Region of Waterloo
PUBLIC HEALTH AND
PARAMEDIC SERVICES

Region of Waterloo Public Health Infection Prevention and Control Lapse

Initial Report	Details/Description
Premise Premise/facility under investigation (name and address)	Temple Green Clinic 6-420 Erb St W., Waterloo ON N2L6H6
Type of premise/facility (e.g. medical clinic, multi-service PSS)	Clinical Office Practice – Gynecology
Date Board of health became aware of IPAC lapse	Inspection conducted May 2, 2023
Date IPAC lapse was linked to the premise/facility	May 2, 2023
Date of Initial Report Posting	June 8, 2023
Source of IPAC lapse information (e.g. routine inspection, public complaint etc.)	Complaint received
Summary Description of the IPAC lapse	Improper reprocessing: - Improper cleaning of instruments prior to sterilization. - Incorrect processing and storage of instruments. - Insufficient quality monitoring and record keeping of sterilization processes. Staff not adequately trained in processes for sterilization of instruments. Medication preparation/Physical space: - No labelling of multi-use vials. - Aseptic technique not followed when handling lubricating gel. - Improper and unlabeled chemical products used for environmental cleaning used on surfaces. Inadequate cleaning and disinfection of environmental surfaces

IPAC Lapse Investigation continued on next page…

IPAC Lapse Investigation	Answers/Explanation
Did the IPAC lapse involve a member of the regulatory college? If yes, which one	Yes - CPSO
If yes, was the issue referred to the regulatory college?	CPSO notified
Were other stakeholders notified? (e.g. Ministry)	No
Concise description of the corrective measures required	All corrective actions identified in letter sent to practice must be implemented.
Please provide further details/steps	Practice requirements to be verified on re-inspection: 1. Follow best practices for cleaning instruments prior to sterilization. 2. Follow best practices for sterilization and storage of instruments. 3. Follow best practices for quality monitoring of cleaning and sterilization process. 4. Follow best practices for aseptic technique. 5. Reprocessing staff to complete formal reprocessing education and have demonstrated competence. 6. Follow best practice when preparing medication and using multi dose vials. 7. Follow best practices for cleaning and disinfection of patient areas/clinical space (i.e. using approved product/following MIFU and adhering to product contact time).
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	Letter issued on May 8, 2023

Initial Report Comments

Final Report	Details/Description
Date of Final Report posting:	
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	N/A
Brief description of corrective measures taken	Practice requirements were verified by re-inspection on May 25, 2023 including: 1. Following best practices for cleaning and packaging instruments prior to sterilization. (Sterilization has been contracted to Steri-Ontario Medical Device Reprocessing Company). 2. Following best practices for reprocessing and storage of instruments. 3. Following best practices for quality monitoring of cleaning and reprocessing process 4. Following best practices for aseptic technique 5. Reprocessing staff have completed formal reprocessing education and have demonstrated competence. 6. Following best practices when preparing medication and no longer using multi dose vials. 7. Following best practices for cleaning and disinfection of patient areas/clinical space (i.e. using approved product/following MIFU and adhering to product contact time).

Final Report	Details/Description
Date all corrective measures were confirmed to have been completed	May 25, 2023

If you have any further questions, please contact: Andy Hong, Manager Health Protection and Investigation, ahong@regionofwaterloo.ca, 519-575-4400, ext. 2379