

THE DENTAL PRACTICE BOARD OF VICTORIA

Dr Zenaidy Castro [2007] DPBV 10

Panel:	Mr Michael Gorton (Chair) Dr Vlad Hardi Ms Gabrielle MacTiernan
Counsel Assisting the Panel:	Ms Sharon Keeling instructed by Monahan + Rowell, Lawyers
Counsel for the Practitioner:	Ms Gail Hubble instructed by DLA Phillips Fox, Lawyers
Date of Hearing:	3 December 2007
Date of Decision:	3 December 2007

FINDING

Pursuant to Section 47(1)(a) of the *Dental Practice Act 1999* ("the Act"), the Panel having considered the Notice of Formal Hearing, the evidence, the admissions made by Dr Castro and the submissions of counsel, finds that Dr Castro has engaged in unprofessional conduct as defined in Section 3 of the Act, and that conduct was of a serious nature.

DETERMINATIONS

Pursuant to Section 47(2) of the Act:

1. Dr Castro's registration is subject to a condition that Dr Castro's practice undergoes an audit, to assess compliance with the Infection Control Code of Practice, by a person approved by an authorised officer of the Board, at regular six monthly intervals for a period of two years. The results of the audit are to be provided directly to an authorised officer of the Board within two weeks of the audit, and a copy is to be provided to Dr Castro. Dr Castro must provide to the Board a plan to rectify any deficiencies identified in the audit within four weeks of the Board receiving the audit. The cost of the audits is to be borne by Dr Castro.
2. Dr Castro is to undertake two days of infection control education. The content of the education and the person providing it is to be approved by an authorised officer of the Board. The education training is to be at the expense of Dr Castro and is to be completed by 30 June 2008. Such training is not to be considered as being in satisfaction of Dr Castro's Continuing Professional Development obligations.
3. Dr Castro is to undergo one half day of training at her dental practice in all aspects of the processes and procedures of infection control by a person to be approved by an authorised officer of the Board. The training is to be completed within the next two months and be at the expense of Dr Castro.
4. Dr Castro is not to conduct her dental practice for longer than three months from 3 December 2007, in the absence of an assisting, qualified dental nurse trained in infection control.

5. Dr Castro is reprimanded for her serious unprofessional conduct.

Reasons for Decision

The Dental Practice Board of Victoria determined under Section 45 of the Act that a Formal Hearing was to be held into the professional conduct of Dr Zenaidy Castro, a registered dental care provider. A Panel was convened and the hearing was held on 3 December 2007.

The allegations heard by the Panel were contained in a Notice of Formal Hearing, dated 29 October 2007, and the attachments thereto.

The allegations made against Dr Castro were as follows:

- (a) At all material times you have been registered as a dental care provider in Victoria under the Act having first been registered with the Dental Board of Victoria on 23 December 1998.
- (b) During November / December 2004, the Dental Practice Board of Victoria (*"the Board"*) promulgated Code of Practice number C006 about the practice of dentistry, entitled *"Infection Control"*, under Section 69(1)(e) of the Act, and this Code of Practice came into effect on 1 March 2005. This Code of Practice was subsequently reviewed and updated on 13 June 2006, and promulgated on the Board's website.
- (c) This Code of Practice together with an accompanying Information Sheet was widely publicised within the dental profession in Victoria, initially being published in the Board's bulletin in December 2004, and later being posted to all registered dental care providers in Victoria in March 2005, and thereafter by being posted on the Board's website.
- (d) The Code of Practice requires in paragraph 8 that every registered dental care provider must:-
 - (i) Ensure the premises in which he or she practises are kept in a clean and hygienic state to prevent the spread of infectious disease;
 - (ii) Ensure that in attending a patient, he or she takes such steps as are practicable to prevent or contain the spread of infectious disease; and
 - (iii) Act in accordance with the requirements set out in the three documents referred to at paragraph 7 of the Code of Practice (namely the Practice Manual, Australian Standard AS / NZS 4815:2006 and the Commonwealth Government Publication *"Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the health care setting"* (published January 2004).
- (e) You, being a dentist bound by the Act and maintaining premises in which you practise at Suite 3, Level 10, 1 Elizabeth Street, Melbourne (*"the premises"*) are in breach of the Code of Practice.
- (f) You have breached your obligations under paragraph 8 of the Infection Control Code of Practice number C006 in various respects, and particulars of such breaches appear from the two attached documents, both headed *"Practice Inspection Dr Zenaidy Castro, Suite 3, Level 10, 1 Elizabeth Street, Melbourne"* and dated 26 June 2007 and 29 August 2007 respectively. Attachments B & C.
- (g) The notes in the two attached documents also identify breaches by you of the provisions referred to in those notes of the *Health Records Act 2001*, the *Occupational Health and Safety Act 2004*, the *Drugs Poisons and Controlled Substances Act 1981* (and Regulations

2006), the Infection Control Guidelines publication referred to above and Australian Standard AS / NZS 4815:2006.

