Safe Care in the Age of COVID

Learnings from Focused Infection Control Surveys in Nursing Homes: Overall Findings, Themes and Contributing Factors

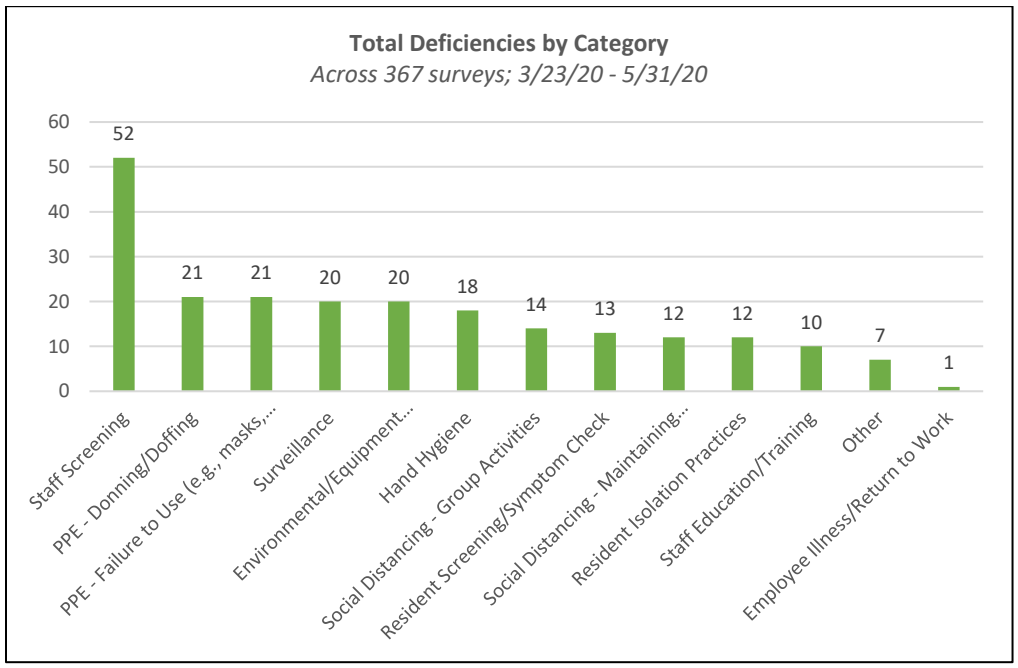
June 2020

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 additional learnings and actions that are not captured here. This information is being shared only for the purposes of sharing, learning, and improvement.

Overall Findings

Between March 23 and May 31, 2020, the Minnesota Department of Health (MDH) conducted a total of 367 Focused Infection Control Surveys. Of the 367 surveys conducted, 120 nursing homes were cited for deficiencies. MDH typically issued just one F-tag (F880) during these surveys. However, in some cases surveyors identified more than one type of deficient practice (e.g. screening and hand hygiene) to support the tag, and each of those deficient practices is counted in the data below.

Across the surveys, **Staff Screening** was cited more than twice as often (52 instances) as any other category. Overall, **PPE use issues** resulted in 42 deficiencies evenly split between Donning/Doffing issues and Failure to Use (e.g., not using a mask or gloves when appropriate). Issues with **Social Distancing** accounted for 26 deficiencies (14 related to failure to suspend group activities; 12 due to failure to maintain appropriate social distance). **Surveillance and Environmental Cleaning** each accounted for 20 deficiencies, followed by **Hand Hygiene** (18 instances), **Resident Screening** (13 instances), **Resident Isolation Practices** (12 instances), and **Staff Training** (10 instances).



A. Common Themes and Contributing Factors Across Categories

Although organizations have improved many of their COVID-related processes over time, it is even more important now than ever, as we begin to move into re-opening, that you closely examine your base infection control practices to ensure that you have well-defined, effective practices that are being consistently implemented across your organization. Below are key general themes observed in the survey reports, along with contributing factors and suggestions to consider as you examine your own practices.

Theme 1: Lack of effectiveness in putting policies into practice

<table>
<tr><td colspan="2">Contributing Factor 1: Lack of a mechanism to proactively anticipate where a process may “break down”</td></tr>
<tr><td>Example Cases:</td><td>“Consider this”</td></tr>
<tr><td>Nursing staff completing staff screening; not always available to screen which led to staff self-screening and then walking through resident care area to find someone who can sign off on their screening sheet.</td><td rowspan="4">Create a simple process flowchart (on paper or computer) and bring together a few staff who will be involved in, or impacted by, the process to brainstorm potential issues with each process step; use input to create a more robust process; develop a schedule, and assigned responsibility, for revisiting key processes.

