Infection Prevention and Control (IPAC) Investigation Report
Kingston Imaging Services

INITIAL REPORT Last updated on: November 19, 2019

Premises or facility under investigation (name and address):

Kingston Imaging Services
797 Princess St. Suite 422
Kingston ON K7L 1G1

Type of premises or facility:

Medical Imaging

Date Board of Health became aware of IPAC Lapse:

November 12, 2019

Date IPAC lapse was linked to the premises/facility:

November 13, 2019

Date of initial report posting:

Not Applicable

Date of initial report update(s), if applicable:

Not Applicable

How the Board of Health became aware of potential IPAC lapse:

Complaint

Summary description of IPAC lapse:

KFL&A Public Health conducted an infection prevention and control complaint inspection on November 13, 2019. At the time of the inspection it was observed that practices on-site did not follow the standards set by the Provincial Infectious Disease Advisory Committee (PIDAC) for reprocessing of medical/dental instruments/devices and infection control in a clinical office setting.

Results of the inspection identified non-compliance in "High Risk" practices in the following areas of reprocessing:

- Cleaning of Semicritical Medical Equipment/Devices
- Chemical Products Used for Disinfection
- High Level Disinfection

Results of the inspection also identified non-compliance in "Medium Risk" practices in the following areas of reprocessing:

- Personal Protective Equipment
- Cleaning of Semicritical Medical Equipment/Devices
- Chemical Products Used for Disinfection

- High Level Disinfection

IPAC LAPSE INVESTIGATION

Did the IPAC lapse involved a member of a regulatory college:

Yes

If yes, was the issue referred to the regulatory college:

Yes. Referral made to College of Physicians and Surgeons of Ontario and College of Medical Radiation Technologists of Ontario

Were other stakeholders notified?

Yes. Notification made to Independent Health Facilities and the Ministry of Health and Long-Term Care

Corrective measures recommended or implemented:

The clinic facility was advised of the required corrective actions as per PIDAC Standards. An Order was issued under Section 13 of the Health Protection and Promotion Act and was in effect until corrective actions were verified at the time of reinspection, November 15, 2019.

Date and list of any order(s) or directive(s) that were issued to the owner or operator, if applicable:

November 13, 2019, H.P.P.A., R.S.O. 1990 Section 13 Order to cease and desist procedure and use of equipment implicated in the IPAC lapse (verbal and written)

INITIAL REPORT COMMENTS AND CONTACT INFORMATION

If you have any further questions, please contact: Environmental Health, KFL&A Public Health by phone at 613-549-1232 or by e-mail at enviro.health@kflaph.ca

FINAL REPORT

Last updated on: November 19, 2019

Date of final report posting:

November 19, 2019

Date and list of any order(s) or directive(s) that were issued to the owner or operator, if applicable:

November 13, 2019 H.P.P.A., R.S.O. 1990 Section 13 Order to cease and desist procedure and use of equipment implicated in the IPAC lapse (verbal and written)

Brief description of corrective measures taken:

A reinspection was completed on November 15, 2019. At the time of the reinspection the required changes had been made to cleaning of semicritical equipment, high level disinfection, and chemical products used for disinfection. These changes were in compliance with PIDAC Best Practices and therefore the Order issued on November 13, 2019 was lifted.

Date all corrective measures were confirmed to have been completed:

November 15, 2019

Date of final report update(s), if applicable:

Not Applicable

FINAL REPORT COMMENTS AND CONTACT INFORMATION

If you have any further questions, please contact: Environmental Health, KFL&A Public Health by phone at 613-549-1232 or by e-mail at enviro.health@kflaph.ca