

inperspective

LIABILITY landscape

BY LINDA WILLIAMS, RN

Is your infection control program effective?

It is well known that the elderly population has a substantially increased incidence and severity of many infectious diseases. In fact, the Centers for Disease Control and Prevention (CDC) estimates that 1.5 million nosocomial infections occur in long-term care residents per year, which translates to an average of one infection per resident per year. Methicillin-resistant staphylococcus aureus (MRSA) poses a particular problem for residents because this type of bacteria causes staph infections that are resistant to treatment with the usual antibiotics.

According to the CDC, MRSA occurs most frequently among patients who undergo invasive medical procedures or who have weakened immune systems and are treated in hospitals and healthcare facilities such as nursing homes and dialysis centers. MRSA in healthcare settings commonly causes serious and potentially life-threatening infections, such as bloodstream infections, surgical-site infections, or pneumonia. The most common sources of transmission are people who already have a MRSA infection or who carry the bacteria on their bodies, but do not have symptoms (colonized). The main mode of transmission to other residents is through human hands, especially healthcare workers' hands. Hands may become contaminated with MRSA bacteria by contact with infected or colonized residents.

It is the responsibility of nursing facilities to have an infection control program to investigate, control, and prevent infections, as they are able to do so. Please review the following situation and make changes as appropriate in your facility.

The Situation

An 80-year-old woman was admitted to



a nursing facility after surgical removal of hardware (from a left hip replacement) because of an infection. Four years earlier, the woman had her hip replaced and, over time, the area became increasingly painful. It wasn't until the surgeon removed the hardware that he discovered that the woman had contracted a MRSA infection that had destroyed some of the bone in her hip. After the surgery, the woman received intravenous vancomycin until her physician felt the MRSA had colonized. Afterward, the woman was transferred to the nursing facility to recover and receive care for her other diagnoses that included anemia, renal insufficiency, and urinary incontinence.

Upon the woman's arrival at the nursing facility, the nurses noted a stage I decubitus ulcer on her sacrum, along with multiple skin

tears elsewhere. The ulcer was described as nonblanchable erythema of intact skin. As such, the staff decided to minimize pressure in the area, watch it closely, and report to the physician if it worsened. Sixteen days later, the redness doubled in size, so the staff notified the physician and treatment orders were obtained.

Throughout the following month, the wound worsened to a stage II ulcer, described as an abrasion. The nurses continued to update the physician and various treatment orders were initiated. Despite the nurses' best efforts, the wound refused to improve. One day, the woman's family took her on an eight-hour outing. When she returned to the facility, the nurse asked a family member if the woman's incontinence brief had been changed. The family member replied that

it hadn't. Overnight, the wound progressed to a stage III ulcer and an abscess began to form near the area. The woman soon became feverish, and her physician decided to send her to the hospital for debridement of the wound because none of the other treatments had helped. By then, two months had passed since the ulcer was first discovered.

During the surgical debridement, a large amount of foul-smelling, necrotic fascia and some muscle were removed from the wound. Afterward, lab reports revealed that the wound had been infected with MRSA. Two days later, the woman was transferred to the skilled nursing unit of the hospital for recovery. The woman slowly improved, but during the following month, she became nonresponsive in the midst of eating an evening meal. Several family members were present and they immediately summoned help. Unfortunately, the woman could not be resuscitated by the nurses and doctor on duty, who was also the medical director of the nursing facility. The death certificate stated that the woman died of an acute myocardial infarction, coronary artery disease, and cellulitis MRSA.

A year later, the woman's family filed a wrongful death lawsuit against the facility for negligent wound care that caused the decubitus ulcer to deteriorate so rapidly that it essentially taxed her heart, causing her death. The family felt that if the MRSA had been identified and treated sooner, the woman would still be alive. They asked for \$125,000 to settle the case.

In response, the facility maintained that the development and progression of the decubitus ulcer was unavoidable and it did not cause the woman's death. A physician expert conceded that the ulcer should have been reported to her physician immediately upon discovery. However, the physician probably would not have initiated treatment until it worsened and became a stage II. Once that occurred, the staff remained in constant communication with the physician and together they attempted various treatments to no avail. Given the woman's history and condition upon entering the facility, there is no evidence that the decubitus ulcer could have been prevented or healed. The woman suffered from many stressors on her body that existed before her admittance to the nursing facility, including:

- iron deficiency anemia;
- renal insufficiency that limited the amount of protein in her diet due to danger of renal shock that could shut down her kidneys;
- the previous infection in her hip that suppressed her already compromised immune system; and
- multiple skin tears that indicated an inability to keep up with protein needs.

