

Hamilton Public Health Services

Hamilton Infection Prevention and Control (IPAC) Lapse Report

Final IPAC Investigation Report					
Premise/Facility under Investigation (name & address)					
Gateshead Dental, 184 Highway 8, Stoney Creek, L8G 1C3					
Type of Premise/Facility					
Dental Practice					
Date of Final Report Posting	Date of Final Report update(s) if				
02-January-2019	applicable				
,	Not applicable				
Brief Description of Corrective Measures Taken					
Hamilton Public Health Services (PHS) has verified, based on the information collected during re-inspection of the premises that all corrective measures recommended by PHS have been implemented.					
Date all corrective measures	Date and list of any order(s) or				
were confirmed to have been	directive(s) that were issued to				
completed 14-November-2018	the owner/operator (if				
	applicable)				
	Not applicable				
If you have any further questions, please contact:					
Infectious Diseases Program, Hamilton Public Health Services					
905-546-2063 or infectious.disease@hamilton.ca					
Date of Initial Report Posting	Date of Initial Report update(s) if				
18-October-2018	applicable				
	Not applicable				
How Board of Health became aware of potential IPAC lapse?					
Complaint received on October 2, 2018.					
Cummany Description of TDAC Lance					

Summary Description of IPAC Lapse

During inspections conducted by Hamilton Public Health Services on October 3, 2018 and October 5, 2018, the following IPAC lapses were identified:

- Reprocessing and re-use of devices intended for single use.
- Reprocessed, sterile items not being stored and maintained sterile until point of use.
- Insufficient personal protective equipment (PPE) available at point of use.

Expired alcohol-based hand rub (ABHR) noted in some areas of clinic. Insufficient ABHR available at point of use.

IPAC Lapse	Yes	No	N/A	Details
Investigation				
Did the IPAC lapse	\boxtimes			Royal College of Dental
involve a member of a				Surgeons of Ontario (RDCSO)
regulatory college?				
If yes, was the issue	\boxtimes			Notified RDCSO on October 2,
referred to the regulatory				2018
college?				

Corrective measures recommended and/or implemented

The following corrective measures were recommended based on current evidence and best practices documents:

- Devices intended for single-use cannot be reprocessed and must be disposed of after client service;
- Critical and semi-critical devices which are reprocessed must be stored in sterile packaging and maintained sterile until point of use;
- Records for verification of sterilization parameters are to be available on site;
- An alcohol based hand rub with a minimum of 70% alcohol must be located in each clinic/treatment room at point-of-care;
- Follow appropriate hand hygiene; and,
- Use a hospital-grade disinfectant wipe with 1 or 3 minute contact time.
 Allow for adequate contact time for cleaning/disinfection of surfaces and equipment between patients; follow the product monograph for appropriate use;

Provide personal protective equipment (PPE), masks gloves, gown, and eye protection, at point of use.

Date and list of any order(s) or directive(s) that were issued to the owner/operator (if applicable)

N/A

Additional Comments:

An inspection report was given to the premise/facility noting corrective measures. Information and education was provided. Re-inspections were conducted on October 10, 2018 and on November 14, 2018 which verified the recommended corrective measures had been implemented.