Infection Prevention and Control (IPAC) Lapse Report

Initial Report

Premises/facility under investigation:

Centre For Vein Care

Address:

18-279 Kingston Rd E, Ajax ON L1Z 0K5

Type of premises/facility: Medical Clinic

IPAC Lapse Details

Date board of health became aware of potential IPAC lapse: 2019-07-04

Date of initial report posting: 2019-07-12

How the potential IPAC lapse was identified: Complaint

Summary description of the IPAC lapse by complainant:

Concerned about the needle tips left in the vials/solution after the injection.

IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college? Yes

If yes, was the issue referred to the regulatory college? Yes

Please provide name of the regulatory college(s) and date(s) referred:

College of Physicians and Surgeons of Ontario (2019-07-09)

Were any corrective measures recommended and/or implemented? Yes

Please provide further details/steps:

- Ensure that once the medication is drawn up, the needle is immediately withdrawn from the vial. The needle must not be left in a vial to be attached to a new syringe.

Date any order(s) or directive(s) were issued to the owner/operator:

Order of a Public Health Inspector served (2019-07-05)

Initial Report Comments and Contact Information

Any additional comments: Operator education and resources provided.

If you have any further questions, please contact the Durham Health Connection Line:

Telephone: 1-800-841-2729, or email us.

Final Report

Date of final report posting: 2020-03-10

Date all corrective measures were confirmed: 2019-08-12

Brief description of corrective measures taken: Order of a Public Health Inspector revoked on 2019-08-12. All items were in compliance and corrected as per the corrective measures indicated above. The extent of the above corrective measures required were considered minimal.

Final Report Comments and Contact Information

Any additional comments: Operator education and resources provided.

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