## Initial Report

### Infection Prevention and Control Lapse Report

**Legget Drive Dental**

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<thead>
<tr>
<th>Premise/facility under investigation</th>
<th>Legget Drive Dental</th>
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<td>201- 555 Legget Drive</td>
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<td>Ottawa, ON</td>
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| Type of premise/facility                     | Dental Office                            |

| Date Board of Health became aware of IPAC lapse | 2019-11-25                               |

| Date of Initial Report posting               | 2019-12- 13                               |

| Date of Initial Report update(s)             | N/A                                      |

| How the IPAC lapse was identified            | In response to a public complaint regarding infection prevention and control (IPAC) in this dental clinic, OPH inspected the premises and determined an IPAC lapse has occurred. |

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<th>Summary Description of the IPAC Lapse</th>
<th>Reprocessing:</th>
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<td>- Foil test for ultrasonic cleaner not performed</td>
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<td>- Autoclave: not monitoring time, temperature and pressure of autoclave, inconsistent monitoring and documentation of BI’s</td>
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<td>- Some reusable dental instruments not packaged for reprocessing according to current best practices</td>
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<td>- No regular servicing of cleaning and sterilization equipment</td>
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<td>- Inappropriate use of flash sterilization</td>
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If you received a letter from Legett Drive Dental regarding this lapse, please visit: [OttawaPublicHealth.ca/Lapse](http://OttawaPublicHealth.ca/Lapse)
- Use of glass bead sterilizer
- Inconsistent flushing of dental lines

Policies and procedures
- No IPAC policies and procedures

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
- Royal College of Dental Surgeons of Ontario
- College of Dental Hygienists of Ontario

Were any corrective measures recommended and/or implemented?
Yes

Please provide further details
Reprocessing:
- Perform foil test weekly on ultrasonic cleaner and maintain records of testing
- Perform and document physical parameters of autoclaves
- Perform reprocessing steps for all dental instruments according to best practices
- Service autoclaves as per best practices
- Remove glass bead sterilizer from use
- Flush dental lines as per best practices
- Do not perform flash sterilization

Education
- Ensure all clinical staff complete Public Health Ontario’s modules on Reprocessing in the Community.

Date all corrective measures were confirmed to have been completed
2019-12-02

Brief description of corrective measures taken
- Foil test performed weekly on ultrasonic cleaner and records maintained
- Monitoring and documenting the function of the autoclave
- Reprocessing in accordance with best practices
- Glass bead sterilizer removed from clinic
- Statim sterilizer out of service indicated with signage
On 2019-11-25 the glass bead sterilizer was removed from use and processes for recording biological and chemical indicators were put in place. Packages that were not reprocessed in accordance with best practices were reprocessed appropriately. Plans are in place to develop policies and procedures for reprocessing, environmental cleaning, staff training and PPE use. Staff members are in the process of completing Public Health Ontario modules on Reprocessing in the Community.

OPH did follow-up visits to the Dental Clinic November 27th & 29th and December 2nd.

If you have any further questions, please contact:

Title:  Dominique Bremner, Program Manager
Infection Prevention and Control Inspection and Investigation
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.

A final site visit occurred on 2019-12-02. The Dental Hygienist/owner had instituted necessary corrective measures.

If you have any further questions, please contact:

Name:  Dominique Bremner, Program Manager
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