# The Legal Cost of Getting Infection Prevention and Control Wrong

Phil Barnes, Associate

Anthony Collins LLP

Anthony Collins solicitors

# What Are Healthcare Associated Infections?

- Infections acquired as a consequence of receiving medical care and treatment e.g
  - Methicillin resistant *Staphylococcus aureus* **(MRSA)**
  - *Clostridium difficile* **(C.diff)**
  - Panton-Valentine Leukocidin associated *Staphylococcus aureus*
  - Vancomycin resistant enterococci (VRE)
  - Glycopeptide resistant enterococci (GRE)

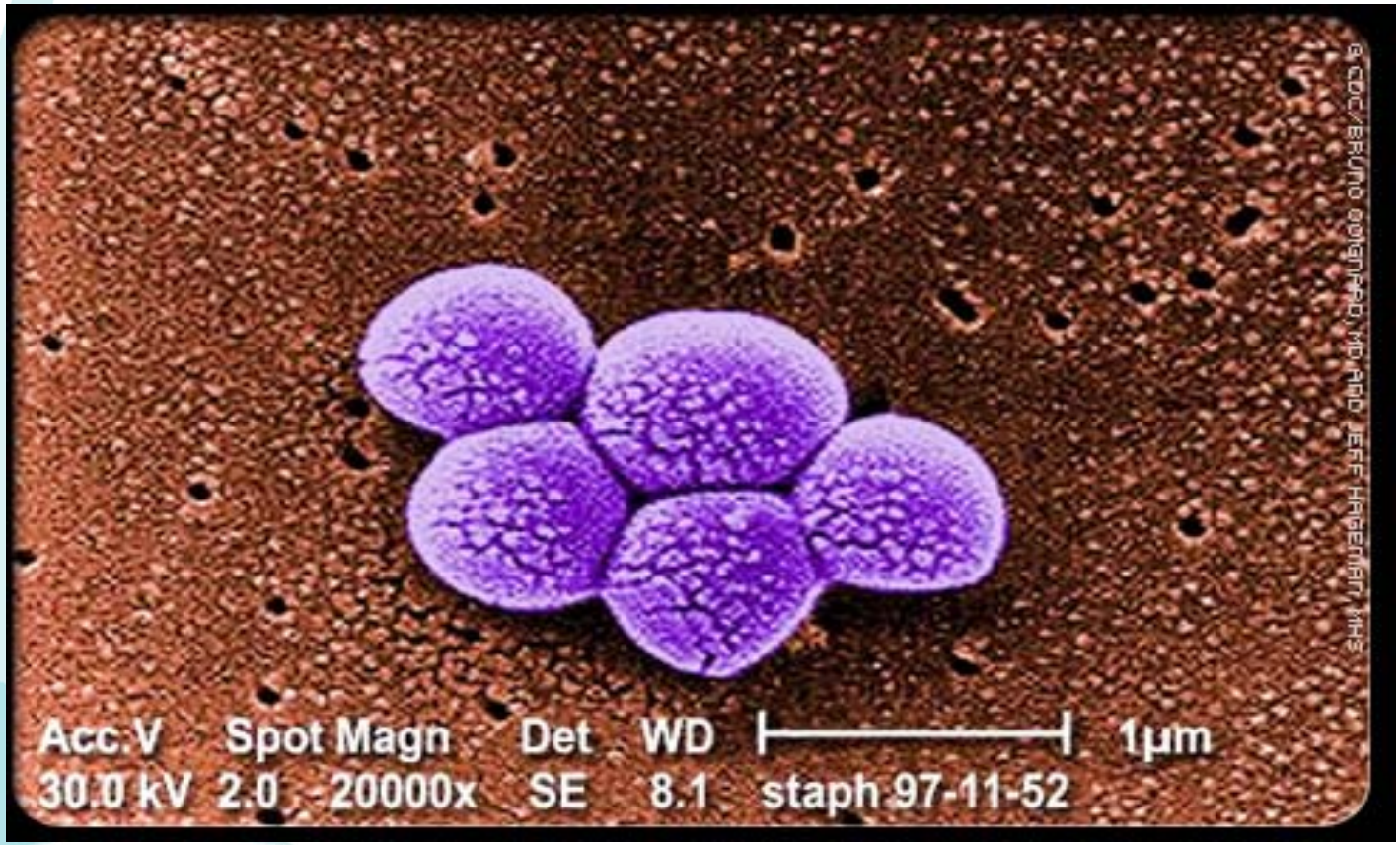
# MRSA – The Facts

- 30% of the general population are colonised with *Staphylococcus aureus*
- *Staphylococcus aureus* is commonly found in the:-
  - Nose
  - Throat
  - Skin
  - Axilla (armpit)
  - Groin
- *Staphylococcus* aureus - developed resistance to Beta lactam antibiotics (MRSA)

# MRSA – The Facts

## (magnified 20,000 times)

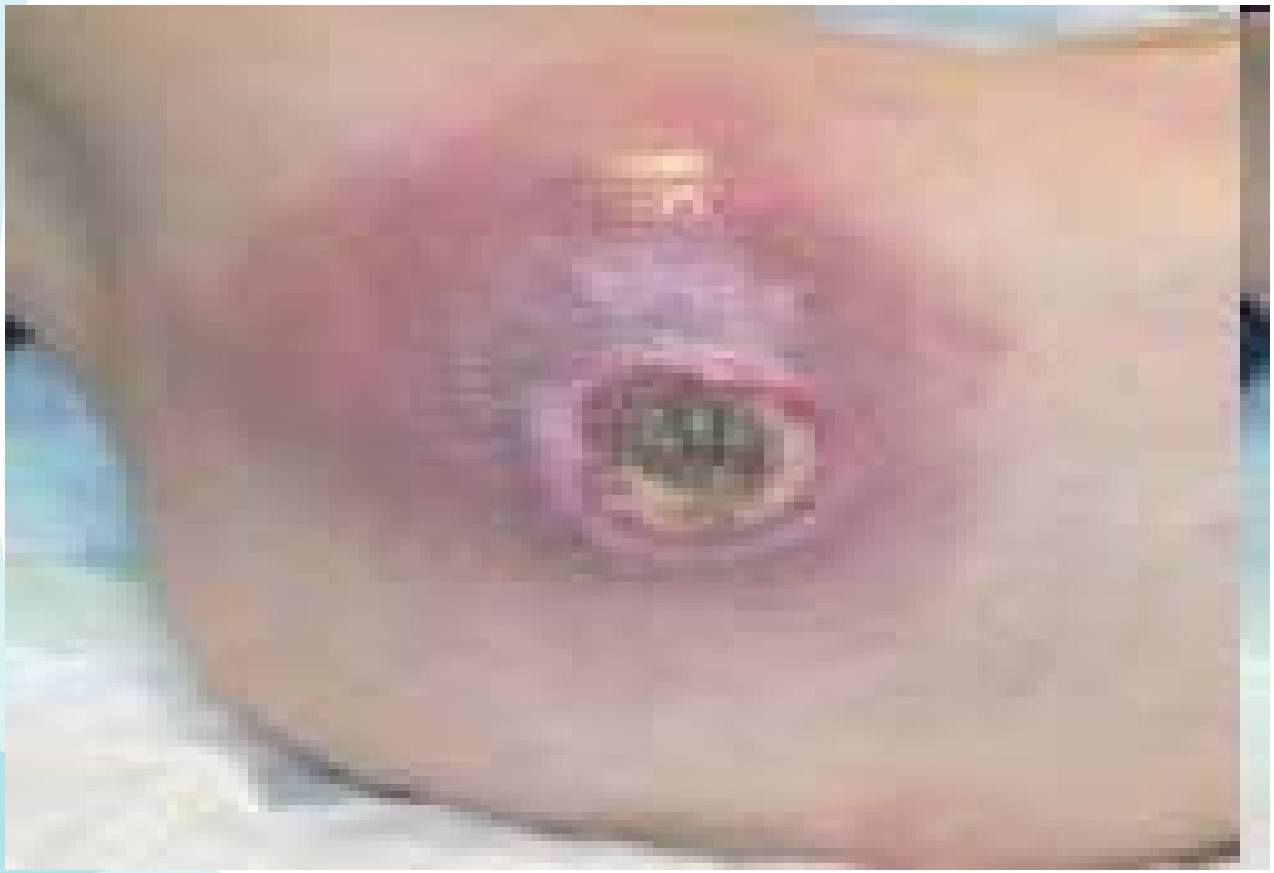
(Source: WebMD Medical News: "MRSA: Experts Answer Your Questions)



