Infection Control & Prevention Standards are Essential for U.S. Nursing Home Residents

Each year, there are from 1 to 3 million infections in nursing homes and up to 380,000 residents who die from them. According to the CDC, “[e]liminating infections, many of which are preventable, is a significant way to improve care and decrease costs.” According to the Office of Disease Prevention and Health Promotion, 380,000 nursing home residents die each year due to health care-associated infections.

CURRENT INFECTION CONTROL REQUIREMENTS ARE REASONABLE & ESSENTIAL

Current standards require each nursing home to “establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.” The infection control program must “be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.”

In an effort to address this burgeoning issue, since 2016 federal standards also require that facilities implement a basic antibiotic stewardship program.

The overwhelming national data, and growing numbers of personal tragedies (see selected news reports, below), all point to the need for improving accountability for meeting basic hygiene and other infection control safeguards, not relaxing them.

SELECTED NEWS REPORTS

Following are excerpts from the growing number of news reports on the often catastrophic impact of lapses in basic infection control and protection standards. All emphases added.

*Infection lapses are rampant in nursing homes but punishment is rare* [LA Times/Kaiser Health News]


Basic steps to prevent infections — such as washing hands, isolating contagious patients and keeping ill nurses and aides from coming to work — are routinely ignored in the nation’s nursing homes, endangering residents and spreading hazardous germs.

A Kaiser Health News analysis of four years of federal inspection records shows 74% of nursing homes have been cited for lapses in infection control — more than for any other type of health violation. In California, health inspectors have cited all but 133 of the state’s 1,251 homes.

Although repeat citations are common, disciplinary action such as fines is rare: Nationwide, only 1 of 75 homes found deficient in those four years has received a high-level citation that can result in a financial penalty, the analysis found. “The facilities are getting the message that they don’t have to do anything,” said Michael Connors of California Advocates for Nursing Home Reform....
Neglected: Even when staffs cause patient deaths, Florida nursing homes face few penalties [USA Today/Naples News]


York Spratling, 84, died in February 2017 after surgery to remove dead tissue from his gangrenous genitals.

Spratling wasn't being bathed at the nursing home. And even though staff could smell the rot when stepping into his room, the doctor wasn’t told about the wounds or severe infection for five days, the state’s death review notes.

The nursing home's staff neglected Spratling by failing to get him treatment and not reporting his condition to a doctor, the state review found.

There is no evidence AHCA [Florida survey agency] investigated the death. When asked how the agency responded to the death, AHCA cited an inspection conducted two months later that didn't reference the incident. The agency never cited the nursing home for any violations related to Spratling’s death.

There were warning signs in Consulate’s previous inspection reports. AHCA cited the home with violations three times in the year before Spratling’s death for not having enough staff to give patients regular showers or personal hygiene care.

“I have not had a shower in I don’t know how long,” an unnamed patient told AHCA inspectors in September 2016, five months before Spratling died, according to an inspection report.

The complaints of neglect and inadequate staffing continued even after Spratling’s death. Eight months later, AHCA again cited the home for understaffing, with one patient telling inspectors, “I wallow around in this bed in my own piss.”

Wanaque virus outbreak: Report details hand-washing lapses [USA Today/NorthJersey.com]

In one case, a nursing assistant removed a soiled diaper from a severely disabled child, then, still wearing the same pair of gloves, attached a respiratory tube to the child.

In another case, after a respiratory therapist placed a breathing mask on a disabled child, she removed her gloves and — without washing her hands — went to a second patient’s room and picked a medical device off the floor and attached it to the resident's foot. Then she failed to wash her hands again before entering a third patient's room.

Those and other lapses in basic hygiene were detailed in an inspection report from a surprise visit on Oct. 21 to the Wanaque Center for Nursing and Rehabilitation, the long-term care center where a virus outbreak led to the deaths of nine children this month.

FURTHER INFORMATION
