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 had been one patient death related to contracting the COVID-19 infection while under the provision of health care services.

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

Findings of the Review:

A patient with a negative COVID-19 test result was admitted into a shared double room with another negative patient. Both patients attended congregate meals where physical distancing of 6 feet between patients and tables were not maintained. This may have had a potential for viral spread to others on the unit during the unknown stages of communicability from the first negative COVID test to date of patient positivity for the virus. The source of viral spread remains unknown as not all staff were mandated to have a COVID-19 Nasopharyngeal Polymerase Chain Reaction (PCR) test at time of the outbreak.

A product complaint was identified during the critical incident review process involving a recent change in supplier for latex gloves. The gloves were reported to break at the wrist and tear easily posing a risk of viral exposure for staff. A Product/Vendor Complaint Form had been initiated and submitted.

A portable fan had been located and removed from an orange designated room (COVID-19 suspect awaiting test results). It is unknown if the fan had actually been used prior to &/or during the outbreak. The air circulated from a fan has the potential of spreading the virus to others.

PPE is worn for extended periods of time (8-12-hour shifts). Staff voiced that practices occurred contrary to Infection, Prevention & Control guidelines (e.g. Touching masks, eye-shields on top of head, masks pulled or worn below nose &/or hanging off one ear, taking sips of water and putting mask back on) that may have unknowingly spread the virus.

Not all staff members felt comfortable approaching staff &/or designated care providers when PPE was worn in a manner that was not consistent with IP&C guidelines. There are negative perceptions and beliefs of the virus in this catchment area.

An entry/exit door to the facility had been discovered to be unlocked during the outbreak. The door had been accessed by community/family members to use the public washrooms. Upon discovery the door was immediately locked. It was communicated prior that all individuals must enter at one designated entrance to ensure the screening process for COVID-19 was completed.

The order of environmental cleaning of patient rooms during the COVID-19 outbreak may have potentially spread the virus to others on a unit e.g.) Cleaning from one end of unit to other versus working from green (COVID-19 negative) rooms to an orange rooms (COVID-19 suspected awaiting test results) to red rooms (COVID-19 positive rooms).

Staff uniforms/workwear are worn to and from the facility. This has a potential for community viral spread as the virus lives for an extended period of time on clothing according to some studies. The provincial IP&C advice on use of PPE, scrubs, uniforms and footwear recommend to change into a uniform immediately prior to starting a shift and into other clothing at the end of the shift including wearing a dedicated pair of shoes for work.

System Learning:

Recommend all Rehab Unit congregate meal area floor plans be arranged to meet the minimum 6 feet radius between patients to maintain social distancing.

Educate a minimum of 80% of all full-time/part-time nurses, health care aides, housekeeping and maintenance staff at the acute care facility on the Product/Vendor Complaint Form for defective products.

Educate a minimum of 80% of all full-time/part-time nurses, health care aides, housekeeping and maintenance staff at all acute care and personal care home facilities

that portable fans are not to be utilized during an outbreak as per regional Policy and Procedure on “Portable Fan Usage in Healthcare Facilities” (CLI.8011.SG.005).

Review and follow the most current COVID-19 Outbreak Management Protocol (CLI.8011.PL.004.SD.03) in conjunction with Shared Health COVID-19 current level of COVID-19 Essential Care Partner and Visitor Guidelines for Acute Care by monitoring compliance as per regional policy Personal Protective Equipment (PPE) Observer (CLI.8011.PR.001)/ PPE Observation log (CLI.8011.PR. 001.FORM.01) during all outbreaks.

Educate all housekeeping staff on the importance of environmental cleaning flow practices on a COVID unit i.e.) start with green rooms to orange rooms to red rooms to decrease the potential for viral spread.

Revise the Regional Dress Code: Attire and Grooming (ORG.1511.PL.001) Policy to align with current Infection Prevention and Control recommendations related to clinical employee uniforms/workwear not be worn to and from the work environment due to an increased risk for viral spread.

Educate/inform clinical staff on the revised Regional Dress Code Policy: Attire and Grooming (ORG.1511.PL.001) including monitoring for compliance.

Date of Posting: