Public Health Ontario | Santé publique Ontario

To view an archived recording of this presentation please click the following link:

https://youtu.be/ESSPkJnB7As

Please scroll down this file to view a copy of the slides from the session.

Public Health Ontario | Santé publique Ontario

Trends and Insights from IPAC Lapse Investigations Supported by PHO

David Ryding, MPH CPHI(C) CIC AL-CIP

Infection Prevention and Control Specialist, Public Health Ontario

Public Health Ontario (PHO) Rounds: October 20, 2026

Welcome and Land Acknowledgement



Presenters and Panelists

- **David Ryding, MPH, CPHI(C), CIC, AL-CIP**
  IPAC Specialist, Infection Prevention and Control, Public Health Ontario
- **Ray Gullekson, BSc, CPHI(C), CIC**
  IPAC Specialist, Infection Prevention and Control, Public Health Ontario
- **Maureen Cividino, MD, FRCPC, CCBOM, CIC**
  IPAC Physician, Infection Prevention and Control, Public Health Ontario
- **Lara Segan, MPH**
  Senior Policy and Program Advisor, Infection Prevention and Control Unit, Office of the Chief Medical Officer of Health, Ministry of Health

Disclosures

- David Ryding does not have any conflicts of interest to disclose.
- Ray Gullekson does not have any conflicts of interest to disclose.
- Dr. Maureen Cividino does not have any conflicts of interest to disclose.
- Lara Segan does not have any conflicts of interest to disclose.

Disclaimer

This presentation was developed by Public Health Ontario (PHO). PHO provides scientific and technical advice to Ontario's government, public health organizations and health care providers. PHO's work is guided by the current best available evidence at the time of publication. The application and use of this presentation is the responsibility of the user. PHO assumes no liability resulting from any such application or use. This presentation may be reproduced without permission for non-commercial purposes only and provided that appropriate credit is given to PHO. No changes and/or modifications may be made to this presentation without express written permission from PHO.

Learning Objectives

By the end of the event, participants will be able to:

- Describe settings where IPAC lapses are occurring most frequently.
- Summarize common deviations from IPAC best practice observed during IPAC lapse investigations.
- Identify setting-specific training and capacity building priorities to help strengthen IPAC programs and prevent future lapses in Ontario.

Why Infection Prevention and Control Lapses Matter



What is Infection Prevention and Control (IPAC)?

IPAC refers to evidence-based principles, practices and procedures that, when applied consistently can prevent or reduce the risk of transmission of microorganisms to health care providers, clients, patients, residents and visitors.

Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Infection protection and control [Internet]. Toronto, ON: King's Printer for Ontario; 2026 [cited 2026 Oct 6]. Available from: https://www.publichealthontario.ca/en/Health-Topics/Infection-Prevention-Control

What is an IPAC Lapse?

A failure to follow IPAC practices resulting in a risk of transmission of infectious diseases to patients, clients, attendees, or staff through exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or contaminated equipment and soiled items.

Source: Ontario. Ministry of Health. Infection prevention and control disclosure protocol, 2022. Toronto, ON: King's Printer for Ontario; 2022. Available from: https://files.ontario.ca/moh-infection-prevention-control-disclosure-protocol-en-2022.pdf

IPAC Lapses Across Settings

Thousands possibly exposed to HIV, hepatitis B, hepatitis C over the past 10 years

CBC News · Posted: Oct 17, 2011 8:39 AM ET | Last Updated: October 17, 2011



Can J Infect Dis Med Microbiol. Mar-Apr 2015;26(2):77-84. doi: 10.1155/2015/160536.

Public health response to a large-scale endoscopy infection control lapse in a nonhospital clinic

Jacqueline Willmore [1], Edward Ellis [2], Vera Etches [3], Lise Labrecque [1], Carla Osiowy [4], Anton Andonov [4], Cameron McDermaid [1], Anna Majury [5], Camille Achonu [6], Maurica Maher [7], Brenda MacLean [1], Isra Levy [1]

Source: CBC News. Ottawa private clinic behind hepatitis, HIV scare. CBC News [Internet], 2011 Oct 17 [cited 2026 Sept 15]; Ottawa. Available from: https://www.cbc.ca/news/canada/ottawa/ottawa-private-clinic-behind-hepatitis-hiv-scare-1.1025222

Source: Willmore J, Ellis E, Etches V, Labrecque L, Osiowy O, Andonov A, et al. Public health response to a large-scale endoscopy infection control lapse in a nonhospital clinic. Can J Infect Dis Med Microbiol 2015;26(2):77-84. Available from: https://doi.org/10.1155/2015/160536

IPAC Lapses Across Settings (Continued)



HEALTH

Guelph nail salon clients urged by public health to get tested for HIV, hepatitis

BY MATT CARTY - GLOBAL NEWS

Posted March 3, 2020 1:12

Updated March 3, 2020 1:

GRAND ERIE PUBLIC HEALTH

Select Language

Health Topics | Classes & Clinics | Professionals & Partners | Statistics & Reports | About Us

Grand Erie Public Health reminds former Brantford dental office patients to discuss testing with their healthcare provider

July 7, 2026

Brantford, Ont. – Grand Erie Public Health (GEPH) is continuing with an infection prevention and control lapse investigation regarding a dental...

Sources: Carty M. Guelph nail salon clients urged by public health to get tested for HIV, hepatitis. Global News [Internet], 2020 Mar 3 [cited 2026 Sept 15]. Available from: https://globalnews.ca/news/6623705/guelph-nail-salon-hiv-hepatitis/

Source: Grand Erie Public Health. Grand Erie Public Health reminds former Brantford dental office patients to discuss testing with their healthcare provider. Brantford: Grand Erie Public Health News [Internet], 2026 July 7 [cited 2026 Sept 15]. Available from: https://geph.ca/news-releases-advisories/

Understanding IPAC Lapse Investigations



Key Organizations Involved in IPAC Lapses

Ministry of Health	Regulatory/policy/protocol support for Public Health Units (PHUs), PHU reporting
Public Health Units	Investigate/inspect, determine health hazard(s), issue orders, support corrective measures, public reporting, facilitate patient notification and testing, as applicable
Public Health Ontario	Scientific/technical advice, consultations, risk assessments, literature reviews, risk communication and laboratory support
Regulatory Colleges	Member/practice oversight, enforcement, inspection or practice advice where relevant

