Legal Issues Column

By Janet K. Feldkamp, JD, RN, LNHA

Clostridium difficile Infections Can Hit Facilities in the Gut, Too

Health care-associated infections can be costly to skilled nursing facilities. Hospital and skilled nursing facility fees for care of this illness have been targeted by regulators as areas of concern and restriction. Already, hospitals stays related to certain infections are no longer reimbursed by Medicare. Providers are also experiencing the sting of lawsuits brought by patients who developed *Clostridium difficile* infections or by their families.

No one wants to hear that a family member has acquired a dangerous or even merely unpleasant case of diarrhea. However, the rapid increase of *C. difficile* remains a common cause of significant morbidity and mortality among hospitalized patients and residents in long-term care facilities. So significant is the issue that the Centers for Disease Control and Prevention (CDC) has distributed specific informational materials on stopping *C. difficile* in those settings. While the health care community blames much of the *C. difficile* problem on bacterial resistance from antibiotic overuse, the public is resistant to having practitioners limit the prescribing of these drugs. The reduction in antibiotic use should be only one aspect of an aggressive plan to prevent *C. difficile* infection in settings.

The CDC has estimated that 14,000 Americans die each year from *C. difficile.* Others have put the figure as high as 30,000, pointing out that the CDC strictly reviews death certificates, which may not list *C. difficile* as a cause of death.

Probably more than 90% of these deaths occur in individuals over 65 years of age. Especially in recent years, as the organism has increased in virulence, *C. difficile* has raised alarms in acute-care and LTC facilities, both being where the diarrheal illness can spread easily. These infections, one-quarter of which are identified in the hospital settling, cost Americans approximately $1 billion dollars in additional health care costs each year.

The courts have also become venues for worries about *C. difficile.* A Texas trial court awarded the family of a nursing home resident $750,000 in a wrongful death action related to an infection in rehabilitation patient Gladys Robins (Health Care of Nashville vs. Robins, Court of Appeals of Texas, First District Houston). The chain of events began when she fell in a grocery store and fractured her hip. After hospitalization for surgery, she was admitted to Mariner Health Care of Nashville nursing home, with some loss of skin integrity noted.

During her stay there, her skin wounds devolved to stage 3 and stage 4 pressure ulcers. The plaintiff's physician expert testified that the LTC facility failed to implement a documented control program for *C. difficile* and that one of Ms. Robins's pressure ulcers was negligently contaminated with *C. difficile* by fecal soiling. Although the verdict was reduced from $750,000 to $250,000 through a Texas cap on noneconomic damages, the case points out the importance of a fully implemented infection-control program.

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A New York malpractice case involving *C. difficile* was ultimately dismissed, but it illustrates that attorneys are representing patients who receive multiple courses of antibiotics and then develop resistant infections. As a prophylactic measure, an orthopedic surgeon treated a 78-year-old man with a course of antibiotics prior to elective hip replacement. The patient became infected with *C. difficile* and died after an LTC stay, and both the surgeon and the facility were sued (Noler vs. NYU Medical Center for Joint Disease, New York Supreme Court, New York County).

A 2012 Ohio nursing home negligence action continues in court at this time (Wood vs. Harborside Health Care, Court of Appeals of Ohio, Eight District, Cuyahoga). The plaintiffs allege that 87-year-old nursing home resident Frank Wood developed a *C. difficile* infection because of negligence by the home following his hospitalization for a knee replacement. While the case has some complicated procedural issues, the allegations are not uncommon. Here, they relate to the failure of the facility to promptly notify a physician about Mr. Wood's diarrhea and administration of inappropriate medications to a patient exhibiting signs of *C. difficile* infection.

Another risk to facilities is identified in a 2009 workers' compensation case in Missouri. Barbara Vickers was employed in the laundry area of the Missouri Veterans Home and became ill with a *C. difficile* infection that resulted in removal of a significant portion of her colon. Her claim was initially denied, but the Court of Appeals ultimately overturned that decision (Vickers vs. Missouri Department of Public Safety, Missouri Court of Appeals, Western District). It was determined that Ms. Vickers was exposed to *C. difficile* in her nursing facility work environment and probably contracted the infection there.

In the same vein, the Centers for Medicare & Medicaid Services (CMS) on Jan. 25 issued a memo (S&C: 13-09-NH) to surveyors providing guidance on infection control. The memo clarifies the requirements of F tag 441 relating to infection control and highlights the importance of handling linens in a way that prevents the spread of infection.

CMS issued the guidance to account for recent changes in laundry equipment and cleaning agent technology. Washing linens above 160°F or at a lower temperature but with a chlorine rinse is recommended to destroy microorganisms. Facilities may use the laundry detergent of their choice as long as they carefully follow manufacturer's instructions regarding processes and equipment. Linen handling must prevent cross-contamination, and laundry workers must be provided equipment that protects them from infection.

With the increasing virulence of *C. difficile* and the continuing climb in deaths from infection, the LTC community must take action to avoid allegations such as failure to appropriately notify a physician of symptoms, failure to appropriately treat diarrhea, failure to implement an effective infection-control program, and failure to prevent contamination of wounds by fecal material.

The CDC, CMS, news media, residents, and families are focusing on the prevention of significant morbidity and mortality from *C. difficile.* Facilities and their medical directors should implement appropriate treatment protocols and infection control programs. Malpractice cases and negative verdicts are likely to increase if the number of *C. difficile*–related deaths continues to go up. Proactive facilities will focus on implementing the protocols and processes to prevent all health care-associated infections and to identify and promptly treat *C. difficile.*

This column is not to be substituted for legal advice. The writer, Janet K. Feldkamp, *practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.*

Medical Expert Perspective

This piece brings up some interesting issues of litigation involving multidrug-resistant organisms (methicillin-resistant *Staphylococcus aureus,* vancomycin-resistant enterococcus, *Clostridium difficile*), which we can probably expect to see more of.

Remember that for plaintiffs to prevail in a civil lawsuit, they need to show – to a reasonable degree of medical probability or certainty (meaning "more likely than not") – that the negligent act caused the bad outcome. In the case discussed here, in my opinion, it would be difficult to prove that the resident would not have contracted the infection had the facility implemented and followed a *C. difficile*–control regimen.

But clearly, the plaintiffs would have had a medical expert testify that the lack of such a program caused the infection. And whether or not that's true, every facility should have solid infection-control policies.

A more valid theory for the cause of most *C. difficile* infections is that a negligent act (e.g., an avoidable pressure ulcer that got infected) required antibiotic therapy, which in turn caused or substantially contributed to the development of *C. difficile* infection. In this scenario, it's pretty clear that if the patient had not been given the antibiotic, he or she would not have gotten *C. difficile*.

I've also seen lawsuits arguing that urinary tract infections are caused by bad catheter care. While that is certainly possible, I don't think it's a reasonable medical probability, considering that virtually every patient with a Foley catheter gets an infection eventually, regardless of the quality of the care. What's more, asymptomatic bacteriuria is often called (and treated as) a urinary tract infection.

Along those same lines, if a patient gets a Foley catheter because of an avoidable pressure ulcer and then dies from a urinary tract infection, I believe that is a wrongful death. If the patient had not developed the pressure ulcer, he or she probably would not have died from the urinary tract infection.

In any event, the lesson here is well taken: Make sure your infection-control policies are up to date and that they are followed.

—Karl Steinberg, MD, CMD, Editor in Chief