In summation, the nursing facility staff and her physician did what they could do to treat the unavoidable ulcer. But in the end, it became one of many stressors that collectively caused her heart to stop. A settlement was reached for a fraction of the amount asked.

Protecting Your Residents and Facility

In this case, the facility staff and physician should have suspected that they were dealing with a MRSA infection when the decubitus ulcer did not improve (despite interventions) and from the mere fact that the woman was a known carrier. Had they obtained a swab culture from the wound and confirmed its existence sooner, would that have made a difference in her treatment and outcome? No one can be sure, but the experts were not optimistic, based on her overall health. One thing is for sure, had they taken those actions through an effective infection control program, it would have lessened the likelihood of negligence allegations later on.

To protect your residents and facility from a similar crisis, please review the following infection control precautions.

1. Designate an infection control person (ICP) to coordinate the facility's infection control processes. The ICP should be knowledgeable about federal, state, and local regulations dealing with infection control in order to conduct the program in compliance with these regulations. The ICP should have specific infection control training, well-defined support from administration, and the ability to interact tactfully with personnel, physicians, and residents. Specific training courses for the ICP can be obtained through the Association for Professionals in Infection Control and Epidemiology (APIC) at (202) 296-

2742 and the Nebraska Infection Control Network at (402) 552-2360.

2. Some APIC guidelines for an effective infection control program include:

- **Surveillance.** Routinely collecting and analyzing data from various sources (e.g., chart reviews, nursing staff, lab reports, etc.) to compare with standard written definitions (criteria) of infections to identify the infection and to establish baseline rates, track progress, determine trends, and so on.
- **Outbreak control.** Early detection and prevention is the best way to avoid outbreaks. When the number of cases exceeds the baseline, an outbreak should be considered. Even a single case of tuberculosis (TB) or MRSA should trigger an evaluation. The BD GenOhm™ blood test can identify the source of a staph infection in only two hours (rather than the traditional wait of more than two days for test results), allowing for more effective diagnosis and treatment of MRSA. Facilities should develop a policy for obtaining prospective consent that gives the medical director the power to act in an infectious disease outbreak in the event of an emergency crisis.
- **Policies and procedures.** Facilities should continuously update their policies and procedures to reflect changes in regulations and guidelines, as well as facility practices.
- **Education.** Information should be provided to personnel on disease transmission, hand-washing, barrier precautions (e.g., wearing gloves and gowns), and basic hygiene. Direct-care staff should receive additional training on early problem or symptom recognition. Training should be conducted upon orientation, annually, and as needed.
- **Resident health program.** This is to ensure vaccines, immunizations, and TB testing are addressed accordingly and properly recorded in the resident's record. Other resident care practices that should be addressed include prevention of aspiration, skin care, prevention of urinary tract infections, and oral hygiene.
- **Employee health program.** Ensure that vaccines, immunizations, and TB testing for staff also are addressed and recorded

accordingly. Employee health policies should address post-exposure follow-up or prophylaxis for certain infections such as HIV, HBV, TB, and scabies. Protective equipment should be readily available to staff, according to OSHA regulations. Providers should prohibit employees with communicable diseases or infected skin lesions from direct contact with residents and their food.

- **Antibiotic monitoring.** This should be done to determine the appropriate use of antibiotics and to identify any resistance pattern that may develop. Since the transfer of MRSA residents between hospitals and nursing homes is problematic,

providers should meet with their medical director to develop an institutional strategy for control of the resistant organisms based on local considerations.

- **Disease reporting and other functions.**

This includes visitation, food handling, pest control, laundry, waste disposal, and other environmental issues.

3. The infection control committee functions should meet regularly to review infection control data and policies, and to monitor program goals and activities. Records of these meetings should be kept.

By heeding these precautionary measures,

you can protect your residents and facility now and into the future. ■

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The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk management issues. For more information, phone (877) 448-4331, ext. 5175, e-mail slc@guideone.com, or visit www.guideone.com. To send your comments to the author and editors, e-mail williams0208@nursinghomesmagazine.com.