Event Review Report

COVID-19 Staff Infection at Wellington Hospital

21 May 2020

Event Review

This report provides an account of the review undertaken into an event where a registered nurse (RN 1) contracted COVID-19.

Between 24 March – 6 April 2020 the nurse had been working on a ward caring for patients with COVID-19 at Wellington Hospital.

REPORTABLE EVENT NUMBER: 83259	
Staff member: Registered Nurse 1 (RN 1)	Date review commissioned: 17/04/2020
Date of event: 24/03/2020 – 06/04/2020	Commissioned by: Chief Executive, Capital & Coast and Hutt Valley DHBs

Review Team
Patient Safety Manager RGN, MNurs, BNurs (Hons)
Associate Director of Nursing for Quality Improvement & Patient Safety RGN, MHM, BNurs (Hons)
Clinical Leader, Infectious Diseases MBChB, FRACP, FRACPath
General Manager, COVID Ward MSN, MS-Rehab, BSW, BSN
Consultation
Clinical Leader, Occupational Health MBChB, BSc (Hons), FAFOEM
Occupational Health Registered Nurse
Infection Prevention & Control Clinical Nurse Specialist (IPC CNS)
Charge Nurse Manager, COVID Ward (CNM)
Contracted Services Manager (Cleaning)
Health & Safety Manager

Scope of review

Inclusion: patient care and management, CCDHB COVID-19 processes, staff training and support, nursing hours.
Exclusion: diagnosis, medical treatment.

Review Methodology

The review was undertaken using systems analysis methodology. The aim of the review was to understand what happened, why it happened and what can be done to prevent similar events from occurring in the future.

Adverse event reviews at CCDHB are undertaken according to the following principles:

- To look for improvements in the process/system of care
- To develop recommendations and agree on an action plan
- To provide a report as a record of the investigation process and share learnings from the incident.

Sources of information:

- Patient records
- COVID-19 policies and procedures
- Discussions with the ward nursing staff and Infection Control Nurse Specialists
- Information from nursing acuity system, TrendCare
- Personal protective equipment (PPE) training records
- Information from CCDHBs electronic messaging system, SmartPage.

A timeline was established from 12/03/2020 – 16/04/2020.

The Timeline	
Date & Time	**Description of Events**
12/03/2020 – 23/03/2020	The first case of COVID-19 was reported in New Zealand on 28 February 2020. A four-level alert system was introduced on 21 March with the alert level initially set at level 2. A COVID-19 watch group across CCDHB, HVDHB and WrDHB was established at the end of January 2020 to establish a framework for pandemic preparedness. This was escalated to a 3DHB Incident Management response from 28 February 2020. Preparations included establishing COVID-19 readiness with COVID streams (red/orange/green), hospital level and service level contingency plans, standardised guidance and training for the use of PPE, procurement and supply lines of key equipment including PPE, pathways for recognition, preparations for the management of patients with suspected or confirmed COVID-19 infection across the DHB, enhancing occupational health support and working with contracting partners for cleaning and food services to provide a safe environment for staff and patients A programme to refresh clinical staff training in PPE was implemented using a train-the-trainer model, targeting initially 'high risk' areas (Emergency Department, Medicine, Intensive Care Unit (ICU), Paediatrics, Maternity, Anaesthetics) and then made available to other clinical areas. Specific changes were planned for Alert Level 4, with a dedicated COVID-19 area on a ward with separation of clinical staff (medical, nursing and allied health on the ward) into COVID 'hot' teams (working with COVID-19 patients) and 'cold' teams (not working with COVID-19 patients), to manage acute flow of suspected COVID-19 patients from the Emergency Department. The plan included: • Service contingency and COVID-19 response plans developed with advice from Infection Prevention Service, General Managers, Charge Nurses, Medical and Nursing staff. • COVID-19 specific education of all staff working in the COVID-19 ward • Specific areas for management of COVID-19 patients made ready as per the CCDHB Hospital Bed Escalation plan – initially negative pressure rooms with ante-rooms, then a designated pod within the ward. • Signage placed on isolation room doors, which included instructions for donning and doffing of PPE. • Areas for donning and doffing of PPE identified. Storage places for PPE on the ward arranged. • A *buddy* system established for the 'hot' area in the COVID-19 ward: this was a dedicated team of nurses who had responsibility for observing donning and doffing of PPE (safety checking), relief for meal breaks, clinical tasks and nursing activities. • A daily log of staff involved in the care of suspected and confirmed COVID-19 patients implemented. NB these staff did not have other clinical duties in the medical ward. • Handover meetings/safety huddles (morning and evening) were modified to include COVID-19 updates. Specific issues relating to this Reportable Event : • PPE training was commenced for the ward staff.

