

WORKED EXAMPLE

SEVERE HOSPITAL ASSOCIATED *CLOSTRIDIoidES DIFFICILE* 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 REOCCURRENCE. REVIEWS MUST BE CARRIED OUT IN LINE WITH THE HSE INCIDENT MANAGEMENT FRAMEWORK AND GUIDANCE: VERSION 2

PLEASE NOTE: A REVIEW MUST BE COMPLETED FOR ALL INCIDENTS OF SEVERE HOSPITAL ASSOCIATED *C. DIFFICILE* INFECTION -

FOR THIS PURPOSE SEVERE *C. DIFFICILE* INFECTION IS INFECTION THAT REQUIRES ICU ADMISSION OR COLECTOMY

NOTE A HOSPITAL MAY DECIDE TO PERFORM INCIDENT ANALYSIS ON CASES OF HOSPITAL ASSOCIATED *C. DIFFICILE* OTHER THAN SEVERE CASES PARTICULARLY IF THERE IS A HIGH INCIDENCE OF INFECTION

(2 OR MORE CASES WITHIN A WARD WITHIN A MONTH WHERE PERSON TO PERSON TRANSMISSION IS SUSPECTED)

PART A – CASE REPORT					
(I) [CONSULTANT WITH PRIMARY RESPONSIBILITY FOR PATIENT CARE OR NOMINEE TO COMPLETE THIS SECTION]					
NIMS REFERENCE NUMBER	12345X	HOSPITAL GROUP	HOSPITAL GROUP A		
DATE REPORT COMPLETED	01/10/2020	NAME OF ACUTE HOSPITAL	HOSPITAL A		
DETAILS OF PATIENT	PATIENT NAME AND MRN: MARY JONES 0123456 RESPONSIBLE CONSULTANT: DR A NOTHER				
BRIEF CLINICAL BACKGROUND HISTORY OF GASTRIC CANCER; ADMITTED WITH URINARY TRACT INFECTION					
WARD(S) [THIS ADMISSION] (LIST ALL UNIT/WARDS IN CHRONOLOGICAL ORDER)		ADMISSION DATE	TRANSFER DATE IF APPLICABLE		
WARD 1A		01/09/2020	03/09/2020		
WARD 2B		03/03/2020	CLICK HERE TO ENTER A DATE.		
ANTIBIOTIC HISTORY IN THE 12 WEEKS PRIOR TO ONSET OF ILLNESS (IN SO FAR AS AVAILABLE)					
ANTIBIOTICS (NAME, ROUTE)	DATE COMMENCED	DATE COMPLETED	INDICATION	COMPLIED WITH HOSPITAL GUIDELINES	
CIPROFLOXACIN	01/09/2020	07/09/2020	UTI	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES <input type="checkbox"/>	NO <input type="checkbox"/>
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES <input type="checkbox"/>	NO <input type="checkbox"/>
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES <input type="checkbox"/>	NO <input type="checkbox"/>
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES <input type="checkbox"/>	NO <input type="checkbox"/>
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES <input type="checkbox"/>	NO <input type="checkbox"/>

IF ANTIBIOTICS WERE NOT COMPLIANT WITH HOSPITAL GUIDELINES PLEASE PROVIDE REASONS FOR VARIATION FROM GUIDELINE:
LACK OF AWARENESS OF LOCAL HOSPITAL GUIDANCE BY PRESCRIBER

COLLECTION DATE OF 1ST POSITIVE STOOL SAMPLE	07/09/2020
--	------------

IS PATIENT CONSIDERED PART OF AN OUTBREAK/CLUSTER OF CDI?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
---	------------------------------	--

(2) LABORATORY RESULTS RELATED TO POSITIVE SAMPLE ON WHICH DIAGNOSIS OF THIS EPISODE IS BASED [SURVEILLANCE SCIENTIST OR MICROBIOLOGIST TO COMPLETE THIS SECTION]

DATE-COLLECTED	07/09/2020
DATE RECEIVED	08/09/2020
PRIMARY DIAGNOSTIC TEST	PCR
SECONDARY (CONFIRMATORY) TEST	GDH
IF TYPING PERFORMED PROVIDE DETAILS	N/A

(3) FACTORS RELATING TO THE PATIENT [MULTIDISCIPLINARY TEAM MEMBERS WITH RESPONSIBILITY FOR PATIENT CARE OR NOMINEE TO COMPLETE THIS SECTION]

DID THE PATIENT HAVE ANY OF THE FOLLOWING RISK FACTORS FOR DEVELOPING A *C. DIFFICILE* INFECTION?

