Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

VERSION 01 JANUARY 2021

HOSPITAL ACQUIRED INFECTION

REVIEW TOOL- CONFIDENTIAL

(THE PURPOSE OF THIS REVIEW IS TO IDENTIFY WHAT HAPPENED, WHY IT HAPPENED AND TO IDENTIFY RECOMMENDATIONS TO REDUCE THE RISK OF SIMILAR INCIDENTS OCCURRING IN THE FUTURE. REVIEWS MUST BE CARRIED OUT IN LINE WITH THE HSE INCIDENT MANAGEMENT FRAMEWORK AND GUIDANCE: VERSION 2

PART A – CASE REPORT

(I) [CONSULTANT WITH PRIMARY RESPONSIBILITY FOR PATIENT CARE **OR NOMINEE** TO COMPLETE THIS SECTION]

NIMS REFERENCE NUMBER		HOSPITAL GROUP	
DATE REPORT COMPLETED		NAME OF ACUTE HOSPITAL	

DETAILS OF PATIENT	
BRIEF CLINICAL BACKGROUND:	

WARD(S) [THIS ADMISSION] (LIST ALL UNIT/WARDS IN CHRONOLOGICAL ORDER)	ADMISSION DATE	TRANSFER DATE IF APPLICABLE
	Click here to enter a date.	Click here to enter a date.
	Click here to enter a date.	Click here to enter a date.
	Click here to enter a date.	Click here to enter a date.

DATE OF ONSET OF THE CLINICAL SIGNS OF INFECTION?

DESCRIPTION OF INFECTION

(2) LABORATORY INFORMATION (TO BE COMPLETED BY SURVEILLANCE SCIENTIST OR MICROBIOLOGIST)

(3) CLINICAL ASSESSMENT OF LIKELY SOURCE OF INFECTION [MULTIDISCIPLINARY TEAM MEMBERS WITH RESPONSIBILITY FOR PATIENT CARE OR NOMINEE TO COMPLETE THIS SECTION]

ASSESSING IMPACT OF INFECTION		

(4) FACTORS RELATING TO THE ENVIRONMENT & EQUIPMENT [WARD MANAGER AND IPC TEAM TO COMPLETE]		
WERE THERE ANY DEFICIENCIES WITH THE WARD/UNIT ENVIRONMENT & EQUIPMENT INFRASTRUCTURE LIKELY TO HAVE CONTRIBUTED TO THIS EPISODE OF INFECTION?	YES☐	NO☐
IF YES PLEASE GIVE A BRIEF INDICATION OF ISSUES:		

(5) FACTORS RELATING TO STAFFING [WARD MANAGER TO COMPLETE]		
HAVE THERE BEEN ANY ISSUES IN RELATION TO STAFFING/SKILL MIX IN WEEK PRIOR TO ONSET OF THIS EPISODE OF INFECTION THAT ARE LIKELY TO HAVE CONTRIBUTED TO THE EPISODE OF INFECTION?	YES ☐	NO ☐
IF YES PLEASE GIVE BRIEF INDICATION OF ISSUES:		

(6) FACTORS RELATING TO POLICIES AND PROCEDURES [INFECTION PREVENTION AND CONTROL TEAM TO COMPLETE]		
DOES THE SERVICE HAVE RELEVANT LOCAL INFECTION CONTROL POLICY IN PLACE?	YES ☐	NO ☐
IF YES, IS THIS ACCESSIBLE TO ALL RELEVANT STAFF?	YES ☐	NO ☐
IS THIS POLICY IN LINE WITH CURRENT HSE GUIDELINES ON HEALTHCARE ASSOCIATED INFECTIONS?	YES ☐	NO ☐
(7) FACTORS RELATING TO STAFF TRAINING AND EDUCATION [WARD MANAGER AND CONSULTANT OR NOMINEE TO COMPLETE]		
IS HAND HYGIENE TRAINING UP TO DATE FOR ALL NURSING AND SUPPORT STAFF WORKING IN THE AREA? [WARD MANAGER]	YES ☐	NO ☐
IS HAND HYGIENE TRAINING UP TO DATE FOR ALL MEDICAL STAFF WORKING IN THE AREA? [CONSULTANT OR NOMINEE]	YES ☐	NO ☐
IS TRAINING ON APPLICATION OF INTRAVENOUS LINE CARE BUNDLES UP TO DATE FOR ALL NURSING STAFF?	YES ☐	NO ☐
(8) FACTORS RELATING TO COMMUNICATION [CONSULTANT WITH PRIMARY RESPONSIBILITY FOR PATIENT CARE **OR NOMINEE** TO COMPLETE]		
IS THERE EVIDENCE THAT THE PATIENT/ RELEVANT PERSON WAS INFORMED THAT THE PATIENT HAD AN HEALTHCARE ASSOCIATED INFECTION?	YES ☐	NO ☐
IS THERE EVIDENCE THAT THE PATIENT WAS INFORMED THAT THIS WAS A HOSPITAL ACQUIRED INFECTION AND GIVEN INFORMATION ON THE LIKELY SOURCE OF INFECTION?	YES ☐	NO ☐

PART B – REVIEW [CONSULTANT WITH PRIMARY RESPONSIBILITY FOR PATIENT CARE OR NOMINEE TO COMPLETE THIS SECTION]

(9) PLEASE INDICATE THE DECISION IN RELATION TO THE LEVEL OF REVIEW TO BE CONDUCTED

COMPREHENSIVE [PLEASE REFER TO HSE IMF]	YES ☐	NO ☐
CONCISE [PLEASE REFER TO HSE IMF]	YES ☐	NO ☐

WHAT IS THE STATEMENT OF FINDINGS REGARDING CAUSE OF THE INFECTION?

(*FINDINGS ARE GENERALLY EXPRESSED AS STATEMENT OF FINDINGS WHICH DESCRIBE THE RELATIONSHIPS BETWEEN THE CONTRIBUTING FACTORS AND THE INCIDENT AND /OR OUTCOME. THE STATEMENT FOCUSES ON THE CONTRIBUTING FACTORS AND SHOULD BE AS SPECIFIC AS POSSIBLE. THE SUGGESTED STATEMENT FORMAT IS AS FOLLOWS: THE CONTRIBUTING FACTOR(S), WITHIN THE CONTEXT OF THE INCIDENT, INCREASED/DECREASED THE LIKELIHOOD THAT THIS OUTCOME WOULD OCCUR).*

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(10) WERE THERE ANY INCIDENTAL FINDINGS? (IF YES PLEASE PROVIDE DETAIL)

(11) RECOMMENDATIONS

1	
2	
3	

(12) INFORMATION CONTAINED WITHIN THIS DOCUMENT HAS BEEN SHARED WITH:

PATIENT/ GUARDIAN	YES☐	NO☐
RELEVANT PERSON (SUBJECT TO PATIENTS CONSENT UNLESS THE PATIENT IS MINOR OR UNABLE TO CONSENT)	YES☐	NO☐
HOSPITAL STAFF & HOSPITAL MANAGER (IF YES PLEASE PROVIDE DETAILS OF TYPE OF STAFF HERE) WARD MEDICAL AND NURSING TEAM; QUALITY AND SAFETY COMMITTEE; GENERAL MANAGER	YES ☐	NO☐
CONTRIBUTORS TO THIS REVIEW	YES ☐	NO☐
SIGNED BY: (CONSULTANT OR NOMINEE)		