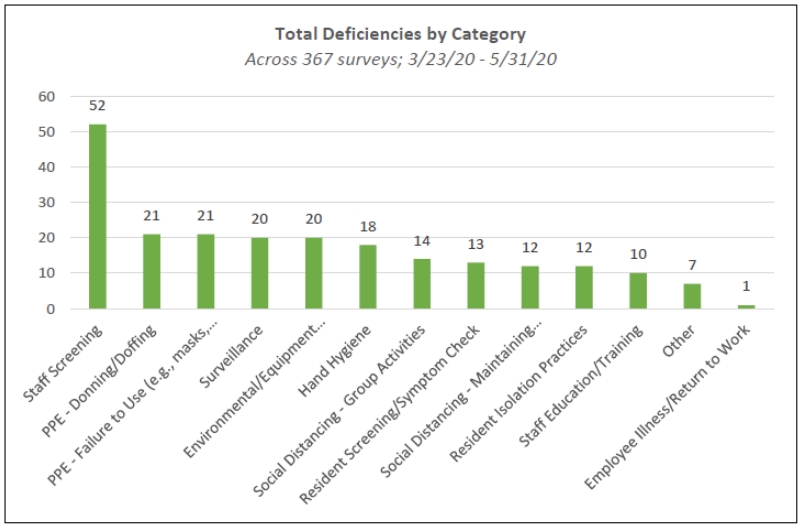
Focused Infection Control Surveys in Nursing Homes: Deficient Practices Commonly Cited by MN Department of Health

MDH recently provided LeadingAge Minnesota with statements of deficiencies from **120 focused infection control surveys** of Minnesota nursing homes conducted during April and May 2020.



Across these surveys, as shown in the figure above, staff screening, PPE issues, surveillance, environmental cleaning, hand hygiene, social distancing, resident screening and isolation practices, and staff education stood out as the most common issues identified by MDH to support a citation at F880. What follows are examples of findings documented by MDH within these key areas.

Screening of Staff (and others) Entering Facility

What deficient practices did MDH identify?

- Lack of active screening / issues with who does the screening.
  - Staff self-screening at the start of shifts – e.g. taking own temperature and self-completing screening questions.
- Issues relating to the screening location.
  - Screening was performed in a resident care area (such as a nurses station) rather than at one or all entrance(s) to the facility. MDH also cited a variation of this issue, where screening occurred at the entrance to the building, but staff would need to go to the nurses station to report any symptoms / issues with the screen.

- Screening was performed at single entrance to the facility, but system ineffective because staff entered the building through multiple entrances, due to proximity to parking or other factors.
- Crowding, not maintaining appropriate distancing, in the screening area prior to start of shift. (Variation: if a long line had formed, a staff might bypass the screening, walk through facility to put away personal items, then return to the line.)

- Not everyone was screened before entering.
  - Some staff were screened but not all staff (e.g. administrator or DON not screened)
  - All staff were screened but not all visitors or essential healthcare personnel entering the facility were screened.
- The individual assigned to screen those entering the building was not trained on (or was trained but failed to follow) the policy and procedure for what to do in the event a person showed symptoms; or the policy was not clear on what was to happen in the event of a "positive" screen.
- Incomplete documentation of screening activities (lack of logs, logs with incomplete information)
- Inconsistent Implementation – drift from the formal policy and procedure. Sound system on paper, but lack of oversight or clarity about accountability to ensure the screening process is being followed.

PPE: Did Not Use; Inappropriate Use; Donning & Doffing

What deficient practices did MDH identify?

- Failure to use full PPE for residents on droplet precautions.
  - Sign on door indicated resident was on droplet precautions and staff were to wear face mask, gown, gloves and eye protection. Nursing assistant entered without goggles (had been trained but forgot).
  - Housekeeping staff and activities aide did not have on full PPE when entering room of resident on droplet precautions, despite appropriate signage; didn't think the sign pertained when only cleaning or delivering meal tray.
- Failure to use source control masks.
  - Staff were not utilizing source control masks unless they were assisting a resident who was on isolation (e.g. after hospitalization) and was symptomatic. (Note: this is just one example where MDH found a facility had not implemented the most current guidance relating to use of masks, as of the date of the survey.)
  - Family member visiting resident on hospice not wearing mask; stated facility had not instructed or asked them to use masks while in the building.
- Inappropriate use of source control masks.
  - Staff removing or pulling mask down when talking to other staff, and to the surveyor, to make communication easier.
  - Face mask covering only the mouth and not the nose. Explanations from staff of various facilities included:
    - Eye protection fogged when mouth and nose covered
    - Hard to breathe