PHU Responsibilities for Inspections, Complaints and Disclosure

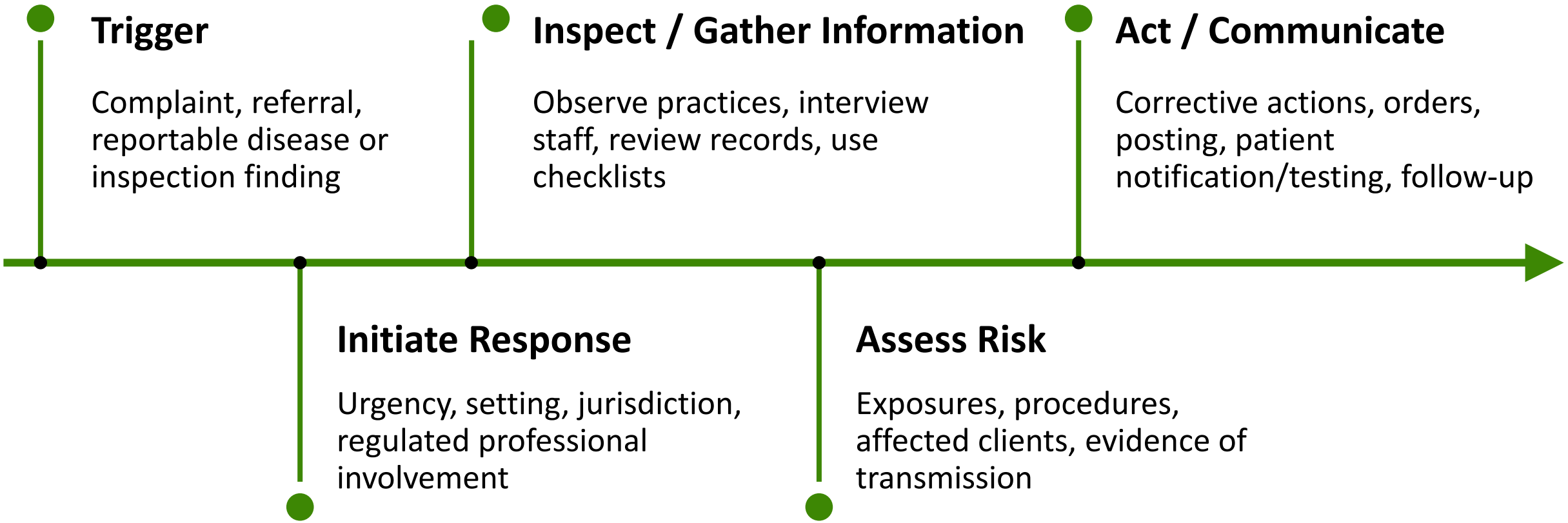
- PHUs are mandated to inspect licensed childcare and personal service settings (PSS) annually
  - Infection Prevention and Control Protocol, 2019
  - Personal Service Settings Guideline, 2019
- PHUs are mandated to respond to and investigate IPAC-related complaints
  - Infection Prevention and Control Complaint Protocol, 2022
- PHUs are mandated to publicly disclose all routine IPAC inspections and IPAC lapse investigations
  - Infection Prevention and Control Disclosure Protocol, 2022

How are IPAC Lapses Identified?



- IPAC lapses are identified by:
  - Complaints or self-referrals
  - Communicable disease investigations
  - Referrals from a regulatory college or PHUs referrals related to multijurisdictional investigations

Typical Steps in an IPAC Lapse Investigation



PHO's Role in IPAC Lapse Investigations

- PHO supports local PHUs with:
  - IPAC lapse consultations
  - IPAC lapse risk assessments
  - Multijurisdictional IPAC lapse coordination
  - Risk communication
  - Laboratory testing
- PHO is not involved with:
  - On-site inspection(s)
  - Corrective measures/follow-up actions

How PHO Conducts IPAC Lapse Risk Assessments

- PHO's interprofessional team includes IPAC Physicians and IPAC Specialists with expertise spanning infection prevention and control (IPAC), infectious diseases, public health inspection, microbiology, and medical laboratory science.
- **Risk Assessments:**
  - Questionnaires are used along with detailed discussions with the PHU to create a clear picture of their investigation
  - A targeted literature review is conducted along with reviewing best practices/standards and legislation
  - A report is developed with expert and evidence-informed recommendations and considerations

Key Questions in an IPAC Lapse Risk Assessment

What happened?	Procedures performed, equipment used, dates, staff involved, reprocessing/medication administration steps
Who was exposed?	Affected clients/patients, staff, procedures, timeframe, records available
Risk of infection transmission?	Procedure invasiveness, reprocessing pathways, medication preparation, handling and administration
Is there evidence of transmission?	Epidemiological links, iPHIS searches, laboratory testing results

Trends and Insights from PHO Supported Investigations



At A Glance: PHO Supported IPAC Lapse Investigations (2016 – 2026)

