Ombudsman Saskatchewan
Promoting Fairness

OUTBREAK TIMELINE

COVID-19 OUTBREAK AT EXTENDICARE PARKSIDE

Abbreviations

Authority = Saskatchewan Health Authority
Extendicare = Extendicare (Canada) Inc.
LTC = long-term care
Ministry = Saskatchewan Ministry of Health
Parkside = Extendicare Parkside facility in Regina
PPE = personal protective equipment
Public Health = Authority public health officials
+TR = positive test result

BEFORE THE OUTBREAK

March 3, 2020 - The Authority begins frequent updates to LTC homes about requirements and offers of assistance to deal with the pandemic.

March 18 - Saskatchewan declares state of emergency.

March 22 - The Authority asks all LTC homes to complete its COVID19 pandemic planning readiness checklist and to report progress to the Authority. Extendicare's corporate pandemic plan requires each of its facilities to have a pandemic plan that includes a staff contingency plan.

Concerns about Parkside's physical layout

March 26 - Concerns are raised about Parkside's physical layout and its ability to comply with public health orders when serving meals to residents; also that 4-bed rooms were a challenge in the past for outbreak management and prevention.

Pandemic readiness checklist late, incomplete

April 29 - The Authority notes Parkside has not completed the COVID-19 readiness checklist, has not ensured it has the necessary PPE to deal with an outbreak, and does not have a staffing plan to maintain services when working with reduced staff.

October 26 - The Authority reminds Parkside that several items on its COVID-19 readiness checklist are still not complete.

THE OUTBREAK

Staff member with several symptoms keeps working & puts off doc's advice to get tested

November 11 - An employee starts having COVID-19 symptoms, including cough, headache, dizziness, and loss of sense of taste. This was the first person to have COVID-19 symptoms at Parkside. The employee:

- continues to work November 12, 13, 14, 15, 17, 18, 19 & 20
- wears a mask but works in close contact with unmasked residents
- does not wear a mask or socially distance from other staff on breaks
- is told by a doctor to get tested, but does not do so until November 20
- begins isolating November 21; +TR November 22

November 15 - An employee socializes for 3 hours in a private home with 3 other colleagues, and also carpools unmasked to and from work the next day with another employee.

Staff member who has been socializing with other staff has symptoms & works shift, then stays home.

1st resident taken to hospital

1st resident dies

2nd resident has symptoms

25 COVID-19 cases, but only 2 known

Mass testing underway

"Ripping through more PPE"

Link found between 1st + resident and staff member

40 COVID-19 cases; 24 known

November 16 - One more employee works while symptomatic; reports having a tickle cough and works until receiving a +TR on November 22.

November 17 - The employee who socialized with co-workers on November 15 works while symptomatic. They report having a headache, aches and chills, but no fever so continues to work. Passes meds to unmasked residents. After shift, takes temp at home. Has fever. Stays home; +TR November 20.

The first resident shows symptoms and is taken to hospital.

November 18 - 1:42 AM The first resident passes away.

Two more employees have COVID-19 symptoms. One continues to work until +TR November 22. The other has a "little bit of a sore throat", cough, & fatigue; works until November 20. Both report having close contact with other employees.

November 19 - 5 more employees have symptoms; they wear masks while working, but do not all wear masks or social distance during breaks in the staffroom.

A second resident starts showing COVID-19 symptoms and is isolated.

November 20 - OUTBREAK DECLARED

The deceased resident's +TR is received; the Authority issues notice of suspected outbreak. At 9:00 PM 1 employee gets a +TR. At 9:28 PM, an outbreak is declared.

Although there are only 2 known +TR, 23 more people are symptomatic and will later get a +TR, so there are actually 25 cases: 13 residents and 12 employees. Many employees continue to work while symptomatic, and have close, unmasked contact with co-workers; some will work closely with residents who are not masked.

November 21 - Another +TR is received, so there are 3 known cases (2 residents, 1 employee), but based on symptomatic people who will later get a +TR, there are actually 31 cases: 16 residents and 15 employees. All residents and 78 staff are swabbed.

