Peterborough Public Health

PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT

Summary Report

Premise/facility under investigation (name and address)	Kawartha Endodontics, 425 Water Street, Suite 200. Peterborough, ON, K9H3L9
Type of premise/facility: (e.g. clinic, personal services setting)	Dental Clinic
Date Board of Health became aware of IPAC lapse	7/11/2019
Date of Initial Report posting	09/19/2019
Date of Initial Report update(s) (if applicable)	N/A
How the IPAC lapse was identified	Public Complaint
Summary Description of the IPAC Lapse	1) Evidence suggesting medical equipment/devices were not reprocessed as per provincial infection control best practices. As such, the sterility of reprocessed medical equipment/devices used during patient treatment could not be verified. 2) Complete records pertaining to the monitoring of reprocessing practices could not be produced and as such, the sterility of the reprocessed medical equipment/devices used during patient treatment could not be verified.This included lack of evidence of completion of necessary scheduled preventative maintenance and efficacy testing on sterilization equipment. 3) Staff lacked knowledge of infection control best practices and were not aware of the manufacturer requirements for the operation and maintenance of reprocessing equipment. 4) Incomplete policies and procedures were evident with regard to IPAC best practices, staff training, auditing and reprocessing 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
Were any corrective measures recommended and/or implemented?	Yes
Please provide further details/steps	Clinic was issued oral closure order on July 15, 2019 based on findings. A follow up written closure order was hand delivered on July 16, 2019. A re-inspection was conducted on July 18, 2019 and the premise was not approved for re-opening. A final re-inspection was conducted on July 25, 2019, a rescind order was issued based on the assessment of the public health inspector that the health hazard had been remediated and the clinic was approved for re-opening on July 26, 2019.
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	July 15, 2019: Initial oral closure order July 16, 2019: Written closure order July 26, 2019: Closure order rescinded August 27, 2019: Patient notification order August 29, 2019: Patient notification order (updated to include date of birth)

Initial Report Comments and Contact Information

Any Additional Comments (Do not include any personal information or personal health information)	On August 27, 2019 and August 29, 2019 the dentist was ordered to provide contact information for patients who received dental treatment at Kawartha Endodontics between April 2010 and July 16, 2019. This would allow Peterborough Public Health (PPH) to notify patients of the risk of infection. As the dentist appealed this Order, PPH was not able to conduct direct patient notification and conducted public notification using media on September 19, 2019. Due to reasons beyond PPHs control, the appeal hearing was delayed until June 15 and June 16, 2021. On July 29, 2021, the Health Services and Appeal Board (HSARB) issued their decision in favour of PPH, confirming the Order to release patient contact information. The dentist has now appealed this decision to the Divisional Court. Since the public notification in 2019, 950 patients have been tested for Hepatitis B, Hepatitis C and HIV. Of those we have received six positive results (positive lab results for Hepatitis B, Hepatitis C and HIV are reportable to public health)

If you have any further questions, please contact:

Telephone	(705)743-1000 ext. 401

Final Report

Date of Final Report posting:	
Date any order(s) or directive(s) were issued to the owner/operator (if applicable)	July 15th: Initial oral closure order July 16th: Written closure order July 26th: Closure order recinded August 27th: Patient notification order August 29th: Patient notification order (updated to include date of birth)
Brief description of corrective measures taken	Clinic was re-inspected to ensure that they were following infection control best practice guidelines. Some of the corrective measures taken included the following: Where necessary, new equipment and instruments were purchased. Remaining instruments were reprocessed to remove debris that was found at the time of initial inspection. Required record keeping related to reprocessing equipment maintanence, operation and efficacy testing was put into place. IPAC consulting company services were retained to develop and implement IPAC policies and procedures. Staff were trained on IPAC best practices and evidence of training certification was provided.
Date all corrective measures were confirmed to have been completed	7/25/2019

Final Report Comments and Contact Information

Any Additional Comments (Do not include any personal information or personal health information)	

If you have any further questions, please contact:

Telephone	(705)743-1000 for questions related to the lapse or questions regarding this report.