233

Investigations Supported

October 2016 to September 2026

167

Risk Assessments

72% of all support

27 of 29

PHUs Supported

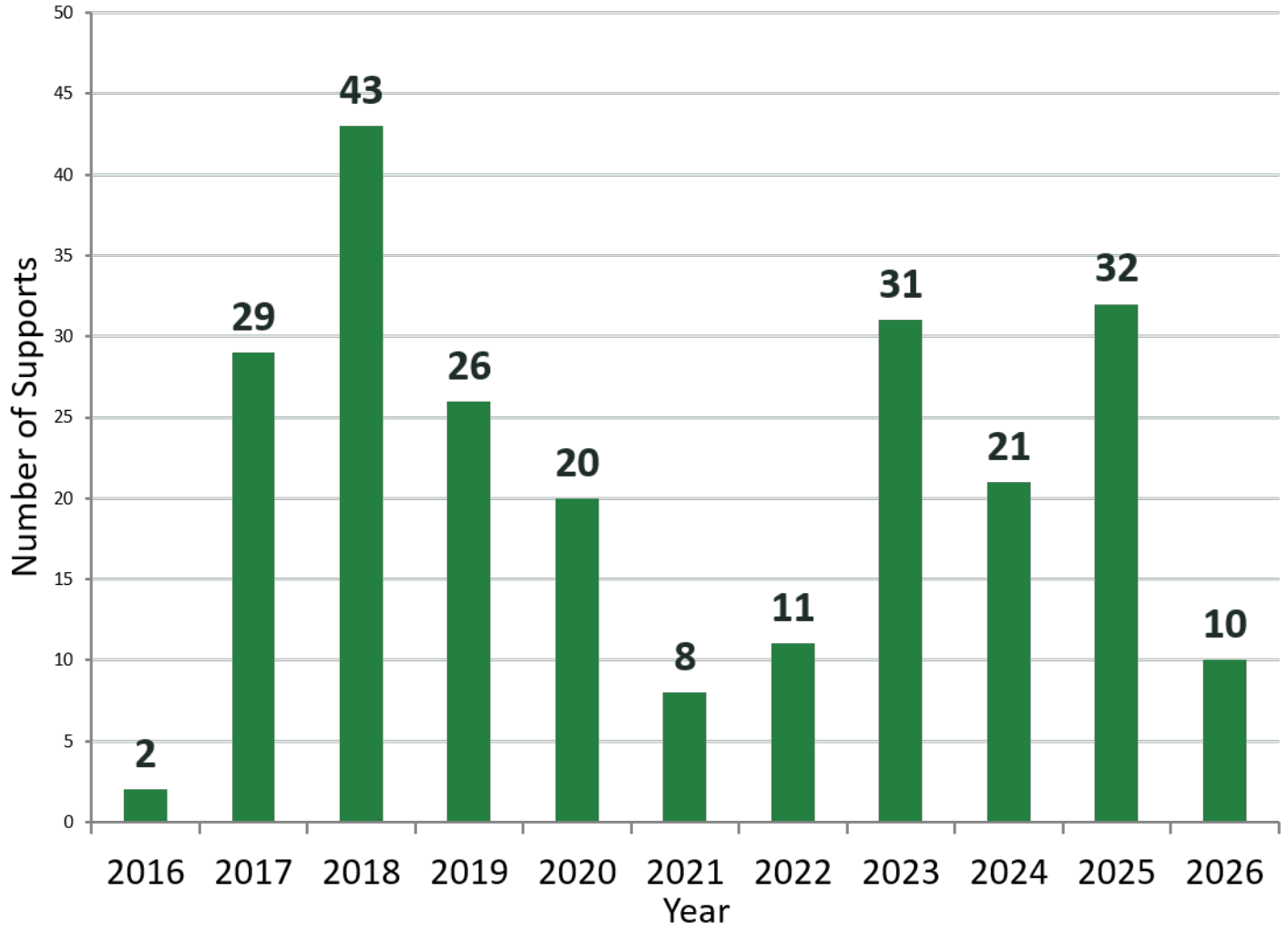
32 of 34 Legacy PHUs

54

Patient Notification/Testing

32% of all PHO risks assessments

Trends in PHO Supported IPAC Lapse Investigations (2016 – 2026)



