Investigating breaches of infection control in dental practice

Megan Reilly ACIPC November 2019





Disclosures

- Independent IPC in private practice
- Periodic engagement by Department of Health CDCD
- Co-coordinator Graduate Cert in Infection Prevention & Control
- Co-lead ACIPC WA SIG (inactive)

Minimum infection prevention and control standards for the maintenance of a safe and healthy environment for dental healthcare professionals and consumers

Objectives

- Describe the approaches undertaken to investigate IC breaches
- Discuss common assessment findings, patient and practice outcomes
- Recommend an improved public health and infection control approach

Practice 1 (2015)

- Inspection by a DBA/AHPRA representative identified IC issues
- DBA referred to WA Health Public Health Division → CDCD
- Restricted from practicing

Process

- CDCD convened Advisory Group
- Access to practice granted by dentist
- Risk assessment of practice environment, work practices and patient management system by IPC and CDO
- BBV testing
- Provision of detailed reports to advisory group
- PQ and OQ of steriliser
- Advisory group reconvened to consider findings
- Briefing note to DG of Health
- Communique to AHPRA

Outcome

- Significant infection control breaches
 - 84 recommendations for improvement
 - Lack of knowledge, skills and awareness
- No incidence of disease transmission
- Look-back investigation not recommended
- Continued work restrictions supported
- AHPRA imposed registration conditions

Practice 2 (2019)

- Practice self-reported reprocessing breach to ADA WA
- AHPRA received complaint from practice employee
- AHPRA notice of incident to WA Health CDCD and HAIU
- Media letter to WA newspaper

Process

- Telephone investigation and assessment conducted by CDCD Public Health Physician
- Notification letters to parents of exposed patients
- Inspection of practice's reprocessing procedures and review of clinical records by IPC and CDO
- Provision of reports to CDCD, AHPRA and practice

Outcome

- Immediate changes to practice implemented post breach
- Low risk of BBV transmission
- No further blood tests or look-back investigation
- Ten recommendations for improvement
- Continued practice
- Education of all team

Common findings

- Limited or no access to required reference documents
- Minimal documentation of systems and processes
- Knowledge and skills gaps
- Multiple staff perform reprocessing activities
- Regular skills assessment not performed
- Poor premise design for reprocessing
- Manual cleaning still prevalent
- Inadequate PPE when performing cleaning tasks
- Drying instruments in ambient air
- Wet/moist instrument packs
- Performance testing, monitoring and validation deficits
- No BCI/tracking critical items

Future WA approach (CDC Model)

- 1. Identification of infection control breach
- 2. Additional data gathering
- 3. Notify and involve key stakeholders
- 4. Qualitative assessment of breach
- 5. Decision regarding patient notification and testing
- 6. Communication and logistical issues

Acknowledgements

- Consumers and staff of investigated/ reviewed practices
- Dr Soniya Nanda, Chief Dental Officer
- CDCD team
- HAIU team
- Advisory group members