

Region of Waterloo Public Health Infection Prevention and Control Lapse

Initial Report	Details/Description
Premise Premise/facility under investigation (name and address)	247 King Dental 247 King St N, Unit 1B, Waterloo ON N2J 2Y8
Type of premise/facility (e.g. medical clinic, multi-service PSS)	Dental Office
Date Board of Health became aware of IPAC lapse	October 19, 2021
Date IPAC lapse was linked to the premise/facility	October 19, 2021
Date of Initial Report Posting	October 29, 2021
Source of IPAC lapse information (e.g. routine inspection, public complaint etc.)	Complaint received on Friday October 15, 2021
Summary Description of the IPAC lapse	<ol style="list-style-type: none"> 1. Incorrect packaging of instruments prior to sterilization. 2. Incorrect processing and storage of instruments. 3. Insufficient quality monitoring of sterilization processes. 4. Incorrect labelling of sterilized instruments 5. Aseptic technique not followed when handling sterile instruments. 6. Inadequate PPE supply and storage. 7. Staff not adequately trained in processes for sterilization of instruments

IPAC Lapse Investigation	Answers/Explanation
Did the IPAC lapse involve a member of the regulatory college?	Yes – Royal College of Dental Surgeons of Ontario
If yes, was the issue referred to the regulatory college?	Yes
Were other stakeholders notified? (e.g. Ministry)	No
Concise description of the corrective required	Verbal directive to re-sterilize all instruments in the office provided on October 19, 2021. Practice must immediately implement all corrective actions identified in letter sent to practice October 21, 2021.

IPAC Lapse Investigation continued on next page...



IPAC Lapse Investigation	Answers/Explanation
Please provide further details/steps	Practice requirements to be verified on reinspection: 1. Follow best practices for cleaning and packaging instruments prior to sterilization. 2. Follow best practices for sterilization and storage of instruments. 3. Follow best practices for quality monitoring of cleaning and sterilization process 4. Accurately label sterilized instruments 5. Follow best practices for aseptic technique 6. Provide adequate supply and storage of PPE 7. Reprocessing staff to completed formal reprocessing education and have demonstrated competence.
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	Verbal directive to re-sterilize all instruments following best practices on October 19, 2021. Practice notified that they must immediately implement all corrective actions identified in letter sent to practice October 22, 2021. On October 25, 2021, a re-inspection was conducted and all instruments in the office had been re-sterilized.

Initial Report Comments

If you have any further questions, please contact: Andy Hong, Manager Health Protection and Investigation, ahong@regionofwaterloo.ca, 519-575-4400, ext. 2379

Final Report	Details/Description
Date of Final Report posting:	November 8, 2021
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	

Final Report continued on next page...



Region of Waterloo
PUBLIC HEALTH AND
EMERGENCY SERVICES

Final Report	Details/Description
Brief description of corrective measures taken	Practice requirements were verified by reinspection on November 4, 2021 including: 1. Following best practices for cleaning and packaging instruments prior to sterilization. 2. Following best practices for sterilization and storage of instruments. 3. Following best practices for quality monitoring of cleaning and sterilization process 4. Accurately labelling sterilized instruments 5. Following best practices for aseptic technique 6. Providing adequate supply and storage of PPE 7. Reprocessing staff have completed formal reprocessing education and have demonstrated competence.
Date all corrective measures were confirmed to have been completed	November 4, 2021

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