Manitoba
Health, Seniors and Active Living

Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Healthcare Acquired COVID-19 Infection

Summary:

A COVID-19 outbreak was declared during the third wave of the global pandemic at a rural healthcare facility. There were four in-patient/resident deaths related to contracting the COVID-19 infection while under the provision of health care services.

An aggregate review was completed of the four (4) in-patient/resident deaths to look at any commonalities or contributing factors related to the spread of the virus.

As the world remains to be in a pandemic to date, with no full eradication of the virus, we continue to learn daily with and from others around the globe. The findings and learnings are shared to assist in mitigation strategies to prevent future outbreaks from occurring in healthcare facilities.

Keywords: Healthcare acquired COVID-19 infection

(This review is based on a multiple number of events)

Findings of the Review:

The world remains in a pandemic to date with no full eradication of the virus as we are living in real time and learning with and from others around the globe.

The facility was ill-prepared for the management of a COVID-19 outbreak due to multi-factorial system failures including reduced staffing in various disciplines due to unfilled vacant positions located in an isolated remote area. There were multiple staff vacancies and no identified lead to fulfill the roles and responsibilities held by these positions. These staffing vacancies lead to communication gaps, disorganization and outdated protocols being utilized at the site. Due to staffing available, at the time of the outbreak, there had been no visitor monitor/screener at any of the entry and exit points to the facility increasing the probability of viral spread to others.

Some cognitively impaired residents (COVID-19 positive &/or negative) were wandering in and out of other resident rooms increasing the potential of virus spread to others. There was no clear concise specific site plan/floor plan at facility for rapid assignment of in-patient/resident placement and zones during the outbreak.

There was limited stock of personal protective equipment (PPE) available at the beginning of the outbreak such as and not limited to i.e.) nitrile extended gloves; full face-shields and correct sizing of N95 masks for staff which increased the probability of PPE breaches/ exposure and spread of the virus.

At the time of the outbreak there was no rapid testing in place. All staff and inpatients/residents required a mandatory COVID-19 Nasopharyngeal Polymerase Chain Reaction (PCR) test with results available in 48 hours. There was one asymptomatic staff member who tested positive for COVID-19 despite completing the self-screening tool for signs and symptoms of COVID-19. The staff member had worked during the time frame of communicability increasing the potential for spread of the virus to others. Not all in-patients/residents &/or staff were fully vaccinated.

System Learning:

Undertake a review to determine the feasibility of maintaining the current model of health care delivery in this remote community.

Adopt and tailor the *"Personal Care Home (PCH)/Transitional Care Centre (TCC) COVID-19 Management Outbreak Preparation and Facility Plan" at the site.*

Review and revise the regional policy Personal Protective Equipment (PPE) Observer (CLI.8011.PR.001) and other regional/provincial policies on PPE use to ensure there is direction for monitoring PPE compliance of designated caregivers during outbreaks.

Implement any revised Personal Protective Equipment (PPE) policies/documents at all long-term care/transitional care centers.

Forward the following recommendations to Provincial Infection Prevention and Control for COVID-19 Respiratory Outbreak Management documents to include the following and not limited to:

- Consideration of management strategies for the wandering cognitively impaired in-patient(s)/residents in long term care/transitional care centers.
- Utilize laminated floor plans at facility for rapid assignment of patient/resident placement and zones

Monitor if the above recommendations submitted to the Provincial Infection Prevention and Control for COVID-19 Respiratory Outbreak Management documents have been implemented.

Designate/re-assign duties for supply chain management of all stock / supplies at the facility including and not limited to i.e.) nitrile extended gloves; full face-shields and correct sizing of N95 masks

Implement and follow the current Manitoba Public Health Orders for COVID-19 vaccination protocols and requirements for all in-patients/residents/visitors and staff in healthcare facilities including adding a Rapid Covid-19 test for all unvaccinated staff.

Date of Posting: