Infection Prevention and Control Lapse Report
Retina Centre of Ottawa

Initial Report

Premise/facility under investigation

Retina Centre of Ottawa

2211 Carling Ave.

Ottawa, On

K2B 7E9

Type of premise/facility

Ophthalmology Clinic

Date Board of Health became aware of IPAC lapse

2021-01-26

Date of Initial Report posting

2021-04-01

Date of Initial Report update(s)

N/A

How the IPAC lapse was identified

During an inspection related to COVID practices, OPH identified an infection prevention and control (IPAC) lapse.

Summary Description of the IPAC Lapse

Reprocessing of reusable medical devices:

- Disinfection of semi-critical devices did not meet the provincial best practice standards
- Using the wrong product to clean critical items prior to sterilization
- Poor dirty to clean flow in the reprocessing area
- Not sufficiently monitoring and documenting sterilizer function as per provincial best practice standards

Environmental cleaning:

- Surfaces in some clinical areas were not being cleaned with an appropriate disinfectant

- Surfaces in the reprocessing area not regularly disinfected

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

Were any corrective measures recommended and/or implemented?

Yes

Please provide further details

Reprocessing of reusable medical equipment:

- Reprocess semi-critical medical equipment, including tonometer prisms, using high-level disinfection (HLD) at a minimum and according to provincial best practice documents and manufacturer's instructions for use (MIFUs).
- Perform reprocessing of medical equipment in a designated area with dirty to clean flow and regularly disinfect the reprocessing environment with a low-level hospital grade disinfectant
- Complete and retain a permanent record of reprocessing which includes monitoring biological indicators, chemical indicators and the physical parameters of the sterilizer

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

On 2021-01-26, the practitioner stopped using medical devices until they could be reprocessed adequately and had single-use medical devices available.

Initial Report Comments and Contact Information

If you have any further questions, please contact:

Title: Dominique Bremner, Manager

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.

Interim Report

Date of Interim Report

February 1, 2021

Were any corrective measures recommended and/or implemented?

With OPH's assistance, the clinic staff completed a BI challenge January 29, 2021 to confirm sterilizer function on January 30, 2021

Final Report

Date of Final Report posting:

2021-04-01

Date all corrective measures were confirmed to have been completed

February 8, 2021

Brief description of corrective measures taken

- Using single-use disposable tonometer tips
- Reprocessing area set up with good dirty to clean flow with sufficient space to clean, dry and package equipment
- Purchased neutral detergent to clean reusable critical medical devices
- Disinfecting clinical and reprocessing surfaces regularly with hospital grade low level disinfectant
- Purchased a new sterilizer with printer in addition to the current sterilizer
- Monitoring and documenting the reprocessing process (Bis, CIs and physical parameters)

Final Report Comments and Contact Information

Any Additional Comments

If you have any further questions, please contact:

Dominique Bremner, Program Manager

Infection Prevention and Control Inspections and Investigations

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