MAPLES PERSONAL CARE HOME COVID-19 OUTBREAK

External Review Final Report

CONFIDENTIAL AND PRIVILEGED
ADVICE TO THE MINISTER

Submitted to the Honourable Heather Stefanson
Minister of Health and Seniors Care

Presented by:
Dr. Lynn Stevenson, External Reviewer
January 15, 2021

Reviewer Acknowledgements

I would like to express my condolences to the families who lost a loved one during the Maples Personal Care Home outbreak.

I would like to recognize the participation of residents, families, staff, leaders at Maples/Revera, the Winnipeg Regional Health Authority, Shared Health, Manitoba Health and Seniors Care, Winnipeg Fire/Paramedic Service and the Canadian Red Cross. Sharing their experiences during the outbreak was often difficult and emotional but done in a respectful manner with a view to learning and improvement. Their candid and open comments have greatly enriched this report.

During this review, I have endeavoured to be comprehensive in the review of documents, studies, data, and in the large number of interviews conducted but acknowledge that there are multiple issues relevant to the Long Term care sector that are not covered in this report. The timelines were short due to the importance of putting recommendations/learning into action. To that end many changes have already been implemented during the review time period to improve the planning and response to current and potential outbreaks.

I would like to thank Manitoba Health and Seniors Licensing Branch for their support and in particular Laurie, Valerie and Jayne. I could not have completed the review without their assistance. I also would like to recognize my local colleague Jana for all her efforts and assistance in completing the report.

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Executive Summary

Maples is a 200-bed Personal Care Home (PCH) operated as a private (for profit) facility in Winnipeg, Manitoba. Maples, which is part of the Revera organization, experienced a large COVID-19 outbreak that began on October 20, 2020. As of December 22, 2020, 73 staff and 157 residents tested positive and 54 residents died. On January 12, 2021, the outbreak at Maples was declared over.

Prior to the outbreak, Maples was viewed positively by residents/families, the Ministry of Health, Seniors and Active Living (MHSAL) licensing and compliance branch, Winnipeg Regional Health Authority (WRHA), and many external clinical stakeholders. There are many examples of Maples staff working tirelessly to provide care to residents during the outbreak.

There was clear evidence that a significant amount of planning had occurred for a potential second wave of COVID-19 at the provincial, regional (WRHA), Revera, and Maples levels. Revera was proactive in much of their planning and incorporated learnings from other provincial jurisdictions and aligned with Manitoba guidelines and directives. Revera's COVID-19 playbook was robust and in line with expectations. Maples pandemic plan aligned with Revera's but the review was not able to ascertain if it was fully complete. Plans did not identify actions to address the precipitous and significant loss of staff at Maples.

This report focuses on the preparation and planning of pre-outbreak, the actions during the outbreak and lessons learned that can be shared with Maples, other PCH in Manitoba, Revera facilities, and other jurisdictions. It is important to note that significant changes have already occurred including enhancing operating practices/policies, rules, and plans that previously had not been designed for an outbreak the size and scale that occurred at Maples.

The key drivers that contributed to the outbreak involved:

1. Significant staffing shortages in care and housekeeping
2. Questionable consistency of cleaning techniques in common areas and resident rooms
3. Availability of Infection Control Practitioner (ICP) expertise on site

The report has 17 recommendations, broken out as follows:

- Facility level: Maples (Revera)
- Regional level: Winnipeg Regional Health Authority
- Provincial-level: Health Incident Command Structure (HICS) Planning Tables
- Provincial-level: Manitoba Health, Seniors and Active Living (MHSAL)
  NB. As of January 5, 2021 this is now known as Manitoba Health and Seniors Care
- Additional Considerations

A summary of the recommendations follows. In Section 7, recommendations are provided with additional detail. The recommendations are noted as complete, underway or not started, and either short term (complete within three months or less) or long term (complete within three months or longer). Further information and supporting evidence for the findings and recommendations are described in the report.

Recommendations

Facility Level: Maples (Revera)

1. Revise the Maples Outbreak Plan to ensure the ability to operationalize it
2. Identify and implement clear care priorities for residents during an outbreak situation, including but not limited to medication management and minimum standards for documentation
3. Mobilize and deploy additional onsite Revera resources at the beginning of an outbreak through to when stabilization is achieved (e.g. clinical expertise; leadership expertise)
4. Ensure that regular (daily) on site physician rounds are immediately in place once an outbreak has been declared
5. Recognize that housekeeping is a critical essential service in Long Term Care and ensure it is staffed appropriately during any outbreak
6. Improve communication for stakeholders

Regional Level: Winnipeg Regional Health Authority (WRHA)

7. Revise the WRHA pandemic plan to ensure adequate support for PCHs in Winnipeg
8. Revise the Service Purchase Agreement between WRHA and Maples

Provincial Level: Health Incident Command Structure (HICS) Planning Tables

9. Simplify and clarify communication and decision making roles between WRHA and Health Incident Command Structure Planning Tables
10. Coordinate and prioritize the multiplicity of information, directives and guidance documents being pushed out to the PCH sector by a variety of sources

Provincial Level: Manitoba Health and Seniors Care

11. Mandate and fund a province-wide healthcare system response for pandemic outbreaks to reduce fragmentation and delays in outbreak response

Additional Considerations

12. Ensure that LTC is an integral part of the continuum of care in the health care system
13. Establish a clear system for deployment of infection prevention and control (IPAC) clinical resources during outbreak situations, including COVID-19 and other outbreaks like influenza
14. Continue to develop and implement a robust PCH Workforce Plan
15. Review funding for PCHs to ensure that staffing levels and services provided are appropriate to the complexity of current and future residents
16. Review and streamline the licensing standards for PCHs to ensure currency and applicability to the changing needs of residents
17. Given the impact of an outbreak of this magnitude, work must be done to rebuild trust with families. Consideration must also be given to the staff who have been negatively impacted by the experience and the amount of media scrutiny. This will require a multifaceted and ongoing approach to ensure healing and sustainability.

Terms/Abbreviations and Definitions

Term/Abbreviation	Definition
ADL	Activities of Daily Living
AST	Asymptomatic testing for COVID-19 on individuals who are not experiencing any symptoms
Baseline staffing	Used in the outbreak – Normal staffing based on the 3.6 hours per resident Day staffing guideline for Personal Care Homes
CARF	Commission on Accreditation of Rehabilitation Facilities
CDN	Canadian
CIHI	Canadian Institute of Health Information
CIVT	Community Intravenous Team
CRC	Canadian Red Cross
Code orange and code red	Manitoba has identified four levels of risk related to the pandemic response along with associated levels of restrictions. These include code green (limited risk), code yellow (caution), code orange (restrictions), and code red (critical). The orange, or "restricted," level is intended to be used when health officials see evidence of community transmission, but new clusters can be contained with self-isolation, and the health-care system can handle the caseloads. The highest risk level, red or "critical," means there is extensive community transmission and clusters of COVID-19 that are not contained, and the cases are putting a strain on the health system.
Cohorting	Assignment of patients known to be infected with the same microorganisms to the same room or assignment of infected and non-infected patients to separate wards or areas. (Public Health Agency of Canada, 2012).
Critical Incident	An unintended event that occurs when health services are provided to an individual and results in a consequence to him or her that is serious and undesired.
DOC	Director of Care
ED	Executive Director
EpiCurve	An epidemic curve, also known as an epi curve or epidemiological curve, is a statistical chart used to visualize the onset and progression of a disease outbreak. Epi curves typically display a graph of the onset of illness among cases in an outbreak
FTE	Full-time Equivalent
HCA	Health Care Aide
HICS	Health Incident Command Structure (may be known to some as Provincial Unified Incident Command)
ICP	Infection Control Practitioner
IPAC	Infection Protection and Control
LPN	Licensed Practical Nurse
LTC	Long Term Care
LTCAM	Long Term Care Association of Manitoba
MDS 2.0 assessment	Minimum Data Set and is an Inter-Rai Assessment tool
MHSAL	Manitoba Health, Seniors and Active Living (Manitoba), now known as Manitoba Health and Seniors Care

Term/Abbreviation	Definition
NP swab	Nasopharyngeal swab
NP	Nurse Practitioner
OESH	Occupational and Environmental Safety and Health
PCH	Personal Care Homes
PHI	Public Health Inspector
PHIMS	Public Health Information Management System
PI	Pressure Injuries
PPCO	Protection of Persons in Care Office
PPE	Personal Protective Equipment
PRRT	Provincial Recruitment and Redeployment Team
Playbook	Revera's organizational COVID-19 Pandemic Plan
RCM	Resident Care Manager
RN	Registered Nurse
SDO	Service Delivery Organization
SPA	Service Purchase Agreement
Shared Health	The organization in Manitoba that leads the planning and coordinates the integration of patient-centered clinical and preventive health services across Manitoba. The organization also delivers specific province-wide health services and supports centralized administrative and business functions for Manitoba Health
WRHA	Winnipeg Regional Health Authority
WRHA LTC Huddles	A meeting of WRHA LTC leadership with all the PCH operators of Winnipeg for the purpose of planning, updates, policy information, etc.
WS&H	Work Safety and Health department

Section 1: Introduction

On November 13, 2020, the Manitoba Government commissioned a "review of the situation at Maples Long Term Care Home to provide feedback and recommendations. The expert advisor will conduct a review and provide a thorough report of what occurred, the current situation, and provide recommendations on how we can move forward to support the best care possible to residents" (News Release – Manitoba, November 13, 2020).

Purpose

"As per Schedule A of the Maples Personal Care Home/COVID-19 review, the Minister has directed that a review of the events at Maples PCH be undertaken by an external reviewer to determine if:

a. Maples PCH was providing appropriate care to meet the needs of all residents, including those that had tested positive for COVID-19. Based on an analysis of the medical charts/records and care plans for residents at this facility at the time of the event.
b. There were any steps or actions Maples PCH could have taken to mitigate or prevent the events that occurred. Based on advice and directions from Shared Health, the Winnipeg Regional Health Authority, the Public Health Agency of Canada, the Government of Manitoba including but not limited to Public Health and the Chief Provincial Public Health Officer, and others.
c. The impact of any pre-outbreak/pre-event steps or actions taken by Maples PCH to mitigate or prevent the negative outcomes. Based on actions and timing of staff training, staffing efforts, communication with staff/residents/visitors, testing, cohorting, evaluation and review of preparedness plans, execution of plans by Maples PCH, etc.
d. Understanding the validity of the reports from paramedics that staffing levels (numbers and types) were not appropriate for the number and level of care required by residents. Based on a review of schedules, time records, discussion with Maples PCH management team and staff, and discussion with attending paramedics and others.
e. Contextualizing findings in contrast to approaches by other personal care homes in Manitoba with similar COVID-19 case levels have done/are doing to manage the care needs of residents during the pandemic. Based on a high-level overview provided by Manitoba to reviewer and investigation of navigator and support team.
f. Identify learnings from this event for long term care in Manitoba.
g. Identify opportunities to strengthen facility communication with the region, personal care home standards, policy development, and reporting."

The review was conducted by Dr. Lynn Stevenson RN, former Associate Deputy Minister of Health in British Columbia.

The outbreak at Maples PCH unfortunately is not unique to Winnipeg. The first wave of COVID-19 infections saw outbreaks in virtually every province in Canada. Many were small and contained but there were several examples of large outbreaks in Nova Scotia, Ontario, and Quebec (Latta & Stevenson, 2020; Lapierre, 2020).

In addition to answering the questions posed by MHSAL for the review, and in the spirit of improving care for seniors in PCH, the report includes additional points for consideration by the Minister of Health and Seniors Care.

This report has been informed by extensive consultations with residents and their families, staff members, healthcare practitioners, and leaders involved in the preparation, planning, and response to the outbreak. The consultations were primarily conducted on-line except for residents and some Maples staff when the reviewer was on site on December 2-3, 2020. An on-line survey was not effective in gathering input as the response rate was very low. Three teleconference focus groups were held with a total of 38 family participants. An extensive document review was undertaken, and clinical chart reports were examined.

Section 2: About Maples Pre-Outbreak

Introduction

Maples Long Term Care Home (Maples) is a for-profit (private) 200-bed Personal Care Home (PCH) located in Winnipeg, Manitoba. It is a licensed facility operated by AXR Operating (National) LP, an entity owned by Revera together with its joint venture partner, Axium Infrastructure Inc. (Axium), and managed by Revera LTC Managing GP Inc., a wholly-owned subsidiary of Revera Inc. There is a Service Purchase Agreement in place between the Winnipeg Regional Health Authority (WRHA) and AXR Operating (National) LP. Maples is accountable to the WRHA for the delivery of services as described in the Service Purchase Agreement. Funding for the PCH comes through MHSAL to WRHA. This home also participates as a member of the Long Term Care Association of Manitoba (LTCAM).

Revera, together with its partners, owns and operates more than 500 seniors' living facilities across Canada, the United States, and the United Kingdom. They focus on dedicated support and personalized care. In Manitoba, Revera operates eight PCHs, six of which are jointly owned together with Axium. Revera corporately has an LTC division with executive leadership assigned to Manitoba operations. In 2017, Revera Inc. Manitoba received three-year accreditation status through the Commission on Accreditation of Rehabilitation Facilities (CARF) for all eight personal care homes.

Similar to other PCHs in Manitoba, Maples provides a range of long-term care services, including 24-hour nursing services, residential, personal, and other health services[1]. The two-floor facility has ten units divided across two floors with single rooms for all residents. The floors are divided into red, brown, green, blue, and yellow wings. Some wings have 18 beds, some have 22 and many have 20 beds. The facility also has large dining areas, program space, and large outdoor areas (Floor Plan in Appendix 1)

Maples was a participant in the WRHA PCH Operators Table (Long Term Care Huddles) meeting twice weekly before the outbreak. WRHA Long Term Care (LTC) leadership indicated a good working

[1] ltcam.mb.ca/personal-care-home-faq.htm

relationship with Maples and that they often took some of the more complex resident care situations and seemed to manage these well.

Resident Population

For the 2018/19 year, Maples indicated a 99.4% occupancy rate. During the period April 1, 2020, through June 30, 2020, the median age of residents at Maples was 85 with more female residents (63.1%) than male (36.9%), similar to other Winnipeg PCHs. During the same period, the median length of stay was 271 days, which is less than other PCHs in Winnipeg.

In comparison to other Winnipeg PCHs, in the period of April 1, 2020, through June 30, 2020, the clinical characteristics of the resident population at Maples were:

Table 1: Clinical characteristics of resident population at Maples

Clinical Characteristic	Maples PCH	Winnipeg PCH
Overall behavior symptoms (e.g. aggression, wandering, verbal/physical abuse, etc.)	24.8%	36.3%
Cognitive performance (moderate to very severe)	48.4%	57.2%
Depression (rating of 0 to 2 – low depression)	96.9%	88.5%
Health conditions		
- Neurological diseases	75.2%	76.6%
- Heart/circulation	70.8%	70.6%
- Psychiatric/mood diseases	52.0%	40.4%
- Endocrine/metabolic/nutritional	44.6%	41.1%
- Musculoskeletal	32.7%	44.9%
- Sensory diseases	14.4%	22.6%
- Pulmonary diseases	13.9%	14.6%
- Other diseases	37.1%	44.9%

Using the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) completed on or shortly after July 1, 2020, Maples resident population was compared to other Winnipeg PCHs to identify the percentage of residents at a greater risk of death if they contacted COVID-19. The data indicated:

Table 2: Risk classification of resident population at Maples

Risk Classification	Maples PCH	Winnipeg PCH/LTC
Low risk	16.0% (higher)	12.2%
Moderate Risk	75.0% (lower)	79.1%
High Risk	3.7% (lower)	6.5%

Staffing

As of November 18, 2020, more than 200 staff were employed at Maples, including a mix of recreation aides, registered nurses, licensed practical nurses, health care aides, dietary aides, cooks, a part-time personal support assistant, and a full-time rehabilitation assistant. Before the Outbreak, the staff was floating between units, and the MSHAL PCH staffing guideline of 3.6 paid hours for a general PCH unit was in place and being met as of fiscal year-end March 31, 2019.

The staff works a variety of full-time (eight hours) and part-time shifts, with different patient ratios depending on the role. For nurses and health care aides, as reported by the Maples Director of Care, the following staffing numbers and ratios applied per shift:

Table 3: Staffing numbers and ratios by shift at Maples

Role	Days		Evenings		Nights	
	Staff	Ratio	Staff	Ratio	Staff	Ratio
Health Care Aides (HCAs)	20[a]	1.9	20[b]	1:11	10	1:20
Nurses (RNs and LPNs)	8	1:25	8	1:25	3	1:67

a. With an extra 4x five-hour shifts to support baths/meals
b. 17 FT, two of these as six-hour shifts and one four-hour shift to support baths/meals

Maples is staffed with a variety of leadership, support employees, health care workers, and other employees. Leadership includes one Executive Director who is based out of Kildonan PCH (pre-Outbreak held responsibility for both Maples and Kildonan), one director of care (DOC), five full-time resident care managers (RCMs) plus one part-time and one casual. The RCMs have multiple functions, such as helping with education requirements, infection control leadership, and more.

Additional support workers included a full-time social worker and occupational therapist, and a part-time dietitian, a full-time recreation manager, office manager, payroll clerk, staffing/nursing clerk, receptionist, food services manager, and a building services engineer. At some point in the fall of 2020, Maples also introduced a housekeeping manager.

Turnover reports indicated approximately 19 employees left in the 2020 calendar year, as of November 24, 2020. According to Maples quarterly vacancy reports, there were no vacant positions in the nursing department (nursing and HCAs) in the most recent quarter (July to September) leading up to the outbreak.

Quality and Performance Indicators

The Canadian Institute for Health Information (CIHI) *Your Health System website* provides comparison data collected by long-term care facilities using the RAI-MDS 2.0. The following table outlines averages for Maples, WRHA overall, and Canada for the years 2018-19 and 2019-20. For the year 2019-20, comparison data was also available for seven Revera Inc. Manitoba facilities, and as such averages for Revera have been included.

NB. CIHI indicates that: “Results are based on full coverage in Newfoundland and Labrador, Ontario, Alberta, British Columbia and Yukon, and partial coverage in Nova Scotia and Manitoba. Results for jurisdictions with partial coverage should be interpreted with caution.”

