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Infection prevention and control lapse report

Navan Medical Centre

Initial report

Premises / facility under investigation	
Navan Medical Centre 3349 Navan Road Ottawa, ON K1W 0K7	
Type of premises / facility	Medical clinic
Date Board of Health became aware of IPAC lapse	2025-09-10
Date of initial report posting	2025-12-03
Date of initial report update(s), if applicable	N/A
How the IPAC lapse was identified	Complaint
Summary description of IPAC lapse	

Inadequate reprocessing of reusable medical equipment:

- No dedicated medical device reprocessing area
- Sterilizer was not licensed by Health Canada
- No biological or pre-vacuum chemical indicator testing
- Sterilization of instruments labelled as single-use
- Expired cleaning and disinfecting products
- Pre-sterilization cleaning steps not aligned with best practices
- Record keeping not aligned with best practices
- Inadequate packaging and labelling of sterilized instruments
- Lack of staff education or training in reprocessing

Non-adherence to IPAC best practices:

- Expired alcohol-based hand rub (ABHR)
- Unlabelled and/or expired ultrasound gel
- Improper storage of medications, including multidose vials

IPAC lapse investigation

Did the IPAC lapse involve a member of a regulatory college?	Yes, College of Nurses of Ontario (CNO) and College of Physicians and Surgeons of Ontario (CPSO)
Were other stakeholders notified (e.g. Ministry)?	Yes, Public Health Ontario and Ministry of Health
Were any corrective measures recommended and/or implemented?	Yes
Please provide further details	• Immediate suspension of reprocessing; clinic switched to single use disposable equipment • Discard and replace expired ABHR, medications and ultrasound gel • Follow best practices for handling multidose vials and medical gels • Follow best practices for cleaning and disinfection of clinical settings
Date any order(s) or directive(s) were issued to the owner / operators (if applicable)	
On 2025-09-10, verbal and written direction was given to suspend reprocessing and use only single-use disposable instruments until OPH's investigation is completed.	
Additional comments	
• Corrective measures were discussed during initial inspection and provided in a written inspection report provided to the clinic • All expired products were discarded and/or replaced by 2025-09-11 • Risk assessment consultation with Public Health Ontario concluded on 2025-11-26 that the above-stated corrective measures were supported and that additional measures would not be indicated.	

Final report

Date of final report posting	2026-01-15
Date of final report update(s)	2026-01-15
Date all corrective measures were confirmed to have been completed	2026-01-13
Brief description of corrective measures taken	
All corrective actions have been implemented. The clinic will no longer reprocess reusable instruments and have permanently switched to using only single-use, disposable equipment.	

Additional comments

Final report and contact information

If you have any further questions, please contact	Michelle Wasser, Program Manager Infection Prevention and Control Program IPAC/PCI@ottawa.ca 613-580-2424 extension 26325