Peak

43 Investigations in 2018

Variability

Investigations per year range from 8 to 43

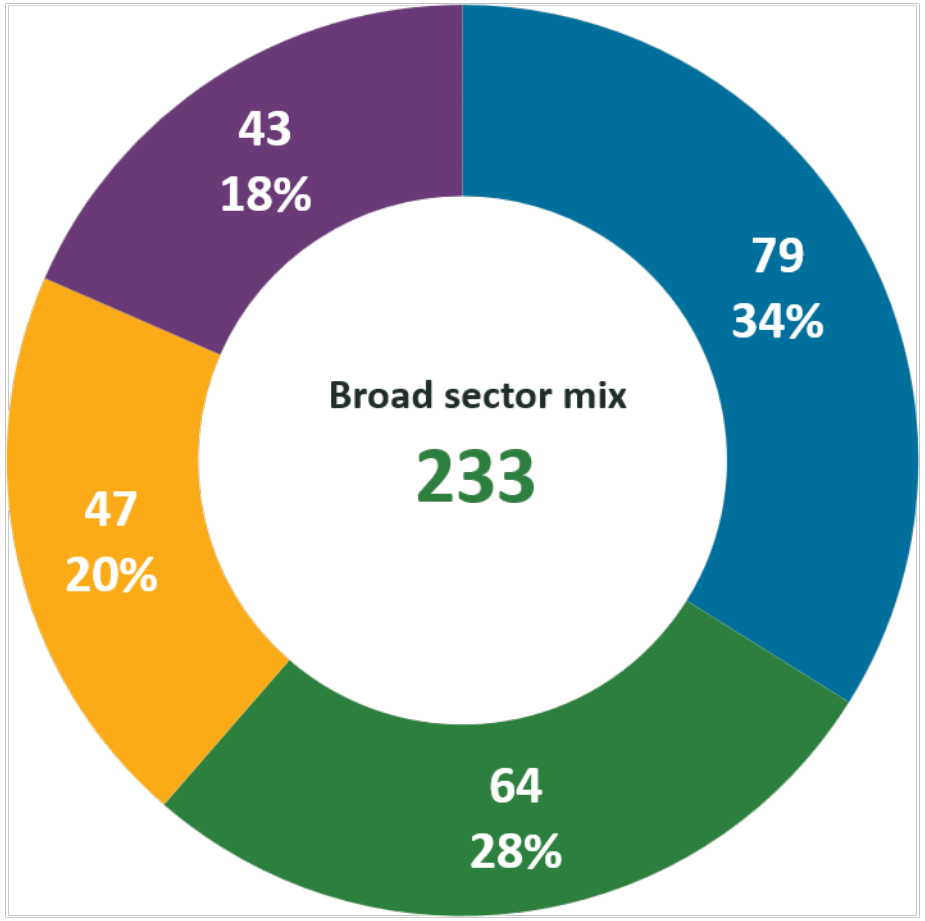
Support Type

167 Risk assessments
55 Consultations
11 Multijurisdictional coordination

Geographical Reach

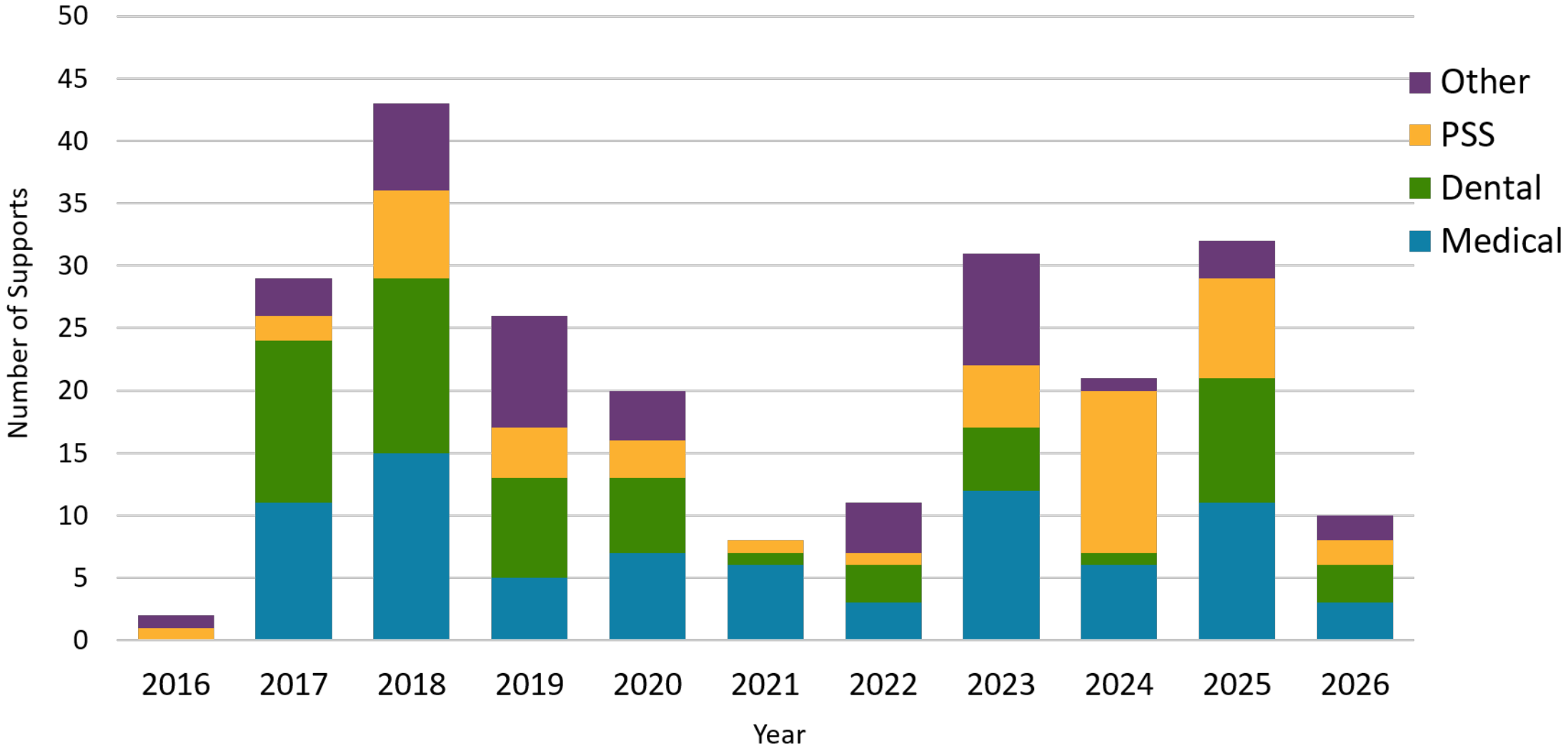
27 of 29 PHUs supported

PHO Supported IPAC Lapse Investigations by Sector (2016 – 2026)

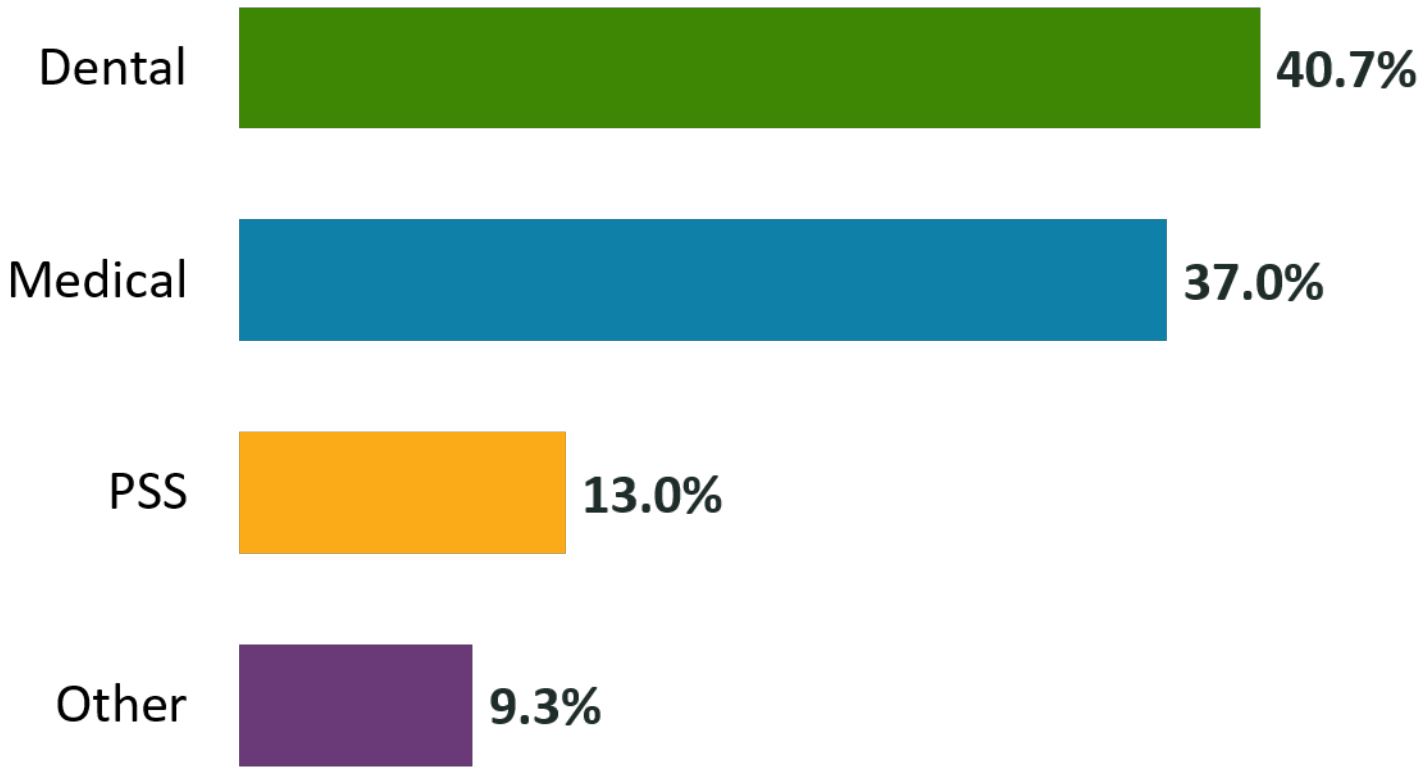


Medical Clinics	Family/walk-in, OB/GYN, dermatology, ENT, ophthalmology
Dentistry	Dentists, hygienists, denturists
Personal Service Settings	Medi-spas, aesthetics, piercing/body modification, tattooing
Other Settings	Foot care, diagnostic imaging, pharmacy, blood collection centers

PHO Supported IPAC Lapse Investigations by Setting and Year (2016 – 2026)