Table 4: Frequency of CIHI indicators within LTC resident populations for years 2018-19 and 2019-20

CIHI Indicator - % of Residents	2018-19			2019-20			
	Maples	WRHA	Canada	Maples	Revera	WRHA	Canada
Appropriateness and Effectiveness							
Antipsychotics Without a Diagnosis of Psychosis	16.4%	20.1%	20.7%	15.6%	15.0%	21.0%	20.2%
Daily Physical Restraints	2.2%	10.1%	5.2%	1.4%	1.4%	9.7%	4.6%
Safety							
Fell in the Last 30 Days	13.7%	17.5%	16.7%	10.3%	11.8%	16.8%	16.7%
Worsened Stage 2-4 Pressure Ulcer	2.6%	2.5%	2.7%	1.2%	1.6%	2.6%	2.6%
Health Status							
Improved Physical Functioning	34.9%	29.9%	31.4%	35.0%	36.5%	30.4%	31.3%
Worsened Physical Functioning	19.7%	26.5%	33.2%	21.2%	28.8%	27.0%	33.5%
Worsened Depressive Mood	7.6%	8.1%	21.3%	6.6%	8.5%	7.6%	21.1%
Experiencing Pain	1.5%	8.5%	6.7%	1.7%	2.7%	5.1%	6.2%
Experiencing Worsened Pain	4.7%	4.5%	10.1%	2.9%	4.3%	4.6%	10.0%

Legend for 2019-20: Above CDN Average | Same as CDN Average | Below CDN Average

PCH Standards Reviews

As one of the 125 licensed personal care homes in Manitoba[2], Maples must meet the standards outlined in *The Personal Care Home Standards and Licensing Regulation* under the *Health Services Insurance Act*. There are a total of 26 standards, with a regular review conducted at each personal care home at least once every two years and unannounced reviews at 20% of facilities in 'off years'[3]. Also, in 2020 modified reviews specific to COVID-19 were conducted at all 125 personal care homes, including Maples, with a specific focus on care and resident safety during the COVID-19 pandemic. The status of reviews at Maples since 2016 are as follows:

Table 5: Overview of PCH standards reviews at Maples

Review Date	Review Type	Results
March 2016	Full Review (12 standards)	The report indicated that Maples met ten standards and partially met two standards (housekeeping and infection control)
Sept 2016	Status Update	The report indicated that Maples had implemented the changes required and now met both partially met standards from March 2016 review
June 2018	Full Review (12 standards)	The report indicated that Maples met all 12 standards reviewed. NB. Housekeeping and Infection Control were not part of the standards review at this visit
July 2020	Modified review	The report indicated that no significant findings required follow-up by Maples

[2] http://www.manitoba.ca/openmb/infomb/departments/pch/index.html
[3] https://www.gov.mb.ca/health/pchinfo.html

During the July 2020 review, it was noted that:

- Screening at the front entrance was comprehensive and appropriate
- Personal Protective Equipment (PPE) was available and use was noted throughout the facility
- Physical distancing was observed generally; however, some residents were sitting side-by-side in chairs at the desk – this was immediately addressed by the facility
- The 3.6 hours per resident daycare requirement continued to be met and all staff shifts were filled with adequate staff to provide care to residents
- All vacancies had been filled, however not all shifts are filled and some shifts in nursing left units short-staffed due to unfilled shifts (generally due to unplanned staff absences). An increase in sick time was noted

Protections for Persons in Care Office Results

The following table outlines the number of reports of abuse or neglect by fiscal year sent to the Protection for Persons in Care Office (PPCO). The Director of the PPCO indicated that these numbers are a bit low for a facility of 200 beds, but the reporting has been consistent over time. No concerns were expressed.

Table 6: Reports of abuse or neglect at Maples by fiscal year

Facility	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Maples	57	56	32	37	36	23	29	34

Critical Incidents

There were no critical incidents in the last three years prior to the outbreak (Personal communication with WRHA Director of Quality and Patient Safety).

Resident and Family Satisfaction

Resident experience measures reported in May 2019 (n=59 for the 2019 year) outlined the following:

Table 7: Resident experience scores at Maples

Overall Ratings (% positive score)	Maples Avg.			Revera Corp Avg.	LTC Avg.
	2017	2018	2019		
Overall quality of care/services	92.5%	89.1%	90.4%	85.5%	81.6%
Would recommend this facility	85.2%	81.4%	80.9%	81.0%	Not avail.
Rate overall emotional health	75.8%	89.1%	93.9%	78.0%	70.6%
All domains combined	83.9%	87.7%	82.9%	78.6%	72.9%

The following table outlines the top five strengths and top five areas for improvement in Resident Experience for Maples PCH:

Table 8: Resident experience strengths and areas for improvement at Maples (top five)

Strengths (% positive score)	**2017**	**2018**	**2019**	**N Size**
Helped if in pain/uncomfortable	94.6%	93.3%	98.1%	54
Spiritual/religious needs met	94.4%	96.4%	93.5%	31
Comfortable place to live	88.0%	89.6%	89.7%	58
Feel you can express feelings/opinions	93.2%	97.3%	88.2%	51
Staff show they care	81.3%	91.3%	87.9%	58
Areas for Improvement (% positive score)	**2017**	**2018**	**2019**	**N Size**
Staff promptly answer your calls	58.4%	63.6%	70.2%	57
Can get foods you like to eat	68.5%	85.1%	71.9%	57
Enough food choices	78.3%	81.3%	72.4%	58
Can talk to Dr. when needed	75.3%	91.2%	74.5%	55
Treated how you want to be treated	82.6%	83.7%	80.0%	55

Resident and Family Experience during COVID-19

In 2020, Revera surveyed resident and family experiences related to the Coronavirus pandemic. From January to August 2020, survey results indicated that 79% of Maples residents were satisfied or very satisfied (n=64) and that 91% of Maples families were satisfied or very satisfied (n=55) with Revera's handling of COVID-19. In comparison, 89% of residents and 96% of families during the same period rated their overall satisfaction at Maples as either good or excellent (n=64) and would definitely or probably recommend (n=55) the Maples.

Findings

Before the outbreak, Maples PCH materially met: MHSAL licensing standards, WRHA Service Purchase Agreement expectations, CARF Accreditation Standards, industry quality, and safety metrics, and resident satisfaction expectations.

Section 3: Preparation and Planning

Introduction

This section is focused on pre-outbreak preparation and planning steps taken by Maples to mitigate or prevent negative outcomes from a potential COVID-19 outbreak. While a review of the actions taken by Maples is essential, it is also important to look at the interrelated preparation and planning activities undertaken by:

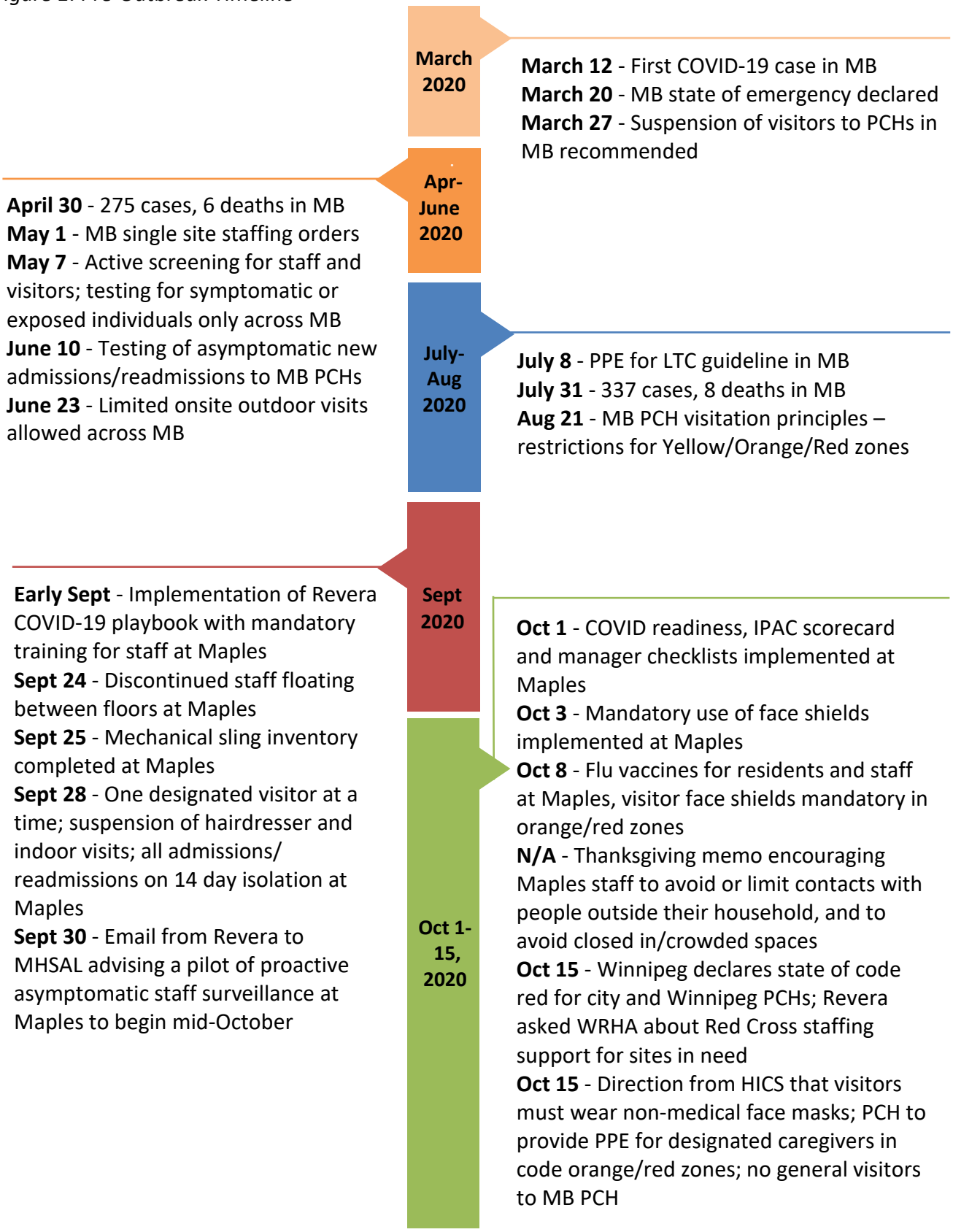
- Manitoba Health, Seniors and Active Living (MHSAL), with responsibility for oversight of all health care standards, required changes to provincial orders/regulations/policies, and pandemic planning activities
- Health Incident Command Structure (HICS) for health systems, with attention on provincial directives for COVID-19
- Winnipeg Regional Health Authority (WRHA), with focus on Winnipeg COVID-19 incident planning and command as well as on translation of provincial guidance and direction across sectors including long term care
- Revera, with responsibility for guiding pandemic response within their long term care facilities, such as Maples, and ensuring plans were in place
- Maples, with an emphasis on the implementation of provincial and organizational guidance and plans

This section will encompass activities over the period leading to the outbreak at Maples, from March 2020 through to mid-October 2020. This is not intended to be a comprehensive list of all preparation and planning activities by the above groups but rather focuses on the guidelines, standards, or assessments that were required of Maples. It includes versions the reviewer was provided.

Pre-Outbreak Timeline

At a high level, the critical events and activities occurring in this period are outlined on the following page:

Figure 1: Pre-Outbreak Timeline



Guidelines and Instructions

Before the outbreak at Maples, numerous guidelines, instructions, and guidance documents were prepared to support planning, decision-making, and actions by PCHs during COVID-19. These included guidelines around general IPAC practices, visitor restrictions, clinical care, and staffing. There were numerous iterations of these as changes were made. A summary is provided below, with a full list in Appendix 2. Updates were shared on a regular basis through the WRHA LTC Huddles with PCH Operators.

General Guidelines

These documents encompassed a range of information and guidelines regarding COVID-19, such as screening, exposure criteria, signs and symptoms, infection prevention and control guidance, checklists, scientific evidence and expertise, readiness assessments, and more.

Six documents in total were reviewed, each ranging from one to 12 pages in length, with approximately 19 versions in total between the six documents. Documents included:

Table 9: General COVID-19 guidelines for LTC/PCHs

Source	Document(s)
HICS/Shared Health Manitoba	▪ COVID-19 Highlights for Long Term Care ▪ COVID-19 Infection Prevention and Control Guidance for Personal Care Homes ▪ Infection Prevention and Control Checklist for Personal Care Homes
WRHA	▪ Draft COVID-19 Outbreak Long Term Care Guideline
Revera	▪ COVID-19 Playbook
Maples	▪ LTC COVID-19 Preparation and Facility Plan

Visitor Guidelines

In March 2020, shortly after the state of emergency was declared, many visitation recommendations and restrictions were introduced to protect PCH residents. These documents encompassed recommendations regarding visitor access, letters to resident families, visitation request forms, visitation principles, visitor education, and more.

Five documents in total were reviewed, each ranging from one to 41 pages in length, with approximately 17 versions in total between the six documents. Documents included:

Table 10: COVID-19 visitor guidelines for LTC/PCHs

Source	Document(s)
HICS/Shared Health Manitoba	▪ Memo: COVID-19 Visitor Restrictions at LTC facilities ▪ Outdoor Visitation Letter ▪ PCH On-site Outdoor Visitation Request Form ▪ COVID-19 LTC Resident Visitation Principles ▪ COVID-19 LTC Visitor IP&C Teaching Resource List

Clinical Care Management Guidelines for Long Term Care

Early in the pandemic response, the following was provided to LTC clinicians. These documents encompassed guidance regarding physical visits from clinicians, transfer to hospital, use of N95 masks, and an order for LTC and transitional care.

Three documents were reviewed, each ranging from one to three pages in length, with one version of each document. Documents included:

Table 11: COVID-19 critical care management guidelines for LTC/PCHs

Source	Document(s)
HICS/Shared Health Manitoba	▪ COVID-19 Guiding Document on LTC Communication & Symptom Guidelines ▪ Memo: COVID-19 Aerosol Generating Medical Procedures (AGMP) in LTC
WRHA	▪ COVID-19 Confirmed Medication Standing Orders

Staffing

Preparatory activities to support staffing during the COVID-19 pandemic were taken at multiple levels before the outbreak at Maples. These documents encompassed memos, frequently asked questions (FAQ), forms, plans and guidance related to single-site staffing, the Provincial Recruitment and Redeployment Team (PRRT), staffing models, COVID-19 staffing planning considerations and guiding principles

16 documents in total were reviewed, each ranging from one to 15 pages in length, with one document having three versions. Documents included:

Table 12: COVID-19 critical care management guidelines for LTC/PCHs

Source	Document(s)
HICS/Shared Health Manitoba	▪ Memo: Single Site Staffing Model for Licensed PCHs ▪ Single Site Staffing FAQ ▪ Single Site Staffing Declaration Form (four different documents) ▪ Memo: Provincial Recruitment and Redeployment Team (PRRT) ▪ COVID-19 Incident Management LTC Staffing Models ▪ Plan for Staffing in all Licensed PCHs during COVID-19 outbreak ▪ PCH Staffing Triggers ▪ Options to address staffing challenges
Revera	▪ Emails: Observations from other jurisdictions (four different emails)
Maples	▪ Maples Pandemic Staffing Plan

Preparation Audits and Assessments

As of March 2020, Maples was regularly participating in Infection Control and Hand Hygiene Audits. Also, required organizational IPAC Audit Schedules were conducted by Revera on September 23, 2020. Many significant reviews, audits, and assessments were completed between July and October 2020, the scope and results of which are outlined in Appendix 3. In short, the following was completed:

Table 13: Significant reviews, audits and assessments at Maples pre-outbreak

Source	Name	Date
MHSAL Licensing Branch	PCH Standards Modified Review Report	Review July 8, 2020; Report August 25, 2020
Maples	Maples IPAC Audit	Completed July 22, 2020
Revera	RDO IPAC Audit	Completed September 29, 2020
	COVID-19 Preparedness Readiness Assessment	Last update October 16, 2020

Findings

General Observations

COVID-19 pandemic planning was occurring from spring through fall 2020 across sectors and planning tables. This includes, but is not limited to, structures such as the HICS, WRHA Incident Command, and both Revera and Maples site-level responses.

The multitude of planning tables established proved to be confusing, unwieldy, and created redundant communication and inquiry pathways to address challenges. As such, it was unclear how information was meant to flow up, down, and across, who was responsible for decision-making and which guidelines were required to be followed. In addition, it is unclear which plans were approved or actioned.

Guidelines and Documentation

The multiple guidelines and directives that were sent to PCHs from various parts of the system did not appear to be coordinated:

- Many topics were duplicated or overlapped between documents (e.g. IPC Guidance for Personal Care Homes by HICS/Shared Health, Revera COVID-19 Playbook, the WRHA COVID-19 Outbreak Long Term Care Guideline, and the Maples COVID-19 Preparation and Planning document). It was unclear to the reviewer which document Maples staff would primarily refer to in the overall management of an outbreak
- There were multiple versions of many of the guideline and staffing documents with little or no indication of what had changed between versions. Many documents were noted as a draft and it is not clear if they were finalized by the time of the outbreak at Maples. This may have made it difficult for PCHs to keep up with the changes
- Not all documents noted how and when they were to be used. In some cases, instructions were noted as ‘strongly recommended’ but not required. It would have been difficult to understand which documents must be followed
- Many documents were greater than ten pages and were not necessarily user-friendly, containing complex algorithms, checklists and links to other documents. People need simple, usable tools. Appendix 4 provides an example of a clinical support tool that is simple, clear and provides ‘just in time’ information for clinicians

Many guidelines appeared to be focused on prevention and managing outbreaks and few around clinical care management of COVID-19 patients. Therefore the clinical guidance needed during the Maples outbreak was not readily apparent.

In mid-November 2020, WRHA shared numerous clinical care guidelines, resources, and referral procedures at their LTC Huddles with PCH Operators. As well, information about available WRHA resources such as palliative care, Community IV team (CIVT), respiratory therapy, etc. was made available.

Two additional documents were created in early December 2020 entitled, "WRHA LTC COVID-19 Pathways", and "Care of COVID-19 Recovered PCH residents". These easy to follow and comprehensive documents were designed to guide care through the COVID-10 outbreak phases in PCHs.

Staffing

The PRRT shared 17 options to address staffing challenges with PCH operators. Section four will include more detail on what was done to address staffing during the outbreak at Maples. Review indicated that Revera and Maples attempted to use all methods available to them to address outbreak staffing shortages. The audits referenced in this section indicate that staffing levels were being met pre-outbreak and a staffing contingency plan was in place as of September 29, 2020. However, it is unclear if the Maples Staffing Plan document was fully completed based on the version reviewed. Based on the COVID-19 Readiness Assessment on October 16, 2020, planning around staff shortages had not been fully completed.

The HICS/Shared Health PCH Staffing Triggers document included recommendations for:

- Collaboration/coordination at the provincial level
- Implement a Rapid Response/SWAT team concept – moving staff from other programs to PCHs
- HICS (Provincial Incident Command) to assess priority areas of service and staff across regions and sectors
- Consider issuing government emergency orders as required

At this point, it is not clear whether any of these recommendations were actioned. Further, it was reported that in some sectors it was 'business as usual' in the midst of this significant outbreak (e.g. conducting attendance management, Prime day programs, etc.). It was also identified that the Provincial Recruitment and Redeployment Team (PRRT) and the COVID-19 casual pool were not able to meet the demands for service requests coming from the PCHs as early as September 2020 (personal communication).

Between March and April 2020, many conversations occurred between Revera and the WRHA to share observations of staffing-related planning activities within other jurisdictions to manage the impact of COVID-19 outbreaks. At the time, these approaches were not being considered.

As of October 20, 2020 when the outbreak was first announced, Maples suspended all visitation. An unintended consequence of this change is that it further exacerbated the staffing shortage as the staff needed to pick up the care often provided by the family.

Asymptomatic Testing of Staff

On September 30, 2020, Revera sent a letter to the Minister of Health, Seniors and Active Living advising that they would be conducting a pilot of proactive staff surveillance at Maples, with a focus on ensuring

the ongoing health and safety of staff and residents. The letter advised that other jurisdictions completed bi-weekly staff surveillance testing, and would expedite early detection and management. The goal would be to detect asymptomatic carriers leading to self-isolation, reducing the risk of unknowing spread to other staff or residents. The approach was noted to be voluntary for staff and Revera would be providing their own contracted lab service to support this testing.

The impact of the decision to implement asymptomatic testing on the outcome of the Maples COVID-19 outbreak is unclear.

