Peterborough Public Health

| PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT | |
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| | **Summary Report** |
| Premise/facility under investigation (name and address) | Norwood Family Dentistry, 4243 Hwy #7, Norwood, ON, K0L2V0 |
| Type of premise/facility: (E.g. clinic, personal services setting) | Dental Clinic |
| Date Board of Health became aware of IPAC lapse | 5/21/2019 |
| Date of Initial Report posting | 7/15/2019 |
| Date of Initial Report update(s) (if applicable) | |
| How the IPAC lapse was identified | Referral from other Medical Officer of Health |
| Summary Description of the IPAC Lapse | 1) Evidence suggesting medical equipment/devices were not reprocessed as per provincial infection control best practices. 2) Records showing consistent monitoring of equipment involved in reprocessing could not be fully verified. 3) Staff lacked full knowledge of provincial infection control best practices with regard to equipment reprocessing. 4) Incomplete policies and procedures were evident at the time of inspection |
| **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 |
| Were any corrective measures recommended and/or implemented? | Yes |
| Please provide further details/steps | 1) Reprocessing of medical equipment/devices to take place that is consistent with provincial infection control best practices. 2) Records maintained at all times showing evidence of full monitoring of reprocessing procedures/steps and any necessary preventative maintainence of equipment as per manufacturer instructions for use. 3) Staff being fully knowledgable of provincial infection control best practices as they pertain to reprocessing of all medical equipment/devices. 4) Policies and procedures being fully written and incorporated into daily work practices |
| Date any order(s) or directive(s) were issued to the owners/operators (if applicable) | 05/22/2019 and 06/21/2019 |
| **Initial Report Comments and Contact Information** | |
| Any Additional Comments (Do not include any personal information or personal health information) | Clinic was issued verbal closure order on May 22nd based on findings. And a follow up written closure order was hand delivered on May 23rd. |
| **If you have any further questions, please contact:** | |
| Phone number | 705 743 1000 Ext. 401 |
| **Final Report** | |
| Date of Final Report posting: | 7/15/2019 |
| Date any order(s) or directive(s) were issued to the owner/operator (if applicable) | |
| Brief description of corrective measures taken | 1) Reprocessing area updated to align with best practices. 2) Staff demostrated knowledge of IPAC best practices. 3) Policies and procedures have been updated and reference best practices. |
| Date all corrective measures were confirmed to have been completed | 7/12/2019 |
| **Final Report Comments and Contact Information** | |
| Any Additional Comments (Do not include any personal information or personal health information) | 07/12/2019: Patient notification is in progress. |
| **If you have any further questions, please contact:** | |
| Phone number | (705)743-1000 ext. 401 for a Nurse re: questions related to the lapse (Brian Sammon, Public Health Inspector ext. 235 for the disclosure) |