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TAG

F441

TOPIC

Have a program that investigates, controls and keeps infection from spreading

SCENARIO

In this scenario, the facility failed to ensure that it established and maintained an infection control program designed to provide a safe, sanitary and comfortable environment. 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?

NOTES

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Topic: Have a program that investigates, controls and keeps infection from spreading ***(continued)***

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NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observations, record review, and interviews during a standard and extended recertification survey, the facility failed to ensure that it established and maintained an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for two (2) of two (2) units reviewed for wound care. Specifically, the facility failed to ensure that licensed facility staff followed recognized infection control practices (e.g., hand hygiene, use of standard precautions) for the prevention of cross contamination while providing wound care for three residents (#11, #25 and #61). This is a repeat deficiency from the recertification surveys conducted on 5/30/13.

This resulted in Immediate Jeopardy to the resident health and safety as evidenced by the following:

An undated Policy and Procedure titled Standard Precautions/Contact Precautions documented to wash hands after touching blood, bodily fluids, secretions, excretions, and contaminated items whether or not gloves are worn. It documented to wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid the transfer of microorganisms to other patients or environments, and that it may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

An undated Policy and Procedure titled Infection Control documented that hands should be washed before and after resident contact and after removing gloves. It documented that gloves must always be used as an adjunct to and not a substitute for handwashing.

An undated Policy and Procedure titled Dressings, Dry /Clean documented to wash and dry hands thoroughly and put on clean gloves. It documented that after removing old dressings, a glove should be pulled over the dressing and discarded into a plastic or biohazard bag. Hands should then be washed and dried thoroughly before applying clean gloves to clean the wound. It documented to clean from the least contaminated area to the most contaminated area. It documented to remove gloves and to wash and dry hands after the procedure.

Resident #25

The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) dated [DATE] documented the Brief Interview for Mental Status (BIMS) as 15 (cognitively intact).

Hospital and Community Patient Review Instrument (H/C-PRI) dated 11/5/14 documented a Stage 4 decubitus (pressure) ulcer in the sacral area, a Stage 4 pressure ulcer on the left buttock, contact precautions-MRSA (Methicillin-resistant Staphylococcus aureus) wound, VRE ([MEDICATION NAME]-resistant [MEDICATION NAME]) in the urine, and [MEDICATION NAME] (antibiotic) 500 mg po (by mouth) bid (twice daily) for VRE, MRSA, and wounds.

There was no documented evidence in the Comprehensive Care Plan that the resident had VRE and MRSA and was on contact precautions.

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An undated Policy and Procedure for Infection Control documented that residents with superbugs (MRSA, VRE) will be placed on contact precautions. In addition, these residents would be placed in private rooms. It documented that Personal Protective Equipment (PPE) such as gowns, goggles, or masks should also be used in addition to gloves if contact with the resident's source of infection was expected.

A Resident Physical Assessment Admission/Re-Admission/Transfer form dated 11/6/14 documented that the resident has VRE in urine, and MRSA in wounds.

A Wound Assessment/Notification Form dated 11/6/14 documented left hip/buttock unstageable 6 cm x 3 cm x 0.5 cm with yellow slough, flank near colostomy stage II 3.5 cm x 0.5 cm x 1 cm, and abdominal midline surgical incision 9 cm x 3 cm x 1.2 cm.

A Daily Routine Card (used by caregivers to provide care) dated 11/6/14 documented precautions for VRE in urine and MRSA in wounds.

A Comprehensive Care Plan (CCP) for Skin Impairment dated 11/6/14 documented a Stage III pressure ulcer on the left medial buttock, an unstageable pressure ulcer on the left hip, a surgical wound on the abdomen, and two open areas on the right side related to surgery.

A Physician order [REDACTED] contained instructions to apply [REDACTED] to old drain site right flank one time a day and prn (as needed) after cleanse with wound cleanser, and cover with one 2x2 (gauze) and abd (abdominal) pad. A second Physician order [REDACTED] with instructions to apply REDACTED] to posterior old drain site right flank one time a day and prn after cleanse with wound cleanser, and cover with 2x2 and abd pad. A third Physician order [REDACTED] contained instructions to apply REDACTED] to abdomen one time a day after cleanse with wound cleanser, and cover with 4x4 (gauze) and lge (large) bordergauze.

A Wound Tracking Flow Sheet dated 12/23/14 documented an unstageable pressure ulcer on left hip and a Stage III pressure ulcer on the left medial buttock.

A Weekly Wound (Non-pressure)/Skin Condition Report dated 12/23/14 documented an abdominal incision, an old drain site on the right flank and an old drain site posterior to right flank.

