How the Nursing Staph Let Me Down

By Lynn Serra RN, BA, MBA

Background

You cannot pick up a paper or turn on the television news lately without finding something about methicillin-resistant Staphylococcus aureus (MRSA), the “super bug”. Consumer advocates state and early evidence suggest that this super bug kills more Americans than AIDS. Recent studies found that over 90,000 Americans each year are infected by MRSA.

Those of us who work in the healthcare field have always been aware of nosocomial infections and our role in creating them. Essentially, we have been over confident that we, as individuals, have never caused such an infection. Of course, this is the perfect example of living in denial.

Now let us extend that reality. Studies are now being done on community acquired-MRSA or CA-MRSA. In June 2007 the CDC published *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007*. This document goes beyond the inpatient settings and for the first time discusses home health and hospice settings along with ambulatory care, free-standing specialty care sites, and long-term care.

The CDC recognizes that healthcare delivery is transitioning to outside acute care facilities. In fact, the term “nosocomial infections” is being replaced with “healthcare-associated infections” (HAI).

Even with the emergence of new pathogens Standard Precautions remains the best technique for preventing HAI. However, nurse staffing levels and composition plus an organization’s safety culture play important roles in the adherence to this standard. Another significant factor has proven to be a nurses’ tenure in his/her position, as **the more tenured nurse is more likely to break technique**.

Personal Experience

As I reflect on my recent experiences as a patient in the healthcare arena I flash back to being a student nurse. I remember in nursing school that every student **knew** they had each and every disease process the class was studying at that time. I then fast forward to the present, as I have just read the CDC document and am going through some “I’ve turned 50” healthcare screenings.

Three years ago I moved about 100 miles away from my primary doctor’s office. So, trying to be efficient, I schedule a physical with my primary doctor, a pap smear, a mammogram, and an appointment with a gastroenterologist on the same day and a colonoscopy for the following morning.

Everything went smoothly on day one. I requested an order for a CA-125 (a test for a multitude of female disorders) during the physical and had the blood drawn on the same day.

Day two I reported to the out-patient surgical center. I was then taken to a room where the clinical preparation took place. I was met there by an RN. When I asked her how long she had worked there

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she proudly told me, “Eight years.” Part of the preparation was the placement of an IV. After looking at my hand the RN began making comments regarding how difficult it may be to place the catheter. I was surprised to hear this because in the past, when I needed an IV placed, I was always told what good veins I had. I suggested she insert the catheter higher; however, she stated that was not an option due to physician preference. She did not make an effort to ask the physician for an exception.

She attempted to start the IV in my left hand. After the needle was in she began pulling it partially out and them pushing in back in repeatedly. I asked her to stop “fishing”. The pain in doing that was too much for me and certainly unnecessary. She stated she had the vein and then it blew. She pulled out. She made another attempt using her “fishing” method again and this time was successful.

All of the above is only tangent to the fact that the **RN did not don gloves prior to the IV insertion.** And I am uncertain if she washed her hands. When I scanned the room I saw no sink, gloves, or waterless gel.

I slept through the colonoscopy and the results were as unremarkable as was the procedure for me. In the days that followed I received each of my test results which were normal except the CA-125. The result came back as a 78 which is well above the normal (0 – 35). An ultrasound was ordered as follow up.

Since there was no doctor contact involved in having an ultrasound I elected to have it done at a facility close to home. The test went well. The gel was cold.

When the results came back from the latest test it was obvious I needed even more follow up to rule out any cancer. A MRI was ordered. Again I looked to the closer facility as no physician contact was required.

I had never had a MRI before and was unaware of what to expect. Above all, I was not expecting to be escorted to a bus parked in the hospital parking lot for my test. I donate blood every eight weeks in a bus, why not have a MRI in a bus? I had blood drawn just prior to entering the bus, so the MRI was first run without contrast awaiting the blood results. After the blood results came back, I was backed out of the MRI tube and an IV was placed in my hand, a large syringe attached, and the contrast pushed in.

As I raised my head, with the pounding of the MRI still in my ears, I saw the RN (you guessed it) was starting the IV and pushing the contrast in without wearing gloves. I am sorry now that I forgot to ask him how long he was in his current position.

Conclusion

It is obvious to me following that experience that the average consumer of healthcare is unaware of Standard Precautions except when it comes to blood draws. I am certain that the only way consumers know about the protocol with blood draws is because of all the press coverage dirty needles and HIV/AIDS has gotten over the last couple of decades. Hopefully, now that the press is focusing on MRSA and other HAIs including CA-MRSA, the average consumer will have increased knowledge and be willing to demand proper precautions be taken.

Watch for the next month’s Pathfinder to find out the results of the MRI and the result of the two nurses not wearing gloves during the IV insertions.

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