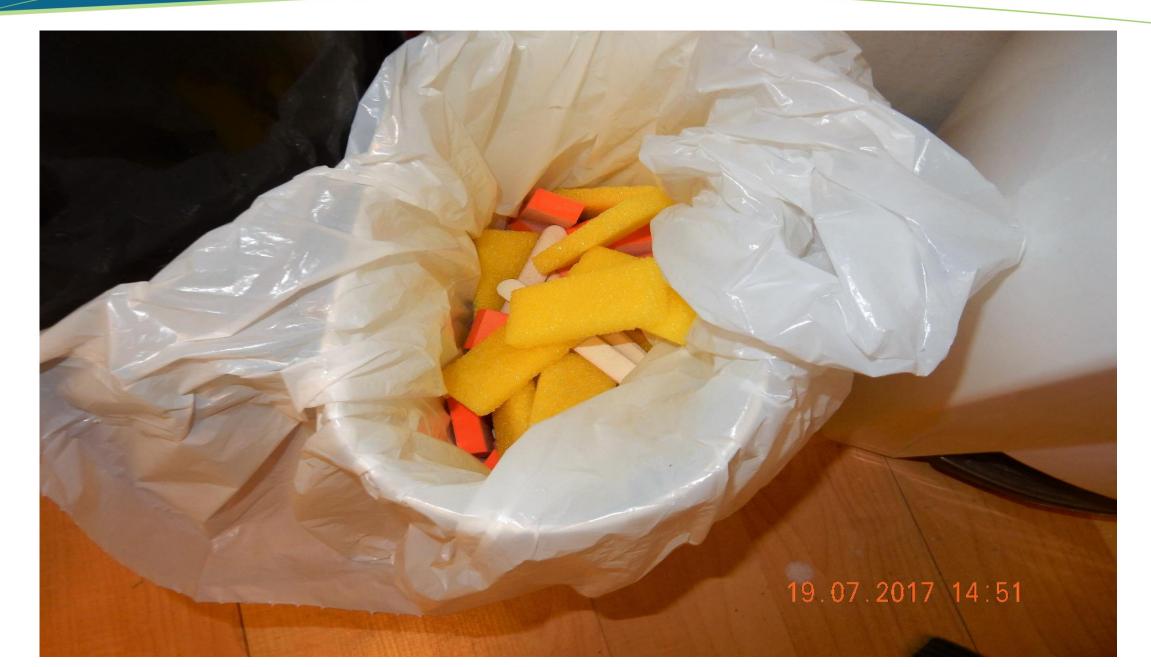


Personal Service Settings (PSS)

















Disclosure - www.niagararegion.ca

Inspection Results by Program Area















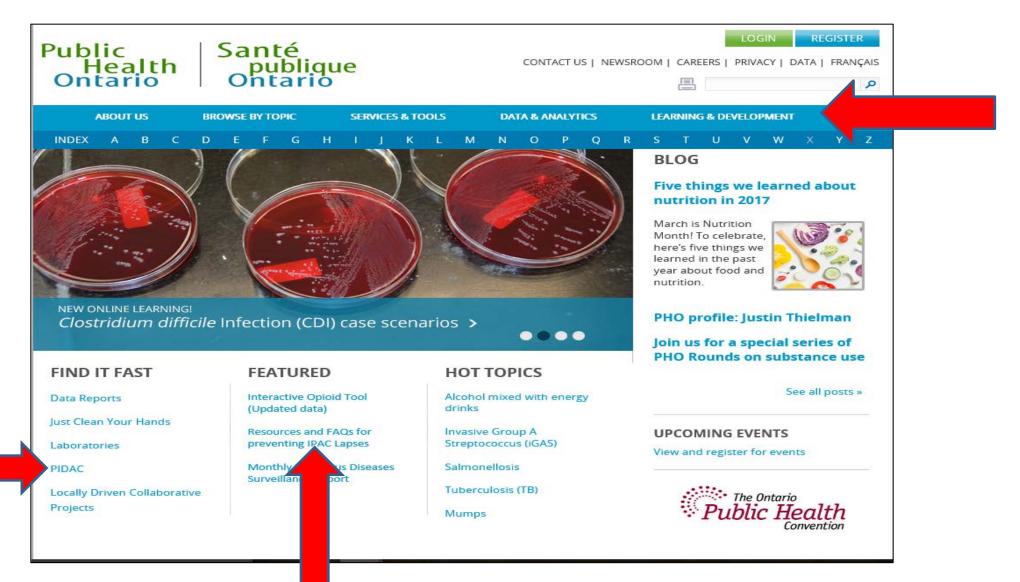


Team Niagara-Practice Makes Perfect

- Internal Audits (Dental Program, Vaccine Preventable Division, Breastfeeding, Mental Health, Sexual Health, School Based Vaccine & Dental Programs, Outreach Program)
- PHO Checklists completed for each audit and reviewed with Managers/Directors of each PH Program and recommendations provided
- January 2018-All PH staff are completing PHO modules and this will be captured through our Learning Management System
- IPAC specific corporate, departmental, divisional and program policies & procedures are being revised



Coaches & Trainers





IPAC Starts With You!!!!





The Infection Stops Here