As of October 22, 2020, the Infection Prevention and Control (IPAC) guidelines for PCH recommended asymptomatic testing for new admissions/readmissions only. Staff and residents would only be tested if symptomatic or potentially exposed to a positive case.

Education and Training

Revara and Maples rolled out the COVID-19 playbook with mandatory training to staff in September 2020. In addition, they were conducting ongoing training in PPE use, donning and doffing and routine IPAC practices.

Preparation Audits and Assessments

Multiple audits and assessments were completed at Maples in the months leading up to the outbreak. There were significantly more factors assessed as 'passed' versus 'not in compliance' and/or 'failed'. It is unclear if all the areas for improvement noted were addressed by the facility before the outbreak. As reported by the Director of Care (DOC), a table top exercise practicing for an outbreak had not taken place and was scheduled for after the outbreak occurred.

Looking back, it may have been difficult to identify specific factors that foreshadowed an outbreak like the one at Maples. However, the national experience points to staffing issues, housekeeping issues, PPE breaches, physical distancing, staff exhaustion, and IPAC education and coaching (Eastabrooks et al, 2020) as areas that increase the risk of COVID-19 outbreaks. Some of these factors were flagged during the various assessments and audits at Maples between July and October 2020 (Appendix 3).

Overall Compliance with Provincial Guidelines

It was evident that Maples was aware of and following provincial guidelines such as:

- Single site staffing (until exemption was granted)
- Visitor restrictions
- Compliance with signage
- Active screening at entrances for staff and visitors
- Screening of residents
- IPC practices, education, and audits

Based on their audits and readiness assessments, it was also apparent there were areas for improvement including consistent PPE use and hand hygiene practices, ensuring IPAC audits for housekeeping were being completed, management outbreak table top exercises, designating space for staff breaks with adequate spacing, and planning around anticipated staff outages.

Section 4 – Maples Outbreak

Introduction

This section is focused on the Maples COVID-19 outbreak that was declared on October 20, 2020. The intent is to provide clarity on the actions taken by Maples PCH to meet the needs of residents as well as what policies and procedures were actioned and followed during the outbreak. It also outlines barriers and issues that prevented Maples from meeting established standards of care.

This section will encompass activities from October 18, 2020, through to December 22, 2020. It is not intended to be a comprehensive assessment of all of the actions undertaken by Maples but rather focuses on those actions that were identified to have a material impact on resident care during the outbreak.

Outbreak Declaration and Immediate Actions

On Oct 18, 2020, a resident on the second floor of Maples (yellow wing) was identified as having symptoms indicative of COVID-19 and was immediately swabbed. On October 20, 2020, results were reported back to Maples that the resident was positive for COVID-19. This began the string of events that occurred between October 18, 2020, and December 22, 2020. On January 12, 2021, the outbreak at Maples was declared over.

The immediate actions that occurred in response to the positive screen included:

- Contact and droplet precautions and appropriate signage were initiated for this resident pending results
- An outbreak was declared and outbreak protocols were initiated as per LTC IPC guidelines, such as contact tracing, screening 2x/day for resident symptoms, and point of care risk assessments
- Families were all contacted about the outbreak
- Notification of authorities (e.g. Revera, WRHA LTC ICP)

These actions seemed to be appropriate and followed established guidelines.

Limitations

There are multiple sources of information related to resident and staff cases. As such, the numbers and dates are not always consistent; however, the differences are not material to the review.

Overarching Outbreak Timeline

At a high level, the critical events and activities that occurred in the period of October 18, 2020, through to December 22, 2020, are outlined on the following page:

Figure 2: Outbreak Timeline

Oct 18-29, 2020

Oct 18 - Symptomatic resident (2nd floor yellow)
Oct 20 - **Maples outbreak declared**; Outbreak protocols initiated: WRHA IPAC notified; Outbreak mgmt. team organized; 2x/day resident screening; Family communication; ~165 staff tested over four days
Oct 21 - Contracted security to site; tray service to 2nd floor yellow
Oct 22 - Housekeeping contracted for yellow wing; 2nd floor residents isolated to rooms; blue wing residents with symptoms swabbed; tray service for entire 2nd floor
Oct 23 - Resident/staff cohorting for 2nd floor yellow and blue; 1st floor residents isolated to rooms; Request to PRRT for staffing; National recruiters for Revera engaged
Oct 24 - Request to 36 agencies for staffing support; Streamlined medications
Oct 26 - Letter to Robertson College re: employing practicum students; First positive case on 1st floor red; Request to COVID provincial pool/PRRT for staffing
Oct 28 & 29 - Notified WRHA of staffing and contact tracing concerns; Request to Shared Health for staffing; RCMs assisting with patient feeding; Single site exemption requested - received verbal approval Oct 29

Oct 30-Nov 8, 2020

Oct 30 - Critical staffing situation this week; Reviewed essential care with shift to shift huddles; Single site exemption letter received; Health Incident Command Structure reactivated provincially
Oct 31 - 113 residents and 20 staff positive
Nov 1 - WRHA confirms Red Cross support; Compass contracted for dietary aide supports to start Nov 4
Nov 2 – Security staff in Maples 24/7; Revera exploring with WRHA if staff can return to work earlier; Unannounced visit by MHSAL, WRHA, WS&H and PHI
Nov 4 - Hiring of untrained HCAs started; 20 private dietary aides and 28 housekeeping staff started; 39 staff confirmed positive
Nov 6 - Request for transfer of 11 residents to hospital; WRHA LTC Medical Director advised EMS would be sent to assess patients; WRHA and EMS on site; MOH advised they were considering request for staff to return early
Nov 7 - WRHA received email re: potential PPE breach with EMS staff providing care between units and followed up; eight deaths in 48 hours; Winnipeg Homicide Unit visit*
Nov 8 - Physicians begin daily rounds; 15 active residents (84 resolved)

*Email dated January 4, 2021 notes preliminary review completed and only will become involved in the future if criminal allegations are brought

Nov 9-30, 2020

Nov 9 & 10 - NP and WRHA nursing leader on site
Nov 12 – CIVT and Palliative care on site; All PCHs in MB elevated to Level Red Response
Nov 13 - Respiratory program on site; Revised single site staffing orders received; WRHA shared Hypodermoclysis guidelines with PCH Operators
Nov 16 - Red Cross staffing (20) on site
Nov 18 - WRHA shared COVID Resident Screening Tool, National Early Vital Signs Record, and Nutrition and Hydration Guidelines with PCHs; moved six resolved residents back to rooms
Nov 20 - WRHA LTC ICP resource on site; WRHA shared multiple COVID-19 care guidelines, referral processes and reassignment/redeployment extensions
Nov 23 - 23 active resident cases, 43 overall deaths, 16 staff remain off; N95 fit tester on site (133 staff fit tested, followed by another 28 on Nov 30)
Nov 26 - Updated LTC guidance for physicians
Nov 27 - Cohorted remaining positive patients to one wing and closed one wing to optimize staffing

Dec 1-22, 2020

Dec 2 & 3 - External reviewer on site
Dec 7 - WRHA LTC Medical Director provided LTC COVID Pathways and Care Post COVID-19 Residents to PCH medical leadership
Dec 22 - Epi report: 73 staff cases to date, 157 resident cases. 54 residents deceased

Jan 12, 2021

Jan 12 - Outbreak declared over

Maples Staffing Situation

During the outbreak at Maples, staffing was a significant concern. From a review of email communications, as of October 15, 2020, Revera asked WRHA to consider connecting with the Canadian Red Cross for potential resources in anticipation of outbreaks. Further requests for staffing were noted starting October 23, 2020, and onward including engaging Revera national recruiters, contacting 36 staffing agencies, offering paid practicums to Robertson College Health Care Aid students, submitting requests to the PRRT, and further communication with WRHA.

As reported by the Director of Care for Maples, the period of October 30 to November 8, 2020, saw 56 staff go off with symptoms or due to testing positive. By October 30, 2020 staffing shortages were critical and impacted the ability to provide effective resident care.

During the outbreak, the complement of staff on each day may have been comprised of resident care managers who were providing direct care, agency staff, and staff who were working significant overtime and sometimes double shifts to help meet resident care needs. Although there were many "general workers" brought in by Revera/Maples, they were not able to provide direct hands-on care to residents.

Regular staffing for this 200-bed facility is outlined below. This excludes Resident Care Managers (RCMs), of which Maples usually had three on days and one on evenings/nights.

Table 14: Staffing numbers and ratios by shift at Maples

Direct Care Role	Days		Evenings		Nights	
	Staff	Ratio	Staff	Ratio	Staff	Ratio
Health Care Aides	20[a]	1.9	20[b]	1:11	10	1:20
Nurses (RNs and LPNs)	8	1:25	8	1:25	3	1:67

a. With an extra 4x five-hour shifts to support baths/meals
b. 17 full time, two of these as six-hour shifts and one four-hour shift to support baths/meals

The table below reflects the nursing and HCA staffing for the period of October 30, 2020, through to November 8, 2020. There were numerous shifts for both nursing and HCAs where staffing was below 70% of regular (highlighted in purple).

Table 15: Maples Nursing (RN/LPN) and HCA staffing for the period of October 30 to November 8, 2020

Date	Census	Shift	Nursing (RN/LPN)			HCA		
			Actual Nurses compared to Regular	% Regular Staffing	Actual Nurse to Resident Ratio	Actual HCAs compared to Regular	% Regular Staffing	Actual HCA to Resident Ratio
Oct 30	190	Days	5/8	63%	1:38	12/20	60%	1:16
		Evenings	5/8	63%	1:38	11/20	55%	1:17
		Nights	3/3	100%	1:63	7/10	70%	1:27
Oct 31	183	Days	5/8	63%	1:37	13/20	65%	1:14
		Evenings	4/8	50%	1:46	13/20	65%	1:14
		Nights	1/3	33%	1:183	6/10	60%	1:31

Table 15 Continued

Date	Census	Shift	Nursing (RN/LPN)			HCA		
			Actual Nurses compared to Regular	% Regular Staffing	Actual Nurse to Resident Ratio	Actual HCAs compared to Regular	% Regular Staffing	Actual HCA to Resident Ratio
Nov 1	183	Days	6/8	75%	1:31	14/20	70%	1:13
		Evenings	6/8	75%	1:31	14/20	70%	1:13
		Nights	2/3	67%	1:92	6/10	60%	1:31
Nov 2	181	Days	8/8	100% (2 RCMs)	1:23	17/20	85%	1:11
		Evenings	6/8	75%	1:30	11/20	55%	1:16
		Nights	1/3	33%	1:181	8/10	80%	1:23
Nov 3	177	Days	8/8	100%	1:22	17/20	85%	1:10
		Evenings	7/8	88% (1RCM double shift)	1:25	15/20	75%	1:12
		Nights	2/3	67%	1:89	7/10	70%	1:25
Nov 4	175	Days	6/8	75% (1 RCM)	1:29	17/20	85%	1:10
		Evenings	6/8	75% (1RCM)	1:29	16/20	80%	1:11
		Nights	2/3	67%	1:88	8/10	80%	1:22
Nov 5	170	Days	6/8	75%	1:28	20/20	100%	1:8
		Evenings	7/8	88% (1RCM)	1:24	13/20	65%	1:13
		Nights	3/3	100%	1:57	10/10	100%	1:17
Nov 6	162	Days	5/8	63% (1 RCM)	1:32	21/20	105%	1:8
		Evenings	7/8	88% *	1:23	13/20	65% **	1:12
		Nights	3/3	100%	1:54	11/10	55%	1:15
Nov 7	156	Days	9/8	112% (2 RCM)	1:17	14/20	70%	1:11
		Evenings	8/8	100% (1RCM)	1:20	13/20	65%	1:12
		Nights	2/3	67%	1:78	13/10	130%	1:12
Nov 8	151	Days	9/8	112% (1 RCM)	1:17	17/20	85%	1:9
		Evenings	5/8	63%	1:30	12/20	60%	1:13
		Nights	2/3	67%	1:76	9/10	90%	1:17

Notes:

a. * 5 nurses scheduled the entire evening shift plus: 1 RN, Resident Care Manager (worked on the floor for 16 hours from day shift to evening until 11:00 pm), 1 RN, Regional Manager (worked on the floor from the day - evening shift, left at 10 pm), 4 nurses worked 4 hours OT until 7:30 pm, and 1 RN came in early from night shift and started at 7 pm.

b. ** 7 HCA's scheduled and covered with significant OT hours to equate to 13 EFT until 7:30 pm only. The remaining four hours were completed on evenings with only 7 HCA's (1:22 ratio).

A multitude of strategies were employed to address the staffing situation and make the best use of the limited staff available during the period outlined above. This included Maples contracting private staff for more housekeeping and dietary aides to support the care of residents (who started November 4, 2020) along with hiring some untrained HCA staff.

Between the start of the outbreak and October 30, 2020, Revera brought in 'general laborers' to support staff and assist with companionship, PPE auditing, supply management, and nutrition and hydration for residents without swallowing issues. These general laborers were not skilled to provide resident care. Resident Care Managers were assigned to support resident care, but as they became ill this was not a viable strategy. Revera leadership came on-site to support the Director of Care with operations, although at the same time they were also supporting another Revera PCH outbreak.

Following November 6, 2020, additional staffing resources and expertise external to Maples were available on-site and contributed to stabilizing the site and ensuring appropriate resident care, including physicians conducting daily rounds, a Nurse Practitioner, WRHA clinical leadership, the Community IV team, Palliative Care team, respiratory therapy, and the WRHA LTC ICP. Canadian Red Cross staff started on November 18, 2020.

Clinical Care Documentation

One of the ways to understand clinical care during the COVID-19 outbreak at Maples would be to conduct a chart review of individual residents. Given the short time the reviewer was on site and the fact that Maples uses an electronic chart which would necessitate pulling a clinical staff member to assist with access and review, it was decided that doing a random chart review was not feasible. Instead, a random sample of clinical documentation reports was pulled for 20 residents that represented the 1st and 2nd floors and resident care areas. The reports were pulled on specific questions using the 'Reports' feature in the electronic clinical records, and include:

- COVID screening assessments
- Nutrition
- Fluid Intake
- Activities of daily living
- Wound and skin care
- Progress notes (three in total)

It is difficult to draw conclusions from the data reviewed, however, the following points are of note:

- Given the number of asymptomatic or pre-symptomatic residents, it was not entirely surprising for the COVID-19 screening assessment to indicate 'passed' for a resident who tested positive for COVID-19 (no noted symptoms of COVID-19)
- The combination of staff shortages, residents isolated in their rooms for meals, lack of availability of families or volunteers to assist, and the impact of active COVID-19 illness all may have contributed to a lack of meal intake
- Paper-based intake records were introduced early in November during the height of the staffing challenges to help facilitate documentation completion (e.g. agency staff, etc.). As such, it is difficult to ascertain whether the assessments were done and not charted or if the assessments were not completed

- It is difficult to accurately address the question of dehydration without a more in-depth chart review as other factors aside from fluid intake can impact the determination of dehydration such as COVID-19 status, other medical conditions. However, observations of residents by non-Maples clinicians indicated dry mouths and symptoms of dehydration including lack of skin elasticity
- There was an increase in 'total' and 'new' Stage 2 pressure injuries in the early phases of the stabilization period. This is not unexpected considering the increased level of acuity/morbidity, decreased mobility, and level of nutrition and fluid intake experienced by residents during that time

With the staffing frequently less than 70% of regular staffing levels, it would not have been possible to ensure resident care needs were being adequately met during this time. The full results of this clinical documentation review are included in Appendix 5.

NB. Chart reviews are being conducted by the WRHA Patient Safety Team on all residents who acquired COVID-19 resulting in a serious outcome under *Critical Incident Legislation*.

Communication

At the beginning of the outbreak, daily letters were being sent to families updating them on the outbreak status. These letters did not provide the level of specificity that families wanted about their loved ones. After the media interest, the site began receiving a high volume of calls from concerned family members asking for validation that their loved one was receiving adequate care. This increased volume coincided with the height of the staffing shortages and resident specific communication with families became difficult to manage. This in turn created more anxiety for family members and eroded trust and confidence.

EpiCurve / Resident Attack and Death Rates

An EpiCurve report from Manitoba Health epidemiology for Maples has been included for the period of October 20, 2020, through to December 22, 2020 (Appendix 6). This report demonstrates the progression in numbers of COVID-19 positive cases in staff and residents, including how quickly the virus spread in the early days of the outbreak. Highlights from this report, as provided by the Director of Epidemiology and Surveillance, MHSAL, include:

- Asymptomatic testing of staff was initiated on the day the outbreak was called (October 20, 2020) and concluded on Oct 23 with 165 staff tested
- Although it was reported that considerable efforts were made around PPE and IPC education pre outbreak, it was apparent there was still education being provided after the peak of the outbreak (possibly due to all the additional staff such as security, housekeeping, dietary aides, and general laborers)
- Staffing shortages appeared to be a considerable issue early in the onset and resolution to the staffing shortages really only happened post-peak, which would have contributed to ongoing staff fatigue and burn out and impacted on compliance with overall PPE and infection prevention and control practices
- While cohorting is commonly done in respiratory outbreaks, it seemed less effective in this scenario. This is likely due to cases appearing to be asymptomatic being mixed in with non-COVID cases

An analysis was undertaken to compare PCH outbreaks while considering bed numbers (Appendix 7). Sites were analyzed for attack rates and death rates. The report is organized by facility size to determine if there was any significance to the outbreaks based on the number of beds, including large PCHs of which Maples is one. Highlights for large PCHs, as provided by the Director of Epidemiology and Surveillance, MHSAL, are:

- There is a wide range of attack and death rates in this category. For example, several PCHs have very low case counts and no deaths. Conversely, some PCHs have much higher cases and deaths within their institutions
- The attack rates span from <0.1 to 78.5%
- Percentages of cases that have had fatal outcomes range from zero to 23.5%
- Maples LTC had the highest attack rate (78.5%) and percentage of deaths (23.5%) of the ten PCHs in this category
- The three Revera institutions in this category also experienced a range of outcomes (Poseidon PCH had an attack rate of 9.2% and Parkview Place PCH 46.0%; Poseidon did not have any fatalities and Parkview Place had a percentage of deaths equal to 17.6%)

Findings

Cohorting

In discussion with the MHSAL Director of Epidemiology and Surveillance, the question of the benefits versus risks of resident cohorting was raised. Maples adhered to the IPAC guidelines and direction when initiating cohorting. As new test results were ongoing, cohorting resulted in the movement of residents, their beds, and personal belongings around in the facility to accommodate cohorting them by diagnosis (COVID-19 positive, probable, or negative) at the time. This sometimes involved several moves. With every move, housekeeping was required to do a comprehensive clean of the resident's room which increased the need for additional housekeeping resources. This was very time consuming for staff during a period of critical staff shortages and may not have been necessary for a facility where residents already had individual (not shared) rooms. This question is worth pursuing.

Staffing

It was apparent in reviewing the documentation and talking to stakeholders that there was some confusion regarding staffing requests. There were mixed views of the staffing needs and the relative urgency of requests. Based on the PCH Staffing Triggers document that had been reviewed by the LTC Planning Table and PRRT Director, the staffing shortages at Maples should have triggered a system-wide response involving provincial incident command, SWAT teams, mandatory redeployment, and potential emergency orders. This did not occur.

