How Will I Know… Is This an IPAC Lapse?

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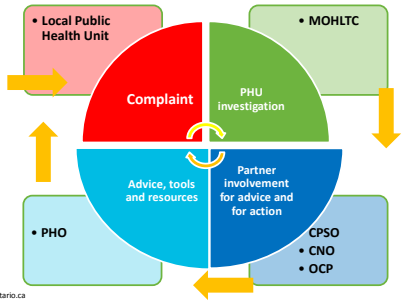
Objectives

- To review the steps of the IPAC lapse process
- To discuss the collaboration and partnership between Public Health Ontario (PHO) and the local public health unit (PHU)
- To give examples of past IPAC lapses
- To share and review PHO resources

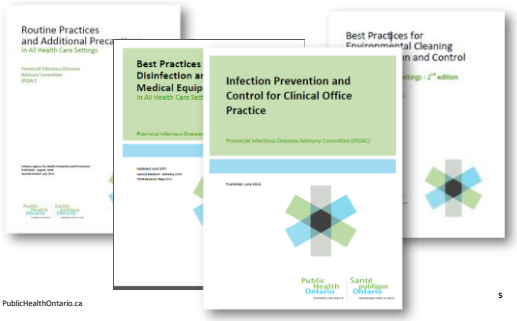
Partners

- Public Health Ontario (PHO)
- Public Health Units (PHU)
- Ministry of Health and Long-Term Care (MOHLTC)
- Regulatory colleges

Anatomy of a Complaint Investigation



PIDAC Best Practice Documents



Expert Guidance Provided

- General IPAC practices
- Cleaning, disinfection and sterilization of medical equipment and devices
- Safe medication administration
- Environmental cleaning

Working with the PHU

- PHO supports the PHU with:
  - IPAC Risk Assessment
    - Review information and analyze audit results
  - Qualitative/quantitative risk assessment to inform decisions about patient look-back
    - Determine the risk of exposure to blood-borne pathogens
      - Identify issues with improper reprocessing of medical equipment/devices or improper medication administration practices
    - Complete literature search
  - Access to IPAC Resources – checklists and IPAC training
  - Access to laboratory/epidemiology support

IPAC Lapses

Cleaning, Disinfection and Sterilization Lapse #I

- Physician using improperly reprocessed critical instruments to perform minor procedures such as removal of cutaneous warts, skin tags and sutures
  - No pre-clean or cleaning of instruments
  - Instruments being placed directly in enzymatic cleaner
  - Soaked for an undetermined period of time (may be up to one week)
  - Instruments removed from solution when needed, rinsed and pat dry
- Not compliant with established CSR practices
- Improper reprocessing practice stopped
- Follow-up inspection completed by the PHU

Lapse #I (cont…)

- Issues:
  - Minor procedures were considered high risk (excessive bleeding)
  - Instruments classified as critical requiring sterilization
  - No pre-cleaning done and cleaning was questionable
    - No monitoring of enzymatic soaking solution
  - Increased risk of exposure to blood-borne pathogens
  - Carrying out these procedures for decades
  - Large caseload and difficult to track patients having had a high risk procedure done
  - Literature search did not reveal any relevant information

Decision

- Physician's practice could have resulted in the risk of transmission of BBP (HBV, HCV & HIV)
- Those patients verified as having one or more of the minor procedures of concern to be notified and offered testing for HBV, HCV & HIV

Outcome

- 580 patients were sent letters with testing recommendations
  - 150 patients initially identified but because record keeping was an issue, PHU went public
    - Revealed additional patients
  - Practice then came forward with additional 400 patients
- As of mid-February 2016, 360 tested but additional results trickle in (2-3 per week)
- BBP identified but not definitively attributable to the practice:
  - 1 HIV
  - 2 HBV
  - 4 HCV

Cleaning, Disinfection and Sterilization Lapse #2

- Improper reprocessing of reusable medical equipment/devices after procedures completed in a family physicians/specialists practice.
- Practice operating for approximately 10 years
- High risk procedures identified were intra-uterine device (IUD) insertion and endometrial biopsies
  - Use of tenaculum

Lapse #2 (cont…)

- Issues:
  - High risk procedures (IUD insertion and endometrial biopsies)
  - Use of tenaculum during high risk procedures
  - No policies and procedures in place to guide consistent approach to cleaning
  - No training on use of sterilizer
    - No physical, biological or chemical indicators used
  - Improper preparation of instruments for sterilization
    - Too many per package
    - Hinges left in closed position
  - Instruments placed in an open container of disinfecting solution following sterilization (no monitoring of solution)

Decision

- The improper reprocessing of the tenaculum could have resulted in a risk of transmission of blood-borne viruses, especially HBV and HCV given their greater degree of infectiousness when compared with HIV.
- That said, the risk is likely exceedingly small.
- Those patients verified as having received one or more IUD insertions or endometrial biopsies notified of their exposure.
- While a recommendation for testing for BBV could also be made, any cases identified as a result of testing likely could not be linked specifically to the deficiencies in reprocessing discussed above.

Medication Administration Lapse #3

- Anaesthesiologists in a clinic setting indicated they inserted a blunt needle into a multi-dose Propofol vial and normal saline bag and left it in for future access.
- May be using contaminated syringes to re-access vial.
- May be accessing for multiple patients.
- Medication and medication-filled syringes were observed left on cart in high traffic area of the clinic
- Pre-filled syringes kept in a container in procedure room that may be used on multiple patients.

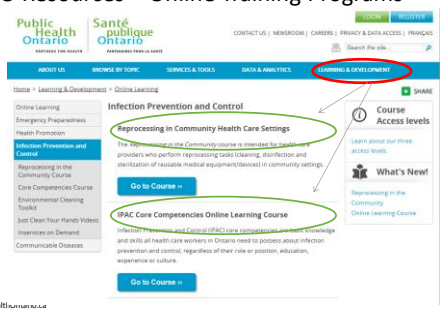
Decision

- Clinic was advised to:
  - Not leave a needle of any kind in a multi-dose vial.
  - Use a needle and syringe for one draw and then discard.
  - Preferentially use single-dose medication vials, or the smallest multi-dose vials and access appropriately.
  - Only access normal saline bags once then discard.
  - Use single-use normal saline syringes for flushing IV lines.
  - Store medication in a secured area.
  - Take pre-filled syringes into room only as needed.
- No patient notification was required

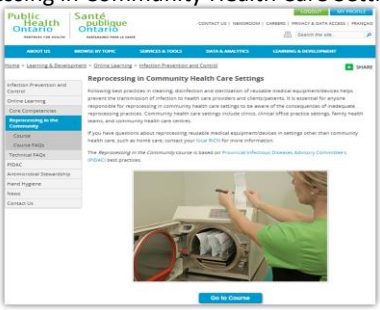
PHO Resources - Checklists

- Three checklists in development:
  - Core
  - Reprocessing of medical equipment/devices
  - Endoscopy
- Based on IPAC best practices (Provincial Infectious Diseases Advisory Committee (PIDAC) and Canadian Standards Association (CSA) documents)
- Useful audit tools

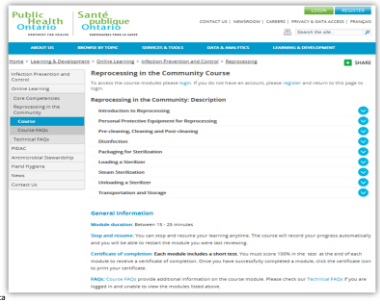
PHO Resources – Online Training Programs



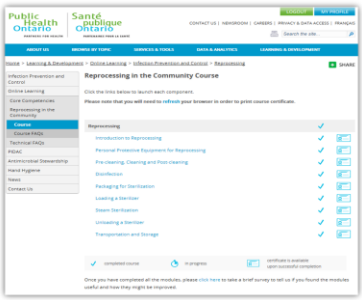
Reprocessing in Community Health Care Settings



Reprocessing in Community Health Care Settings (cont…)

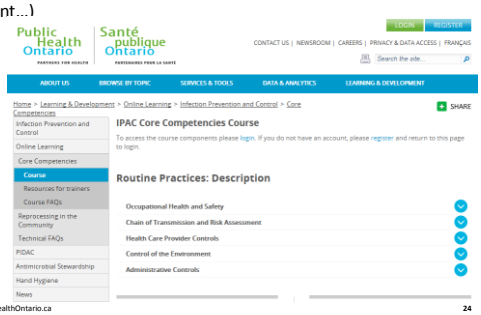


Reprocessing in Community Health Care Settings (cont…)



IPAC Core Competencies Online Learning Course

IPAC Core Competencies Online Learning Course (cont…)



IPAC Core Competencies Online Learning Course
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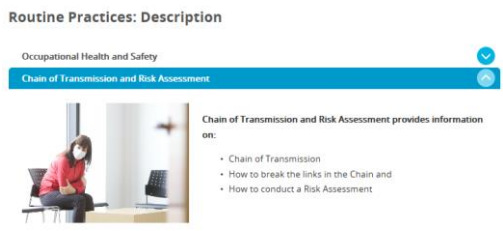

Summary

- Each IPAC lapse has unique characteristics and must be handled on a case-by-case basis
- Importance of open communication with the local PHU is key
- A standardized approach and the use of tools and resources is important