York Region
Infection Prevention And Control Lapse Report

Initial Report

Premise/Facility under investigation (name and address)

Dr. C.K. Yeung Family Doctor, Walk-in Clinic and Home Visit
4261 Hwy 7 Unit B2
Markham, Ontario

Type of Premises/Facility

Medical Clinic

Date Board of Health became aware of IPAC lapse (yyyy/mm/dd)	Date of Initial Report posting (yyyy/mm/dd)
2019/04/08	**2019/07/09**
Date of Initial Report update(s) (if applicable) (yyyy/mm/dd)	How the IPAC lapse was identified **Complaint**

Summary Description of the IPAC Lapse

York Region Public Health conducted inspections on April 10, 2019, April 11, 2019 and April 18, 2019 and noted the following: physical parameters (time, temperature, pressure) monitoring and daily spore testing of the Ritter M7 SpeedClave sterilizer were not being conducted; no chemical indicators (e.g., Type 5 or 6 chemical indicator) were being used on the inside of sterilization pouches containing medical equipment/instruments; the Ritter M7 SpeedClave sterilizer was not being used in accordance with the manufacturer's instructions for use and the reprocessing process for reusable medical equipment/instruments was not in accordance with the "Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in all Healthcare Settings", 3rd Edition, May 2013; blood sugar monitoring lancing devices (e.g., lancet holder, end cap) designed for single-client use were being used on multiple clients.

IPAC Lapse Investigation	Yes	No	N/A	Please provide further details/steps
Did the IPAC lapse involve a member of a regulatory college?	☒	☐	☐	
If yes, was the issue referred to the regulatory college?	☒	☐	☐	**College of Physicians and Surgeons of Ontario**
Were any corrective measures recommended and/or implemented?	☒	☐	☐	

Please provide further details/steps

Inspections were conducted April 10, 2019, April 11, 2019, and April 18, 2019. The premise must ensure the following:

Prior to resuming blood sugar monitoring:

- Discontinue using lancing devices on multiple clients that are intended for single-client use
- Ensure lancing devices (e.g., lancet holder, end cap) that are designed for single-client use are used on one client only, in accordance with manufacturer's instructions for use

Prior to resuming sterilization of reusable medical equipment/instruments:

- Discontinue offering any services at this premise whereby equipment/instruments are required to be sterilized
- Discontinue the use of any multi-use equipment/instruments that were reprocessed in the Ritter M7 SpeedClave Steam Sterilizer
- Discontinue the use of the Ritter M7 SpeedClave Steam Sterilizer for the sterilization/reprocessing of medical equipment/instruments
- Conduct three consecutive successful spore tests (using biological indicators) on the Ritter M7 SpeedClave Steam Sterilizer
- Use a sterilization process that is in accordance with the "PIDAC Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings", 3rd Edition, May 2013
- Ensure sterilized items are not released for patient use until the results of the spore test (using biological indicators) are

IPAC Lapse Investigation	Yes	No	N/A	Please provide further details/steps
				available and found to be negative; if this is not possible, sterilized items may be released for patient use after obtaining passed results from Type 5 or 6 chemical indicators and verifying the appropriate cycle physical parameters (time, temperature and pressure) have been achieved ○ Ensure records are kept (i.e., log book) to document that biological indicators, chemical indicators and physical parameters (time, temperature and pressure) have been met for every sterilization cycle and are stored and maintained on-site ○ Ensure supplies for quality assurance monitoring are kept on-site ○ Ensure that a recall process is in place in the event of sterilization failure ○ Alternatively, the operator can use sterile, single-use medical equipment/instruments and discard after use

Date any order(s) or directive(s) were issued to the owner/operator (if applicable) (yyyy/mm/dd)
2019/04/15, 2019/04/25, 2019/06/13

Initial Report Comments and Contact Information

Any additional Comments: (Please do not include any personal information or personal health information)

York Region Public Health provided an inspection report to the premise on April 12, 2019 outlining corrective measures to be implemented. The operator was educated on site during the inspections and instructed to use proper infection prevention and control practices. Follow-up written Orders under the Health Protection and Promotion Act were issued on April 15, 2019, April 25, 2019 and June 13, 2019. A re-inspection was conducted on May 9, 2019 where it was noted that all corrective measures have been implemented.

If you have any further questions, please contact
Health Connection

Telephone Number	Email Address
1-800-361-5653	Health.inspectors@york.ca

Final Report

Date of Final Report posting (yyyy/mm/dd)
2019/07/09

Date any order(s) or directive(s) were issued to the owner/operator (if applicable) (yyyy/mm/dd)

Brief description of corrective measures taken

Date of all corrective measures were confirmed to have been completed (yyyy/mm/dd)
2019/05/09

Final Report Comments and Contact Information

Any Additional Comments: (Please do not include any personal information or personal health information)

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