12/03/2020 – 23/03/2020	• RN 1 received further specialised education on working in the COVID-19 ward including PPE training. RN 1 was also the Infection Prevention and Control link nurse (IPC resource nurse) for the ward prior to COVID-19 outbreak.) • 16/03/2020: an area for patients with COVID-19 was designated in the ward, called the 'hot' area. • 18/03/2020: The Charge Nurse Manager (CNM) and Infection Prevention and Control Clinical Nurse Specialist (IPC CNS) met with the Contracted Services Manager, cleaning staff and cleaning managers, to plan improvements for cleaning and safe removal of infectious waste. The plan included: additional waste bins and rubbish removal, increased frequency of cleaning, contactless meal ordering, clarity regarding cleaning of rooms after patients with COVID-19 have been discharged, and training of contractors (cleaners and food services assistants) by an IPC CNS. The CNM, IPC CNS and cleaning manager established regular communication, to discuss the cleaning needs of the ward and address any issues. The ward cleaning schedule at this time was the same as pre-COVID levels. • 19/03/2020: The nurse-to-patient ratio was increased for staff caring for suspected or confirmed COVID-19 patients in recognition of nursing hours required. • The CNM implemented a daily check of PPE. • Twice daily inventory checking on procurement levels was commenced. • Development of COVID-19 planning documents, a COVID-19 notice board and a resource folder were established. • Flu vaccinations for staff commenced. • The ward initiated daily 'safety huddles' attended by IPC CNS, COVID-19 Registrar, Directors of Nursing, CNM, Associate CNM, Clinical Nurse Educator (CNE), and General Manager. The huddles aimed to identify any clinical and non-clinical issues, help prioritise work and provide a mechanism for escalating concerns. A template was developed to capture decisions, actions and escalation.
23/03/2020	On 23 March 2020 New Zealand implemented alert level 3.
Midnight	The Public Officer of Health was contacted due to concerns that two [redacted]
04:01 am	[redacted] (patients A and B) were transported into Wellington Hospital.
04:07 am	**Patient A** was admitted to the ward and placed in a negative pressure isolation room. Patient A had a fever, and COVID-19 swabs were taken.
11am-12pm	**Patient B** was [redacted]. Swabs were taken for COVID-19 testing.
14:10pm	Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation.
No Time	**Patient A** was seen by a Medical Registrar, who documented that the COVID test was positive.
21:30pm	**Patient B** was seen by a Medical Registrar, who documented that the COVID test was positive.

23/03/2020	**Patient B** **RN 1 Entry (evening shift)** *"Environment patient* [redacted] *The patient tested positive for COVID-19 as per Med Reg (Medical Registrar) notes needing Enhanced Droplet and Contact precautions in a negative pressure room. Early Warning Score 0 - afebrile"* [redacted] RN 1 assisted both patients to and from the bathroom throughout the evening shift. [redacted] RN 1 donned and doffed PPE appropriately, and a *buddy nurse* supported RN 1 each time. TrendCare recorded a positive variance in the "hot area" for nursing hours for the shift. Patients A and B required 5 hours 48 minutes of nursing time each (11 hours 36 minutes combined), for the shift. RN 1 showered and changed clothes at the end of each shift. **COVID-19 Management** A shower room was allocated to nurses directly caring for COVID positive patients. The cleaning company operational manager discussed the need for additional cleaning requirements in all the 'hot areas' of the ward as the cleaning process in place was one clean a day. The existing cleaning schedule did not include additional cleaning of the donning and doffing areas. Work was undertaken to create a new COVID cleaning schedule. A request was placed in SmartPage for additional infectious waste bins. This request was actioned that day.
24/03/2020 **11am-12pm**	**RN 1 was allocated to care for Patients A and B** Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation. RN 1 was relieved for all required meal breaks, buddied as per guidelines, and followed the uniform policy concerning uniform changes and showering at the end of each shift.
No time	**Patient A** **RN 1 Entry (evening shift)** *"COVID-19 - Enhanced droplet contact isolation precautions. Early Warning Score 1 due to patient febrile 38.6˚C. Cooling cares continued."*
20:30 pm	**Patient B** **RN 1 Entry (evening shift)** *"COVID-19 - Enhanced Contact & Droplet precautions maintained."* TrendCare data showed that RN 1's workload was high during this shift- patient A and B required 5 hours 48 minutes of nursing time each. This was recorded in TrendCare. A *buddy* registered nurse supported RN 1 with all nursing care provided to patients A & B. In total 11 hours 36 minutes of care was required in an 8 hour shift. **COVID-19 Management**