- (h) Accordingly, and by this conduct, you have engaged in unprofessional conduct as defined in Section 3 of the *Dental Practice Act 1999*.
- (i) Such unprofessional conduct is of a serious nature.

At the commencement of the hearing counsel for Dr Castro advised the Panel that Dr Castro admitted the allegations made against her and that her unprofessional conduct was of a serious nature.

In June 2007 Dr Castro's practice was inspected by Dr Roseman, the Dental Practice Board of Victoria's Investigative Officer. A copy of Dr Roseman's inspection report was attached to the Notice and marked "Attachment B". A copy of that report is annexed to these Reasons and forms part of them. It details Dr Casto's shortcomings and failures in respect of infection control and other statutory requirements.

In August 2007 Dr Roseman returned to Dr Castro's practice and the result of his second inspection is set out in Dr Roseman's report which was attached to the Notice and marked "Attachment C". A copy of that report is annexed to these Reasons and forms part of them.

This second report details Dr Castro's continuing shortcomings and failures in respect of infection control and other statutory requirements.

Needless to say these reports indicate very serious failures of infection control, among other failures to comply with statutory obligations.

Dr Castro arranged to have her practice inspected by the well respected Infection Control and Risk Management Consultant, Dr Vincent Amerena, who gave evidence to the Panel about his inspection in July 2007.

Without going into detail it is sufficient to say that Dr Amerena found the state of the premises to be as unsatisfactory as had been noted by Dr Roseman.

Infection control was virtually non existent and his opinion was that, Dr Castro's understanding of infection control requirements was less than satisfactory.

Dr Amerena made many suggestions to Dr Castro as to what was required.

Dr Amerena inspected the practice again on 19 November 2007, i.e. after Dr Roseman's second visit in August 2007 and after the Notice of Formal Hearing had been served. He noted "very pleasing marked improvement". Despite that comment Dr Amerena noted ongoing problems with the Autoclave and as a general comment said:

"All drawers are very badly organised with a mix of stores instruments and junk. The employment of a trained full time nurse with an interest in infection control would enable systems to be developed which would facilitate patient treatments plus infection control." (The emphasis is Dr Amerena's.)

Overall the Panel has no hesitation in saying it is completely satisfied that the allegations are made out, and can quite understand the admissions made by Dr Castro.

The Panel is aware that its role is not a punitive one, but rather to protect the public.

“the Power of a court to discipline a barrister is entirely protective and notwithstanding that its exercise may involve a great deprivation to the person disciplined, there is no element of punishment involved.”¹

The Panel has considered it necessary in its determination to impose conditions on Dr Castro’s registration and thought it necessary to do so because of the fundamental importance of infection control in dental practice. The training and audit requirements are necessary considering that, after some eight years of professional practice, Dr Castro does not demonstrate more than a very limited understanding of what was, and is, required of her.

Mr Michael Gorton
Chair

Dated: 13 December 2007

¹ *New South Wales Bar Association v Evatt* 117 CLR @ 183

Practice Inspection Dr. Zenaidy Castro
Suite 3, Level 10,1 Elizabeth Street Melbourne
26 June 2007

Report of inspection of the practice of Dr Zenaidy Castro at Suite 3, Level 10, Elizabeth Street, Melbourne by Dr Anthony Roseman and Ms Trish McNally on Tuesday 26 June 2007 commencing at 12.20pm. This report was written using the practice inspection checklist dated April 2007, transcript of recorded interview and photographs taken at the inspection.

The practice is located in a city building. It consists of a waiting room/reception area off which there is a treatment room and instrument processing area including an office. The premises were generally cluttered and untidy. Dr Castro informed us that her nurse was undergoing training at RMIT.

Dr Castro was unable to produce a completed practice manual or a current copy of Australian Standard AS/NZS 4815 (COP 006). There was no evidence of a practice privacy policy (Health Records Act 2001HPP5).

In the surgery and instrument processing area there was no evidence of appropriate zoning (ICG sec.11.4.2) and no protocol for the management of contaminated spills (ICG sec.18.2.1). Barrier techniques were inadequate (ICG sec.35.3). There was no protocol for the appropriate management of waterlines (ICG sec.35.5). Latex and non latex examination gloves were available. No sterile gloves were available (ICG sec.35.2, 13.2). The one sink in the surgery is used for hand washing sink. Handwashing detergent was available in containers that Dr Castro informed us were "topped up" when required (4815 sec.2.8) and the pump was not cleaned regularly. The management and disposal of sharps did not comply with the required standards (ICG sec 14). All instruments were not routinely bagged prior to sterilization (4815sec3). Instruments were stored unbagged, in drawers which Dr Castro advised were cleaned on an irregular basis (4815 sec.9). Endodontic instruments were not identified for single use or single patient use. Most bagged items were not dated (4815 sec.9.6) and there was no protocol for tracking critical instruments (4815 sec.8.5.2.1). Local anaesthetic was not stored in a locked cupboard (Drugs, Poisons & Cont. Substance 2006 reg 34,35). There were no appropriate protocols for the transfer of instruments and materials within or out of the surgery (4815 sec2.4). There was no protocol for the management of needlestick (ICG sec.23.1) or other work-related injuries. (OH&S Act 2004 sec.21.2.d.e)

