Dorothy Henderson Lodge Report
Baptist Care

Background

Dorothy Henderson Lodge (DHL) is an 80-bed aged care facility in Macquarie Park, Sydney, and is owned and operated by Baptist Care. All residents have single rooms with en-suite bathrooms and balconies. The facility has two floors which is divided into six wings. There is a shared lounge and dining area in each wing and additionally on each floor.

COVID-19 was first identified in the DHL on 3rd March 2020 after a health worker, (HW) was diagnosed on the same date. Two residents had been admitted to Ryde Hospital on 1st and 2nd March; One deceased on 3rd March and was tested for COVID-19 after death. The other was tested on 4th March and deceased on 7th March.

Further cases of COVID-19 were reported on 4th and 5th March in residents and staff.

Between 9th and 14th March, three further residents and one staff member were diagnosed with COVID-19. Subsequently, one of these residents deceased on 14th March.

On 20th March, all residents and staff were tested for COVID-19 to review isolation measures that were introduced for residents, at the time of the first identified case. Four residents and one HW were identified to be COVID-19 positive with one resident’s results inconclusive. One of the newly identified cases deceased on 27th March.

Between 28th and 30th March, four residents of Wing C2 were identified as COVID-19 positive. This was despite negative results from the testing occurring on 20th March. One of the four, had twice tested negative but serology results on 9th April confirmed COVID-19. Two of these four residents deceased.

Expert infection prevention and control clinicians from the Clinical Excellence Commission (CEC) have been providing ongoing infection prevention and control (IPC) support since 4th March 2020, as requested by Chief Health Officer and NSW Health Protection, NSW Ministry of Health. The CEC provided onsite support to Dorothy Henderson Lodge (DHL) following the identification of a COVID-19 cluster.

Ms Carolyn Ellis from the CEC visited the DHL on Friday 03/04/2020.

Attendance

Friday 3rd April 2020
Onsite observation was undertaken as a follow-on visit when continued positive COVID-19 cases were identified. The DHL points of contact were Anderson Millen and Tracy Burling. The intent of the CEC visit was to observe the DHL environment regarding:

- Service’s compliance with current infection control management plan, instituted 4th March 2020;
- Identify potential ongoing risks in Outbreak management plan; and
- Develop potential infection control management plan, including PPE management that responds to the service’s current COVID-19 infection status.

This included:

14 April 2020
• A review of current PPE usage
• A review of waste management
• Identification of potential ongoing risks
• Provision of support/advice for Infection Prevention and Control

Additionally, opportunity was taken to engage with staff wherever possible. Staff were very polite and respectful and were observed to focus on adhering to IPC principles.

Findings
Since Monday 30 March 2020 the DHL management team have implemented a range of additional measures:

• COVID-19 care teams – 2 Assistants in Nursing (AIN) per team that are solely responsible for all care of COVID-19 confirmed/suspected residents. This team do not engage in the care of other residents.
• All wings in lock down – only the COVID care teams, Registered Nurses accessing S8 DD and cleaning staff enter/exit wings on any one shift.

Front Entry:

On arrival, the main entry to DHL was via automated doors that opened with a keypad and number code system. Alcohol based hand rub, (ABHR) solutions were on either side of the main entrance door. There is a well-defined and staffed area for all visitor/staff/contractor entering the facility to
• sign in,
• donning of P2/N95 mask and
• repeat ABHR for hand hygiene

There was uncertainty between the two staff at the entrance on arrival regarding the need for temperature monitoring. Regardless, a search of the reception area and offices behind the same established there was no thermometer to be found.

Beyond the entrance to DHL, Tracy Burling greeted and escorted Ms Ellis throughout the onsite visit. Just past the delineated sign in area, there was a small table where staff and contractors access cleaned and reusable protective eyewear. The protective eyewear is deposited in a collection bag once the wearer is leaving the facility. All protective eyewear is cleaned with Tuffie 5 branded wipes at the end of each shift/day and returned to the clean table for pick up the following shift/day.

General Common area level 1
On the lower level within the staff dining area, it was noted 1 x kitchen attendant was double gloved. On enquiry this staff member wears personal pair of cotton gloves with the disposable glove on top of the cotton gloves. The staff member has an allergy to the workplace supplied disposable gloves. There were obvious work arounds implemented by this staff member to manage the allergy and concurrently attempt adherence to standard precautions. It is unknown if the
- Staff member workplan restricts her daily movements to the kitchen and staff dining area of DHL or attends/complete workplans in other areas of DHL.
- facility management were aware of the WH&S risk identified prior to this observation.

There are staff that move between the lower and upper common areas of DHL with variation with behaviours to hand hygiene and glove use observed.

There was clear definition for social distancing with the use of tape on the floor at common congregation areas.