	The ward ACNM and IPC CNS advised nursing staff in 'hot areas' to use disinfectant wipes for surface cleaning: every four hours in shared spaces (including the nurses station and ante-rooms) and a surface clean every time a nurse left the 'hot area'.
25/03/2020 **11am-12pm** **21:00pm** **21:30pm**	**RN 1 was allocated to care for Patients A & B** Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation. **Patient A** **RN 1 Entry (evening shift)** *"Early Warning Score 3 due to patient's oxygen requirements at 2 Litres via nasal prongs to maintain oxygen saturations >91%."* Entry into the clinical notes states that COVID precautions were taken. **Patient B** **RN 1 Entry (evening shift)** *"Early Warning Score 0 – afebrile. COVID-19 Enhanced Droplet/Contact precautions."* RN 1 was relieved for all required meal breaks, buddied as per guidelines, and followed the uniform policy regarding uniform changes and showering at the end of each shift. TrendCare data showed that RN 1's workload was high during this shift – patient A and B required 5 hours 48 minutes of nursing time each. This was recorded in TrendCare. A buddy nurse supported RN 1 with all nursing care provided to patients A & B. A third confirmed case Patient C was admitted to the ward and placed in a bed space 3 to 4 metres away from the room where patients A & B were being cared for. A separate nursing team cared for this patient. **COVID-19 Management** The cleaning company implemented a 'buddying' system for cleaning staff donning and doffing PPE. RN 1 used disinfectant wipes to clean surfaces following instruction from infection control nurse.
26/03/2020 **11am-12pm**	RN 1 was not on duty. Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of the decisions made, actions or escalation. **COVID-19 Management** Cleaning 'wipe down' checklists were installed in each COVID-19 room to guide staff on cleaning.
27/03/2020 **11am-12pm**	RN 1 was not on duty. Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation. **COVID-19 Management** An increased surface COVID cleaning schedule and process was commenced on the ward in recognition that the cleaning schedule did not meet COVID-19 requirements. Surface cleans increased from once a day to twice a day. In addition, a 'high touch' cleaning schedule was implemented to take place 4 times in a 24 hour period.
28/03/2020	RN 1 was not on duty.

11am-12pm	Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation. A fourth confirmed case (patient D) was admitted to the ward and placed in a bed space 5 metres away from the room where patients A & B were being looked after.
29/03/2020 **05:05am** **05:25am** **11am-12pm**	**RN 1 was allocated Patients B & C; RN 2 was allocated Patient A** **RN 1 Entry (night shift)** *"Warning Score 9-10, due to oxygen saturations 85% on 4L oxygen via nasal prongs, Heart Rate 104 per minute, Respiratory Rate 20-24 per minute, short of breath ++."* A buddy nurse supported both RN 1 and RN 2. Patient A was transferred to the ICU accompanied by RN 2. TrendCare data showed that RN 1's workload was high during this shift – patient B and C required 5 hours 48 minutes of nursing time each. This was recorded in TrendCare. RN 1 and RN 2 cared for their allocated patients only, ensuring continuity of care. A full COVID-19 room clean and change of curtains was not performed in the shared bed space after patient A had moved to ICU. Patient B remained in the room. Staff confirmed that the daily ward huddle occurred, during which COVID-19 patient care was discussed. There was no documentation of decisions made, actions or escalation. **COVID-19 Management** Changes were made to the process for changing curtains in isolation rooms. The COVID-19 schedule was amended to ensure curtains are changed every time a room undergoes an infectious clean.
30/03/2020 **No time**	**RN 1 was allocated patients B & C** **RN 1 Entry (night shift)** *"Contact isolation."* Patient B had clinically improved, and discharge planning [redacted] was underway. TrendCare data showed that RN 1's workload was high during this shift – patients B and C required 5 hours 48 minutes of nursing time each. This was recorded in TrendCare. A buddy nurse supported RN 1 with all nursing care provided. RN 1 was relieved for all required meal breaks, buddied, and followed the uniform policy regarding uniform changes and showering at the end of each shift.
03/04/2020 **18:00pm**	**RN 1 was allocated two patients during this shift with suspected COVID-19 (Patients E & F)** TrendCare data showed that RN 1's workload was high during this shift - patient E required 4 hours, 43 minutes and patient F required 10.00 hours of nursing time. This was recorded in TrendCare. A *buddy* nurse supported RN 1 with all nursing care provided. **Patient D**