Advanced planning for staffing shortages at a site, region, and provincial level is vital. Staffing shortages cannot be addressed fully by individual PCHs. In addition, expertise including IPC, leadership, and crisis management are required in outbreak situations. It is doubtful that individual PCHs have this expertise on site.

Large numbers of extra untrained staff in the building added additional workload to regular staff, as they required education, orientation, upskilling, and time to be in roles where they can be useful and helpful.

Given the complexities of the outbreak situation at Maples and the increased needs of very ill residents, increases to staffing ratios for nurses and HCA are important to consider. The rationale for staffing increases are based on the understanding that outbreaks result in additional resource requirements for multiple reasons, including but not limited to:

- Time spent on PPE donning/doffing and ensuring appropriate IP&C practices
- Individual resident tray service/meal support
- Increased cleaning/housekeeping including terminal cleaning of rooms
- Existing staff shortages exacerbated by more staff going based on symptoms and/or testing
- Increased audit and education requirements as new staff are introduced
- Increased contact tracing and reporting requirements
- Increased resident care needs for those who were becoming symptomatic
- Extremely limited family support for resident care needs

During the outbreak, Maples received an unannounced visit by MHSAL Licensing and Compliance staff, WRHA, a Public Health Inspector, and Workplace Safety and Health (within the Department of Finance). This visit highlighted significant concerns with staffing, resident food containers unopened, no workplace safety committee in place at the site, and some issues with physical distancing requirements not being met at entrance screening areas and staff break rooms.

Maples was required to provide follow up reporting from this visit, along with the already extensive reporting required for contact tracing, line listing, death notifications, and daily reporting to WRHA LTC ICP, and others (Appendix 8). Although follow up reporting from this visit was important and necessary, there were no additional resources, other than stretched Revera and Maples leadership, to support this work.

Clinical Care

As noted in section three of this report, the reviewer found that before the outbreak there was evidence of preparation around PPE, IPAC practices, visitor restriction guidelines, and more. There was little evidence of resources and guidelines to equip staff on-site with clinical skills required to manage acutely ill COVID-19 positive residents in LTC PHCs. This includes consideration of staffing ratios that would support this clinical care and expectations related to on site physician presence.

From November 18-20, 2020, WRHA shared numerous clinical care guidelines, resources, and referral procedures at their LTC Huddles with PCH Operators.

Communication

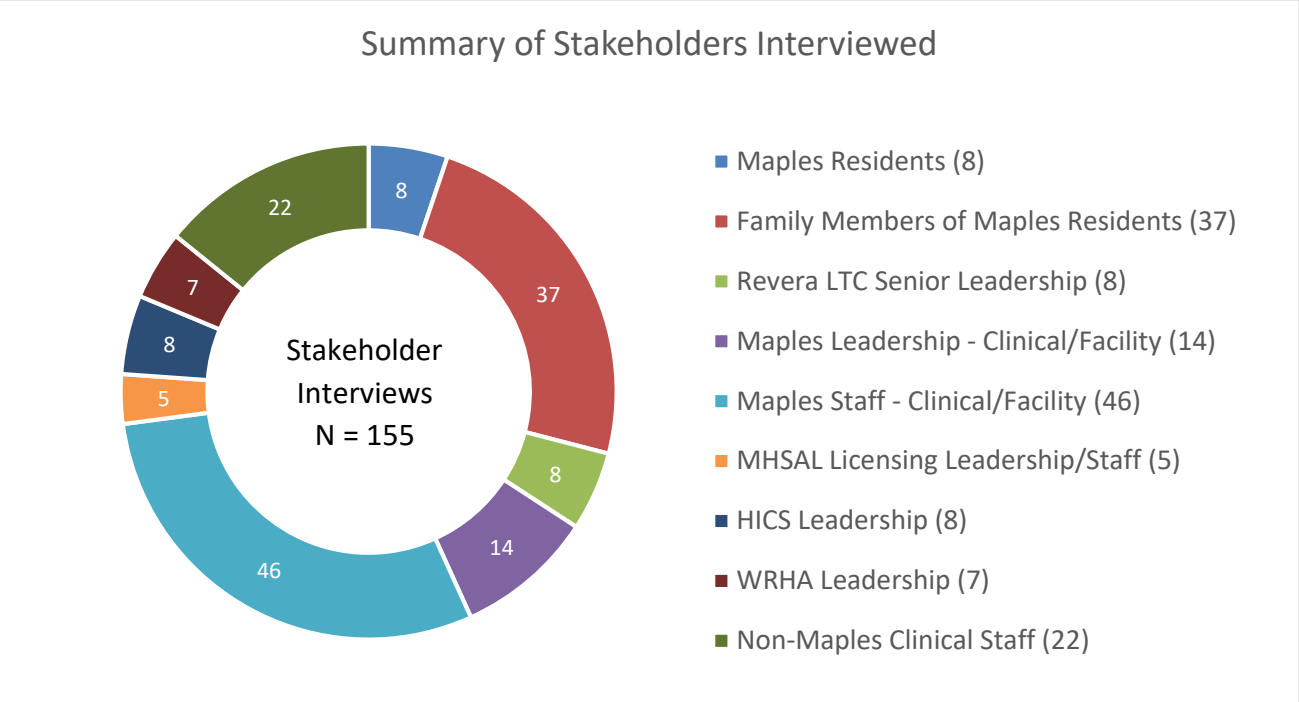
Communication with families decreased during the course of the outbreak. Families were dissatisfied with the volume and limited information about their loved ones.

Section 5: Stakeholder Interviews/Consultations

Introduction

As identified in Appendix 9, the reviewer met with over 150 stakeholders (some several times) to discuss care at Maples before the outbreak (preparation and planning), during the outbreak, and any learnings going forward. The majority of the interviews were done by teleconference or Microsoft teams. Following is a summary of the findings and themes from those interviews.

Figure 3: Summary of Stakeholder Interviews



1. Maples Residents

The reviewer met individually with eight residents on December 2 and 3, 2020 in the education room at Maples with proper masking and distancing. Residents ranged in age from 67-94 years and tenure at Maples ranged from three months to five years. Several residents had tested positive for COVID-19.

Pre-outbreak

- All residents commented positively about the staff and their 'caring' nature. At times staff appeared 'rushed and busy' but residents indicated that their needs were met, albeit a bit slowly at times. Many participated in activities and missed them once COVID-19 measures were put in place. All commented on missing connection with the family members, other residents and the inability to leave their rooms.

Outbreak

- All residents understood why they had to stay in their room and eat in their room but didn't like it. During the outbreak, many were moved out of their regular rooms and had not been moved back. They were worried about their belongings. They felt that they were kept informed about what was going on generally and that staff made an effort to help them keep in contact with the family but added that their family members were quite anxious. Some indicated that there were long periods when they did not see any care staff (they were not able to quantify) but knew they were busy with others. Additional comments included the experience of boredom, fear during the outbreak, and loss of friends. The meeting with the reviewer was the first time that many had been out of their room since October 20, 2020.

2. Family Members of Maples Residents

There were three teleconference focus groups held over three evenings. Family members included some who had lost a loved one during the outbreak. Several participants were angry and wanting accountability, some with a more positive experience were looking for improvements, others were sad and had lost some trust in the ability of Maples to care for their loved ones.

Pre-outbreak

- **General comments**: There wasn't consensus amongst the group regarding life at Maples. Many described the "caring" staff, in particular from the HCAs. Many had loved ones at Maples for many years and identified that care needs were not consistently met.
- **Staffing**: Virtually all commented on the chronic shortage of staff particularly on evenings and weekends. Even when fully staffed, they did not believe that care needs could always be met adequately and required care to be provided by families in particular at meal times. Suggestions were made to ensure staff were scheduled to be available during meal times to assist with feeding, rather than being on breaks.
- **Communication**: Feedback was not consistent, some indicating that they were satisfied with communication and others suggesting that unless they actively pursued issues, they often would not hear back from Maples staff or leadership. Several started using email to communicate as they were not receiving timely responses to phone calls. Care improvement suggestions were often not followed up and the reasons were not always communicated back by Maples. Several mentioned that they seldom had direct communication with a physician even in circumstances (e.g. fall that resulted in a broken hip) where they would have expected to have been contacted. A few commented that staff would talk in languages that were not understandable, which at times caused confusion for residents.
- **Housekeeping**: There was some feedback that the site was not as clean as it should have been and routine maintenance was not attended to.
- **Personal Protective Equipment**: Families noted that they had witnessed PPE breaches.
- **Care Plans**: There were mixed reviews about whether care plans were followed. All agreed that lack of consistency in care delivery increased their concern about the care that was being provided. Care conferences were held according to standard but many were unclear whether changes discussed during those conferences were made, and if changes were made over time the care seemed to slip back into previous patterns.

Outbreak

- **Staffing**: This continued to be the primary area of concern given experiences pre-outbreak with staff shortages. Almost all were concerned about how meals/fluids were being managed as many family members regularly assisted at mealtimes pre-outbreak. Several were angry that pandemic plans had not contemplated the shortages as there had been examples in Ontario and Quebec where there were significant staff shortages.
- **Communication**: There were mixed experiences amongst participants ranging from 'satisfied' to 'extremely dissatisfied' with communication. Dissatisfaction reasons included: inconsistency in frequency or total lack of response to phone calls, the content of information, and lack of trust in the information they received. Several examples were provided when they were told that a loved one was 'fine' and then in less than a day had died, which left families questioning the accuracy of what they were told. Not all families were aware of the designated caregiver protocol that would have allowed some family members to be present to support care.
- **Leadership/management**: Many commented on how committed most of the care staff were and how caring they were towards family members. Families, in general, were concerned about follow up by Maples leaders/management when concerns were brought to their attention. Some families simply gave up while others would take their concerns outside of Maples to WRHA and Manitoba Health, with mixed results. Their prior experiences further eroded family member confidence in management's ability to address the outbreak.

Additional comments

In addition to the perspective above, a few additional questions of note were raised by family members:

- Would the report be released to the public?
- Could the ventilation system (HVAC) have contributed to the spread?
- Who will be held to account for the outbreak?

3. Revera LTC Senior Leadership

Pre-outbreak

- **Planning**: Revera developed their COVID-19 Pandemic Playbook in summer 2020 with training and orientation of staff to the Playbook to be completed in September. It was comprehensive with sections including prevention and preparedness measures (checklists, readiness assessments), outbreak management measures, post-outbreak recovery, and reopening. It had links throughout to appropriate resources, education/training videos, and information around IPAC procedures which were in alignment with provincial guidelines and/or allowed for the inclusion of provincial directives. The section on surge planning in the playbook was limited.

  Maples reported to Revera that education around hand hygiene, PPE, and the practice of donning and doffing was ongoing. IPAC audits were being completed, signage and visitor restrictions were in place in line with provincial guidelines, and active screening at the door of the facility was occurring. N95 fit tests were not up to date, possibly related to the single site restriction limiting fit testers from being in the building. Maples did have a Maples COVID-19 Preparation and Planning document (WRHA template) that outlined key roles and contact information and

referenced back to the Revera COVID-19 Playbook. Revera also had an essential services/pandemic staffing plan.

Outbreak

- **Staffing**: Revera leadership identified that they were not prepared for the volume of staffing lost as a result of asymptomatic testing. Some of the Revera LTC leadership staff were deployed to Maples at the height of the outbreak. Plans in place to augment care staff in the event of an outbreak could not be implemented due to a lack of availability of staff. There was no redundancy of Maples senior leader assignments and if a leader had to go off due to testing positive for COVID-19 Revera had to reassign coverage in the moment. Many creative actions occurred to support the staffing including contracted housekeeping and dietary aid staff and introducing general labor such as Canadian Red Cross support and security. It is unclear if a formal incident command was set up at Maples and in place throughout the outbreak. The Single Site Staffing Order was initially a barrier to getting additional staff as agencies refused to assign staff until a formal letter of exemption was received. There was also some suggestion from Revera leadership that asymptomatic testing could have been initiated earlier based on lessons learned in other provinces.
- **Communication**: Initially daily communication update bulletins were sent to families and staff. However, as the outbreak increased, Maples staff was not able to maintain this frequency which created uncertainty for families as they did not know when the next bulletin would come. In the absence of communication from Maples, negative media reports became the source of information. It was acknowledged by Revera that communication with families was an area for improvement, including the expected trajectory of care with residents who are COVID-19 positive. This perhaps could have been done as part of the planning stage, such as an information session for families. Maples did hold several Town Hall meetings as communication forums for families.
- **Decision making**: A complex system of outbreak response structures between Revera, Maples, WRHA, and HICS caused some confusion and frustration at times as there wasn't clarity where decisions were made. Maples/Revera participated in WRHA LTC huddles for regular updates and round table.

4. Maples Leadership – Clinical/Facility

Pre-outbreak

- **Planning**: The Maples leadership team reported that over the summer and early fall of 2020, there was continued education related to COVID, including PPE training, IPAC audits, review of the Revera playbook, with adaptation to the Maples site. Screening of visitors at the entrance was in place and aligned with Public Health and Shared Health Directives. Outbreak plans for adjustment to medications and times of dispensing were developed as part of the quarterly medication reviews for each resident. Housekeeping standard operating procedures were in place that aligned with Public Health guidance. The team had completed their organization's COVID-19 readiness assessment and would describe that they felt quite well prepared in their planning.

Outbreak

- **Staffing/roles**: Revera and Maples leadership indicated support for the actions to become a pilot site for asymptomatic testing (staff and residents). It was identified that as soon as the COVID-19 outbreak started at the facility, they lost several of their trained screeners for entrances and did not have a backup plan. Several of the staff interviewed took on lead roles for various aspects of the outbreak, education, communication, food service, and logistics. If one of the leads then went off work after testing positive, there was no one to fill their role. The leadership indicated that they were not prepared for the workload impact resulting from having to implement tray service to individual resident rooms as many residents requiring support for feeding. The team shared they were creative with upskilling staff to take on different roles as much as possible (e.g. dietary aides assisting with feeding residents). Earlier in the outbreak, they noted that on site physician assistance would have been beneficial.

  The influx of new staff and general labour (e.g. security, Canadian Red Cross, contracted housekeeping/ dietary aides, and agency) with varying levels of knowledge and skills necessitated ongoing orientation and education. This need pulled leaders away from working with care staff to ensure resident care needs were being met. When it was not possible for all the outbreak-related tasks to be accomplished by Maples, Revera added resources to assist with contact tracing. When the WRHA added a site leader who took a "command and control" approach with all hands on deck, it was well-received by Maples leadership and staff.
- **Communication**: As the communication bulletins decreased due to staffing shortages, Maples leadership reported that much effort was made to assist residents to communicate with family via telephone or computer. All indicated that they were not able to keep up with communication needs.

5. Maples Staff – Clinical/Facility

Staff were interviewed mainly in groups of three (on site with masks and distancing) and groups of three via Microsoft Teams and teleconference. A total of 46 staff contributed.

Pre-outbreak

- **Staff Preparedness**: Staff believed that they were 'ready' for the second wave. They described practicing donning and doffing and hand hygiene audits that occurred over the summer of 2020. They indicated that there was enough PPE. Most staff indicated that they were short-staffed at times, usually on weekends but this was nothing unusual. The staff believed that use of N95 masks was essential. They had not been fit tested to use those types of masks and usage was not recommended for the resident population.

Outbreak

- **Staffing/Clinical Care**: All of the staff described overwhelming staff shortages. Many of the staff tested positive and had a variety of symptoms. Staff shared feeling guilty for going off as they were aware of how difficult it was to find replacement staff. They described the additional staff resources such as security, general labour, etc. as both a benefit and burden primarily because many did not have the skills to assist in direct care. This increased their workload as staff

participated in orientations, education sessions and also had to remain vigilant to ensure that PPE was being used properly and that those providing resident care had enough skills. Assistance with emptying garbage and laundry bins was appreciated, but not necessarily completed appropriately.

Staff described with pride the efforts they made to provide care such as: working double shifts; working without a day off for eight, ten and 12 weeks; sleeping at Maples to be available and not expose their families; and taking on new roles such as educator, auditor, resident care aide duties, housekeeping, and more. They also identified that there should have been work done ahead of an outbreak to clearly identify resident care priorities. Staff suggested that clarity of roles would have been helpful particularly related to who was responsible for assignments as everyone pitched in resulting in 'everyone doing everything'.

- **Communication**: Staff felt supported by Maples leadership and were kept up-to-date on the outbreak situation. Staff identified that the media communication (such as from paramedics on Twitter) exacerbated communication challenges as families started calling with concerns. It became impossible to respond to family calls in a timely and comprehensive manner. As bulletins to families decreased, it frequently was left to the staff to respond to family questions and concerns, which necessitated leaving their care duties. This increased an already stressful situation. Staff supported the idea that team huddles needed to occur earlier in the day to help them coordinate at the start of their shift.
- **Impact**: Many interviews with staff were very emotional as they relayed their experience(s) during the height of the outbreak. Many have been impacted by the significant loss of residents that they deeply cared for, the effect of the negative media reports, and the outbreak as a whole. Many have left their families for prolonged periods to work at Maples. Some felt afraid at the height of the outbreak but put duty over personal concerns. Most spoke very highly of the support and appreciation that continues to be expressed by Maples and Revera Leadership.

6. MHSAL Licensing and Compliance Branch – Leadership and Staff

Pre-outbreak

- **PCH Standards Reviews**: At the July 2020 visit, the Standards Review Team noted the staff was observed to be wearing masks; visitor restrictions and pandemic planning were in a place that aligned with Public Health/Shared Health guidelines/directives. They recalled that there was some concern about the potential impact of the single site staffing directive and the ability to secure skilled staff. The review team reported that resident/family feedback indicated that the staff was busy and sometimes residents needed to wait for care but did not flag this as an unusual or urgent issue.

Outbreak

- **Communication/staffing**: Given the surge in cases after the outbreak was declared on October 20, 2020, an unannounced visit from staff representing MHSAL (Licensing and Compliance Branch, and Public Health Inspection), Workplace Safety and Health, and WRHA LTC was made on November 2, 2020. That visit revealed concerns with staffing shortages and some questions about whether resident care needs were being met. Staff was observed to be using approved

PPE. Staff doing screening at the entrance were using the HICS script. The participants in the November 2, 2020 visit did a virtual team debrief on November 4, 2020 to discuss findings and prepare the contents of a letter outlining the concerns that had been noted during the visit. The letter was sent to the CEO WRHA on November 6, 2020. WRHA would be responsible for sharing the letter with Maples/Revera.

7. Health Incident Command Structure Leadership

Pre-outbreak

- **Structure**: There was a structure in place to steer the pandemic response in the province. The structure included planning groups representing all facets of the health care system. Time and effort were put into directives and guidelines to support PCH IPAC practices, visitor restrictions, outdoor visitation shelters, single-site staffing, and PPE management. HICS leadership's perspective was that these documents were useful and up-to-date, and were maintained on the Shared Health website/COVID-19 resources. There was a gap in having a WRHA PCH senior leader at the operations table reporting to HICS. This gap has since been addressed. The Provincial COVID-19 HICS formally stood down in June 2020 although HICS leaders were meeting regularly.
- **Workforce Planning**: As a result of the PCH Single Site Staffing work, it was already recognized how fragmented the PCH staffing was pre-outbreak. This included a PCH Workforce Strategy that had been developed in consultation with PCH operators. It was recognized that there should have been more focused efforts provincially to improve PCH staffing resources before outbreaks occurred. Surge planning discussions had occurred with the PRRT lead and the LTC Planning Team as evidenced by the COVID-19 PCH Staffing Triggers document.