**General Common area level 2**

On level 2, there are 3 wings of residential accommodation. All 3 wings are linked via a common landing that connects level 1 and 2 via a set of stairs. All 3 wings are in lock down with the glass doors to each wing closed and clear signage advising of lock down. Outside each entry door of each wing and still in the common landing area sits a small table where ABHR is intended to be located. Only 1 wing had visible ABHR on this small table.

The common landing on level 2, unfortunately did not meet principles of Infection Prevention and Control (IPC). Piles of clinical waste bags and dirty linen bags outside each door of the wings. This meant a clinical waste and dirty linen collection emerged next to the entry/exit point for each wing. Additionally, access to available ABHR required, leaning over the clinical waste. One lift, transporting meals and clean resources was immediately next to 1 waste pile and required staff exiting with supplies to negotiate the pile.

Staff in the common area was limited but observation demonstrated variation with behaviours to hand hygiene and glove use. Several staff members were observed entering/exit each wing with the same level of variance in hand hygiene and glove use.

**Waste removal**

The waste removal contractor was observed onsite and in progress of removing the above-mentioned waste after my arrival. The CEC understands that the contractor was late arriving this morning. The contractor, wearing PPE for contact-droplets precautions, was obliging and engaged with being observed.

The workflow of the contractor was observed and followed to the point of disposal in the industrial skip bins. The contractor loads clinical waste into a designated trolley then travels to a lift in one wing, down to level 1, through another wing to the dirty clinical room to exit the building to access the industrial size bins. Without changing any PPE or hand hygiene, (until prompted) the contractor retraced his steps through the facility with the now empty trolley back to level 2 for the next load of waste removal.

**Wing C2**

The C2 wing has the new emerging cluster of COVID-19 that was identified on the C2 wing can accommodate 15 residents in single rooms all with ensuites. At the time of the CEC visit to wing C2, there were
- 4 vacant rooms
- 11 residents present
• 4 confirmed COVID-19 positive residents. Unfortunately, 2 residents had deceased prior to the CEC visit. A total of 6 confirmed COVID-19 cases in this new cluster.
• With the new cluster, 5 residents’ rooms were in one (1) corner of wing C2. Two (2) residents in this same corner were -ve for COVID-19 at the time of the CEC visit.

The layout of the wing follows a central corridor in an L and a reverse L shape that join at the common area in this wing.

**Floor Plan Wing C2**

![Diagram of Wing C2]  
- Resident’s rooms (Cluster identified)  
- Common area of C2  
- Entrance to wing C2 from common landing on level 2

Immediately after entering the closed doors there is no opportunity for hand hygiene. Throughout this wing and the observed other wings are open clinical waste bags taped to the wooden handrails. Cleaning of high touch surfaces, (door handles) is attended twice daily.

Staff are disposing of all waste into the clinical waste bags regardless of blood/body substance contamination. These bags remain very open and protrude into the common corridor (thoroughfare).

**Hand hygiene**

There is only 1 hand basin for washing hands with soap and water in this wing. Presumably this is the same setup in the other wings of DHL. There is abundant supply of ABHR, but the location of the same is not standardised. This meant, 2 x staff were observed exiting 2 different rooms post resident care, removed gloves immediately but with no access to ABHR on exit, travelled the common corridor in contact-droplet PPE to the closest ABHR point.

**Donning/doffing PPE**

Whilst the sequence for donning of PPE may not be as essential, Staff were frequently observed donning PPE in incorrect sequence; gloves were routinely donned prior to gowns. Education of staff was undertaken at the time of observation.

The sequence for Doffing of contact-droplet PPE was observed to be correct including attention to hand hygiene but the manner of gown removal required input to staff.

**Gaps and opportunities for consideration**

- Several staff were observed to be wearing wrist watches and rings throughout DHL.
- PPE usage appears to be excessive; contact-droplet precautions are followed by all care staff in all wings regardless of the residence COVID-19 status.

14 April 2020
• Variation in behaviours of hand hygiene and glove use
• Limited cleaning schedules for high touch surfaces (handrails, doorknobs and lift panels)
• Variation in access to ABHR – some access points had more than enough ABHR while others had nil.
• Limited sinks for handwashing with soap and water in each wing (1 central hand basin in each wing)
• Waste management concentrated on overuse of clinical waste
• COVID care team carry a plastic basket between COVID-19 resident rooms with shared resident equipment for measuring observations. The shared equipment is cleaned on exiting each resident’s room, but the basket was not observed to be cleaned between wings.

