

<b>PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT</b>	
<b>Initial Report</b>	
Premise/facility under investigation (name and address)	Peterborough 360 Degree Nurse Practitioner Led Clinic (Formerly VON 360 Degree Nurse Practitioner Led Clinic) 360 George St. N. Peterborough ON. K9H 2H6
Type of premise/facility: (E.g. clinic, personal services setting)	Clinic
Date Board of Health became aware of IPAC lapse	2017-10-04
Date of Initial Report posting	2017-10-25
Date of Initial Report update(s) (if applicable)	2017-11-17
How the IPAC lapse was identified	Other
Summary Description of the IPAC Lapse	Instruments were not sterilized. These instruments were used on patients.
<b>IPAC Lapse Investigation</b>	
Did the IPAC lapse involve a member of a regulatory college?	Yes
If yes, was the issue referred to the regulatory college?	Yes
Were any corrective measures recommended and/or implemented?	Yes
Please provide further details/steps	Patients affected by this lapse have been contacted directly. Facility was provided with recommendations to be completed by December 31, 2017.
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	2017-11-08
<b>Initial Report Comments and Contact Information</b>	
Any Additional Comments (Do not include any personal information or personal health information)	
<b>If you have any further questions, please contact:</b>	
Name	Gillian Pacey
Title	Public Health Inspector
E-mail address	<a href="mailto:gpacey@peterboroughpublichealth.ca">gpacey@peterboroughpublichealth.ca</a>
Phone number	705 743 1000 Ext. 224
<b>Final Report</b>	
Date of Final Report posting:	2018-01-05
Date any order(s) or directive(s) were issued to the owner/operator (if applicable)	
Brief description of corrective measures taken	A new policy was created which included the following: procedure for the recall and reprocessing of improperly reprocessed medical equipment/devices; requirements for training in reprocessing and ongoing audits of staff; documentation of physical monitoring parameters for each load; process for maintaining instruments in moist container while awaiting reprocessing. The clinic has also improved their recording method for physical, chemical and biological parameters and included this in their policy. The reprocessing room layout was reorganized into a one-way flow with clear signage of designated spaces and procedures.
Date all corrective measures were confirmed to have been completed	2018-01-03
<b>Final Report Comments and Contact Information</b>	
Any Additional Comments (Do not include any personal information or personal health information)	Lapse was self-reported by the clinic and immediate corrective actions were taken to prevent further risk to patients.
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