The Legal Cost of Getting Infection Prevention and Control Wrong

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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
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
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).
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
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)
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 **suitable 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)


• 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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