# MRSA – The Facts

- Transmitted by hand
- Environment in dust and on surfaces
- Mandatory surveillance of MRSA bacteraemia in England since April 2001
  - **April 2007 to March 2008 – 4,448 reported cases of MRSA bacteraemia in England**
- Number of patients "colonised" with MRSA or with wound infections in England is not recorded
- Office of National Statistics reported **6,201** deaths where MRSA reported on death certificates between 2002 and 2006

# MRSA Wound Infection





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# MRSA – The Facts

- Those most at risk of acquiring MRSA:
  - Patients with Open Wounds/Burns
  - Surgical Patients
  - **The Elderly and Infirm**
  - Newborn
  - **Patients with Long Term Health Problems e.g**
    - Diabetes, Cancer
  - **Patients with Urinary Catheters/ IV Lines**
  - **Patients with Skin Disorders**
    - Psoriasis, Leg ulcers

# *C.difficile* – The Facts

# *C.difficile* – The Facts

- Gram positive spore forming bacteria which is found in the intestinal tract of 3% of healthy adults.
- **Most prevalent in the Elderly and Infirm**.
- Transmitted from person to person by the faecal-oral route.
- Spores remain in the environment for long periods of time.
- Mandatory surveillance of *C.difficile* infection started in January 2004.
  - **In 2007 over 50,000 people aged over 65 were reported with *C.difficile***
- In 2007 in England and Wales there were **8,324** death certificates which mentioned *C.difficile*

# Cost of HCAI

- **Human Cost**
  - Pain, suffering, anxiety and depression
  - Permanent disabilities
  - Death

- **Treatment Cost**
  - NHS spends an estimate £1bn per annum
  - Costs 3 x more to treat patient with HCAI
  - On average an extra 11 days in hospital

- **Litigation Cost**
  - £7.5 million paid by NHS since 2007
  - Average payout of compensation £70,000
  - NHSLA £42 million fund

# HCAI Compensation Claims

- There are 2 types of claims:

1. **Negligent Treatment of HCAI**
   (i.e delay in diagnosing, delay in treatment, wrong treatment)

2. **Negligent Acquisition of HCAI**



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# Negligent Treatment of HCAI

Burden on the Claimant to prove on the balance of probabilities (51% or more) that the:

- Treatment or failure to treat HCAI was negligent **(Breach of Duty)**

and

- The negligence caused the injury and loss (**Causation**)

# Negligent Acquisition of HCAI

- To succeed the Claimant will need to prove on the balance of probabilities (51% or more) that:
  - The HCAI was acquired in the healthcare setting; and
  - Contracting the HCAI infection and resulting injury was foreseeable; and
  - Standard of Care was negligent (Breach of Duty); and
  - “But for” the negligence that he/she would not have contracted the HCAI and suffered the injury and loss (Causation).