Outbreak

- **Staffing/Communication**: The HICS was stood up again on October 30, 2020. The Maples outbreak had been underway for ten days at this time. It was reported that the critical staffing at Maples was not being communicated to HICS despite questions being asked about critical staffing pressures at the Operations table. There was only one WRHA LTC ICP for 38 PCHs in Winnipeg. The lack of centrally coordinated IPAC resources to support PCHs in outbreaks was identified as an issue. Interviewees shared that it was unclear why the recommendations from the COVID-19 PCH Staffing Triggers document were not actioned provincially when the outbreak at Maples occurred and staffing became so compromised.

8. WRHA Leadership

Pre-outbreak

- **Maples Status**: WRHA leadership identified there were no 'red flags' related to clinical care. The Service Purchase Agreement was adhered to. Some financial issues with Maples were being resolved, none of which impacted care. They reported a good working relationship with Maples leadership and were able to resolve issues effectively. There was recognition that Maples managed some complex residents and had a waitlist for their rooms. They were responsive with audits (hand hygiene) and reporting and complied with the PCH staffing guideline (3.6 hrs per resident day). Maples was participating at Regional LTC leadership tables.

Outbreak

- **Staffing**: WRHA indicated that they were not aware of the magnitude of the situation at Maples until November 6, 2020. The scheduling clerk at Maples tested positive, and filling that role was highly problematic. At the height of the outbreak, the lack of a dedicated ICP may have slowed Maples' response to issues and impacted consistent application of IPAC practices. Strong Maples site leadership was not evident at the beginning. Revera assistance on site was seen as positive.
- **Communication/Decision-making**: There appeared to be frequent communication between Maples Leadership and WRHA at the beginning of the outbreak but it is unclear how decisions were made or escalated. WRHA did not believe that they received adequate timely information about the outbreak situation.

9. Non- Maples Clinical Staff Who Attended on Site at Maples

Non-Maples clinical staff included, but was not limited to, paramedics, Nurse Practitioners, agency staff, Canadian Red Cross, palliative care team members, CVIT, respiratory therapy, and WRHA senior clinicians.

Pre-outbreak

- **Communication**: Very few had been to Maples before the outbreak; however, they reported that when they had needed to connect, the staff were professional and open to feedback or advice. They indicated that Maples PCH had a good reputation in the larger community. Interviewees indicated there is a gap in understanding as to what PCH staff can provide. This comprises what PCHs are staffed for and what competencies PCH staff have (e.g. hydration therapy, IVs, hypodermoclysis, etc.).

Outbreak

- **Staffing/Roles**: The shortage of staff was readily apparent and several commented that it was not clear who was leading the outbreak response. It appeared to be an 'all hands on deck' approach. The addition of multiple 'general laborers' was noted as compounding an already intense situation. Crowding in the corridors, unclear roles/responsibilities for these staff, and who they reported to contributed to a chaotic workplace. In addition, those interviewed shared that there was overflowing waste receptacles and PPE breaches.
- **Clinical Care**: All indicated that it would be virtually impossible to have been able to provide adequate care during the height of the outbreak when staff numbers were so low. Several mentioned that mouth care was not adequate for some residents. Others remarked that some residents were dehydrated and needed interventions. Consistent organization of care and focusing on the vital needs of residents (mouth care, hydration, nutrition, turning or mobility and essential medications) was not apparent.

Section 6: Closing Notes

Introduction

It would be remiss not to position the Maples outbreak within the context of the devastating number of deaths that have occurred in Long Term Care (LTC) Homes across Canada during the COVID-19 pandemic. A CIHI report in June 2020 indicates that:

> *"While Canada's overall COVID-19 mortality rate was relatively low compared with the rates in other OECD countries, it had the highest proportion of deaths occurring in long-term care. LTC residents accounted for 81% of all reported COVID-19 deaths in Canada, compared with an average of 38% in other OECD countries." (CIHI, 2020).*

This is a sobering fact and one that is likely to be explored more fully in the months and years to come.

Eastabrooks et al, 2020 and EDCC Public Health Emergency Team et al, 2020, suggest that the features of LTC facilities, such as staffing, have not kept pace with the realities of the complex needs of residents. A strong argument is made to include LTC as part of any health care planning, as the acute care sector in particular relies on LTC homes for efficient and effective patient flow. In general, this is not the case.

Many of the stakeholders interviewed as part of this review demonstrated a lack of awareness or understanding of the care capabilities and requirements of a PCH. Some of the criticism levelled at the Maples' response is situated in the belief that Maples should have provided a level of care that in some cases they are not permitted to do under the current accepted standards (e.g. intravenous therapy). In cases where they would be permitted to do so, the staffing ratios in place are not sufficient to provide a higher level of care.

Evidence from time-motion studies and modelling (McGregor and Harrington, 2020) has calculated the number and types of staff needed to meet resident care needs. They suggest minimum standards need to be higher than currently exist in most long term care homes, without the overlay of COVID-19. Their recommended staffing numbers take into consideration the added time required for pandemic-related safety tasks such as meticulous handwashing, careful donning and doffing of personal protective equipment, and consistent compliance with infection control standards during a pandemic.

Latta and Stevenson (2020) suggest that LTC is fundamentally different and more complex than acute care. This is because the care goals in LTC normal operations are to provide residents (not patients) with a home and to maximize quality of life, dignity and function. It can be argued that because PCHs are distinct from hospitals in this way they require more planning to ensure safety in an emergency situation such as a pandemic.

Planning

There is no doubt that enormous efforts were put into pandemic planning at the local (Maples/Revera), Regional (WRHA) and Provincial (HICS) levels. Section 3 of this report reveals that the majority of guidance documents were of a general nature, with less guidance specific to care of COVID positive residents. There were also no directives regarding proactively increasing staffing to ensure care could be provided during outbreaks.

A report commissioned by the Chief Science Officer of Canada in April 2020 and written at the height of the first wave of COVID-19 identified priority areas for immediate attention together with practical options aimed at ensuring adequate care capacity in LTC homes. They included:

1. Ensuring sufficient human and physical resources are available for residents care
2. Ensuring staff with the right skills are deployed at the right place and the right time
3. Enhancing support for the LTC sector from local health and hospital systems
4. Enhancing infection prevention training and control for LTC staff (Government of Canada, 2020)

If one accepts these options as articulated in April 2020, then system-wide planning and follow-up for PCHs in Winnipeg should have been more robust. For example, implementation of the single site staffing order highlighted fragmented staffing across PCHs. There were many staffing strategy documents, but in many cases these had not been completed, nor had action been taken.

There was only one certified WRHA ICP assigned for 38 sites and there was no plan for reallocation of additional resources in place prior to the outbreak. The planning that occurred suggested enhanced IPAC education and audits for staff, but once the staffing numbers decreased it was virtually impossible to maintain appropriate PPE practices. This was due to the increased complexity of care needs and the high number of residents to each care provider.

Outbreak Management and Response

Members of the HICS and WRHA senior staff indicated that they were not fully aware of the staffing crisis at Maples. While planning for health human resources occurred, there wasn't a system wide approach to implementation. PCHs were given assistance in relation to how they might obtain additional human resources rather than concrete direct support from the region or province. The trigger tools/staffing scenarios that were developed in the planning phase were not fully utilized. Maples implemented many strategies to enhance their staffing numbers but in the end they were not effective in mitigating the care consequences of a significant shortage of skilled care and housekeeping personnel.

Lui et al (Sept 2020) indicate that early in the first wave (March 7, 2020) BC "sent specialized teams comprising infection control practitioners, public health staff and clinicians to all homes under their governance, irrespective of ownership and assisted with all aspects of infection prevention and control, from providing PPE to testing residents". This onsite presence and expertise not only provided strong levels of support for LTC staff and leadership, but also freed up care staff to provide hands on care to residents.

Post COVID-19: Moving beyond planning and outbreak management

Family and residents who were interviewed had a wide range of views related to visitor restrictions and isolation of their loved ones. One resident who had been in her room for three months described the difference between pre-COVID and COVID days at Maples is that she used to be "free". Families described in excruciating detail the experience of losing a loved one without the ability to say goodbye. They further discussed the physical and cognitive deterioration of loved ones after a long period of isolation. Families indicated that lack of or insufficient communication during the outbreak exacerbated their anxiety and stress.

Latta and Stevenson (September 2020) in a review of a Halifax Care Home outbreak indicated that the COVID 19 outbreak situation in LTC in Canada has opened up serious ethical-moral questions related to how care delivery should change during an outbreak. This includes the balance between resident autonomy and group safety, and the limits on visitation restrictions during illness or end of life.

The Chief Science advisor also highlights the importance of adopting a "humanistic and compassionate approach with LTC residents, their families, and the staff who care for them." This approach emphasizes dignity and respect for residents both outside of and during a pandemic and also supporting staff to provide safe, compassionate care.

Although there are no easy answers to these considerations, all of them are relevant in examining the outbreak at Maples.

Recommendations

This report outlines 17 recommendations, broken out as follows:

- Facility Level: Maples (Revera)
- Regional Level: Winnipeg Regional Health Authority
- Provincial Level: Health Incident Command Structure (HICS) Planning Tables
- Provincial Level: Manitoba Health and Seniors Care
- Additional Considerations

Each recommendation is noted as complete, underway or not started, and either short term (complete within three months or less) or long term (complete within three months or longer). Additional detail and supporting evidence for the findings and recommendations have been described in the report.

NB. It is important to note that significant changes have already occurred concerning the Maples outbreak including enhancing operating practices/policies, rules, and plans that previously had not been designed for an outbreak the size and scale that occurred there.

Facility Level: Maples (Revera)

1. Revise the Maples Outbreak Plan to ensure the ability to operationalize it:
    - 'Skill up' security and general labor staff before an outbreak (underway – short term)
    - Determine what constitutes a current or pending staffing issue (triggers) and ensure response occurs (underway – short term)
    - Determine critical roles and responsibilities during an outbreak and ensure redundancy for these critical roles within the assignments (complete)
    - Identify the leader for response during an outbreak (complete)
    - Identify and implement increased direct care and housekeeping staff during an outbreak (underway – short term)

2. Identify and implement clear care priorities for residents during an outbreak situation, including but not limited to medication management and minimum standards for documentation:
    - Identify care parameters that will be paused or monitored during an outbreak (underway – short term)
    - Have a clear care plan for each resident before an outbreak that includes personal directives, vital medications, hydration directives, etc. (underway – short term)

3. Mobilize and deploy additional onsite Revera resources at the beginning of an outbreak through to when stabilization is achieved (e.g. clinical expertise; leadership expertise) (underway – short term)

4. Ensure that regular (daily) on site physician rounds are immediately in place once an outbreak has been declared (underway – short term)

5. Recognize that housekeeping is a critical essential service in Long Term Care and ensure it is staffed appropriately during any outbreak:

- Augment housekeeping staff with individuals skilled and knowledgeable in PPE and enhanced cleaning standard operating procedures (underway – short term)
- Ensure housekeeping staff are assigned to specific wings in the building to reduce spread (underway – short term)
- Enhance waste management, including:
  - Adequate waste receptacles (complete)
  - Skilled staff to complete waste removal, such as PPE (complete)

6. Improve communication for stakeholders:
   - Revise the Maples outbreak communication plan to proactively clarify to families what information they will receive, frequency of contact, and by which route it will be provided in the event of an outbreak. This recommendation should also be considered at the system and regional levels (underway – short term)
   - Consult families in development and revision of the outbreak communication plan (not started)

Regional Level: Winnipeg Regional Health Authority (WRHA)

7. Revise the WRHA pandemic plan to ensure adequate support for PCHs in Winnipeg:
   - Implement the SWAT approach for response to outbreaks outlined in the September 29, 2020 COVID-19 PCH Staffing Triggers document, including:
     - Deployment of onsite expertise in infection prevention and control, older adult clinical care, Community IV team, palliative care, nurse practitioners, logistics, and leadership (underway – short term)
   - Provide clear and comprehensive care priority guidelines that are to be implemented by PCHs during an outbreak (underway – short term)

8. Revise the Service Purchase Agreement between WRHA and Maples:
   - Clarify and strengthen the expectation for medical (physician) oversight during a PCH outbreak situation as per requirements outlined in Schedule A (not started – short term)
   - Review existing PCH medical bylaws to ensure appropriate physician oversight for this vulnerable population and communication to families (not started – long term).
   - Clarify and strengthen infection prevention and control expectations, which are critical in any PCH both before and during an outbreak (not started – short term)

Provincial Level: Health Incident Command Structure (HICS) Planning Tables

9. Simplify and clarify communication and decision making roles between WRHA and Health Incident Command Structure Planning Tables (underway – short term)

10. Coordinate and prioritize the multiplicity of information, directives and guidance documents being pushed out to the PCH sector by a variety of sources:
    - Focus on streamlining, simplifying and communicating the critical guidelines and directives that are to be implemented in an outbreak situation. It is impossible given the

limited resources at PCHs to ensure adherence to a multiplicity of complex directives and guidelines without clear prioritization (not started – short term)
- Ensure that there are guidelines around the clinical care management of COVID positive patients in LTC (underway – short term)
- Identify and establish a 'single source of truth' for where decisions are made and where information, directives, and guidance documents are housed (not started – short term)
- Develop scripts or templates that specifically and concisely identify the critical information required for appropriate responses during an outbreak. For example, include questions such as. "what is your current staffing per shift for the next 48 hours" rather than "are there staffing concerns" (underway – short term)
- Review cohorting guidelines for facilities where residents have individual (not shared) rooms (not started – short term)

Provincial Level: Manitoba Health and Seniors Care

11. Mandate and fund a province-wide healthcare system response for pandemic outbreaks to reduce fragmentation and delays in outbreak response:
    - Clarify roles and expectations of HICS and regional structures (underway – short term)
    - Establish clear triggers for emergency response to staffing (underway – short term)
    - Have PCHs represented at the HICS table (complete)
    - Remove barriers for staff mobility:
        - Ensure that appropriate memoranda of understanding with unions are in place for the entire sector should broad deployment or redeployment be necessary, recognizing that some PCH's have their own agreements (underway – short term)
        - Ensure that the process for implementing single-site exemptions is responsive to emerging staffing needs (underway – short term)
        - Consider drafting emergency orders for deployment or redeployment of staff for use in case of emergencies (not started – short term)

Additional Considerations

12. Ensure that LTC is an integral part of the continuum of care in the health care system
    - Consistently and comprehensively include PCHs in all aspects of health system planning, programming, and resource allocation

13. Establish a clear system for deployment of infection prevention and control (IPAC) clinical resources during outbreak situations, including COVID-19 and other outbreaks like influenza:
    - Build a provincial inventory of system-wide certified IPAC resources with criteria for deployment and expected actions during outbreaks, including staff that are working in non IPAC roles
    - Pre and post-outbreaks, ensure proactive and ongoing visits and collaboration with PCH to ensure preparedness in basic IPAC practices
    - Given ongoing changes that occur in IPAC practices, a provincial approach to IPAC expert resourcing may be necessary with a clear mandate, reporting structure and accountabilities. Additional resources may be necessary.

14. Continue to develop and implement a robust PCH Workforce Plan:
    - Recruitment strategies must include the value of working in seniors' health, one of which is reasonable remuneration
    - Relying on staffing agencies to supply staffing to PCHs is not sustainable or desirable

15. Review funding for PCHs to ensure that staffing levels and services provided are appropriate to the complexity of current and future residents
    - Given the complexities of outbreak situations and the increased needs of very ill residents, increases to staffing ratios for nurses and HCA are important to consider

16. Review and streamline the licensing standards for PCH to ensure currency and applicability to the changing needs of residents:
    - Prioritize licensing standards to ensure emphasis on critical clinical care standards that must be reviewed every two years
    - Develop and implement metrics for clinical care standards that impact quality and safety for residents and report these out to the public
    - Align Service Purchase Agreement expectations and accountabilities with the licensing standards

17. Given the impact of an outbreak of this magnitude, work must be done to rebuild trust with families. Consideration must also be given to the staff who have been negatively impacted by the experience and the amount of media scrutiny. This will require a multifaceted and ongoing approach to ensure healing and sustainability.

This report has captured the events that occurred in connection to the outbreak at Maples and provides recommendations for moving forward. Many improvements have already occurred and others are underway. Families are hopeful that while these changes may not bring back their loved one, the actions outlined in this report may prevent an outbreak such as the one at Maples from occurring in the future.