	RN 1 assisted with transferring patient D to the High Dependency Bay for high flow oxygen. Three staff wore full PPE, the patient wore a face mask, and the bed was cleaned before it was moved into the corridor. RN 1 was relieved for all required meal breaks, buddied and followed the uniform policy regarding uniform changes and showering at the end of each shift.
04/04/2020	RN 1 received refresher PPE training.
05/04/2020	RN 1 was not on duty
06/04/2020	**Patient B** COVID-19 test was negative. **RN 1** RN 1 was designated as a float COVID-19 RN to be able to work with ACNM in COVID-19 planning and resources for wards. RN 1 became symptomatic of COVID-19 overnight, after the afternoon shift, between 0000-0200hrs.
07/04/2020	RN 1 contacted the COVID-19 team at Occupational Health and described having a fever and being generally unwell overnight, starting after their shift on 06/04/2020. - RN 1 was sent for a COVID-19 swab and influenza swab. - RN 1 was advised to remain in self-isolation and stay away from work while symptoms persisted.
08/04/2020 – 13/04/2020	RN 1 did not return to work. An initial COVID-19 swab was negative for RN 1.
11/04/2020	The ward completed PPE training for staff.
14/04/2020	Patient B was discharged [redacted] on 14 April 2020.
16/04/2020	Repeat testing for RN 1 confirmed a positive diagnosis of COVID-19. RN 1 remained off work. Infection Prevention and Control and Occupational Health initiated a contact tracing plan. Ten staff members were considered to be high risk, and were placed in self-isolation, pending swab results. 79 staff members working on the COVID ward from 23/03/2020 were tested. All 79 COVID-19 tests were negative. It was confirmed that RN 1 had no likely contacts outside of the work environment as a potential source of COVID-19.

After analysis of the factual timeline, and extra information, the team identified the following findings.

FINDINGS

FINDING 1. The ward did maintain safe staffing levels for the 'hot area' during this COVID period. It was documented In TrendCare that for each shift that RN 1 cared for patients A & B, the hours of care required for these two patients was more than one RN could provide. However on discussion with nursing staff, it was found that there was a *buddy* nurse who provided support to RN 1 and assisted with patient care; however, the buddy nurse's hours were not recorded in TrendCare. The RN 1 and the *buddy* nurse's hours when combined exceeded the total care hours required and placed the 'hot area' in a TrendCare Positive Variance. It was noted that nurses working in the 'hot area' did not provide care for non-COVID-19 patients.

FINDING 2. There were ward processes, schedules and checklists developed during this COVID-19 period;
Service contingency and COVID-19 response plans were developed with advice from Infection Prevention Service, General Managers, Charge Nurses, Medical and Nursing staff. This covered COVID-19 specific education of all staff working in the COVID-19 ward.
Specific areas for management of COVID-19 patients made ready as per the CCDHB Hospital Bed Escalation plan – initially negative pressure rooms with ante-rooms, then a designated pod within the ward.
Signage placed on isolation room doors, which included instructions for donning and doffing of PPE.
Areas for donning and doffing of PPE identified. Storage places for PPE on the ward arranged.
A *buddy* system established for the 'hot' area in the COVID-19 ward: this was a dedicated team of nurses who had responsibility for observing donning and doffing PPE (safety checking), relief for meal breaks, clinical tasks and nursing activities.
A daily log of staff involved in the care of suspected and confirmed COVID-19 patients implemented.
Handover meetings/safety huddles (morning and evening) were modified to include COVID-19 updates.