        - Mask did not fit properly and slipped down; one LPN shared that she had a better fitting mask, but preferred to use the looser one.
    - Staff touched face masks (or reached under eye shield) frequently without performing hand hygiene.
    - Nursing assistant was assisting resident in eating and eating herself from a separate plate of food. NA surgical mask was pulled down below chin and goggles were on top of head.
    - Residents did not wear source control masks when out of room.
- Confusion and inconsistency about how to store and handle masks during shift and at end of shift.
    - Masks hanging on hook when taking break; not aware should be storing in a paper bag or breathable container; staff removing masks and placing on lap during lunch breaks.
- Doffing after leaving resident room.
    - Staff doffing PPE in the hallway outside of resident's room.
    - No bin or basket inside door of room for staff to discard PPE before exiting the room. E.g. staff standing doorway and reaching out of resident room (past clean isolation supplies) to place in bin.

Surveillance

What deficient practices did MDH identify?

- Lack of surveillance system; no tracking or trending for a period of time, due to turnover (e.g. a new DON assuming his/her role and lack of time given demands of other responsibilities).
- Surveillance system tracked infections treated with antibiotics, however there was no provided evidence which demonstrated the facility tracked or trended resident symptoms of potential infection which were not treated with antibiotics (i.e. common cold symptoms, viral infections).
- Lack of analysis of the data.
    - In several cases MDH found the facility was collecting data, but the facility did not demonstrate comprehensive analysis of the collected data; no evidence to show the facility had adequately investigated and tracked the infections to determine if they were related (patterns, trends) and/or spreading within the facility or respective unit(s), to help reduce the risk of recurrence to the same and/or other resident(s) and to educate staff.
    - Timeliness. For example, logs were updated with data on resident/staff infection status on a monthly basis, rather than in real time; one RN stated she had been busy doing other things relating to COVID and would complete the analysis of the data as soon as possible.
- Infection control surveillance logs did not include residents that were tested for COVID-19 for tracking and monitoring of symptoms (several residents had been tested for COVID, with negative results); logs only tracked residents with diagnosed, treated infections.
- There was no evidence the facility had correlated the residents' infection data with the staff illness report(s) for the same period to determine if any of the infections were related.
- RN used a line listing to track the actual and potential infections in the facility; however, had run out of blank forms and stated s/he did not know where to obtain new forms.

Environmental/Equipment Cleaning and Disinfecting

What deficient practices did MDH identify?

- Failure to clean/disinfect lifts between uses with different residents.
    - Lifts cleaned nightly, rather than after each resident transfer.
    - In one facility there was apparent confusion about who cleans the lifts – nursing staff or housekeeping staff.
    - Slings used for multiple residents without disinfecting; only laundered when visibly soiled.
- Failure to ensure a shared glucose meter was disinfected properly between uses; did not follow manufacturer's recommendation. In one facility, residents had individual glucometers but staff followed used multi-resident use for convenience.
- Appropriate disinfectants not available or accessible.
    - Facility using personal wipes; hand sanitizing wipes vs. bleach wipes; LPN verified bleach wipes not currently available on unit; central supply was supposed to restock wipes; central supply stated bleach sanitizing wipes locked in a given staff person's office, but s/he was there every other day and stocked wipes when staff told her running low; if s/he wasn't in the building, staff did not have access.
- Contact Time; issues of staffing know contact time for each disinfectant product.
    - Therapy department staff stated the department is using peroxide multi-surface cleaner on equipment and not sure if it has to sit for a period of time or not. TD staff stated there was no instruction or education on how to use.

Hand Hygiene

What deficient practices did MDH identify?

- Failure to perform hand hygiene between glove changes from dirty to clean during service to a given resident, and after glove removal that occurred between service from one resident to the next.
    - When interviewed a nursing assistant stated, "You wash hands before you put your gloves on and wash them after your take them off, if doing personal cares and change your gloves, you have to wash your hands between. We had to watch a video when this first started, shortly after, and then the education nurse was walking around and watched me do hand hygiene maybe 3 weeks ago, we all had to wash our hands and sign off on a sheet. I don't think I did (hand hygiene) when caring for R9, I know I took my gloves off after doing the personal cares, I honestly didn't think of it, sometimes it is too much."
    - Activity aide observed measuring vital signs for the residents. Did not perform hand hygiene after removing her gloves and re-gloving prior to measuring the next resident's temperature, oxygen saturation, and heart rate. Stated she had been educated on hand hygiene after removing gloves but she forgot because there wasn't any hand sanitizer in the equipment basket.
- Failure to change gloves.
    - Laundry Aide wore the same contaminated gloves to collect all soiled linen from all the utility rooms in the facility, cross contaminating door handles and other high-touch objects. Only performed hand hygiene after collecting all the linen from the wings and sorted the linen.