References and Resources

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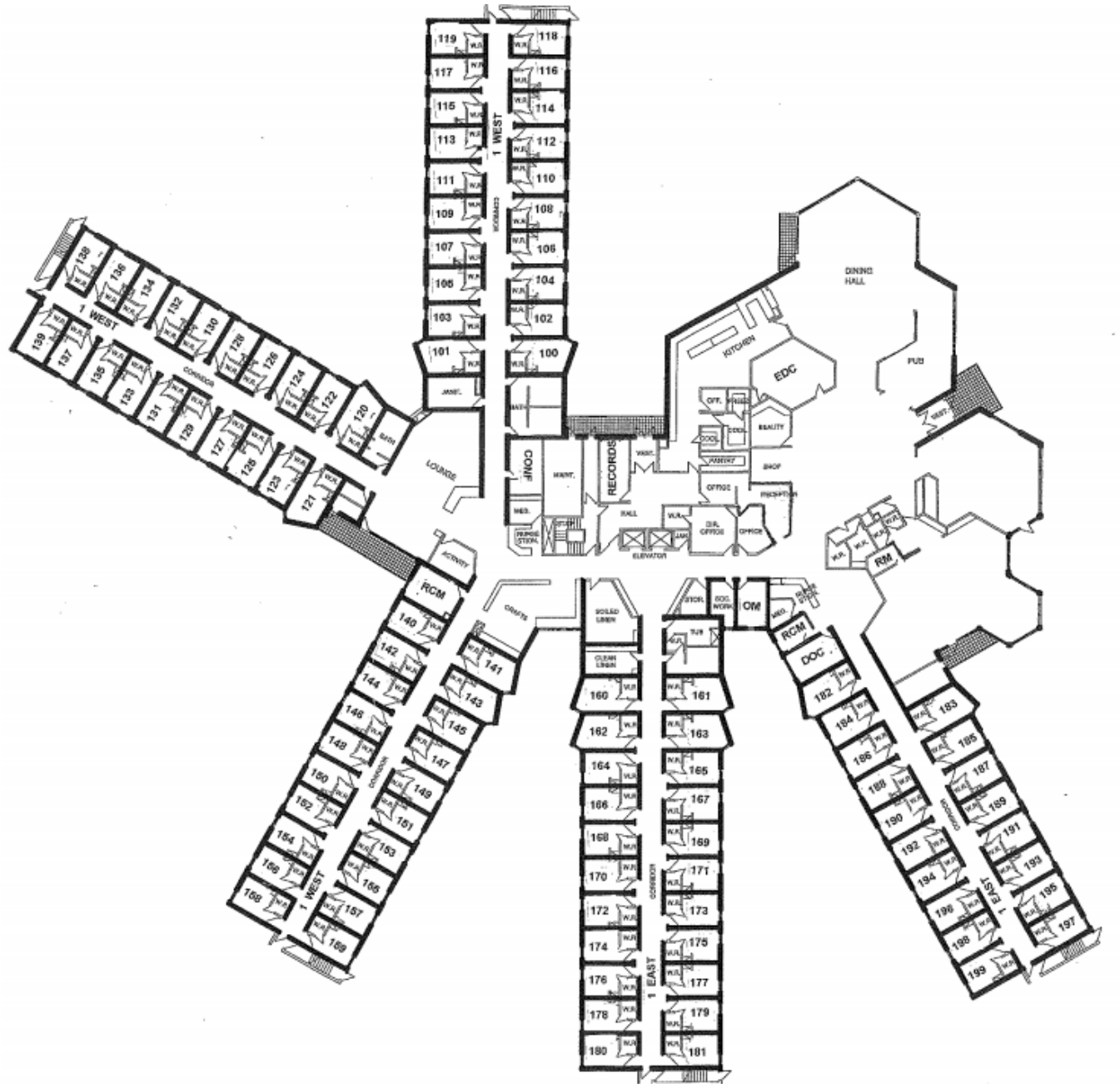
Appendices

Appendix 1: Maples 1st Floor Plan



Appendix 2: Guidelines and Instructions

General Guidelines

HICS/Shared Health Manitoba		
Document	**Description**	**Versions**
COVID-19 Highlights for Long Term Care	▪ One- to two-page documents provided every one to two weeks from March 2020 through to July 2020 ▪ Included general information regarding screening, exposure criteria, and signs and symptoms criteria. Also, the documents provided the most recent instructions for infection prevention and control measures	Eight, between March 27 and July 8, 2020
COVID-19 Infection Prevention and Control Guidance for Personal Care Homes	▪ The 20-page guidance document, regularly updated with the most current available evidence ▪ Included highlights, description of COVID-19 symptoms, and guidance for infection prevention and control, screening, managing visitors, resident care and infection control measures, admissions/re-admissions, testing, outbreak management, waste management, resident transport, transfers, etc.	Seven, between May 15, 2020, and October 22, 2020
Infection Prevention and Control Checklist for Personal Care Homes	▪ Intended to guide PCH in Manitoba in conducting COVID-19 IPC assessments to ensure preparedness for prevention and readiness to respond in the event of a COVID-19 outbreak. ▪ Could also be used by MHSAL during standard review visits ▪ Included human resources, environmental cleaning, outbreak management preparedness, testing, PPE, screening, etc.	One, dated June 29, 2020
WRHA		
Document	**Description**	**Versions**
Draft COVID-19 Outbreak Long Term Care Guideline	▪ The 41-page draft contained the most currently available scientific evidence and expert opinion informed guidance for COVID-19 ▪ Included infection prevention and control practices, outbreak management LTC response processes, contact tracing, media rules of engagement, scripts of suspected or confirmed cases, resident and staff cohorts, handling of bodies, transfers, etc.	One (draft), dated August 26, 2020
Revera		
Document	**Description**	**Versions**
COVID-19 Playbook	▪ The 59-page document, developed as a resource for LTC operators to guide pandemic response efforts ▪ Included a COVID-19 readiness assessment, policies, directives and other guidance, manager checklists, prevention and preparedness instructions (e.g. screening, signage, masks and PPE, IPAC measures, cohorting, testing, visitors, etc.), and best practices and guidelines for outbreak response, post-outbreak recovery and reopening as the pandemic winds down	One, dated August 26, 2020

Maples		
Document	**Description**	**Versions**
LTC COVID-19 Preparation and Facility Plan	▪ 12 page document developed by Maples Management Team ▪ Designed to aid and support development of a facility-specific COVID-19 outbreak plan ▪ Document does not appear to be complete	One, no date

Visitor Guidelines

In March 2020, shortly after the state of emergency was declared many visitation recommendations and restrictions were introduced to protect PCH residents.

HICS/Shared Health Manitoba		
Document	**Description**	**Versions**
Memo: COVID-19 Visitor Restrictions at LTC facilities	▪ The memo recommended suspension of visitor access within LTC facilities, with exceptions for compassionate reasons or end of life on a case-by-case basis. ▪ Included recommendation to suspend all adult day programs	Three, between March 23 and May 21, 2020
Outdoor Visitation Letter	▪ Letter to resident families advising that on-site outdoor visits were being supported, indoor visits remain suspended, and off-property visits are not permitted ▪ Advised screening of all visitors must occur, and all visitors must comply with IPC measures ▪ The referenced visitation request form (below)	Three, between May 20 and June 23, 2020
PCH On-site Outdoor Visitation Request Form	▪ Form to request on-site outdoor visitation during COVID-19 ▪ Included 'need to know' information about essential visitors, screening, physical distancing, etc. ▪ Information to be filled in is the name, contact information, and preferred visit day/time for each essential visitor	Three, between March 20 and June 23, 2020
COVID-19 LTC Resident Visitation Principles	▪ Four-12 page document (varied number of pages over time) updated regularly in the months leading up to the outbreak ▪ Designed to emphasize a flexible, compassionate, resident and family-centered approach regarding visitations, and also minimize the risk of COVID-19 outbreaks in LTC facilities ▪ Within the principles, visitor limitations were separated into levels that evolved based on the presence/ transmission of COVID-19 in the province	Seven, between June 5 and October 15, 2020
COVID-19 LTC Visitor IP&C Teaching Resource List	▪ Designed to support visitor education on IPC principles and personal protective equipment, including safe use of non-medical masks/face coverings, hand hygiene, and putting on/taking off PPE	One, dated July 2020

Clinical Care Management Guidelines for Long Term Care

Early in the pandemic response, the following was provided to LTC clinicians:

HICS/Shared Health Manitoba		
Document	**Description**	**Versions**
COVID-19 Guiding Document on LTC Communication & Symptom Guidelines	▪ The three-page document outlined recommendations that PCHs limit the number of physical visits from clinicians (physician or nurse practitioner) and that every patient transfer to hospital be first triaged by a physician or nurse practitioner ▪ Also noted the status of Comfort Care or Medical Care with no heroic interventions for many LTC residents, thus making them ineligible for ICU admission	One, dated March 31, 2020
Memo: COVID-19 Aerosol Generating Medical Procedures (AGMP) in LTC	▪ Memo to all health care providers from Chief Provincial Public Health Officer and Chief Medical Officer and Provincial Medical Specialty Lead, Shared Health ▪ Provided instructions for use of N95s for all AGMP in LTC based on certain criteria ▪ Provided instructions for when to use an N95 respirator	One, dated April 22, 2020
WRHA		
Document	**Description**	**Versions**
COVID-19 Confirmed Medication Standing Orders	▪ Order for LTC and Transitional Care based on: Interim Guidance for Care of Residents in LTC Homes During the COVID-19 pandemic, Public Health Agency of Canada (2020) ▪ Intended to initiate medical and comfort care for COVID-19 residents and be used as a guideline	One, dated August 2020

Staffing

Preparatory activities to support staffing during the COVID-19 pandemic were taken at multiple levels before the outbreak at Maples:

HICS/Shared Health Manitoba		
Document	**Description**	**Versions**
Memo: Single Site Staffing Model for Licensed PCHs	▪ Memo sent to Service Delivery Organization/PCH leadership ▪ Introduced the single-site implementation as of May 1, 2020 ▪ Requested PCH leadership to contact affected staff ASAP, and provided a Frequently Asked Questions (FAQ) document and a letter to families for use	One, dated April 26, 2020
Single Site Staffing FAQ	▪ Five to eight-page document that provided questions and answers (Q&A) related to the single site staffing order ▪ Versions one and two contained 30 Q&A, version three - 37 Q&A, and version four - 42 Q&A ▪ Answers to questions updated over time	Three, between April 28 and May 20, 2020

Single Site Staffing Declaration Form	▪ When single site staffing came into effect, all agency, current PCH hires, new PCH hires, and volunteers were required to sign a Single Site Declaration form ▪ Different forms for each group	Four different forms, all dated May 1, 2020
Memo: Provincial Recruitment and Redeployment Team (PRRT)	▪ Memo sent to Service Delivery Organization/PCH leadership ▪ Announced establishment of PRRT, to support redeployment of Service Delivery Organization resources and expedite the hiring of casual staff to meet the urgent COVID-19 needs ▪ Highlighted that the expected greatest area of need for staffing would be weekend, evening, and night shifts, and particularly nurses (RN/LPN) and health care aides	One, dated April 29, 2020
COVID-19 Incident Management LTC Staffing Models	▪ 15-page draft document (as of version June 15, 2020) ▪ Outlined current guidelines for staffing models, guiding principles, LTC requirements to maintain adequate staffing coverage, and key responsibilities by role ▪ Also included provincial support teams, training principles, and a new staff orientation agenda	One, dated June 15
Plan for Staffing in all Licensed PCHs during COVID-19 outbreak	▪ Ten-page draft guidance document (as of version July 7, 2020) ▪ Designed to be used in conjunction with the COVID-19 Outbreak Preparedness Guide for MB SDOs ▪ Included planning considerations, guiding principles, and three escalating scenarios for general guidance ▪ Noted that Service Delivery Organizations (SDOs) should develop operational planning and support tools to assist sites with contingency planning, prepare operational contingency plans, operational mitigation plans for each of the three scenarios, and determine services required to be provided by each classification in advance	One, dated July 7, 2020
PCH Staffing Triggers	▪ Five-page document (as of version September 29, 2020) ▪ Outlined five potential staffing scenarios for PCH outbreaks ▪ Included strong recommendations for scenario five (an outbreak of the magnitude that occurred at Maples with staffing levels reduced by more than 30%)	One, dated September 29, 2020 (draft)
Options to address staffing challenges	▪ PRRT advised that options to address staffing challenges were shared with PCH operators; options include: 1. Offering additional shifts to part-time staff 2. Offering additional shifts to casual staff 3. Offering additional shifts for longer periods (e.g. three months instead of six weeks) 4. Offering overtime 5. Mandating overtime 6. Under filling shifts (e.g. two HCA for vacant nurse shift 7. Utilizing work short protocols 8. Combining low EFTs 9. Offering higher EFTs (EFT Increase Form)	No date

	10. Changing shift descriptions for hard to fill shifts (e.g. changing N shift to D/E or D/N where feasible) 11. Overscheduling during high sick call shifts 12. Standby staffing for peak periods 13. Implementing 12-hour shifts – can have a combo of 8s/12s 14. Building stats into the rotation 15. Recruiting into existing vacancies 16. Utilizing agency 17. Submitting a request for resources from the PRRT	
REVERA		
Document	**Description**	**# of Versions**
Emails: Observations from other jurisdictions	▪ Emails from Revera to WRHA sharing observations of how other jurisdictions managed the impact of COVID-19 outbreaks ▪ Included cohort deployment of staff and single-site assignments within Ontario, Alberta, and British Columbia; suspension of RAI assessments within Vancouver Coastal Health Authority; and paid clinical placements for HCAs in Alberta ▪ At the time, these approaches were noted as not something being considered in WRHA but might change in the future	Four emails between March 25 and April 20, 2020
MAPLES		
Document	**Description**	**# of Versions**
Maples Pandemic Staffing Plan	▪ Ten-tab spreadsheet that provided instructions for completing a staff skills inventory, essential task listing, essential services, and staffing requirements ▪ Outlined essential care for various staff roles at staffing levels of 100% or more, 65%, 50%, or 35%	No date

Appendix 3: Audits and Assessments

MHSAL (Licensing Branch)		
Document	**Description**	**Date**
PCH Standards Modified Review Report (1.4.7)	**Overview** ▪ Standards review at all licensed PCH in Manitoba between July and December 2020 ▪ Conducted due to increased risk and to ensure standards of care are maintained during COVID-19 pandemic ▪ Modified review process developed based on PCH standards **Scope** ▪ Key areas of care delivery and actions taken by PCHs to safeguard residents from the spread of infection ▪ Consisted of: o A walkthrough tour of common areas and suites, with a focus on cleanliness and general state of maintenance o Review of eight health records o Interviews (four family members, six residents, five staff members, ED and Director of Care) o Review of fire drill records from the 2018-current date o Resident council meeting minutes from the 2018-current date ▪ Standards reviewed: - Bill of Rights - Resident Council - Information on Admission - Right to Participate in Care - Communication - Integrated Care Plan - Use of Restraints - Medical Services - Nursing Services - Pharmacy Services - Nutrition/Food Services - Therapeutic Recreation - Spiritual and Religious Care - Disaster Management Program - Infection Control Program - Staff Education **Results: No follow up by Maples Required** ▪ No significant findings during the review ▪ Screening at the front entrance was comprehensive and appropriate PPE use noted throughout the facility ▪ Physical distancing observed generally – some residents sitting side by side in chairs at the desk; Immediately addressed by the facility ▪ Interviews highlighted the desire for increased visitation from families and the ability to go outside. ▪ More staffing – as a whole needs to be increased	Review: July 8, 2020; Report: August 25, 2020

REVERA		
Document	**Description**	**Date**
RDO IPAC Audit (1.6.8)	**Overview** ▪ A Revera IPAC audit tool **Scope** ▪ Assessment against 19 factors, with a focus on - PPE Audit - Screening process on entering the building - Physical/social distancing - Physical environment **Results: Compliance of 'Yes' on all 19 factors** **Other Points of Note** ▪ Home struggling for space, using conference rooms to maximize social distancing. Need strategies developed to spread out further ▪ Lots of redirection of residents needs to happen – difficult for staff and residents (re dining areas, and resident lounges)	Completed September 29, 2020
Revera Preparedness Readiness Assessment (1.8.7)	**Overview** ▪ Assessment within the Revera COVID-19 Playbook that was required to be completed by October 9, 2020, and ongoing as indicated (1.8.3) **Scope** ▪ Assessment against 64 factors, including but not limited to: - Screening - Physical distancing - Signage - PPE - Precautions - Environmental cleaning - Hand hygiene - Cohorting - Preventative isolation - Staff education - Completion of audits - Media guidelines - Testing - Single-site employment - Admissions isolation - Dining areas - Supply management - Essential visitors - Surveillance testing - Outbreak attendance - Staff wellness - Staffing - Family contact - Communications **Results: 'Pass' for 60 factors; 'fail' for four factors** **Areas for Improvement** ▪ Physical distancing for all residents, staff, and visitors. The action plan included signage posted throughout the facility indicating how many staff allowed to be in each area	Completed by Maples, October 7, 2020

	▪ Outbreak attendance with a focus on asking staff if they would be willing/able to attend work in the event of an outbreak. The action plan included providing education and reassurance that in case of an outbreak, we will be safe with all measures in place. Did not ask staff if willing to work. ▪ Staff change clothes before and after work. No locker room space to achieve this. An action plan was to look into options to obtain more lockers for staff. ▪ IPAC education with a focus on re-educating staff on donning/doffing, cohorting, handwashing, enhanced cleaning, visiting processes, medical apt. procedures. Action plan to have a poster available in report rooms/bulletin boards. Over the next weeks, a review to occur with all staff at shift reports. **Other Points of Note** (for potential improvement) ▪ Cohorting staff – particularly housekeeping ▪ Having medical coverage daily on-site when in outbreak ▪ Housekeeping practices – cleaning of high touch areas 3x/day; proper use of disinfectants and PPE ▪ Finish staffing contingency plan	
MAPLES		
Document	**Description**	**Date**
Maples IPAC Audit (1.6.7)	**Overview** ▪ The IPAC Audit tool used by Maples **Scope** ▪ Audit against 91 factors, including but not limited to: - Hand hygiene - Environmental and equipment cleaning - Routine practices, additional precautions - Handling and storage of laundry and waste mgmt. - Area and room reviews and screening - Access to supports ▪ Also included one question regarding a contingency plan for human resources that identifies minimum staffing needs and prioritizes critical and non-essential services based on resident needs and essential facility operations (result: in compliance) **Results: In Compliance - 'Yes' or 'N/A' for 75 factors; 'No' for 16 factors** Areas for Improvement: ▪ The indication that housekeeping staff needed some further education on hand hygiene moments and what disinfectant contact times were ▪ Need for increased frequency of enhanced cleaning of high touch areas	Completed by Maples, July 22, 2020

	▪ Use of formal PPE audit tool at the screening station ▪ Promotion of hand hygiene with residents ▪ Proper use of masks with staff and need to use eye shields ▪ Staff not socially distanced in break rooms ▪ Staff not able to demonstrate how to access PIAC resource page on MyRevera ▪ Need to increase completion of housekeeping audits **Other Points of Note** ▪ Staff perform twice daily self-checks during work, in addition to screening before coming to work ▪ PPE was available and use was noted throughout the facility ▪ Physical distancing was observed generally, however, some residents were sitting side-by-side in chairs at the desk – this was immediately addressed by the facility ▪ 3.6 hours per resident day care requirement was met and all staff shifts were filled with adequate staff to provide care ▪ All vacancies had been filled, but not all shifts are filled and some shirts in nursing left units short-staffed due to unfilled shifts (generally due to unplanned staff absences) ▪ An increase in sick time was noted	

Appendix 4: Clinical Support Tool (pages one and two only)

Long Term Care	GREEN ZONE	ORANGE ZONE	RED ZONE	Shared health Soins communs Manitoba Revised: July 14, 2020 Version 3
hand hygiene	**Strict HAND HYGIENE is required before and after contact with resident or resident environment, as well as before and after donning and doffing PPE**			**Additional Instructions**
mask	**Extended use for all resident interactions** **Reuse after coffee break(s), change after meal break(s)**			Change when damp, soiled, damaged. New mask after breaks for Orange and Red Zones.
eye protection	**Extended use for all resident interactions**			Retain eye protection for full shift. When removed, clean , disinfect and store per protocol https://sharedhealthmb.ca/files/standard-operating-procedure-disinfecting-eye.pdf Dispose if scratched or damaged.
gloves	**Routine Practices & Additional Precautions** **NOT** required for every resident interaction	**YES** Change between resident encounters	**YES** per Routine Practices and Additional Precautions See specific instructions for Covid-19 Unit	Perform hand hygiene before AND after removing gloves.
gown	**Routine Practices & Additional Precautions** e.g. MRSA, scabies, blood and body fluid contact	**YES** Change between resident encounters	**YES** per Routine Practices and Additional Precautions e.g. MRSA, scabies. See specific instructions for Covid-19 Unit	Change when damp, soiled, damaged, this applies across all zones.
N95 mask	**Use N95 respirator if there is clinical concern of infection with airborne pathogen (eg. TB). Extended use of N95s for repeat encounters with multiple patients (except intubation).**	**AGMPs** N95 required for AGMPs, extended use for repeat encounters with multiple resident (except intubation). N95 may be requested following PCRA.		Change when damp, soiled, damaged. AGMPs in Long Term Care: https://sharedhealthmb.ca/files/agmps-and-long-term-care.pdf

Long Term Care	GREEN ZONE Shared health Soins communs Manitoba Revised: July 14, 2020 Version 3
hand hygiene	**Strict HAND HYGIENE is required before and after contact with resident or resident environment, as well as before and after donning and doffing PPE**
mask	**Extended use for all resident interactions. Reuse after coffee break(s), change after meal break(s)** **Change when damp, soiled, damaged.**
eye protection	**Extended use for all resident interactions** **Retain eye protection for full shift. When removed, clean, disinfect and store per protocol. Dispose if scratched or damaged.** **https://sharedhealthmb.ca/files/standard-operating-procedure-disinfecting-eye.pdf**
gloves	**Routine Practices & Additional Precautions** **NOT** required for every resident interaction **Perform hand hygiene before AND after removing gloves.**
gown	**Routine Practices & Additional Precautions** e.g. MRSA, scabies, blood and body fluid contact **Change when damp, soiled, damaged.**
N95 mask	**Use N95 respirator if there is clinical concern of infection with airborne pathogen (eg. TB). Extended use of N95s for repeat encounters with multiple patients (except intubation).** **Change when damp, soiled, damaged. AGMPs in Long Term Care: https://sharedhealthmb.ca/files/agmps-and-long-term-care.pdf**

Appendix 5: Clinical Documentation Review

Process Undertaken

The reviewer was on site December 2-3, 2020 while the outbreak was still in progress. Given the short time, the reviewer was on site and the fact that Maples uses an electronic chart which would necessitate pulling a clinical staff member to assist with access and review it was decided that doing a random chart review was not possible. Therefore, a random sample of clinical documentation reports was pulled for 20 residents that represented the 1st and 2nd floors, and all four resident care areas. The reports were pulled on specific questions using the 'Reports' feature in the electronic clinical records.

