

How Will I Know ... Is This an IPAC Lapse?

Presentation to: IPAC SWO
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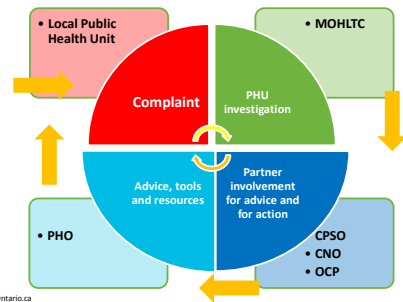
Objectives

- 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

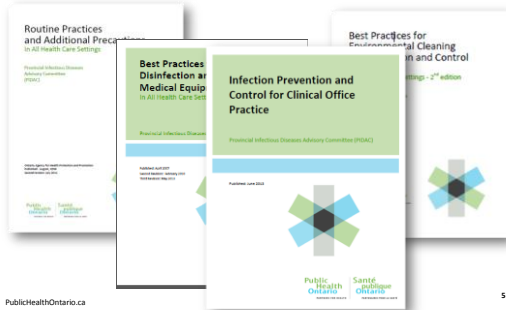
Partners

- Public Health Ontario (PHO)
- Local 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

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IPAC Lapses

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Cleaning, Disinfection and Sterilization Lapse #1

- 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

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Lapse #1 (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

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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

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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

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Cleaning, Disinfection and Sterilization Lapse #2

- Improper use of single patient-use glucometers and lancing device holders during blood-glucose monitoring on multiple patients at walk-in clinics.
- Non-disposable, pen-like lancing devices that holds the lancet that may become contaminated with blood.
- Reprocessing (cleaning and disinfection) of these devices between each patient use was not done.
- Involved multiple walk-in clinics in multiple jurisdictions (within and beyond Ontario).
- MOHLTC was involved.

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Lapse #2 (cont...)

- Issues:
 - Use of these lancing devices by multiple persons could potentially result in exposures to blood borne infections (i.e., hepatitis B, hepatitis C and HIV).
 - Hepatitis B transmission has been epidemiologically linked to the shared use of lancing devices intended for single patient-use in multiple instances in the US and the UK long-term care facility settings.
 - In addition, an increased risk of hepatitis C transmission has been associated with shared lancing device use for blood glucose monitoring in a hospital setting.

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Decision

- Taking the observations and risk estimates into account, it is the unanimous consensus of PHO that a risk of transmission of blood borne viruses is extremely low.
- That said, we therefore recommended that those patients verified as having received glucose monitoring using single patient-use glucometers and lancing device holders be notified of these exposures.
- The affected patients could in turn discuss the situation with their primary care provider and, if they are concerned, testing for HBV, HCV and HIV could be considered.

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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.

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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

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PHO Resources - Checklists

- Three checklists available on PHO website:
 - 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

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PHO Resources – Online Training Programs

This screenshot shows the 'Learning & Development' section of the PHO website. The 'Reprocessing in Community Health Care Settings' course is highlighted with a green circle and an arrow pointing to its description. Below it, the 'IPAC Core Competencies Online Learning Course' is also highlighted with a green circle and an arrow. A 'Go to Course' button is visible for each course.

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Reprocessing in Community Health Care Settings

This screenshot shows the course page for 'Reprocessing in Community Health Care Settings'. It includes a description of the course, its objectives, and a 'Go to Course' button. A small image of a person in a lab coat is also visible.

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Reprocessing in Community Health Care Settings (cont...)

This screenshot shows the 'Reprocessing in the Community' course page. It lists various topics such as 'Introduction to Reprocessing', 'Personal Protective Equipment for Reprocessing', and 'Pre-cleaning, Cleaning and Post-cleaning'. A 'Go to Course' button is at the bottom.

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Reprocessing in Community Health Care Settings (cont...)

This screenshot shows a checklist for the 'Reprocessing in the Community' course. The checklist includes items like 'Introduction to Reprocessing', 'Personal Protective Equipment for Reprocessing', 'Pre-cleaning, Cleaning and Post-cleaning', 'Disinfection', 'Hand Hygiene', 'Antimicrobial Stewardship', 'IPAC', 'Hand Hygiene', 'Transmission and Storage', and 'Control of the Environment'. Each item has a checkbox and a 'Go to Course' button.

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IPAC Core Competencies Online Learning Course

This screenshot shows the 'IPAC Core Competencies Online Learning Course' page. It features a description of the course, its objectives, and a 'Go to Course' button. A photo of a healthcare worker is also present.

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IPAC Core Competencies Online Learning Course (cont...)

This screenshot shows the 'IPAC Core Competencies Course' page. It lists various topics such as 'Occupational Health and Safety', 'Chain of Transmission and Risk Assessment', 'Health Care Provider Controls', 'Control of the Environment', and 'Administrative Controls'. Each item has a dropdown arrow.

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IPAC Core Competencies Online Learning Course
(cont...)

Routine Practices: Description

Occupational Health and Safety

Chain of Transmission and Risk Assessment



Chain of Transmission and Risk Assessment provides information on:

- Chain of Transmission
- How to break the links in the Chain and
- How to conduct a Risk Assessment

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

