



Infection Prevention and Control Lapse Report

Canada Vein Clinics

Initial Report

Premise/facility under investigation

Name of facility: Canada Vein Clinics
Address: 595 Montreal Road suite 205
Ottawa, On
K1K 4K4

Type of premise/facility

Health Care Clinic

Date Board of Health became aware of IPAC lapse

2024-09-03

Date of Initial Report posting

2024-11-08

Date of Initial Report update(s)

2025-08-29

How the IPAC lapse was identified

In response to an infection prevention and control (IPAC) complaint, Ottawa Public Health (OPH) inspected the facility and an IPAC lapse was identified.

Summary Description of the IPAC Lapse

Ottawa Public Health observed the deviations from best practices:

Inadequate reprocessing of reusable and single use medical equipment

- Reprocessing of single-use disposable medical devices endovenous laser ablation (EVLA) laser fiber, did not follow reprocessing steps as per device manufacturer's instructions.

Inadequate reprocessing procedures

- No dedicated medical device reprocessing area, no dedicated reprocessing sink, inadequate staff training for performing reprocessing

Inappropriate use of autoclave

- Expired and inappropriate use of biologic indicators and chemical indicators, record keeping not in accordance with standards, and use of an autoclave not licensed by Health Canada.

Inadequate cleaning and disinfection and hand hygiene supplies

Inadequate IPAC practices for medications, and supplies

- Deviations from IPAC best practices, such as, opened multi-dose medications which were undated, or marked with a date past their use by date, indicating they should have been discarded
- Intravenous solution bags were partially-used and not discarded
- Deviations from IPAC best practices, such as, expired medical devices and supplies, and medical devices not licensed by Health Canada

IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college?

Yes.

If yes, was the issue referred to the regulatory college?

Yes, the College of Physicians and Surgeons of Ontario was notified of the investigation.

Were any corrective measures recommended and/or implemented?

On 2024-09-04 the Clinic was verbally instructed to stop on-site medical device reprocessing, using the autoclave, and to use single-use disposable items only for all procedures. A written letter of instruction was provided on 2024-09-05.

On 2024-10-25, the Clinic was provided written instructions to remove and dispose of the unlicensed autoclave and to dispose of all equipment that was reprocessed at this clinic.

On 2024-11-04, the Clinic was issued written instructions to reinforce infection prevention and control practices, including:

- Continue exclusive use of single-use, disposable medical equipment, and ongoing reprocessing activities be suspended (in effect since 2024-09-04)
- Adherence to best practices for cleaning and disinfection of clinical equipment and procedure rooms

On 2024-12-13, the Clinic was provided an Order for direction to follow best practices with ultrasound gel, multi-dose medication vials, sharps containers, intravenous bags, reusable equipment and posting of any ordered actions for all staff awareness.

On 2025-06-25, the Clinic was provided written instructions to:

- Continue to use only single-use, disposable medical equipment, with exception to, (1) a reusable device which illuminates the veins and (2) the ultrasound probe.
- Clean and disinfect the vein illumination device and ultrasound probe as per best practice.
- Ultrasound probe that is not in good repair must be replaced.

Please provide further details

Based on Ottawa Public Health observations and information gathered during the investigation, the clinic was to notify individual patients who received endovenous laser ablation or therapy (EVLA or EVLT) at this clinic between March 1, 2018 to January 13, 2025 such that they may speak with their health care provider to consider testing for bloodborne infections (BBIs).

On or about 2025-08-29, patients who underwent EVLA or EVLT between the above timeline should have received a letter via registered mail sent by the Clinic.

Date any order(s) or directive(s) were issued to the owners/operators (if applicable)

On 2024-12-13, an Order was issued under the Health Protection and Promotion Act. This Order remains active as of 2025-08-29.

On 2025-01-09, an Order was issued under the Health Protection and Promotion Act that required the premises be closed until a re-inspection was completed. This Order was rescinded on 2025-01-13.

From 2025-01-10 through to 2025-08-29, OPH exercised authority under the Health Protection and Promotion Act (HPPA) with respect to patients of the Clinic being notified of the lapse, including making requests and an Order. The Clinic confirmed with Ottawa Public Health that by August 29, 2025 it completed the patient notification process by sending letters to all patients who underwent EVLA or EVLT procedures between the date of 2018-03-01 to 2025-01-13. ELVA is performed with single-use or reusable laser fibers, medications from multidose vials and intravenous solutions.

Final Report

Date of Final Report posting:

2025-08-29

Date of Final Report Update(s)

N/A

Date all corrective measures were confirmed to have been completed

N/A

Brief description of corrective measures taken

N/A

Final Report Comments and Contact Information

Any Additional Comments

On 2024-12-13, an Order for direction to comply was issued under the Health Protection and Promotion Act. This Order remains active as of 2025-08-29. The Clinic was instructed to consult with public health for set-up of a medical device reprocessing area prior to introducing any reusable equipment on-site.

If you have any further questions, please contact:

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Infection Prevention and Control Inspections and Investigations
Ottawa Public Health

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For general updates regarding this investigation, continue to monitor this report.

The results of routine inspections are posted on the [Ottawa Public Health Disclosure website](#).