Compliance vs. effective practice – you may have a policy that meets the requirements of CDC, CMS, and MDH; however, for that policy to be effectively placed into practice, it is important to understand the goal of the practice to assess your process through a critical lens as to whether it will the achieve the desired outcome, e.g., does your screening process effectively prevent infected staff and visitors from exposure to other staff and residents?</td></tr>
<tr><td>Social distancing observed in the dining room with residents sitting at least 6 feet apart, but tables placed in a manner that prevented clear entry and exit from dining room without coming into proximity of other residents.</td></tr>
<tr><td>Multiple garbage containers located next to clean PPE cart with staff doffing PPE outside the room next to the clean PPE.</td></tr>
<tr><td>Bleach wipes locked in central supply office; central supply staff worked every other day; staff did not have access to re-supply on off days.</td></tr>
<tr><td colspan="2">Contributing Factor 2: Lack of communication to staff on the goal of the policy/practice</td></tr>
<tr><td>Example Cases:</td><td>“Consider this”</td></tr>
<tr><td>With a long line for screening, staff would go to the locker room to put away purses or lunch boxes, or pick up masks and shields, before screening. When asked, staff responded – “am I not supposed to do that?”</td><td rowspan="2">We tend to be logical, cause-and-effect individuals; it is important for staff to know the “end goal” of what you are trying to achieve – especially with a new practice such as screening staff and visitors upon entry – and their role in achieving that goal.</td></tr>
<tr><td>Housekeeping staff not sanitizing shared lifts between resident use because cleaning of lifts happened at night.</td></tr>
<tr><td colspan="2">Contributing Factor 3: Lack of on-going observational auditing and coaching</td></tr>
<tr><td>Example Cases:</td><td>“Consider this”</td></tr>
<tr><td>Multiple staff not performing hand hygiene between glove changes from dirty to clean and after glove removal.</td><td rowspan="2">It is important to observe key practices on a regular basis to provide real-time coaching, address barriers, and/or reinforce positive practices, using approaches, such as:</td></tr>
<tr><td>Dietary aide did not perform hand hygiene between each room when delivering water to residents but performed hand hygiene after finishing task.</td></tr>
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Visitor screening set up as a self-service station at entry; family members visiting for compassionate care reasons had clear difficulty following any of the screening and precautions steps.	• Leadership Rounding (Rounding Toolkit); add critical COVID-19 related practices to your rounding tool. • Manager Rounding to provide coaching and identify and address barriers. • Engage your Safe Care Champions to be an additional set of eyes and ears and provide coaching and support.

Theme 2: Lack of a Culture of "See Something; Say Something"

Contributing Factor: Lack of Speaking Up: Honoring the Safe Care Pledge	
Example Cases:	**"Consider this"**
Staff set dirty breakfast trays on top of clean PPE carts because there was not a place to set trays outside isolation rooms; staff did not disinfect the hard touch surfaces after removing trays. Did not speak up to let someone know that a place was needed to set breakfast trays. After being cited, a cart was added for meal trays.	Engage your Safe Care for Seniors Champions to promote the Safe Care for Seniors pledge and provide examples of speaking up related to infection control practices, e.g., you don't have the supplies you need, PPE is not fitting correctly; social distancing is not being followed. See Something; Say Something Flyer Safe Care Pledge Card

Theme 3: Weak vs. Strong Actions

Contributing Factor: Not getting to the root of the problem and matching the solution to the problem	
Example Case:	**"Consider this"**
CNA moved an EZ-stand into another resident room without disinfecting the stand; CNA confirmed EZ-stand should have been cleaned between residents but that there is usually Sani-wipes on the stand and vital sign machine, and they were not available.	**Action Taken**: provided re-training to the CNA involved, and all CNAs, on sanitizing equipment between use. The root cause in this case was not a lack of knowledge (CNA acknowledged the need to clean between uses) but is tied to a break down in the process for ensuring Sani-wipes are stocked and available to staff. A stronger solution would likely be to assign accountability and a systematic process for re-stocking Sani-wipes. Training/coaching can also be completed once the process is strengthened but will not be effective long-term as a stand-alone solution. 5 Whys & Strong Solutions 5 Whys Example