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

Date of Final Report posting:

2020-01-13

Date of Final Report Update(s)

2020-01-13

Date all corrective measures were confirmed to have been completed

2020-01-07

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

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Phone number: 613-580-2424 ext. 26325

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