BOOTS ON THE GROUND: THE IMPORTANCE OF A HANDS-ON, IN-PERSON IPC APPROACH

The Long-term Care Industry vs. COVID-19

While a sense of normalcy is returning to many communities due to a strong vaccination effort, our long-term care industry continues to be the frontlines of the war on COVID-19. The nursing home population is most disproportionately affected by this virus. Less than 1% of America's population lives in long-term care facilities, yet this tiny fraction accounted for almost 40% of coronavirus fatalities in the U.S. As of **March**, more than 174,000 residents and staff in this industry have died from COVID-19.

Policymakers at every level knew the risk this population faced and the importance of protecting them, yet the coordination and implementation of doing so was disoriented and at times, absent. A CMS response of 15 million dollars in fines was issued, but a punitive rather than supportive effort was moot. **Neither quality ratings nor infection citations** were determining factors in COVID-19 outbreaks. The driving factors were beyond control: **Location of a nursing home** and **asymptomatic spread**. **PPE and staff shortages** exacerbated the situation. As recently as October of 2020, one in five nursing homes reported shortages of personal protective equipment (PPE). Even more (one in four) reported shortages in nursing staff.

380,000 Deaths

Annually due to infection before COVID-19

Infection Prevention & Control: Pre-Pandemic Challenges

Infection control practices in long-term care were undergoing a large overhaul before the COVID-19 pandemic. The attempt to bring hospital standard protocol to long-term care was misconceived as the already understaffed nursing homes were overworked and undertrained. Facilities were given brand new guidelines, under penalty of citation, with training for implementation coming in the form of online materials. Every facility is unique and faces a unique set of challenges. While the curriculum on what needs to be done is plentiful, facilities need guidance on the actual realistic application of the infection prevention and control program.

The long-term care industry saw **380,000 deaths** annually due to infection before COVID-19. The most frequently cited deficiency on state surveys was infection control practices. **40% of nursing homes** were cited in this category, and this shows the scope of challenges these facilities are facing. IPCWell has conducted over 120 in-person nursing home visits in ten months and see that these numbers do not represent a blatant dereliction of duty, nor a lack of effort. We see these numbers telling us this is an industry that needs intrinsic change and immersive help in doing so.

These challenges existed well before the pandemic hit, and now is the time to not only eradicate the spread of COVID-19, but lay the foundation needed for facilities to move forward with more robust infection prevention and control practices.

Part of the difficulty lies in a clear contrast between policy and practice. For example, IPCWell took data from seven of the facilities visited prior to the pandemic. We saw that while all facilities had a designated person responsible for coordinating the infection control program, none of them were reporting active surveillance to monitor and document things like proper adherence to proper PPE selection and hand hygiene protocol.

Boots on the Ground / Strike Teams: The Importance of In-Person Support

As it becomes clear that the support for the long-term care industry needs a more hands-on approach, the use of in-person teams is becoming more prevalent. CMS realized this importance of being in-person and began providing the help that nursing homes needed with their **Task Force Strike Teams**. Traditional methods of technical assistance weren't going to get the job done, so these teams went into facilities that needed the most help and focused on four key areas of support: Keeping COVID-19 out of facilities, detecting COVID-19 cases quickly, preventing virus transmission, and managing staff. Being on-site was the only way to begin to understand what immediate action nursing homes needed to take to help reduce the spread and risk of COVID-19 among residents and staff. This also allowed CMS to better understand what federal, state, and local resources were needed, and the information learned on-site was crucial to determining how to move forward with future remote education and other critical needs required to support nursing homes in mitigating future outbreaks.

President Biden's American Rescue Plan sees the importance of in-person support, as the proposal provides critical funding for more strike teams to long-term care facilities.

Many states and organizations have implemented **strike teams of their own**. The Orlando Health System implemented "COVID Safety Officers (CSOs)" in all its facilities. This health system includes acute care, two long term care facilities and physician practices. Every shift, a designated staff person is the CSO tasked to observe employees donning and doffing personal protective equipment (PPE), performing appropriate hand hygiene, and assuring that all other infection control and prevention policies and procedures are being followed.

In Montana, Governor Bullock established five strike teams made up of a certified nurse and National Guard Members to be deployed across Montana to respond to COVID-19 cases in nursing homes and long-term care facilities or to provide training and assistance with proper infectious disease control protocols.

In Texas, The Rapid Assessment Quick Response Force (RA-QRF) team provides initial triage, site assessment, reviews of the facility's policies and procedures, personal protective equipment (PPE), and infection control guidelines, and provides recommendations to help reduce the spread of COVID-19.

In another set of 43 long-term care facilities that had an initial on-site visit, during the COVID-19 pandemic, IPCWell saw more of the disparate between policy and practice. The current CDC recommendation is that hand sanitizer dispensers are located inside and outside every resident room. Our data showed 52% adherence to inside the room, and only 12% outside the room. 99% of residents were not offered hand hygiene prior to meals and after toileting. Shared resident equipment such as the blood pressure cuff was only cleaned in between resident care 42% of the time. All 43 facilities were reusing N95 masks and face shields, however only 30% were cleaning and disinfecting the face shield appropriately. Ancillary departments that often receive little to no infection prevention and control education were also struggling. 99.5% of the EVS (housekeeping) staff did not conduct hand hygiene prior to donning gloves and only 13% cleaned resident rooms from clean to dirty. Only 22% changed gloves after cleaning a dirty area such as a restroom, potentially contaminating clean areas and spreading infectious disease. 92% of facilities had clear separations in the laundry area, yet only 21% used clean PPE to sort soiled linen. These numbers reiterate the gap we see in practice vs. policy and reassert the need for data collection and ongoing support to reinforce behavioral practices.

On-site Support: Immediate, Effective, & Proactive

The initial on-site visit, based on the CDC ICAR and the CMS IPC assesments, is the bedrock on which the facility can begin to effectively build and improve the infection prevention and control program. By immediately identifying gaps in practices and executing instant training, the visit more productively asseses the needs of the facility and can drive an appropriate, specific plan of action.

The on-site visit consists of direct observation of facility practices, not only on the clinical side, but including areas often overlooked such as housekkeping, food services, water management, and laundry services. The visit includes in depth interviews with staff from all areas of the facility. On the spot training can be conducted throughout the visit, allowing for the immediate correction of issues that are found. The initial assesment generates a detailed analysis, serving as the blueprint for the post-visit report. The post-visit report includes facility-specific action plan, toolkit for implementation of current evidence-based best practices, and resource-rich infection prevention and control binder, serving as a centralized location for information.

Working in domestic nursing homes, Doctors Without Borders and IPCWell "embedded" trainers with housekeeping staff. The embedding consisted of being side-by-side during the cleaning of a resident room, allowing for the trainer to observe the process and provide the training needed for the appropriate infection prevention and control steps.

After the fundamental on-site visit, on-going traditional support becomes much more effective. Broad, general IPC information is substituted for targeted information specified for the facility.

We have been told that one day of in-person training is more valuable than months of searching and studying online material. **IPCWell supports the in-person assessment and training offered by a more personalized and hands-on approach. We support the approach that begins with the experiential, action-based instruction followed by on-going traditional support.** We support this because it delivers more functional, effective, and substantial results. We support the opportunity not only to eradicate COVID-19, but to lay the foundation needed for facilities to move forward with more robust infection prevention and control practices.

For further information, contact:
drbuffy@ipcwell.com
480-709-4548