Infection Prevention and Control Lapse Report
Legget Drive Dental

Initial Report

Premise/facility under investigation

Legget Drive Dental

201- 555 Legget Drive

Ottawa, ON

K2K 2X3

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.

Summary Description of the IPAC Lapse

Reprocessing:

- Foil test for ultrasonic cleaner not performed
- Autoclave: not monitoring time, temperature and pressure of autoclave, inconsistent monitoring and documentation of BI's
- Some reusable dental instruments not packaged for reprocessing according to current best practices
- No regular servicing of cleaning and sterilization equipment
- Inappropriate use of flash sterilization

- 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

Initial Report Comments and Contact Information

Any Additional Comments

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

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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.

Any Additional Comments

Final Report

Date of Final Report posting:

2020-03-10

Final Report Comments and Contact Information

Any Additional Comments

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:

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