PHO Supported IPAC Lapse Risk Assessments with Patient Notification by Setting (2016 – 2026)



167

Number of PHO supported risk assessments

32%

54 of 167

Risk assessments resulted in notification/testing as the primary consideration

61.7%

103 of 167

Risk assessments resulted in no notification/testing as the primary consideration

Frequently Encountered IPAC Practice Issues

Reprocessing

- Not following Manufacturer's instructions for use (MIFUs)
- Lack of point-of-use cleaning
- Wrong level of reprocessing
- Lack of quality assurance indicators
- Improper packaging/storage
- Failure to sterilize semi-critical or critical devices between patients
- Reprocessing single-use devices

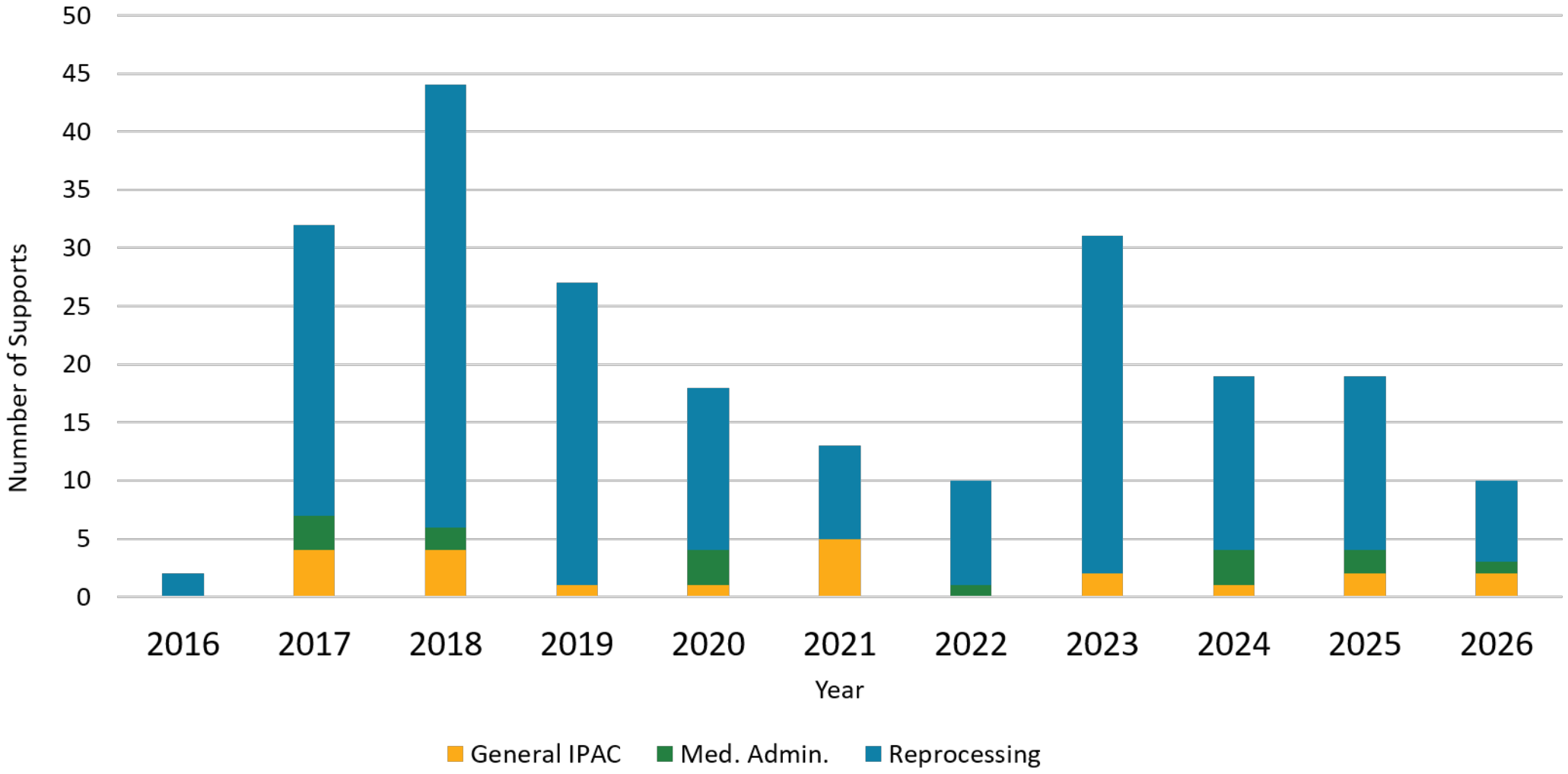
Medication Administration

- Not following MIFUs
- Unsafe use of multi-dose vials
- Pre-drawn syringes
- Reuse of needles/syringes
- Inadequate labelling/dating
- Medication preparation not in a clean area
- Compounding medications in non-sterile environments