Of the 20 residents selected, 17 had a positive COVID test result, three had a negative test result, and four of the residents died during the reporting time frame.

The following periods were chosen for review:

- Pre-outbreak: October 12-21, 2020 (10 days)
- Outbreak: October 22-November 2 (12 days)
- Outbreak: November 3-12 (10 days)
- Beginning of stabilization: November 13-23 (11 days)

The reviewer examined the reports for each of the 20 residents on four clinical dimensions (see below for full descriptions):

- COVID screening
- Nutritional intake
- Fluid intake
- Activities of Daily Living (ADLs)

Also, the reviewer examined a sample of additional documentation (see below for full descriptions), including wound and skin assessments, restraint documentation, and progress notes (see below for full descriptions).

The reviewer looked for patterns across the dimensions and periods to better understand the care being provided to particular residents.

Limitations

There are limitations to the data analysis given the difference in the periods of the chart reports. Simple frequency counts were used, and given assessment data gaps over some periods the numbers do not always add up precisely. This may be reflective of the availability of the residents, for example, there were periods when residents were sent to a hospital or were deceased. Without the ability to go back to the source document (chart) it is difficult to determine the reason for the missing data.

Clinical Dimensions and Documentation

The clinical dimensions in the reports reviewed were:

Dimension	Description
COVID Screening Assessments	▪ Consists of twice-daily screening for temperature, typical and atypical signs and symptoms of COVID-19 ▪ A "fail" in this screening tool should prompt interventions such as sending a nasopharyngeal (NP) swab (if COVID negative), placement on room isolation with droplet/contact precautions, further assessment or monitoring, etc.
Nutrition	▪ Consists of the percentage of a meal that was eaten by a resident ▪ Is documented three times per day as 76-100%, 51-75%, 26-50% or 0-25%. For this review documentation below 75% was noted and frequency per resident
Fluid Intake	▪ Consists of what percentage of fluids were consumed ▪ Is documented three times per day as greater than 75%, 50%-75%, or less than 50%
Activities of Daily Living (ADLs)	▪ Consists of ADLs completed as per care plan, including bathing, dressing, grooming, oral care, skincare, continence care, mobility, transferring, positioning, and meal assistance ▪ Is documented as 'yes' or 'no' (a 'no' indicates that a different level of care and/or support was provided and documented by the Health Care Aide)

The following additional documentation was reviewed:

Documentation	Description
Wound and skin	▪ Wound and skin assessment documentation was reviewed for the three residents in the sample that had wounds within the review period ▪ Includes Stage 2 pressure injuries
Restraints	▪ A sample of restraint assessment documentation from additional residents was reviewed as none of the 20 residents in the main sample used restraints
Progress Notes	▪ Progress notes (paper) from the electronic charts of three residents in the sample were reviewed, specifically for residents where documentation indicated that the residents had failed a COVID screen and required additional follow-up and may have had food intake or fluid intake less than 75%

Analysis

COVID Screening Assessment

For the four-time periods, there were approximately 637 COVID assessments and of those, 126 recorded as 'failed' and 511 as "passed". Given the number of asymptomatic residents, it was not entirely surprising for the assessment to indicate 'passed' for a resident who tested positive for COVID

Of the four residents who succumbed to COVID, the documentation indicated that:

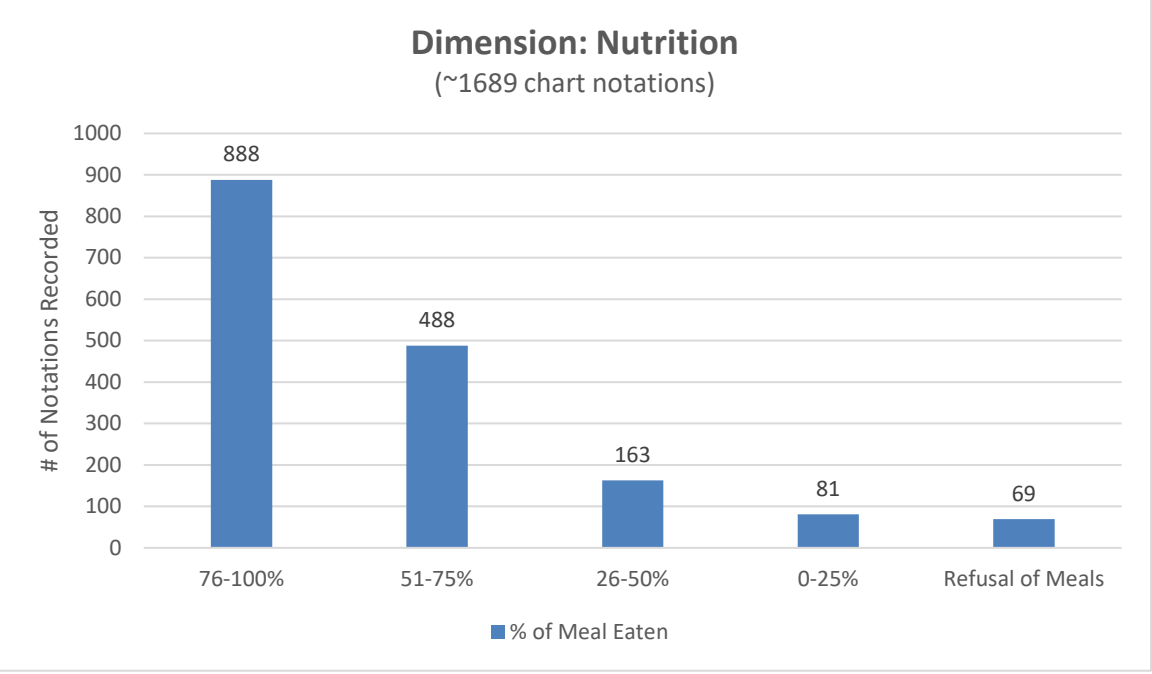
- Two had 'passed' the majority of their COVID assessments
- Two had failed' approximately 35% of their COVID assessments

It would be difficult to ascribe any foreshadowing of resident outcome based on the review of the reporting of this assessment dimension

Progress notes from three residents of the 20 where COVID screens had been indicated as "failed" were examined in more depth. For each of these three reviewed, the accompanying progress notes indicated action to be taken such as physician notified, condition update to family, increased assessments, vital signs, continue to monitor, etc.

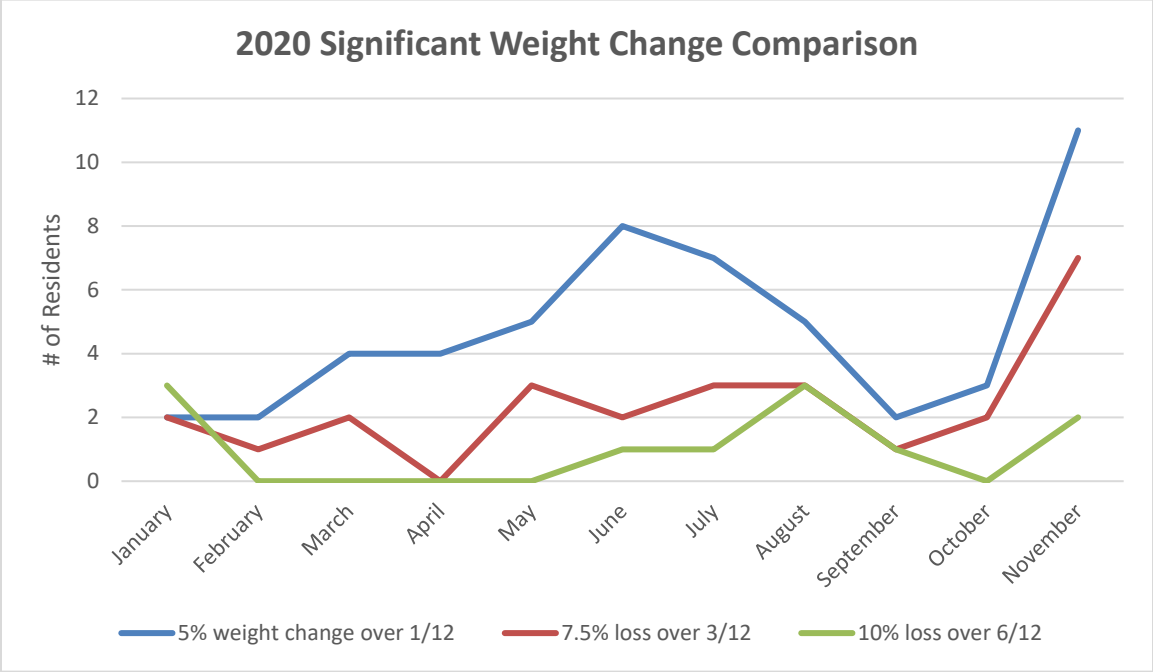
Nutrition

For the four-time periods studied approximately 1689 chart notations were indicating the percentage of a meal that was eaten by each resident. Of these, approximately 888 were recorded as 76-100%, 488 as 51-75%, 163 as 26-50%, 81 as 0-25% and 69 recordings of refusal.

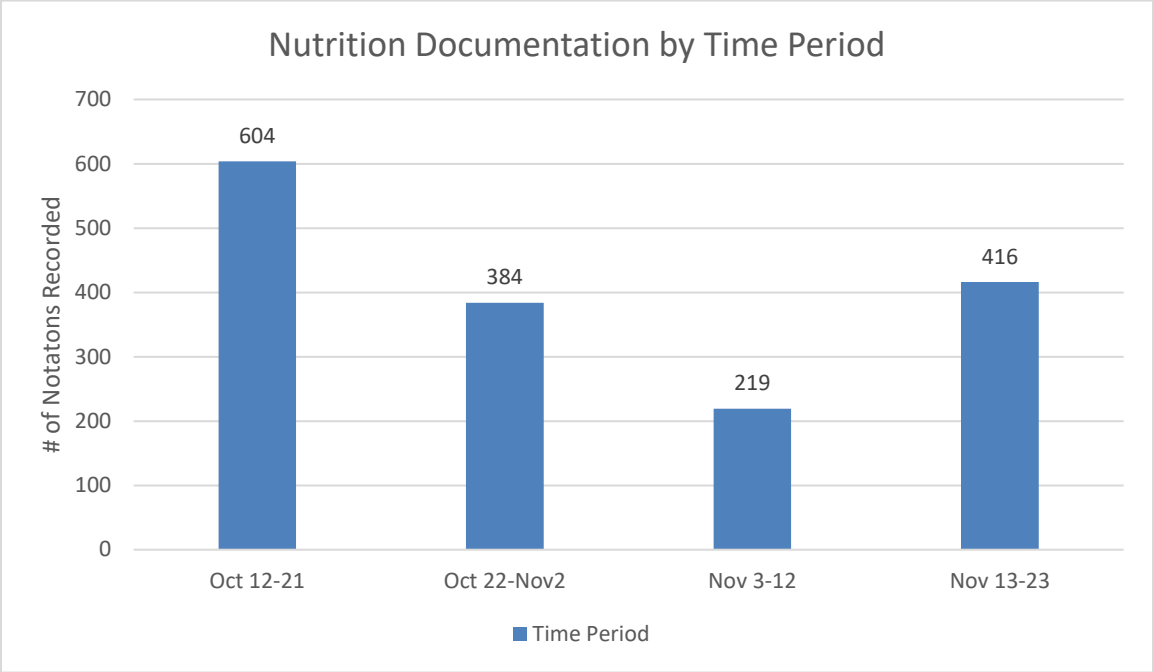


It is difficult to draw any conclusions with this data as the 'usual' patterns of the residents in the sample are unknown. For example, a usual pattern may be to only take in 75% of any given meal regardless of the COVID period.

The period of October 22 to November 12, 2020 (height of the outbreak) had the highest number of <75% of intake and resident refusals which also may be a reflection of the dates when the staffing shortages were acute. The combination of staff shortages, residents isolated in their rooms for meals, lack of availability of families or volunteers to assist and the impact of active COVID illness all may have contributed to the lack of meal intake. Weight loss data provided by Maples for the 2020 year are as follows:



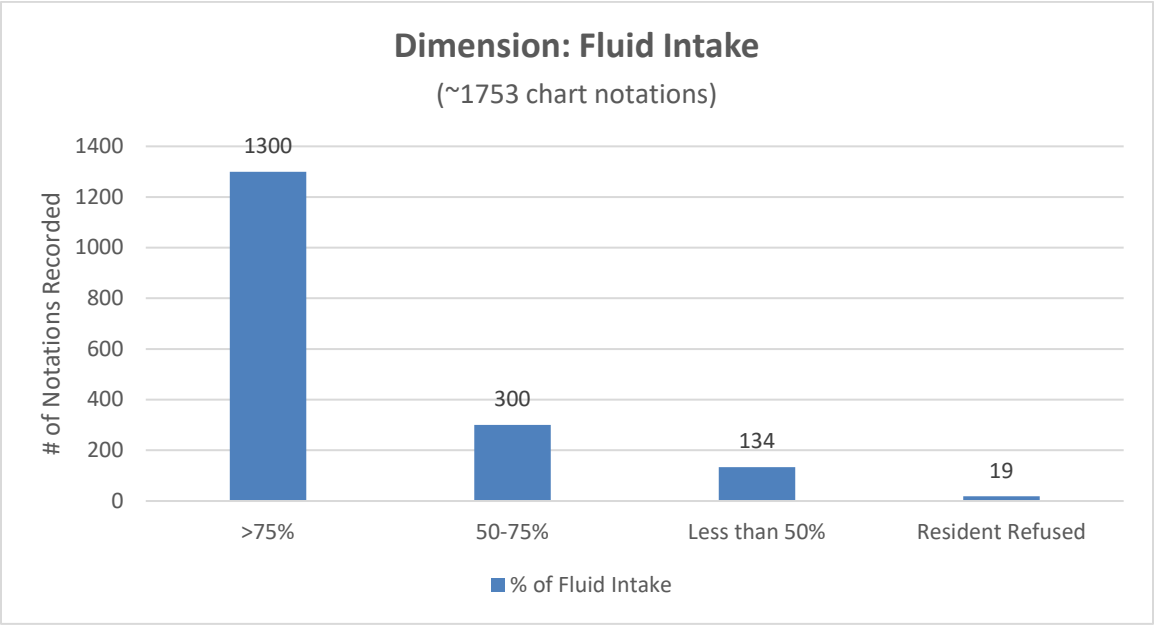
Breaking the data down by period shows a difference in documentation over the four-time periods: October 12-21, approximately 604 assessments; October 22-November 2, approximately 385; November 3-12, approximately 219; and November 13-23, approximately 416. The decrease in numbers coincides with the shortage of staff.



Paper-based intake records were introduced early in November during the height of the staffing challenges to help facilitate documentation completion (e.g. agency staff, etc.). As such, it is difficult to ascertain whether the assessments were done and not charted or if the assessments were not completed.

Fluid Intake

For the four-time periods studied there were approximately 1753 chart notations regarding fluid intake. Of these there were approximately 1300 recorded as >75%, 300 recorded as 50-75%, 134 less than 50% and 19 residents refused.



Breaking the data down by period shows a similar pattern to the nutritional assessments, with considerably less documentation about fluid intake over the four-time period ranging from a high of 573 assessments on October 12-21 to a low of 204 assessments November 3-12.

It is difficult to accurately address the question of dehydration without a more in-depth chart review as other factors aside from fluid intake can impact the determination of dehydration such as COVID status, other medical conditions. However, observations of residents by non-Maples clinicians indicated dry mouths and symptoms of dehydration including lack of skin elasticity. The staffing shortages would have made it difficult to provide fluids regularly.

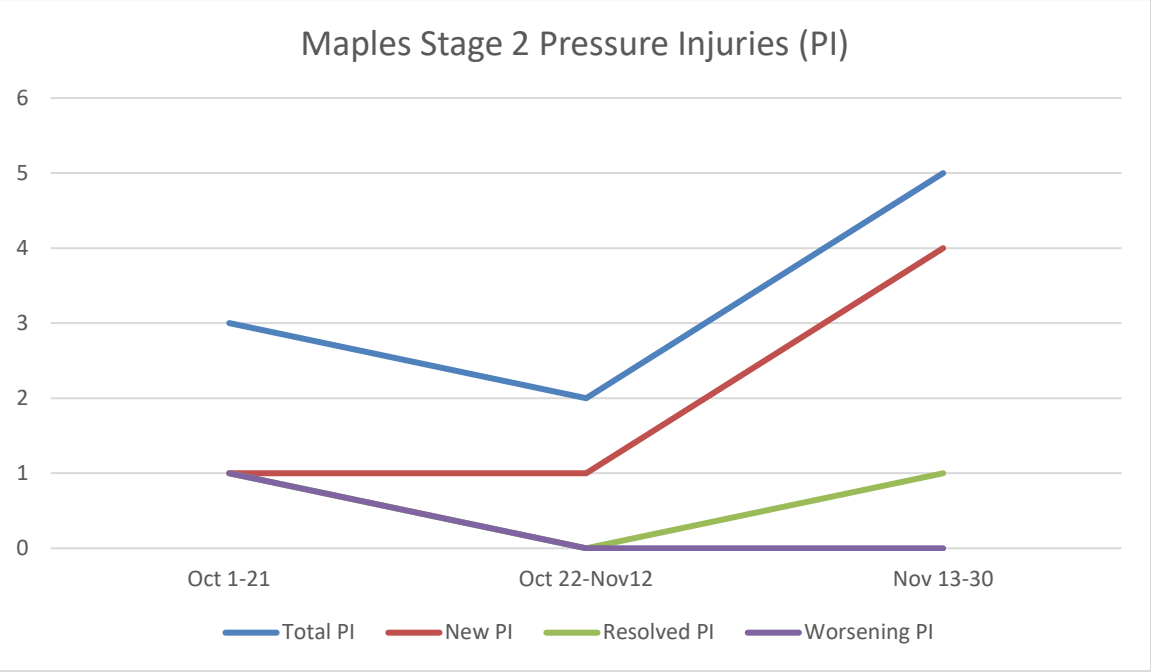
Nutrition and fluid data of three residents with an intake of less than 75% were examined more in-depth to see if there were follow up actions noted. The progress notes did not consistently indicate whether there was a follow-up action. On some dates and times, there would be an extra notation that extra fluids were given or rationale for why the resident refused (such as sleeping), but it was not always apparent that actions occurred if intake was below 75%.