All residents are isolated in their rooms, including for meals. Employees use dining rooms to help social distance during breaks and are cohorted to specific wings. Extra shifts are added.

Parkside says it is "ripping through more PPE"; asks Authority for additional PPE. Audits started for safely donning (putting on) and doffing (taking off) PPE.

November 22 - All known + residents are moved to main wing, aka the 'Red Zone'.

12 more residents receive +TR; 143 results pending. So far, 3 of the 158 employees who were tested are known to be positive. Parkside orders PPE from its own supply chain.

A link is identified between the first resident who tested positive and the direct care worker who had symptoms on November 11.

November 23 - Known cases = 24; actual cases = 40 (17 residents and 23 employees). 8 administration employees are told to self-isolate due to a +TR or being deemed a close contact.

Extendicare doubles its PPE order to its own supply chain but can't get the N95 masks its staff were fit tested for, so the Authority sends 12 boxes.

Questions about what a close contact is

2nd mass testing

Steps to reduce transmission among staff

Staff shortage

"Key signals" about causes

80 cases

Residents moved again

3rd mass testing

On-site assessment

2 doctors call Parkside a "Critical Situation"

November 24 - Parkside questions the 'close contact' definition used by Public Health, alleging it made 'major changes' to the rules during the outbreak, which, if applied, would mean 75-100% of employees would be required to self-isolate. We found that Public Health did not change the rules during the outbreak.

14 Continuing Care Assistant (CCA) students from SK Polytechnic start.

November 25 - Residents and employees are mass tested again. 18 more residents will test positive. Actual cases = 65 (36 residents and 29 employees), but many of these are not yet known.

Public Health tells CCA students to leave Parkside. Later that day, Public Health changes its decision so students can return to Parkside.

November 26 - Authority recommends Parkside take steps to decrease transmission among employees: staggering breaks, using different break rooms; signing in and out of break rooms – and ensuring social distancing "between ALL staff at ALL times."

Parkside confirms +TR residents cohorted in main wing and one room in the north wing.

22 residents and 19 employees now have a +TR and another 35 employees have to self-isolate. Extendicare tells Authority it will not have enough employees for the weekend; wants help from nurses and CCA students.

November 27 - The Authority identifies "key signals" about the causes of the outbreak; that employees come to work with symptoms and don't social distance at breaks or after work. It notes the cycle of transmission will continue uncontrolled if non-positive residents continue to be isolated together in 2- and 4-bed rooms.

The CCA students return for the evening shift.

November 28 - Known cases = 58; actual cases = 80 (49 residents and 31 employees). 34 other employees have been ordered to self-isolate.

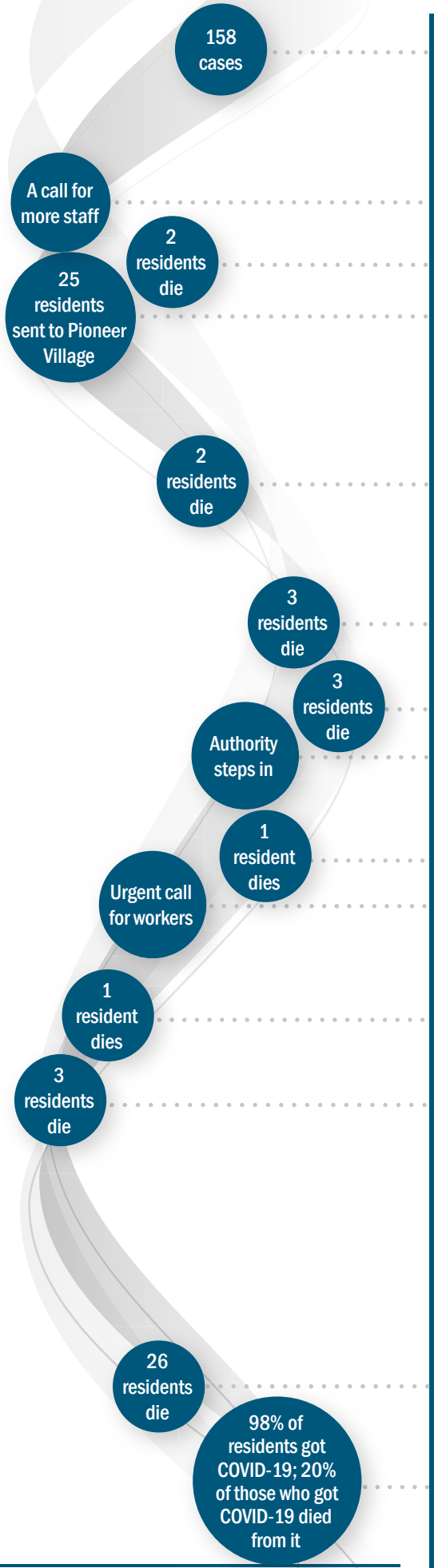
Due to high traffic through the main wing, Extendicare decides to move +TR residents to the north wing. Positive and negative residents are moved at the same time; they are not all masked during the moves; rooms are not fully disinfected between moves. Staff called the moves chaotic.