However, some additional processes specifically around environment management were developed after the COVID-19 ward was made operational and patient care was delivered (refer finding 3). These decisions were made in response to the changing needs of the ward. Communications were mainly via email and not captured in formal documents.

FINDING 3. The ward admitted patients with suspected and confirmed COVID-19, without an implemented COVID-19 cleaning schedule.

Essential/best practice, when establishing an outbreak response, must include enhanced environmental cleaning. Included in this must be assigned roles for cleaning, a documented process for cleaning surfaces and education on how to clean for clinical and non-clinical staff. While the cleaning company worked in partnership with the ward's IPC CNS to make the changes to the cleaning schedule, there was a lag of three days before the agreed COVID-19 cleaning schedule was fully implemented.

The review team recognised that this was a rapidly moving situation, and resulted in variance in practice, omission of key steps and the above lag before the agreed COVID-19 cleaning schedule was fully implemented.

Daily ward safety huddles were held and cleaning issues identified, but there were delays implementing the COVID-19 cleaning schedule. All cleaning requests made through the SmartPage system were actioned in a timely manner.

FINDING 4. There was no documentation of the decisions, actions and escalations made at the daily safety huddles.
Minutes of the daily safety huddles were not kept, which meant it was difficult to know what had been discussed, decisions-made, and who issues had been escalated to. A teaching package and safety huddles template were provided to the ward to assist them with their management of patients with COVID-19. The

template was not used; however, the CNM updated the ward staff regularly at handover, by email and kept the COVID-19 resource folder updated.

FINDING 5. RN 1 became infected with COVID-19 as a result of providing nursing care to patients with COVID-19.

Whilst the review team could not be certain of the exact mechanism of exposure, it seemed most likely that either Patient B [redacted] or a staff member in PPE contaminated the closed-off area outside the negative pressure room. RN 1 most likely became infected by touching the contaminated surfaces. There does not appear to have been a PPE breach and staff were confident and competent regarding PPE practice. The review team felt it was more likely RN 1 contracted COVID-19 due to environmental contamination resulting in indirect transmission by fomite spread (materials or objects which are likely to carry infection, such as furniture, surfaces and clothes).

Recommendations

Following the establishment of the key findings, the review team recommend the following actions be taken:

RECOMMENDATIONS		
Recommendations	**Accountable person & review date**	**Outcome measure**
Recommendation 1 *The nursing hours of all nurses providing direct patient care, including buddy and float nurses, must be recorded in the TrendCare system.*	Chief Nurse Ongoing	Auditing to evidence compliance
Recommendation 2 *Wards that are designated to receive pandemic patients must have documented processes ready to be implemented when needed. These should be stored in the Emergency Operating Centre's shared drive, under Pandemic Planning. All staff working in the ward must be aware of these processes.*	General Managers of clinical areas 3 months	Evidence of processes in the shared drive.
Recommendation 3 *CCDHB's cleaning schedules for a pandemic must be based on best practice and reviewed annually. The cleaning schedule must be part of the organisation's pandemic plan and stored in the Emergency Operating Centre's shared drive. The cleaning plan must be implemented immediately after a pandemic is declared and staff trained in all aspects of the cleaning schedule.*	Executive Director QIPS Clinical Leader Infection Prevention & Control 20 June 2020	Evidence of the cleaning schedule in the pandemic planning documents and Sharepoint.
Recommendation 4 *It is recommended that during a pandemic the dedicated response wards' safety huddles should occur every shift. The safety huddle template record must be used to document the decisions, actions and escalations.*	Chief Nurse Ongoing in time of a pandemic.	Evidence of completed 'huddle' templates – random compliance audits to be undertaken.