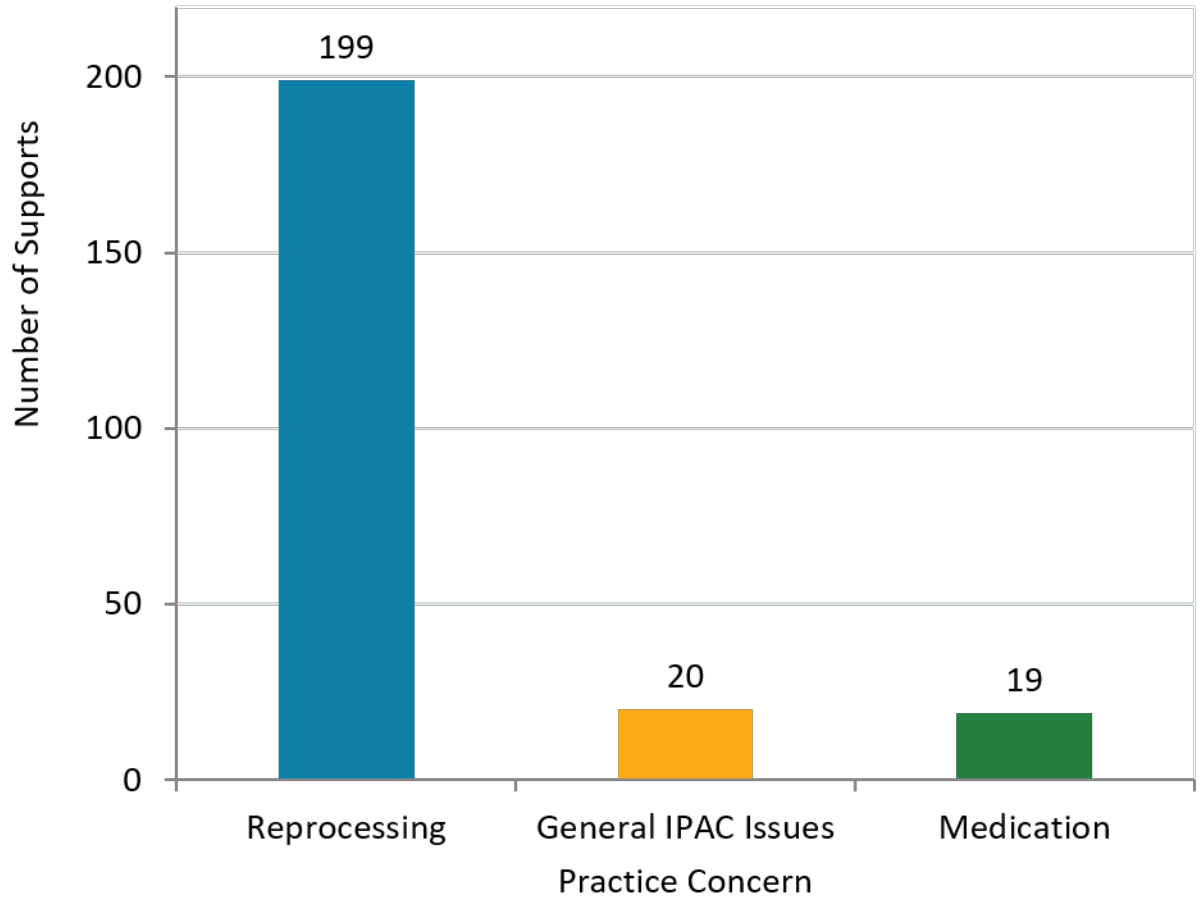
General IPAC

- Lack of IPAC oversight
- Lack of IPAC policies/procedures
- Staff education/training gaps
- Poor hand hygiene
- Poor environmental cleaning
- Lack of space
- Extensive clutter

PHO Supported IPAC Lapse Risk Investigations by Practice Concern and Year (2016 – 2026)



PHO Supported IPAC Lapse Risk Investigations by Practice Concern (2016 – 2026)



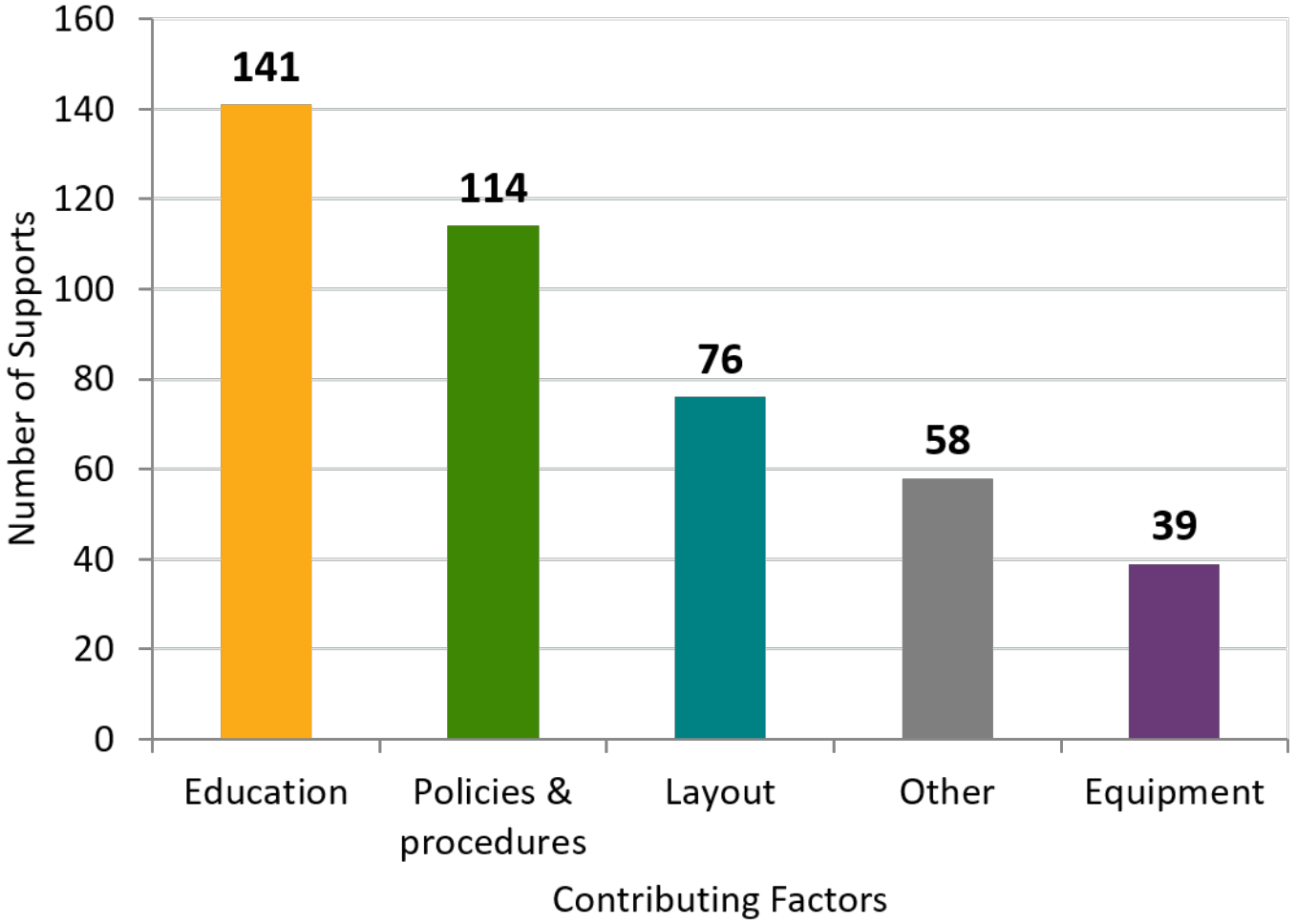
85.4%

199 of 233 investigations included reprocessing as a concern

Factors Contributing to IPAC Lapses

- **IPAC Oversight and Governance:** The presence and effectiveness of IPAC oversight
- **Staff Education and Competency:** Whether staff education is appropriate for the tasks performed, device/procedure specific, and refreshed as required
- **Product Manufacturer's Instructions for Use (MIFUs):** The availability of clear MIFUs that are consistent with IPAC best practices within the setting
- **Physical Layout:** Whether the physical environment supports safe IPAC practices
- **Equipment Condition and Availability:** The suitability, condition, maintenance, and availability of equipment required to follow IPAC best practices
- **Policies and Procedures:** The availability, clarity, and alignment of policies and procedures with current IPAC best practices