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# Negligent Acquisition of HCAI

- The common allegations are:
  - Failure to screen the patient and identify colonisation and treat the colonisation;
  - Failure to isolate the patient from other patients colonised or infected with HCAI
  - Failure to follow infection control protocols and procedures
    - Hand washing protocols
    - Decontamination protocols
  - Failure to keep the environment clean

# Negligent Acquisition of HCAI

**Evidence**

- Witness evidence - Claimant, family, other patients
- Patient Records
- Copies of Infection Control Policies and Procedures
- Infection Rates
- Isolation facilities
- Staff Training
- Staffing levels
- Infection Control Compliance/Audit documents
- CSCI Reports/Inspections
- Expert Evidence (Nursing Experts, Microbiologists)

- **Proving contraction cases under the Common Law is difficult**

# An Alternative Approach


- HCAI e.g MRSA – an “acquired disease”
- COSHH – The Control Of Substances Hazardous to Health Regulations 2002
- Regulation 2(1) defines “Substances Hazardous to Health” to include “biological agents”. A “biological agent” is defined in the regulations as a “**micro-organism which may cause infection**” = HCAI
- Regulation 3(1) places a duty on the hospital to protect employees and “**any other person, whether at work or not”** (patients) from exposure to infectious substances



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# COSHH


- The duties on healthcare providers include:
  - Not to carry out any work liable to expose employees (and it is argued patients) to any substances hazardous to health unless he has made a suitable and sufficient **risk assessment**. (Reg6(1))
  - Ensure exposure of employees (and patients) to substances hazardous to health is **prevented** or where that is not **reasonably practicable, adequately controlled** (Reg7)

# COSHH


- It is not possible to eradicate MRSA from the healthcare environment and consequently the duty is to **reduce** the level of **exposure** to HCAI to the **lowest possible level** by taking **preventative measures** to include:
  - Producing and implementing s**uitable and sufficient Infection Control practices and procedures**
  - Ensuring staff and agency staff **compliance** with Infection Control practices and procedures
  - Screening
  - Isolation/segregation of infected patients

- Failure to implement and comply with Infection Control practices and procedures is a breach of COSHH

# COSHH


- Liability is easier to establish using COSHH
  - There is no requirement to prove foreseeability
  - The **burden is on the Defendant** to prove that the COSHH regulations were complied with. As opposed to a duty under the common law for the Claimant to prove on a balance of probabilities that there was a breach in the standard of care.
  - The "**causation test**" is arguably the "**material increase in risk**" test and not the more stringent "**but for**" test.

# Cases

- The applicability of COSHH to MRSA cases has not been properly considered by the Courts.
- "**Kitty Cope v Bro Morgannwg NHS Trust (2005)** (COSHH argued –Claim settled out of Court for an undisclosed sum)
- **Ndri v Moorfields Eye Hospital NHS Trust (2006)** – (Failed Judge ruled COSHH not apply)
- **Elizabeth Miller v Greater Glasgow NHS Trust** (Scottish Case) (Ongoing – COSHH could apply?)

# Cases

- **Joanne Baumber (As Personal Representative of The Estate of Joan Staples, Deceased) v United Lincolnshire Hospitals NHS Trust (2006)**
  (Settled – £30k COSHH argued)

- **R v Wrightington, Wigan & Leigh NHS Trust (2007)** – Settled out of Court £30K COSHH not argued)

- **Lesley Ash v Chelsea and Westminster Hospital (2008)**
  (MSSA failure to treat case. Settled out of Court £5million)

# HCAI Prevention and Control

- **NHS Bodies -** Health Act 2006 – Code of Practice for the Prevention and Control of Healthcare Associated Infections (The Hygiene Code)
  - Compliance with Code legal requirement.
  - Monitored by Healthcare Commission - publishes annual reports
  - Failure to comply - Improvement Notices, negligence claims
- **Care Homes** – "The Infection Control Guidance for Care Homes" (DoH)
  - Good Practice Guidance
  - Monitored by Commission for Social Care and Inspection
  - Failure to comply - negligence claims
- **Care Quality Commission** (1 April 2009)

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