

PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT

Initial Report

Premise/facility under investigation Dawson Dental Centre – North Bay

(name and address) 1221 Algonquin Avenue #501, North Bay, ON P1B 4Y3

Type of premise/facility: Dental Office

(e.g., clinic, personal services setting)

Date Board of Health became aware of May 21, 2025

IPAC lapse

Date IPAC lapse was linked to the May 21, 2025

premise/facility

Date of Initial Report posting May 30, 2025

Date of Initial Report update(s) Not applicable

(if applicable)

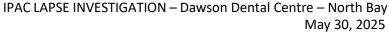
How the IPAC lapse was identified Dawson Dental Centre – North Bay

Summary Description of the IPAC Lapse

Improperly reprocessed reusable instruments used on clients.

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IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college?

Yes.

College of Dental Hygienists of Ontario

• Royal College of Dental Surgeons of Ontario

If yes, was the issue referred to the regulatory college?

May 30, 2025

Were other stakeholders notified

Yes

Concise description of the corrective action required.

IPAC

Please provide further details/steps

The dental clinic identified and notified the impacted clients about the IPAC lapse.

- Sterilization methods, MIFUs shall be followed for every individual instrument, handpiece and motor utilized in the dental clinic to ensure each device is sterilized using the correct sterilization cycle parameters (i.e., time, temperature and pressure).
- Physical indicators for sterilization including cycle time, temperature and pressure shall be checked and recorded for each load.
- 3. External Chemical Indicators on packaged dental equipment/devices shall be checked when packages are:
 - Removed from the sterilizer.
 - Placed into sterile storage.
 - Removed from sterile storage.
 - About to be opened for use.

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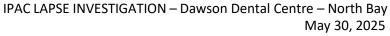
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If you have any further questions, please contact:

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