Infection Prevention and Control Lapse Report
The Ottawa Hospital – General Campus

Initial Report

**Premise/facility under investigation**
The Ottawa Hospital (TOH) – General Campus
501 Smyth Rd
Ottawa, On
K1H 8L6

**Type of premise/facility**
Hospital

**Date Board of Health became aware of IPAC lapse**
2019-05-24

**Date of Initial Report posting**
2019-06-14

**Date of Initial Report update(s)**
N/A

**How the IPAC lapse was identified**
Ottawa Public Health (OPH) identified 5 cases of salmonella infection in patients who had undergone a cystoscopy procedure at TOH - General Campus, Outpatient Department. OPH and TOH initiated a joint investigation and determined that an IPAC lapse had occurred, ultimately identifying a total of 8 cases associated with TOH.

**Summary Description of the IPAC Lapse**
Reprocessing of reusable medical equipment
- Some deficiencies in pre-cleaning and cleaning process for cystoscopes
- Inadequate inspection of cystoscopes

Documentation
- Inconsistent documentation of device for tracking
### IPAC Lapse Investigation

**Did the IPAC lapse involve a member of a regulatory college?**
No

**If yes, was the issue referred to the regulatory college?**
N/A

**Were any corrective measures recommended and/or implemented?**
Yes

**Please provide further details**

**Reprocessing of reusable medical equipment**

**Pre-clean**

- Immediately after use:
  - Use a clean cloth to wipe the exterior of the cystoscope with water or detergent (according to the manufacturer’s instructions for use (MIFUs))
  - Flush or suction all channels with detergent or tap water (according to the MIFUs)

**Clean**

- If the pre-clean step is incomplete or not done, and the cystoscope has been soiled for more than 1 hour, all channels must be flushed with copious amounts of enzymatic detergent before performing manual cleaning
- All cystoscopes must be closely inspected for damage by reprocessing staff

**Documentation**

- Staff in the cystoscopy suite document the serial number and/or hospital-assigned barcode of the cystoscope used on the patient in the patient’s chart and send the patient information with the scope to the Medical Device Reprocessing Department (MDRD) for entry into the tracking system

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

### Initial Report Comments and Contact Information

**Any Additional Comments**

On May 31, 2019, TOH identified one scope associated with the salmonella cases and removed it from service. All patients who had a cystoscopy done with this scope between
February 1st and May 31st were identified. TOH initiated patient notification on 2019-06-10 and follow-up measures were taken.

If you have any further questions, please contact:

Title: Dominique Bremner, Program Manager
Infection Prevention and Control Inspections and Investigations
Ottawa Public Health

E-mail address: IPAC/PCI@ottawa.ca
Phone number: 613-580-2424 ext. 26325

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 posting:
2020-01-13

Interim Report Update(s)

On 2019-10-03 Ottawa Public Health (OPH) determined that 2 additional cases who had procedures done July 11th and August 8th with a second cystoscope formed a second cluster linked to this lapse. TOH had removed this second scope on 2019-08-15, when the initial testing results identified salmonellosis in the first case. TOH and OPH resumed their investigation of the lapse.

Date all corrective measures were confirmed to have been completed
2020-01-07

Brief description of corrective measures taken

- The cystoscope manufacturer did a complete review of all cystoscopes in use at TOH campuses, October 16 and 17, 2019
- Audits of the Cystoscopy Suites and the Medical Device Reprocessing Department were undertaken and are ongoing
- Environmental testing of the cystoscopy suites negative 2019-10-17

Any Additional Comments

TOH has notified the 2 cases who formed the second cluster. After conducting a risk analysis concerning this second cluster using additional information gathered from the investigation,
TOH determined additional patient notification is not warranted. If you have any concerns regarding a cystoscopy at TOH, please call TOH Patient Relations at 613-798-5555 ext. 13377.

**Final Report**

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<th>Date of Final Report posting:</th>
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**Final Report Comments and Contact Information**

If you have any further questions, please contact:

**Title**: Dominique Bremner, Program Manager  
Infection Prevention and Control Inspections and Investigations  
Ottawa Public Health

**E-mail address**: IPAC/PCI@ottawa.ca  
**Phone number**: 613-580-2424 ext. 26325

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