Recommendation 5 *COVID-19/pandemic issues raised at the safety huddle must be escalated through the General Manager of the area, to the Integrated Operating Centre (IOC) Incident Controller, for action.*	General Manager of the COVID ward. Ongoing in time of a pandemic	Completed templates.
Recommendation 6 *A senior leader within the pandemic ward must be identified and released from other duties to provide multi-disciplinary oversight. This would ensure processes and systems are documented and implemented and patient and staff safety is monitored.*	2DHB Director of Provider Services Ongoing in time of a pandemic	Evidence in the Pandemic Plan

Summary

The COVID-19 pandemic, an unprecedented event, presented extreme challenges and stress to staff, patients and family / whānau and affected every aspect of service delivery for CCDHB. During this time of national emergency the DHB was undergoing rapid response planning and implementing process changes to align with national guidelines and react to local issues as they arose.

RN 1 is an experienced registered nurse [redacted] During March and April 2020, the registered nurse cared for three patients with COVID-19, used the correct PPE and was buddied to support patient care and to assist in every donning and doffing occasion.

The ward staff all received PPE training and evidence of the training was recorded.

The CNM initiated COVID-19 planning, which included implementing daily safety huddles and, over time with the IPC CNS, a COVID-19 cleaning schedule. The ward IPC CNS proactively advised the nursing staff to use disinfectant wipes to clean surfaces 4-hourly. The cleaning company worked in partnership and were responsive to the ward's IPC CNS to make the changes to the cleaning schedule. These cleaning decisions were made in response to the changing needs of the ward. Communications were mainly via email and not captured in formal documents.

Documentation of the decisions, actions and escalations made at the daily safety huddles and in planning activities was not well maintained and relied on email and discussions. These were not routinely captured in formal documents.

The nurse contracted COVID-19 while working in the COVID-19 ward. It is most likely that the nurse was contaminated from either Patient B [redacted] or by touching contaminated surfaces in the closed-off area outside the negative pressure room. This most likely occurred before the full COVID-19 cleaning schedule was in place on the ward. A complete COVID-19 cleaning process was introduced on 27 March, three days after the admission of the first COVID-19 positive patient.

The Nursing staff demonstrated compassion in caring for the patients with COVID-19. [redacted] They showed critical thinking and innovation while implementing complex and new processes.

The review team would like to acknowledge the anxiety and suffering this event has caused the registered nurse and their family.

The Chief Executive wishes to formally apologise to the nurse who contracted COVID-19 while at work and wishes the nurse a full recovery from this sad event.

The Chief Executive acknowledges the learning from this review and is committed to the implementation of the recommendations.

Glossary of Terms

Contact Tracing
The act of identifying susceptible persons with whom a case has been in contact with. The process involves a risk assessment of the exposure and implementation of actions to mitigate onward transmission e.g. testing and/or quarantine of contacts.

Donning and Doffing
Donning and doffing refers to the practice of employees putting on (donning) and removing (doffing) work-related personal protective equipment, for isolation precautions.

Personal Protective Equipment for health care professionals
For patients meeting the suspected case definition of COVID-19, health care practitioners should follow the 'contact' and 'droplet' precautions unless an aerosol-generating procedure (AGP) is to be performed. PPE for contact and droplet precautions includes long sleeve impervious gown, gloves, eye protection and a surgical mask. PPE for contact and airborne precautions includes: a long sleeved impervious gown, gloves, eye protection and a particulate respirator (N95 mask).

Safety Huddle
A daily meeting on the ward, attended by Infection Prevention & Control, senior nursing and medical Staff, General Manager and Directors of Nursing. The huddle focused on COVID-19 related updates and developments, bed management, and problem-solving any identified issues. Agenda items included: COVID-19 related policies and procedures, bed placement, a stocktake of PPE, hand gel and cleaning supplies, linen and scrubs, resource, cleaning schedules, physical distancing, and floor planning.

SmartPage
SmartPage is an electronic messaging system which supports the safe and secure transfer of confidential patient data. Clinicians are aware at all times of patient status and care needs. SmartPage provides real-time information, electronic requests, instant dispatching and allocation to individuals. At CCDHB SmartPage is used by clinical staff, as well as the cleaning services. SmartPage provides proof of completed tasks to clients.

TrendCare
A workforce planning and workload management system used to measure patient care hours against nursing resource.

High Touch
Areas that are more often touched, such as lift buttons, door handles, push plates, light switches, taps, toilets and soap dispensers.