PHO Supported IPAC Lapse Risk Investigations by Contributing Factors (2016 – 2026)



Education	141	60.5%
Policies & Procedures	114	48.9%
Layout	76	32.6%
Other	58	16.7%
Equipment	39	16.7%

PHU Investigations of IPAC Complaints in Ontario (2015 – 2018)

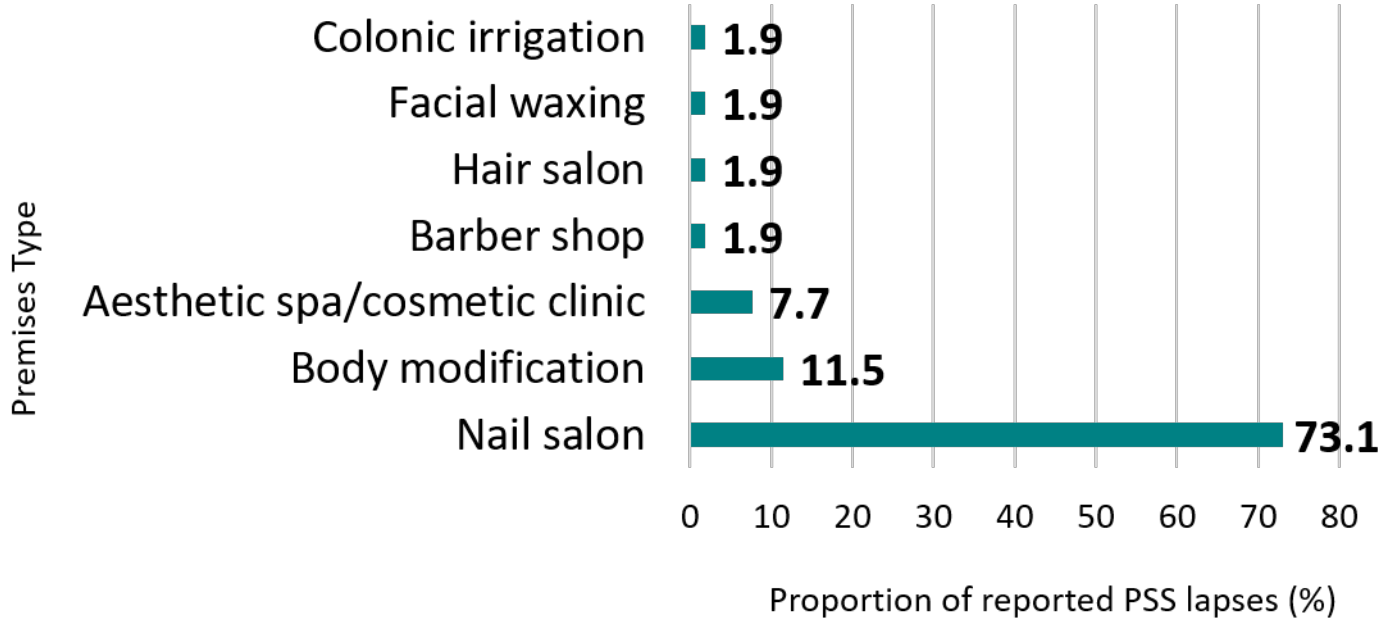
- PHUs surveyed about the occurrence and key challenges of IPAC complaints
  - IPAC complaints increased about 6-fold and IPAC lapses increased almost 3-fold from 2015-2018
- Most common types of IPAC deviations identified:

Identified During Complaint Investigation	# of PHUs	Percent
Reprocessing of medical equipment/devices used to provide patient/client care	**16**	**76.2%**
General Policies and Procedures	**10**	**47.6%**
Environmental cleaning in the health care environment where care is provided	**6**	**28.6%**
Education	**6**	**28.6%**

Source: Cadieux G, Brown C, Sachdeva H. Public health investigation of infection prevention and control complaints in Ontario, 2015–2018. Can Commun Dis Rep. 2019;45(11):289-95. Available from: https://doi.org/10.14745/ccdr.v45i11a03

Common IPAC Infractions and Complaints in PSS in Ontario (2018)

- IPAC lapse data for all publicly reported lapses in Ontario in 2018 were identified via public disclosure webpages for all 35 PHUs
- Most common PSS setting identified:



121
Number of publicly disclosed IPAC lapses in 2018

43.0%
52 lapses were in personal services settings (PSS)

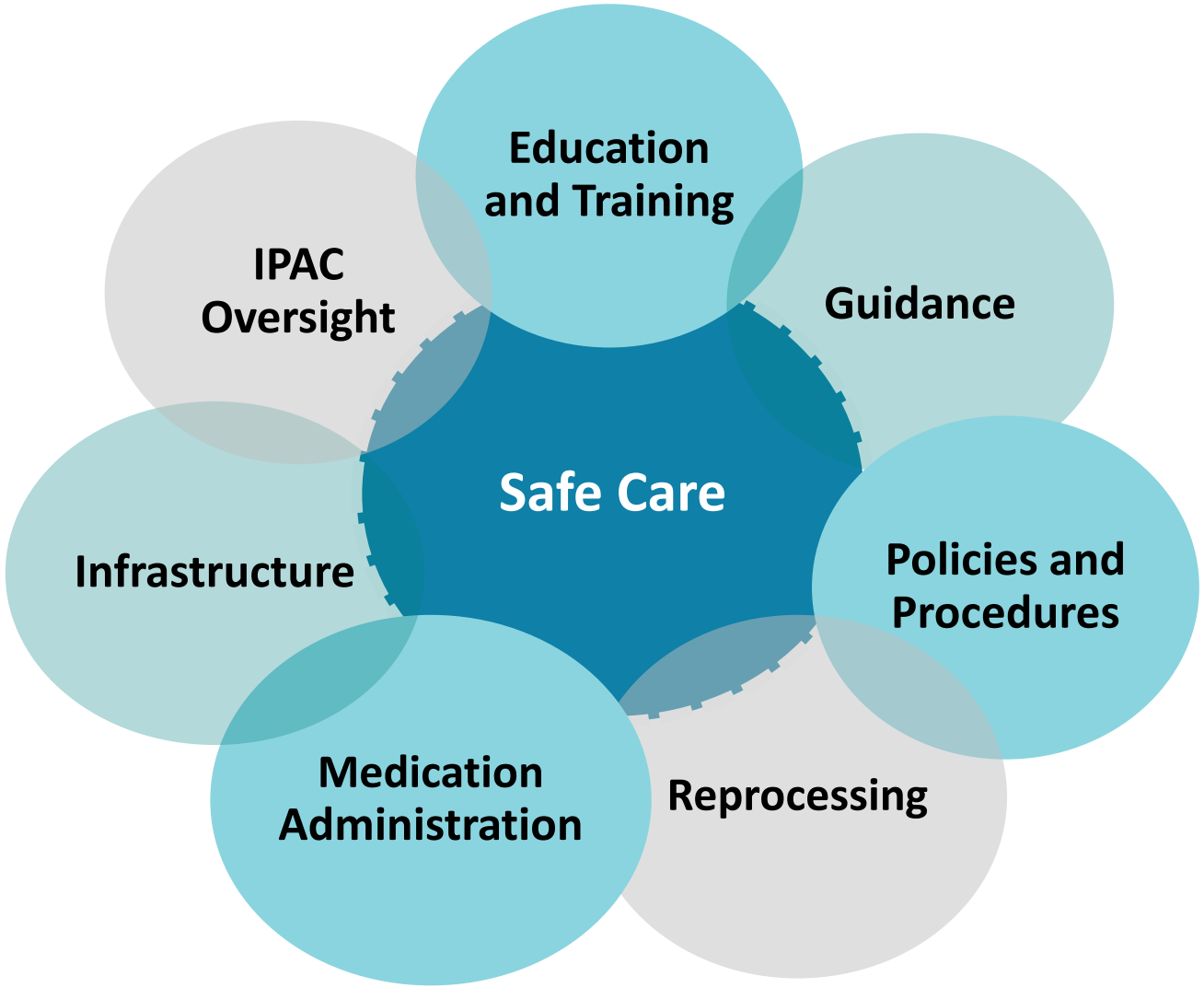
73.1%
38 of 52 PSS lapses were in a nail salon/spas