An observation on 12/30/14 at 7:30 a.m. of the Registered Nurse-Nurse Manger (RN-NM) during wound rounds found that the RN-NM did not wash her hands before donning gloves and gown prior to entering this resident's (who was on contact precautions) room. During the observation of the abdominal wound dressing change on 12/30/14, the RN-NM was observed using the same pair of gloves to remove the existing abdominal wound dressing and to cleanse the wound with wound cleanser. The RN-NM removed her gloves, did not wash her hands, and with un-gloved hands applied wound gel via an applicator bottle to the abdominal wound. The RN-NM left the room to get normal saline from the unit's clean treatment cart located in the hallway to the right of the resident's room. The RN-NM did not wash her hands, nor did she remove the protective gown prior to leaving the resident's room. The RN-NM re-entered the resident's room, did not wash her hands and donned sterile gloves. The RN-NM

applied the normal saline to the sterile gauze, placed the gauze on the abdominal wound, and then measured the wound using the ruler that is on the outside of a cotton swab wrapper. The RN-NM removed her gloves, did not wash her hands, and then donned non-sterile gloves.

During the continued observation of the right flank dressing changes, the RN-NM removed the existing dressings covering the right flank (side) surgical drain sites and cleansed the wounds with wound cleanser without changing gloves. The RN-NM measured the wounds using the same cotton swab wrapper, applied the wound gel via applicator bottle, removed the gloves, did not wash her hands, and donned sterile-gloves. The RN-NM placed sterile gauze over the wounds, removed her gloves, did not wash her hands, and covered the wounds with an abdominal pad and tape using ungloved hands. The RN-NM left the room to get Santyl from the unit's clean treatment cart that was outside of the resident's room. The RN-NM did not wash her hands, nor did she remove the protective gown prior to leaving the resident's room.

The RN-NM re-entered the resident's room, and did not wash her hands. During the left hip/buttock and left medial dressing changes, the RN-NM measured the wound using the same cotton swab wrapper and measured the inside of the wound bed for tunneling using a cotton swab with ungloved hands. The RN-NM donned a pair of gloves without first washing her hands. The RN-NM packed the left medial buttocks with gauze dressing and then, without changing gloves, applied Santyl to the left hip/buttock wound, covered the wound with sterile gauze, and removed her gloves. The RN-NM did not wash her hands, and applied a protective dressing over both wounds with ungloved hands. Without washing her hands, the RN-NM put some wound care supplies in the resident's night stand and then brought the remainder of the supplies outside of the resident's room. The RN-NM did not remove the protective gown, nor did she wash her hands prior to leaving the resident's room; the surveyor did not see where RN-NM went as surveyor was removing isolation gown and washing hands when nurse exited room. When surveyor exited the room, the RN-NM was outside the room not wearing an isolation gown. The RN-NM stated that she washes her hands somewhere else because she doesn't want to touch anything in the resident's room.

During an interview on 12/31/14 at 1:55 p.m. with the RN-NM, the RN-NM stated that she knows that she forgot to do a few things during the dressing changes because she was nervous that she was being watched. RN-NM did not elaborate on the comment but was on her way to re-education for their infection control practice issues identified by surveyors.

Resident #11

The resident was admitted to the facility on [DATE], on antibiotic therapy, post surgical debridement of infected right trochanteric pressure ulcer, with [DIAGNOSES REDACTED].

The Minimum Data Set (MDS) documented the resident to have a BIMS (brief interview mental status) score of 9 (moderately impaired).

Review of the wound tracking sheets indicated the resident was admitted from the hospital on [DATE] with a Stage III pressure area to the R hip, and a deep tissue injury (DTI) to the right heel present on admission. The date of origin was documented as unknown.

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The intervention for the right hip documented a Negative Pressure Wound Treatment [DEVICE] set at 125 mm/ hg continuous.

On 12/12/2014, wound tracking sheets were started for new Stage II areas on the inner and outer right buttock. On 12/16/14, a Stage II area developed on the left buttock.

