Featured
Challenge Scenario

TAG
F441

TOPIC
Facility Establishes Infection Control Program

SCENARIO
In this scenario, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. The facility also failed to develop, implement and educate staff on infection control practices. Could this happen at your facility?

For additional details related to this scenario, see page 2

What actions would you and your staff members take to prevent this from occurring in your facility?

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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Based on observation, record review and staff interview, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection for 10 of 17 residents. The facility failed to develop, implement and educate staff on infection control practices.

Staff used one electric razor to shave multiple residents without cleansing and disinfecting the razor between residents. On more than one occasion, staff noted blood on the razor and proceeded to wipe it off without disinfecting the razor. One resident was noted to have MRSA in his nostrils.

In addition, the facility failed to ensure that glucose meters were cleaned between each resident’s use by three nurses on three of four units.

This is evidenced by:

The Policy and Procedure for Use of Electric Razor, Safety Razor documented that residents receiving anticoagulant medications were required to use an electric razor. A facility-owned electric razor was to be cleaned prior to use by rinsing the razor head in cold water or a new razor head could be obtained.

Review of the Infection Control Current Infection List documented that resident #144 was on contact precautions due to being found positive for MRSA in the nostrils.

During an interview, CNA #1 stated that she purchased an electric razor for the residents. She kept the razor in her personal locker at the facility and used it to shave the five male residents to whom she was assigned. She stated that some of the other CNAs also had brought in electric razors and that these razors were shared among various residents. CNA #1 stated that she cleaned the razor between residents by shaking the whiskers out then used a brush to finish cleaning the razor. CNA #1 stated she would use an alcohol wipe to remove blood when it was seen on the razor.

During an interview, CNA #2 stated that CNA #1 had an electric razor that she had brought in from home for use with residents on the floor. She said that if a resident’s razor was missing or not working, she occasionally used the “community razor” for her residents. She stated that she could not recall which day it was, but earlier in the week she shaved this resident and somehow the resident received some nicks on his face. She stated that there was blood on the razor but she wiped the blood off with a paper tissue prior to using it on another resident.

During an interview with the Infection Control Registered Nurse (RNIC) and the DON, they stated that they were not aware that the CNAs were sharing an electric razor between residents. They stated that it was inappropriate to share a razor between residents because it needed to be disinfected between residents and not just cleaned. They said that using an electric razor with this resident, who had tested positive for MRSA, and then using it on other residents without disinfecting the razor, put the other residents at risk for getting MRSA. This resident was due for a follow-up culture after being treated for the MRSA, but the culture had not yet been obtained.
During observation of the medication pass on Unit 3, licensed practical nurse (LPN) #3 was observed to perform a glucose finger
stick with the facility's glucose meter on resident #193. The LPN did not clean the glucose meter prior to placing it back in the
drawer of the medication cart.

During observation of the medication pass, LPN #4 was observed to have performed a glucose fingerstick on residents 144,
142 and 131 using the same glucose meter. The glucose meter was not cleaned after use or before it was used for each resident.

During an interview, LPN #4 stated he did not clean the glucose meter after each resident's use and he was not aware of any
policy or procedure for cleaning the glucose meter.

During an interview, the DON stated that the glucose meters should be cleaned and disinfected between each resident's use
and also should be cleaned after each use before placing the glucose meter on the medication cart and/or in the drawer of
the medication cart.