The area used for the processing of instruments was untidy and not clean (COP C006). Workflow patterns were incorrect (4815 pg16 (diag), sec 2.5). There is one sink only for washing instruments in the instrument processing area (4815 2.5). There was insufficient personal protection for staff involved in the processing of used items i.e. no waterproof apron, masks or eye protection (4815 sec 2.2.). There was no evidence that instruments were processed in accordance with Australian Standard AS /NZS 4815:2006(4815). There was no

protocol for the proper use of the ultrasonic cleaner (4815 2.9.3.3) or monitoring its efficacy (4815 Table 7.3.). The printer attached to the sterilizer did not appear to give an accurate recording of the parameters required. (4815 Table 7.1). There were no records of the testing and maintenance of the steam sterilizer (4815 sec.7), the chamber of which was not clean. During the inspection a sterilizer cycle was run using a Class 6 emulator which gave a positive result at the conclusion of the cycle.

Anthony M J Roseman

BDS, LDS, FICD

Investigative Officer

Practice Inspection Dr. Zenaidy Castro
Suite 3, Level 10,1 Elizabeth Street Melbourne
29 August 2007

Report of inspection of the practice of Dr Zenaidy Castro at Suite 3, Level 10, Elizabeth Street, Melbourne by Dr Anthony Roseman on Wednesday 29 August 2007 commencing at 1.00pm as arranged. This report was written using the practice inspection checklist dated April 2007 additional to the previous inspection, transcript of recorded interview, photographs and a video recording taken at the inspection.

The premises had been cleaned out but were still generally cluttered and untidy. No staff or patients were in attendance.

Dr Castro produced a completed practice manual (ADAVB-SOP) but did not have or a current copy of Australian Standard AS/NZS 4815 (COP 006) available. There was no evidence of a practice privacy policy (*Health Records Act 2001HPP5*).

In the surgery and instrument processing area zoning was still inadequate and zoned areas not clearly identified (*ICG sec.11.4.2*). The protocol for the management of contaminated spills (*ICG sec.18.2.1*) was also inadequate. Barrier techniques were improved. (*ICG sec.35.3*) There was no protocol for the appropriate management of waterlines (*ICG sec.35.5*). Latex and non latex examination gloves were available as well as sterile gloves for critical procedures (*ICG sec.35.2, 13.2*). The one sink in the surgery is used for hand washing sink. The management and disposal of sharps now complies with the required standards (*ICG sec 14*). All instruments were not routinely bagged prior to sterilization (*4815sec3*). Some instruments are still stored unbagged, in drawers which appear to be cleaned on an irregular basis (*4815 sec.9*). Some endodontic instruments were identified for single patient use but general storage of endodontic instruments and burs and polishers was not satisfactory. Most bagged items were now dated (*4815 sec.9.6*) and it appears that critical instruments were tracked (*4815 sec.8.5.2.1*). Local anaesthetic was now stored in a locked cupboard (*Drugs, Poisons & Cont. Substance 2006 reg 34,35*). The protocols for the transfer of instruments and materials within or out of the surgery were inadequate (*4815 sec2.4*). The protocol for the management of needlestick injuries (*ICG sec.23.1*) or other work-related injuries. (*OH&S Act 2004 sec.21.2.d.e*) was available in ADAVB-SOP manual.

The area used for the processing of instruments was still untidy (*COP C006*) and not zoned (*ICG sec.11.4.2*). There is one sink only for washing instruments in the instrument processing area (*4815 2.5*). Workflow patterns were incorrect (*4815*

pg16(diag), sec 2.5). Personal protection for staff involved in the processing of used items i.e. waterproof apron, masks and eye protection was available (*4815 sec 2.2,*). There was still no evidence that instruments were correctly processed in accordance with Australian Standard AS /NZS 4815:2006(*4815*). There was no protocol for the proper use of the ultrasonic cleaner (*4815 2.9.3.3*) or monitoring its efficacy (*4815 Table 7.3*). The records of the testing and maintenance of the steam sterilizer were not completed correctly (*4815 sec.7*) and showed a lack of understanding of the requirements by the staff member signing off on the process validation. The steam sterilizer was not in service and awaiting repair and Dr Castro undertook to monitor its performance with a Class 6 emulator if necessary until the proper certification was complete.

Anthony M J Roseman
BDS, LDS, FICD
Investigative Officer