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
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.

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

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.
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
✓ Public Health Inspectors

✓ Public Health Nurses

✓ Manager (Environmental Health)

✓ 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
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
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
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
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