



Infection Prevention and Control Lapse Report

Fisher Dental

Initial Report

Premise/facility under investigation

Fisher Dental
1896 Prince of Wales Drive
Ottawa, On
K2C 3W9

Type of premise/facility

Dental Clinic

Date Board of Health became aware of IPAC lapse

2024-11-22

Date of Initial Report posting

2024-12-06

Date of Initial Report update(s)

N/A

How the IPAC lapse was identified

In response to an IPAC complaint, Ottawa Public Health (OPH) inspected the facility and an IPAC lapse was identified.

Summary Description of the IPAC Lapse

- Reprocessing of reusable medical equipment not according to IPAC best practice.
- Inadequately trained staff performing reprocessing.
- Inadequate tracking and documentation.

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, the Royal College of Dental Surgeons of Ontario and the College of Dental Hygienists of Ontario were notified of the investigation.

Were any corrective measures recommended and/or implemented?

Yes

Please provide further details

The facility is working with OPH to ensure that the Medical Device Reprocessing Area and reprocessing processes are congruent with best practices.

Date any order(s) or directive(s) were issued to the owners/operators (if applicable)

N/A

Initial Report Comments and Contact Information

Any Additional Comments

N/A

If you have any further questions, please contact:

Title: Michelle Wasser, Program Manager
Infection Prevention and Control Inspections and Investigations
Ottawa Public Health

E-mail address: IPAC/PCI@ottawa.ca ,

Phone number: 613-580-2424 ext. 26325

For general updates regarding this investigation, continue to monitor this report.

The results of routine inspections are posted on the [Ottawa Public Health Disclosure website](#).

Final Report

Date of Final Report posting:

2025-03-13

Date of Final Report Update(s)

2025-03-13

Date all corrective measures were confirmed to have been completed

2025-03-12

Brief description of corrective measures taken

On 2025-03-03, OPH confirmed that the clinic had taken the following actions to address the IPAC deficiencies:

- Written policy and procedures for reprocessing in accordance with IPAC best practices.
- Dedicated centralized reprocessing area with a one-way flow to prevent contamination.
- Provide employees with education and training on reprocessing.
- Documentation and verification of sterilization process.
- Adequate supplies for reprocessing are readily available.

Final Report Comments and Contact Information

Any Additional Comments

N/A

If you have any further questions, please contact:

Title: Michelle Wasser, Program Manager

Infection Prevention and Control Inspections and Investigations

Ottawa Public Health

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