Activities of Daily Living

The reviewer examined the chart reports and ADL assessments and found the same patterns as the nutrition and fluid findings, a decrease in the documentation at the height of the outbreak.

Wound and Skin Assessments

A count of pressure injuries in the home across the four-time periods was reviewed. The chart below combines the two outbreak periods. Across the timeframe, only Stage 2 pressure injuries were present.

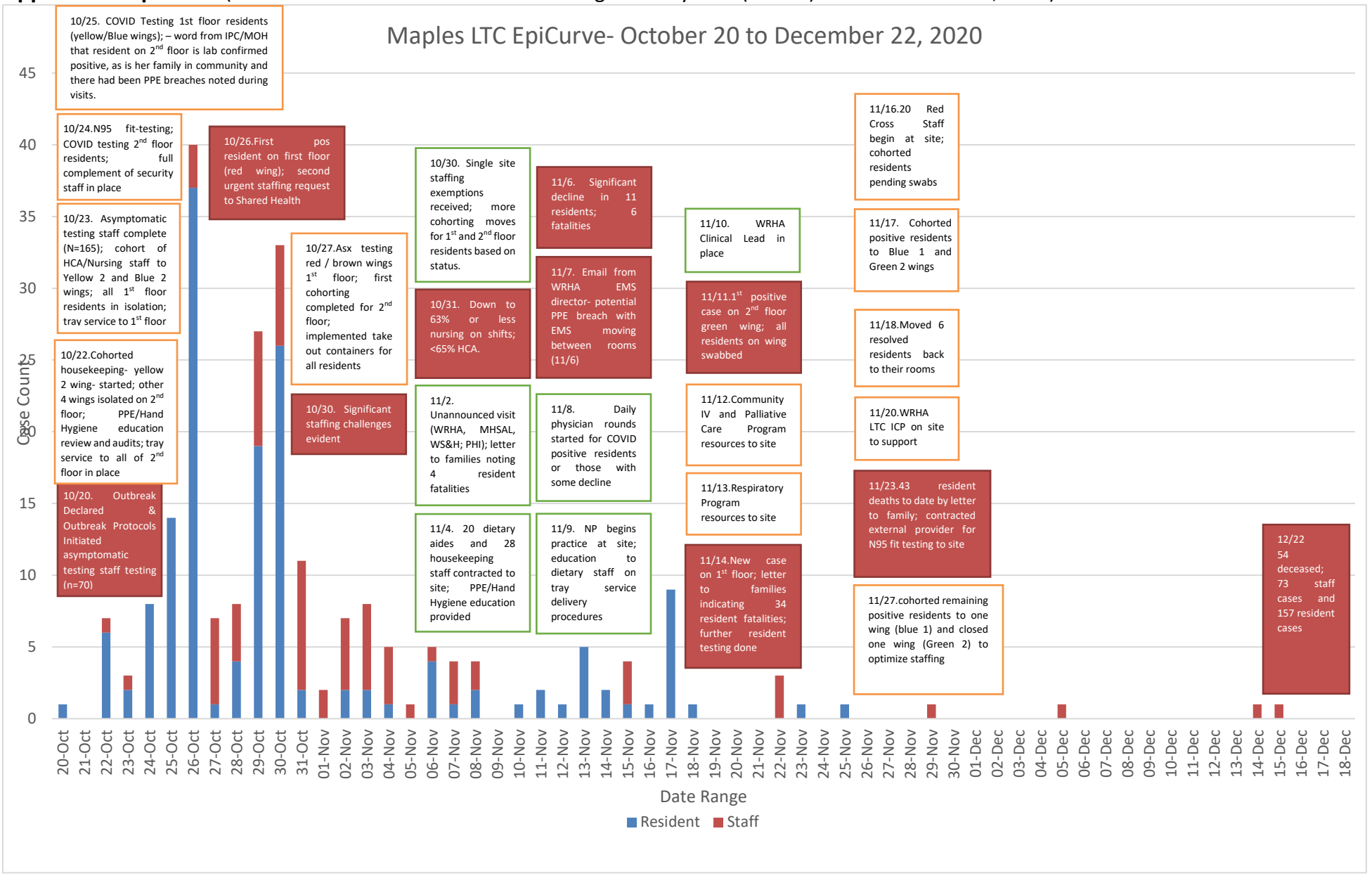


There was an increase in 'total' and 'new' Stage 2 pressure injuries in the early phases of the stabilization period. This is not unexpected considering the increased level of acuity/morbidity, decreased mobility, and level of nutrition and fluid intake experienced by residents during that time.

Restraints

None of the 20 residents in the original sample of chart reports had restraints. An example of restraint monitoring was provided but no further comments would be reasonable.

Appendix 6: EpiCurve (Data in Public Health Information Management System (PHIMS) from December 22, 2020)



EpiCurve highlights as provided by the Director of Epidemiology and Surveillance, MHSAL:

- Asymptomatic testing of staff was initiated on the day the outbreak was called (October 20, 2020) and concluded Oct 23 with 165 staff tested
- Although it was reported that considerable efforts were made around PPE and IPAC education pre outbreak, it was apparent there was still education being provided after the peak of the outbreak (possibly due to all the additional staff such as security, housekeeping, dietary aides, and general laborers)
- Staffing shortages appeared to be a considerable issue early in the onset and resolution to the staffing shortages really only happened post-peak, which would have contributed to ongoing staff fatigue and burn out and impacted on compliance with overall PPE and infection prevention and control practices
- While cohorting is commonly done in respiratory outbreaks, it seemed less effective in this scenario, likely due to cases appearing to be asymptomatic being mixed in with non-COVID cases

Appendix 7: PCH Outbreak Comparison as of December 22, 2020

Resident Attack Rates and Death Rates by Institutional Size (0-99 resident beds; 100-199 resident beds; 200+ resident beds)* only PCHs with Active Cases effective December 22, 2020, are included. Source: Director of Epidemiology and Surveillance, MHSAL

	# of Resident Beds	Location	Total	Staff	Residents	Active	Recovered	Deaths	Attack Rate (Resident Cases / Resident Beds * 100)	Total Deaths / Total COVID Cases * 100
0-99										
	30	Gilbert Plains	41	17	24	1	31	9	80.0	22.0
	36	Northern Lights Manor	5	2	3	1	4	0	8.3	0.0
	39	Grandview PCH	36	11	25	9	24	3	64.1	8.3
	40	Kin Place PCH	38	8	30	18	14	6	75.0	15.8
	40	Menno Home	49	18	31	13	30	6	77.5	12.2
	60	Bethesda Place PCH	5	3	2	0	4	1	3.3	20.0
	60	Rest Haven Care Home	36	17	19	0	25	11	31.7	30.6
	65	Eastview Place	1	1	0	0	1	0	0.0	0.0
	66	Villa Youville PCH	31	8	23	5	20	6	34.8	19.4
	80	*Kildonan Personal Care Centre*	*1*	*1*	*0*	*0*	*1*	*0*	*0.0*	*0.0*
	80	River Park Gardens	1	1	0	0	1	0	0.0	0.0
	84	The Convalescent Home of Winnipeg	68	8	60	60	2	6	71.4	8.8
	86	*Heritage Lodge PCH*	*37*	*15*	*22*	*6*	*25*	*6*	*25.6*	*16.2*
	88	Golden Links Lodge	93	24	69	16	66	11	78.4	11.8
	91	St. Norbert PCH	114	34	80	43	52	19	87.9	16.7
100-199										
	100	Actionmarguerite St. Joseph PCH	2	1	1	2	0	0	1.0	0.0
	100	Misericordia Place PCH	33	14	19	8	22	3	19.0	9.1
	100	Park Manor Care Home	112	38	74	64	24	24	74.0	21.4
	116	Lions Housing Centres Personal Care Home	3	0	3	0	1	2	2.6	66.7
	120	River East PCH	11	5	6	6	5	0	5.0	0.0
	136	Fred Douglas Lodge	43	15	28	24	13	6	20.6	14.0
	146	Salem Home	8	2	6	4	3	1	4.1	12.5
	148	Bethania Mennonite PCH	17	1	16	11	1	5	10.8	29.4
	150	West Park Manor PCH	4	1	3	3	1	0	2.0	0.0
	155	*Charleswood Care Centre*	*139*	*40*	*99*	*71*	*37*	*31*	*63.9*	*22.3*
	175	*Beacon Hill Lodge LTC*	*29*	*12*	*17*	*10*	*18*	*1*	*9.7*	*3.4*
200-299										
	200	***Maples LTC***	***230***	***73***	***157***	***19***	***157***	***54***	***78.5***	***23.5***

	200	Saul and Claribel Simkin Centre PCH	44	17	27	17	19	8	13.5	18.2
	208	Deer Lodge Centre LTC	7	7	0	1	6	0	0.0	0.0
	213	Extendicare Tuxedo Villa PCH	4	4	0	1	3	0	0.0	0.0
	218	*Poseidon LTC*	*31*	*11*	*20*	*24*	*7*	*0*	*9.2*	*0.0*
	245	Oakview Place PCH	80	10	70	68	9	3	28.6	3.8
	248	Fairview PCH	107	41	66	41	55	11	26.6	10.3
	261	*Parkview Place LTC*	*165*	*45*	*120*	*10*	*126*	*29*	*46.0*	*17.6*
	276	Holy Family PCH	156	43	113	72	63	21	40.9	13.5
	299	Actionmarguerite St. Boniface PCH	8	8	0	2	6	0	0.0	0.0

Small PCHs (1-99 resident beds)

- Almost half (7/15) of the PCHs with 1-99 resident beds had attack rates higher than 50%, with an upper limit of 87.9%
- Three of them had more than 20% of their cases with a fatal outcome

Medium PCHs (100-199 resident beds)

- The attack rates span from 1.0 to 74.0%. Percentages of cases that have had fatal outcomes range from zero to 66.7%
- Park Manor Care Home had the highest attack rate (74.0%) and Charleswood LTC had the second-highest attack rate (63.9%). Both of those institutions had high percentages of deaths (22.3 and 21.4% respectively)

Large PCHs (200-299 resident beds)

- There is a wide range of attack and death rates in this category. For example, several PCHs have very low case counts and no deaths. Conversely, some PCHs have much higher cases and deaths within their institutions
- The attack rates span from <0.1 to 78.5%
- Percentages of cases that have had fatal outcomes range from zero to 23.5%
- Maples LTC had the highest attack rate (78.5%) and percentage of deaths (23.5%) of the 10 PCHs in this category
- The three Revera institutions in this category also experienced a range of outcomes (Poseidon PCH had an attack rate of 9.2% and Parkview Place PCH 46.0%; Poseidon did not have any fatalities and Parkview Place had a percentage of deaths equal to 17.6%)

Appendix 8: COVID-related Reporting Requirements and Inspections

This Appendix includes:

- 5A. The checklist of the clinical COVID-related reporting requirements
- 5B. A list of inspections, reporting and information requests that occurred during the outbreak

5A. Reporting Requirements for COVID Cases (MB)

Resident Cases

New Positive Case:

- Notify staff/Resident/family/SDM
- Add new case to WRHA COVID-19 Outbreak Daily Update spreadsheet and adjust total case number (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting in morning calls
- Add new case to contact tracing summary spreadsheet on SharePoint (if in use)
- Update bed map/line list in Home's SharePoint file (if in use)
- Add Infection Case to IPC Dashboard and link to the open COVID Outbreak (for PCC users)
- Initiate/complete Case Investigation form within 24 hours of notification of a positive resident result and fax to Public Health at **204-956-4494** (**new number) http://www.manitoba.ca/health/publichealth/surveillance/docs/mhsu_6683.pdf

New Negative Case:

- Notify staff/Resident/family/SDM
- Adjust total negative number on the WRHA COVID-19 Outbreak Daily Update spreadsheet (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting
- Update bed map/line list in Home's SharePoint folder (if in use)
- Add result to IPC Dashboard under Lab Results tab (for PCC users)

New Resolved Case:

- Notify staff/Resident/family/SDM
- Update case (add resolved date) on WRHA COVID-19 Outbreak Daily Update spreadsheet (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting
- Update bed map/line list in Home's SharePoint folder (if in use)
- Resolve case in IPC Dashboard (for PCC users)

Death – COVID positive/resolved:

- Notify the WRHA LTC Program Team via email of Resident death as soon as possible
- Add to totals for Revera daily reporting
- Within 24 hours of death:

- Clinical Notification of Reportable Diseases and Conditions: https://www.gov.mb.ca/health/publichealth/cdc/protocol/mhsu_0013.pdf
  - Fax to MHSAL – 204-948-3044
  - Fax to MB Public Health – 204-940-2690
  - If Resident passed away in hospital, confirm with Medical Records that they have completed/submitted the form.
- WRHA Summary
  Resident Death Summary Information for WRHA

Resident case #	
Resident age	
Resident gender	
Time & date of death	
Where resident passed away (i.e. PCH or Hospital)	
ACP level	
Date the resident tested positive for COVID	
Notification of death form completed and faxed to PH and MB Health	
With this death, the total # of resident deaths associated with COVID in the Home	
Brief summary of resident condition 24 hours prior to death	

Staff Cases

New Positive Case:

- Direct staff member to contact OESH @ 1-888-203-4066
- Add to WRHA COVID-19 Outbreak Daily Update spreadsheet and adjust total case number (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting
- Add new case to contact tracing summary spreadsheet in Home's SharePoint folder (if in use)
- Add staff Infection Case to IPC Dashboard and Outbreak (for PCC users)

New Negative Case:

- Adjust total negative number on the WRHA COVID-19 Outbreak Daily Update spreadsheet (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting
- Add to staff line listing (if in use)
- Add result to IPC Dashboard under Lab Results tab (for PCC users)

New Resolved Case:

- Update case (add resolved date) on WRHA COVID-19 Outbreak Daily Update spreadsheet (submit updated document to WRHA by 1pm)
- Add to totals for Revera daily reporting
- Resolve case in IPC Dashboard under Lab Results tab (for PCC users)

5B. Inspections, Reporting and Information Requests during the Outbreak

The following inspections, reporting and information requests have occurred during the outbreak:

- Public Health inspection – onsite visit with follow-up action plan
- Workplace Health and Safety inspection – onsite visit with follow-up action plan
- WRHA inspection – onsite inspection
- Canadian Red Cross onsite tours/assessments/meetings (3 half-day sessions in total)
- Medical Examiner's Office – request for chart information on all deaths during outbreak period
- Winnipeg Police Services Homicide investigation – onsite visit and staff interviews
- WRHA on-site management with action plans (3 separate iterations over 4 weeks)
- Protection for Persons in Care Office – three requests for information on Resident care/staffing; third request is the most in-depth (11 Residents)
- WRHA Patient Safety investigation and staff/management interviews (hour-long Teams interviews)
- External investigation – pre-site preparation, on-site visit, staff/management interviews
- Epidemiology team/lead – Resident and staff contact tracing data
- Family requests for chart information (entire chart at times)

Appendix 9: Stakeholder Consultations

Date	Stakeholder
Nov 19/20	CEO WRHA
	Revera Leadership - VP Operations West; Senior VP LTC Canada; VP Legal Services and Assistant Privacy Officer; Past VP Operations Manitoba (retired)
Nov 20/20	MHSAL Licensing and Compliance Branch – Executive Director, PCH Licensing Standards Officers
Nov 23/20	Director IPC WRHA Acute/Community
	Director of Quality and Patient Safety WRHA; Manager Client Relations WRHA
	Chief Health Operations Officer WRHA; Executive Director Long Term Care; WRHA Chief Nursing Officer Deer Lodge and on site currently at Maples; Director of Operations for WRHA Long Term Care
Nov 25/20	Provincial Lead, Legal Services Shared Health
	Chief Medical Officer WRHA
	Chief Nursing Officer and on site currently at Maples WRHA. Follow up meeting from Nov 23/20 interview.
Nov 26/20	WRHA - LTC Infection Control Professional; a second Infection Prevention & Control Specialist from WRHA assigned to support site
	Medical Director Maples PCH
	Medical Director LTC- WRHA
	Interim Executive Director Maples PCH; Director of Care Maples PCH
Nov 27/20	Platoon Chief Paramedic Operations, City of Winnipeg
	District Chief, City of Winnipeg
	WRHA HR Director Provincial Redeployment and Recruitment Team
	Primary Care Paramedic – City of Winnipeg; Advanced Care Paramedic - City of Winnipeg
Nov 30/20	Revera Regional Manager - Clinical Service (and designate responsible for education and ICP) and WRHA Chief Nursing Officer and on site leadership currently at Maples
	Resident Care Manager, Maples PCH Revera – and person in charge at Maples eve of Nov 6
	Maples PCH Team Leaders: PPE Inventory Lead, Food Services & Distribution Lead; Environmental Services Lead, Cohorting & Belongings Lead; Recruitment & Administrative Lead
	Director of Epidemiology and Surveillance, MHSAL - Population and Public Health
Dec 1/20	Maples PCH Team Leader: - Family Communication Team Lead and Education Lead;
Dec 3/20	20 staff on the 2nd and 3rd floors –HCA, RN, LPN, Dietary Aides, Cook, Recreation Staff also 2 security staff. 18 additional were interviewed including HCA, LPN, RN AND Recreation staff. On 2nd and 3rd floors interviewed 10 residents.
Dec 4/20	Two Staff from CRC – Assessor and Site Lead
Dec 7/20	Maples - Occupational Therapist; Dietician; Social Worker
	Maples Staff Interviews every ½ hours from 12:00 p.m. – 3:00 p.m. with groups of 3 staff per session – HCA's, recreation, nurses etc.
Dec 8/20	Chief Medical Officer, Revera

	Maples Nurses - 3 more interviewed
	Maples RCM – designate for Infection Control
Dec 9/20	Shared Health CNO and Co-Lead Unified ICM
	WRHA - Medical Director for LTC–Follow up from Nov 26/20 interview
	Palliative Care Team –MD and Clinical Nurse Specialist
	Chief Health Operations Officer WRHA; Executive Director Long Term Care - Follow up from Nov 23/20 Interview (follow up on a few things and to provide more details around the service contract and expectations)
Dec 10/20	Maples Consultant Pharmacist
	Follow up meeting with the Director of Epidemiology and Surveillance, MHSAL, Population and Public Health
	Nurse Practitioner assigned to Maples
	Leaders of Incident Command for Revera –VP Operations West; Regional Manager of Clinical Services Interim Regional Director of Operations; Regional Manager. Clinical Services; Regional Education, Central Care
	Revera Regional Manager Clinical Services WRHA Chief Nursing Officer and on site currently at Maples
Dec 11/20	WRHA - RRT Clinical Service Lead Respiratory Therapy
Dec 14/20	Director of Quality and Patient Safety WRHA – Follow up from Nov 23/20 interview
	CEO and Provincial Lead, Shared Health
	WRHA CIVTP Nurses – (5 nurses)
Dec 15/20	Chief Provincial Public Health Officer and Co-Lead ICM
Dec 16/20	Provincial Lead, Health Workforce, Shared Health
Dec 17/20	Deputy of MHSAL
Dec 21/20	Executive Director of Public Health (scheduled)
Dec 23/20	Medical Officer of Health – WRHA
Dec 24/20	Chair of Operations HICS-planning table
Dec 30/20	Family Teleconference Focus Group
Jan 4/21	Family Teleconference Focus Group
Jan 5/21	Family Teleconference Focus Group