- Dietary aide did not change gloves or perform hand hygiene between delivery of water to each room; thought she only had to perform hand hygiene after finished full task.
- Housekeeping aide knew that gloves were to be removed and hand hygiene performed between cleaning resident rooms, but s/he was the only housekeeper working and "sometimes corners had to be cut."
- Nursing assistant picked up meal trays from resident rooms without performing hand hygiene between rooms.
- Housekeeping staff said they had not been instructed to use hand hygiene when removing gloves or between resident rooms. Did not fully recognize importance of housekeeping cart as a high-touch surface. Surveyor notes indicate maintenance director who oversees housekeeping staff did not regularly attend infection control meetings.

- Staff touched their mask or exposed nose before entering resident room without performing hand hygiene.
- Failure to remind/assist residents with hand hygiene.

Social Distancing

What deficient practices did MDH identify?

- Communal dining for selected residents was occurring but residents were less than 6 feet apart.
  - Tables not spaced 6 feet apart. E.g. distance was estimated or visually gauged, not measured and marked.
  - Tables properly spaced, but multiple residents seated at each table and not properly distanced (e.g. seated diagonally about 3 feet apart).
  - Tables and residents were properly spaced, but residents observed in close proximity to one another while waiting for meal service to begin or while entering or leaving the dining area.
    - Tables placed in manner that prevented clear entry and exit from dining room without coming into close proximity of another resident.
    - Following activity, staff wheeled some residents, others walked or self-propelled their wheelchairs toward nurses station and hallways. Resulted in congestion around nurses station and in the hallway. As leaving, other residents were passing going the other way only inches apart.
- Failure to maintain social distancing between residents on a designated smoking patio.
- Residents sitting in the lobby without masks and were not socially distancing
- Care plans for 7 residents with cognitive impairment did not include any problem, goal or intervention related to social distancing.

Resident Screening/Symptom Checking

What deficient practices did MDH identify?

- Policy lacked indication of resident screening.
- Screening conducted only for residents showing symptoms; or only for new admissions; or screening conducted for all residents but only documented for residents showing symptoms.

- Not properly monitoring and obtaining daily temperatures; the task was assigned but there was inadequate oversight to ensure the policy and procedure was implemented.
- Policy indicated screening (e.g. twice daily) but facility lacked documentation to evidence that the screening was being done.
- Activities staff was to complete screening with review/sign-off by nursing staff; not always done or evaluated by nursing on the same day; not sure who was the process owner – nursing or activities; activity staff did not work every other Sunday so screening not completed; aides do not have health backgrounds in assessment for signs and symptoms.

Resident Isolation Practices

What deficient practices did MDH identify?

- Issues with immediate implementation of transmission precautions when indicated by symptoms and actions to reduce risk of transmission.
- Failure to isolate newly-admitted residents.

Staff Education

What deficient practices did MDH identify?

- Training regimen implemented but not all staff completed the training.
    - Training was provided in a staff meeting and a recording placed on line, but no clear process or deadline was established to ensure that staff who did not attend the meeting completed the training.
    - DON was posting notes in lieu of formal education because things change so much; posted notes by the time clock and at nurses station but was unable to confirm who had or had not read the notes. Confirmed RN had been working on a binder of education as was just getting ready to put the info at the nurses station; HR had not set up a timeline for completion.
- Informational updates (such as emails, signage) provided but facility policy and documentation lacked indication of formal training / education.
    - Housekeeper had not received training just had a sheet indicated extra cleaning to complete.
    - Staff were to take time to familiarize themselves with proper donning and doffing of PPE; not mention of hands on training.
    - No formal COVID-19 training; staff received emails to tell them about screening and mask use.
- Training provided to all staff but facility lacked evidence of ongoing completed audits and/or competencies for transmission based precautions.

Disclaimer: Information shared in this report is based on an analysis by LeadingAge Minnesota of the information provided in Focused Infection Control Survey Reports published by the Minnesota Department of Health. Providers may have been cited for practices that are not captured here. This information is being shared only for the purposes of sharing, learning, and improvement.