York Region
Infection Prevention and Control Lapse Report

Initial Report

Premise/Facility under investigation (name and address)
Natural Healing Centre
10350 Yonge Street Unit:005
Richmond Hill, Ontario
L4C 5K9

Type of Premises/Facility
Medispa/Personal Service Setting

Date Board of Health became aware of IPAC lapse (yyyy/mm/dd)	Date of Initial Report posting (yyyy/mm/dd)
2022/07/18	2022/08/18
Date of Initial Report update(s) (if applicable) (yyyy/mm/dd)	**How the IPAC lapse was identified** Complaint

Summary Description of the IPAC Lapse
As a result of a complaint, York Region Public Health conducted an inspection at the premises on June 16th and on June 17th, 2022. York Region Public Health noted concerns regarding reuse of single use medical devices (e.g., syringes, needles, cannulas). Sharps were not discarded immediately at point of use. Multidose vials, where used, were not labeled with the date they were first opened/used; and were not discarded according to Manufacturer's Instructions for Use or within 28 days whichever is shorter. Sterile syringes and needles/cannulas were not always used when entering a vial. Once medication was drawn up from vial, the needle was not immediately withdrawn from the vial; needles were left in vials to be attached to a new syringe. Multidose vials were not discarded immediately where sterility was compromised or questioned. Single dose injectables were prepared in advance and not at the time of use. Operator did not ensure that medication/cosmetics were stored and prepared in a clean area on a clean surface that is separate from other areas. Rubber stopper (diaphragm) of vials were not scrubbed with 70% alcohol and allowed to dry prior to entry into vials. Product monograph was not followed and referred to for further clarification regarding correct storage, handling, preparation, expiry date, and directions for administration. Unopened vials, medications, creams, ampules, and sterile single use devices/equipment were not discarded according to manufacturer's recommended expiration date.

IPAC Lapse Investigation	Yes	No	N/A	Please provide further details/steps
Did the IPAC lapse involve a member of a regulatory college?	☒	☐	☐	Medical Director
If yes, was the issue referred to the regulatory college?	☒	☐	☐	Royal College of Physicians and Surgeons of Ontario
Were any corrective measures recommended and/or implemented?	☒	☐	☐	
Please provide further details/steps	**Corrective measures:** a) Ensure all needles are single use only. b) Ensure all syringes are single use only. c) Ensure sharps are discarded immediately at point of use into a puncture-resistant sharps container. d) Ensure the multidose vials are labelled with the date it was first used and discarded according to the MIFU or within 28 days, whichever is shorter. e) Ensure sterile syringes and needles/cannulas are used when entering a vial.			

IPAC Lapse Investigation	Yes	No	N/A	Please provide further details/steps
				f) Ensure that once medication/cosmetic substance is drawn up, the needle is immediately withdrawn from the vial; a needle is never left in a vial to be attached to a new syringe. g) Ensure multidose vials are discarded immediately if sterility is compromised or questioned. h) Ensure single-dose injectable medication/cosmetic substance are prepared at the time of use, used once on a single patient/client and discarded immediately. i) Ensure medication/cosmetic substance are stored and prepared in a clean area on a clean surface that is separate from other areas. j) Ensure rubber stoppers (diaphragm/septum) of vials are scrubbed with 70% alcohol and stopper is allowed to dry prior to entry into vial. k) Ensure product monograph is followed and referred to for further clarification regarding correct storage (e.g., refrigeration, keep away from light), handling, preparation, expiry date, and directions for administration. l) Ensure unopened vials, medications, creams, ampules, and sterile single use devices/equipment are discarded according to the manufacturer's recommended expiration dates m) Ensure critical and semi-critical equipment/devices labelled as single use are not re-used and are discarded immediately after use.

Date any order(s) or directive(s) were issued to the owner/operator (if applicable) 2022-06-21

Initial Report Comments and Contact Information

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

York Region Public Health issued a written order to the premises on June 21, 2022, ordering the operator to cease offering/providing services which are controlled acts.

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)
November 4, 2022

Date any order(s) or directive(s) that were issued to the owner/operator (if applicable) (yyyy/mm/dd)
August 16, 2022, and August 24, 2022

Brief description of corrective measures taken:

York Region Public Health issued a written order to the premises on August 16, 2022, with respect to IPAC corrective measures described in this report. Written order that was issued to the premises on June 21, 2022, was rescinded on August 24, 2022, following a re-inspection.

Final Report Comments and Contact Information

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

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