Source: Paphitis K, Ryding D, MacDougall C, Callery S, Catt B, Garber G. Overview of common infection prevention and control infractions and complaints in personal service settings in Ontario in 2018: a descriptive analysis. Env Health Review. 2021;64(3):60-7. Available from: https://doi.org/10.5864/d2021-016

Capacity Building and Prevention



Priority Areas for Capacity Building



Key Considerations for Public Health Practice

Prevention

Prioritize competency-based reprocessing education, IPAC oversight/policy and procedure development in key, high-volume sectors.

Setting Focus

Using targeted IPAC education and support for dentistry, medical clinics, and PSS, would yield the greatest reach.

Evidence

Call to action for PHUs and PHO to develop high-quality evidence by contributing novel research/case studies.

Ongoing Monitoring

Track settings, IPAC deviations, investigation outcomes, and contributing-factors to identify emerging patterns.

Why IPAC Lapse Investigations Matter

Patient Safety

Unsafe practices can create opportunities for blood-borne or other infectious disease transmission.

Public Confidence

Lapses affect trust in health services and care, personal services, and public health response.

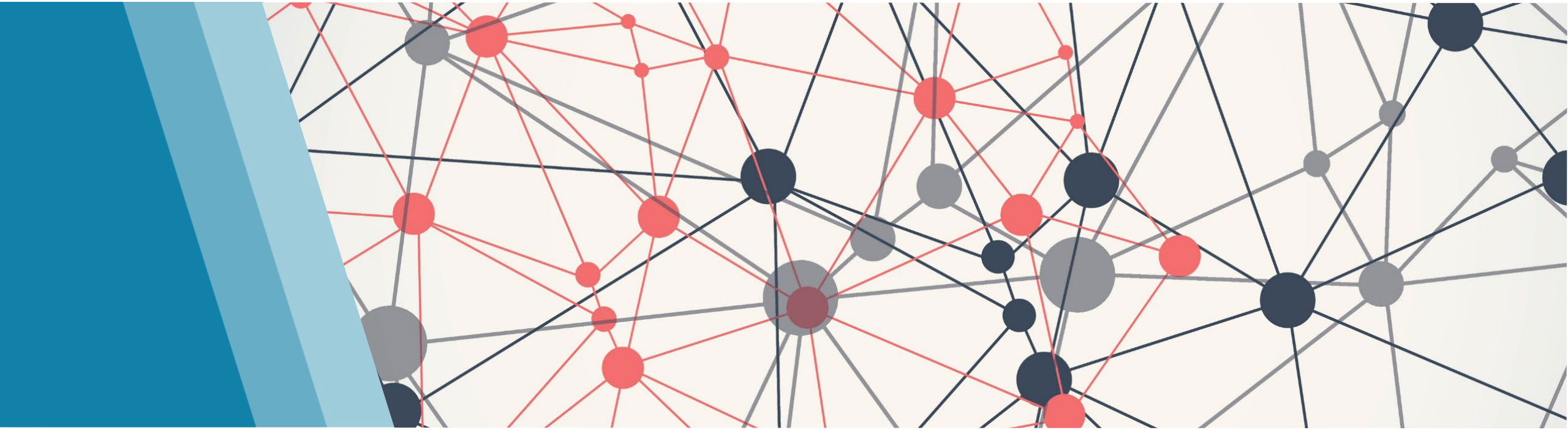
Operational Impact

Investigations require inspections, orders, risk assessments, notification and follow-up.

Learning

They show where systems and training break down and where there are opportunities to build IPAC capacity.

Key Messages and Resources



Key Takeaways

- Individuals receiving care/procedures expect and require safe care/procedures regardless of where it is performed
- IPAC lapses occur in a variety of settings
- Reprocessing and medication administration are common practice concerns found in IPAC lapses
- Capacity building targeting underlying system causes of IPAC lapses such as IPAC oversight and staff education and competency are priority areas
- PHUs, PHO, MOH and regulatory colleges can each play a role in IPAC capacity building efforts across settings

PHO Resources for Preventing IPAC Lapses

- Resources for Preventing Infection Prevention and Control (IPAC) Lapses
- Frequently Asked Questions - IPAC Lapses
- Top Five High Risk Practices: Recommendations and occupational health and safety responsibilities
- Updated Guidance on the Use of Multidose Vials
- Recommendations for Education, Training and Certification for Reprocessing in Clinical Office Settings
- Considerations for Purchasing a Table-top Steam Sterilizer
- Infection Prevention and Control – Online Learning

For More Information About This Presentation, Contact:

Communicable.DiseaseControl@oahpp.ca

Public Health Ontario keeps Ontarians safe and healthy. Find out more at **PublicHealthOntario.ca**

Ontario