Observation of the dressing changes on 12/30/2014: The URN (unit registered nurse), without washing her hands, put on clean gloves and positioned the resident on his left side to prepare for the dressing change to the wound site on the right hip. The vacuum pump dressing was removed and the tubing was taken out of the wound site. The URN coiled the tubing in her gloved hand, then picked the vacuum pump off the floor with the soiled gloves and placed the vacuum pump on the bed to remove the dirty canister (container to hold drainage removed from the wound with negative pressure). She then took the canister into the bathroom. The URN returned to the bedside and put on clean gloves; the wound was exposed and foam packing from the wound had to be removed. The packing was removed and some of the foam from the wound fell on to the bed. The URN, without washing her hands, changed gloves, which she pulled from her pocket, and proceeded to start preparing the dressing for the wound. The URN rinsed the wound site and decided the dressing she pulled for the wound was the wrong size, then left the room and went to the unit's clean treatment cart for 2 x 2s. There were no 2 x 2s on the cart. The DON (Director of Nursing) entered the room at that time with the 2x2's, and placed the packages on the bed. The URN then proceeded to rinse the wound bed wet the dressing, placed the dressing in the wound bed and covered the wound with [MEDICATION NAME]. The URN then proceeded to clean and dress the buttock wounds.

During an interview with the URN at approximately 2:30 p.m. on 12/30/14, she was asked why she placed the dirty vacuum container on the resident's bed to empty the canister. She stated she did not even realize that she had done that. The URN was then asked if she had pulled the gloves she used from the box on the treatment cart, she stated no, she keeps a supply in her pocket as she is always changing gloves.

During the interview with the DON on 12/30/14, she stated that the facility did not have a policy on sterile /clean dressings for the wound vac system until today, 12/30/14. Additionally, the DON stated that the URN should have washed hands/changed gloves and by not doing so, she cross contaminated the wounds.

During an interview on 12/30/14 at 3:30 p.m. the Infection Control Nurse (ICN) stated that there were many breaks in infection control. The ICN stated that staff should have done handwashing before and during the dressing change, as well as changing gloves.

Resident #61

The resident was admitted to the nursing home on 1/4/13 with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) dated [DATE] assessed the resident as having moderately impaired cognitive skills for daily decision making. It documented that the resident usually understood and was usually understood by others.

During an observation of a Negative Pressure Wound Treatment (wound vac) for Resident #61 on 12/29/14 at 10:25 a.m., the surveyor noted that the wound vac was on the night stand with part of the drainage tubing resting in the resident's bed pan that was also on the night stand.

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During a dressing observation on 12/29/14 at approximately 10:45 a.m., the DON donned gloves without washing her hands to remove the dressing from the resident's posterior left hip wound that was applied by LPN (licensed practical nurse) #1. She opened a new wound vac set up on the overbed table without cleaning the surface, applying a barrier, washing her hands or changing gloves. The DON then removed the soiled dressing while wearing the same gloves, went to the bathroom, retrieved a paper towel out of the holder, and handed it to the CNA (certified nursing assistant) to document the wound measurements on. The CNA removed her gloves and put the paper towel on the overbed table next to the opened wound vac supplies to document the measurements that the DON called out. The DON then picked up the new sponge with her soiled gloves, opened the night stand drawer and removed a pair of scissors and cut the sponge. Without changing gloves or cleansing the wound, the DON placed the sponge in the deep portion of the wound, then cut another piece and placed it on the top portion of the wound. While the DON was getting the clear adhesive dressing, the top piece of foam fell from the hip wound onto the resident's linens that were soiled with serosanguinous drainage. LPN #1, who standing in front of the resident and holding the resident over toward her during the procedure, picked up the sponge from the bed with her soiled gloves and placed it back in the wound. During this time the DON was holding the clear dressing and telling the LPN which way to put the dressing because the LPN was in front of the resident and did not have a good sight line as to where the wound was. The DON then covered the sponge with the clear covering and then reconnected the new tubing from the wound to the tubing that was attached to the vacuum and partially in the resident's bedpan. The DON removed her gloves and, without washing her hands, picked up a single use bottle of saline that was also on the night stand, next to the bedpan, opened it and when she saw that the seal was still intact under the cap, she recapped the saline and placed it back on the stand for future use. Additionally, the DON used her ungloved hands to remove the soiled bed linens.

During an interview on 12/30/14 at 11:15 a.m. the Infection Control Nurse (ICN) stated that there were many breaks in infection control. The ICN stated that staff should have done handwashing before and during the dressing change, as well as changing gloves. The scissors should not have been taken out of the drawer and used to cut the foam dressing, and when the foam dressing dropped on the soiled linens it should have been discarded and not placed back in the wound.

During an interview on 12/30/14 at 1:40 p.m., the DON stated she should have washed her hands during the procedure and that she probably should have cleaned the scissors prior to using them. The DON further stated that she did not see the LPN pick up the sponge and thought that she did remove her gloves once because she left the room to get the doctor. Additionally, the DON stated that she should not have used bare hands when handling the resident's soiled bed linens.