November 30 - More mass testing. By this time, 127 people (81 residents and 46 employees) have symptoms, but +TRs will take a few days.

December 2 - Actual cases = 146 (88 residents and 58 employees), but not all are known.

Authority sends infection control team to assess Parkside; finds some significant concerns: employee screening, masking, PPE use, staff breaks/interactions, cleaning, infrastructure/storage, and kitchen/dining. Authority flags unreasonable workloads at Parkside; considers sending some residents to Regina Pioneer Village.

Two physicians attend Parkside in the evening to help employees and round on patients in need. One of them writes the Authority that this is a "Critical Situation" and "we are not responding enough!"



December 3 - Actual cases = 158 people (94 residents and 64 employees).

Authority reviews concerns with Extendicare and commits to providing support. Plans include staffing, resources, contact with families. Authority receives confirmation that Parkside has adopted its masking standard.

December 4 - Authority seeks RNs and RPNs to work at Parkside. Actual cases = 175 (101 residents and 74 employees).

Two more residents die.

December 5 - Transfer of 25 residents to empty unit at Pioneer Village begins. Of those transferred, 19 already had a +TR and 5 others would later have a +TR.

Employees are still missing hand hygiene steps when donning & doffing PPE. Extendicare tells Authority it is working towards having only 2 negative residents per room. Actual cases = 182 (104 residents and 78 employees).

Two more residents die.

December 6 - To assess risk and before Authority employees can start, it requires a detailed checklist of deficiencies and what has been done so far to correct them. Actual cases at Parkside = 188 (105 residents and 83 employees).

Three more residents die.

December 7 - Of the 91 residents tested December 4-7; 63 will have +TR.

Three more residents die.

December 8 - Authority and Extendicare enter co-management agreement; Authority assumes operational control of Parkside at 5:00 PM Extendicare asks if its + asymptomatic employees can be approved to work with residents who are already +.

Another resident dies.

December 9 - Authority sends emergency request for workers at Parkside. An interim waiver of the public health order is issued to reduce the isolation period for COVID-19 positive employees from 14 days to 10 days, either from the onset of symptoms or if asymptomatic from the date of their positive test.

Another resident dies.

December 10 - Priorities are identified at Parkside to improve safety and prevent infection.

Three more residents die.

December 11 - January 20, 2021

- Due to poor ventilation, all employees must wear N95 masks; HEPA filter installed.
- Authority finds 27% of Parkside employees with a +TR reported working while symptomatic.
- The last day of any reported COVID-19 cases was December 21.
- Audit shows infection prevention and control practices improved in several areas, with a few still noted as 'ongoing'.
- All 4-bed rooms are converted to 2-bed rooms.
- Co-management agreement extends to January 30.

26 more residents die.

January 21 - The outbreak is declared over.

Including the residents who were transferred to Pioneer Village, 194 of Parkside's 198 residents contracted COVID-19 and 42 of them died: 39 from COVID-19 and 3 from other causes. 132 employees at Parkside contracted COVID-19. 4 Pioneer Village employees who cared for transferred residents contracted COVID-19.