**Recommendations**

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<thead>
<tr>
<th>Action</th>
<th>Point of reference</th>
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<tbody>
<tr>
<td>Review</td>
<td>staff knowledge and practical application to doffing of contact-droplet PPE</td>
</tr>
<tr>
<td></td>
<td>hand hygiene practices and glove use including allergy/contact dermatitis status of staff</td>
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<tr>
<td></td>
<td>PPE usage for residents negative for COVID-19. Return to standard precautions.</td>
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<tr>
<td></td>
<td>Use of clinical waste bags for non-clinical waste items</td>
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<td></td>
<td>Management of waste/dirty linen central collection point</td>
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<td></td>
<td>Location of ABHR access points</td>
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<td></td>
<td>Suitability of routine Tuffie wipes in confirmed COVID-19 locations</td>
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<td></td>
<td>Storage of the shared equipment used for COVID-19 residents.</td>
</tr>
<tr>
<td></td>
<td>• Is this equipment isolated from other shared resident equipment?</td>
</tr>
<tr>
<td></td>
<td>• Is there risk this equipment could be exposed to negative COVID-19 residents?</td>
</tr>
<tr>
<td>Increase</td>
<td>frequency of cleaning to high touch surfaces, such as door handles and touch surfaces of the lifts</td>
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<td></td>
<td>routine cleaning of COVID-19 care team shared equipment basket,</td>
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<tr>
<td>For consideration</td>
<td>Implement bare below the elbow’s healthcare campaign</td>
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</tbody>
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**Proposed Plan and Application of PPE**

1. All residents to remain within their specific wing of residence. No resident leaves their wing of accommodation. **Implemented**

2. All staff are wearing surgical masks in all areas of the building (DHL) at all times. **Implemented**

3. All residents who have been identified as currently COVID-19 positive or are symptomatic have been allocated to a COVID-19 care team. **Implemented**

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14 April 2020
• Positive Residents are isolated in their room with contact and droplet PPE precautions used by staff.

• Dedicated COVID Care team has been allocated to these residents and travel between wings. Staff dedicated to this group, have clear separation of tasks and models of care between positive cases versus other residents.

4. Standard Precautions be applied to all other residents with negative COVID-19 status including attention to hand hygiene and use of masks for extended wear.

Floor plan Level 2

Suspected/Positive Covid-19 residents

Common Dining area

Resident Wing

Common landing

Resident Wing C2

Stairs to level 1

PRINCIPLES

• Universal Mask use by staff in unit – sessional (extended use recommended)

• Contact & Droplet Precautions applied to all patients confirmed/suspected COVID-19
  o Mask, Gown, Gloves, Eyewear for patient contact

• Stringent screening of residents for acute respiratory symptoms

• Standard precautions applied to all other residents

Acknowledgement

The staff of DHL are to be complemented for their engagement and commitment to the wellbeing of residents.

Completed by

Carolyn Ellis RN, DippApSc, MHEd (Teaching & Learning), DipMidwifery, Certificate IV Workplace Training & Assessment, Certificate Operating Room Nursing.

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14 April 2020
Addendum

Ms Ellis attended DHL for a repeat visit on Thursday 9th April 2020. The intent of the DHL request was to review, and comment of recommendations discussed on Ms Ellis’s visit on Friday 3rd April 2020.

As an overall comment, the visit on 9th April, demonstrated a calmer workplace in respect of the general appearance of the facility and staff feedback when compared to the visit on 3rd April.

Please see review comments in the below table.

<table>
<thead>
<tr>
<th>Action</th>
<th>Point of reference</th>
<th>Review 09/04/2020</th>
</tr>
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<tbody>
<tr>
<td>Review</td>
<td>staff knowledge and practical application to donning of contact-droplet PPE</td>
<td>One staff member was observed to be wearing a surgical mask around her neck. Guidance provided at the point of contact. DHL provided further follow up. Another two staff were asked of their understanding of standard precautions and contract-droplet PPE. Staff responses were consistent and appropriate. Two residents were observed in their respective residential wings to be incorrectly wearing supplied surgical mask. One corrected without prompting. Ongoing</td>
</tr>
<tr>
<td></td>
<td>hand hygiene practices and glove use including allergy/contact dermatitis status of staff</td>
<td>Hand hygiene practices observed were appropriate. Ongoing</td>
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<tr>
<td></td>
<td>PPE usage for residents negative for COVID-19. Return to standard precautions.</td>
<td>Implemented. All wings on level two have demonstrated staff transition from contract-droplet to standard precautions for all residents not suspected/negative for COVID-19. Observed and completed</td>
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<tr>
<td></td>
<td>Use of clinical waste bags for non-clinical waste items</td>
<td>Implemented. Clinical waste bags have been removed from outside all resident rooms other than for residents suspected/positive for COVID-19. Observed and completed</td>
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<td></td>
<td>Management of waste/dirty linen central collection point</td>
<td>There was no observation of a central waste collection point.</td>
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14 April 2020
| Location of ABHR access points | Implemented. Immediately observed was increased and consistent visual cues for hand hygiene. Alcohol-based hand rub (ABHR) solutions have been placed on either side of the entrance doors of each wing on level two. |

**Completed by**

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