AGE >65 YEARS	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
PREVIOUS HOSPITAL ADMISSIONS	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
PREVIOUS HISTORY OF CDI	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
RECENTLY ON WARD/UNIT WITH OTHER CASES OF CDI	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
PROTON PUMP INHIBITOR	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
LAXATIVE USE	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
IMMUNOSUPPRESSION	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
INFLAMMATORY BOWEL DISEASE	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
NG FEEDING	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
GI SURGERY	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

ASSESSING IMPACT OF CDI

DID PATIENT REQUIRE ICU ADMISSION FOR CDI?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
DID PATIENT REQUIRE COLECTOMY FOR CDI?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
DID THE PATIENT SURVIVE (ASSESSED AT TIME OF DISCHARGE/TRANSFER OR AT 30 DAYS FROM ONSET?)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IF PATIENT SURVIVED WAS PATIENT DISCHARGE DELAYED?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IF PATIENT DECEASED, WAS CDI IDENTIFIED ON THE DEATH CERTIFICATE AS A PRIMARY OR CONTRIBUTORY CAUSE OF DEATH?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

(4) FACTORS RELATING TO THE ENVIRONMENT & EQUIPMENT [WARD MANAGER AND IPC TEAM TO COMPLETE]

WERE THERE ANY DEFICIENCIES WITH THE WARD/UNIT ENVIRONMENT & EQUIPMENT LIKELY TO HAVE CONTRIBUTED TO THIS EPISODE OF INFECTION?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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 <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IF YES, IS THIS ACCESSIBLE TO ALL RELEVANT STAFF?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IS THIS POLICY IN LINE WITH CURRENT HSE GUIDELINES ON HEALTHCARE ASSOCIATED INFECTIONS?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
(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 <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IS HAND HYGIENE TRAINING UP TO DATE FOR ALL MEDICAL STAFF WORKING IN THE AREA [CONSULTANT OR NOMINEE]	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IS TRAINING ON APPLICATION OF INTRAVENOUS LINE CARE BUNDLES UP TO DATE FOR ALL NURSING STAFF	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
(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 A CDI?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IS THERE EVIDENCE THAT THE PATIENT WAS INFORMED THAT THIS WAS A HOSPITAL ACQUIRED INFECTION AND GIVEN INFORMATION ON THE LIKELY FACTORS CONTRIBUTING TO INFECTION?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
IF THIS EPISODE OF CDI IS PART OF AN OUTBREAK WAS THE PATIENT/RELEVANT PERSON INFORMED OF THIS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
CONCISE [PLEASE REFER TO HSE IMF]	YES <input checked="" type="checkbox"/>	No <input type="checkbox"/>

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).

ANTIBIOTICS PRESCRIBED OUT WITH HOSPITAL ANTIBIOTIC GUIDELINES. NO CLEAR RATIONALE RECORDED. PRESCRIBER WAS A NEW MEMBER OF STAFF AND WAS NOT AWARE OF LOCAL HOSPITAL GUIDANCE. NO EVIDENCE OF DAILY REVIEW OF ANTIBIOTICS NOR OF REVIEW WITHIN 72 HOURS OF INITIATION. ANTIBIOTIC TREATMENT NOT STOPPED AT ONSET OF DIARRHOEA. TREATMENT STOPPED AT DIAGNOSIS OF *C. DIFFICILE* INFECTION. CONTRIBUTING FACTORS INCREASED LIKELIHOOD OF THIS OUTCOME. EVIDENCE OF SEVERE CDI, INCLUDING ICU ADMISSION. MANAGED APPROPRIATELY WITH DAILY REVIEW OF SEVERITY AND PROGRESS RECORDED AS WELL AS CORRECT TREATMENT IN LINE WITH HOSPITAL CDI GUIDELINES. PATIENT RECOVERED ALTHOUGH DELAYED DISCHARGE AS RESULT OF THIS HAI.

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

(11) RECOMMENDATIONS

1	FOCUSED TRAINING SESSION/S ON ANTIMICROBIAL PRESCRIBING PRINCIPLES AND HOSPITAL GUIDELINES ESP FOR NEW STARTERS
2	REVIEW SYSTEMS IN PLACE FOR CONTROL OF CIPROFLOXACIN AND OTHER RESTRICTED ANTIBIOTICS
3	

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

PATIENT/ GUARDIAN	YES <input checked="" type="checkbox"/>	No <input type="checkbox"/>
RELEVANT PERSON (SUBJECT TO PATIENTS CONSENT UNLESS THE PATIENT IS MINOR OR UNABLE TO CONSENT)	YES <input checked="" type="checkbox"/>	No <input type="checkbox"/>
HOSPITAL STAFF & HOSPITAL MANAGER (IF YES PLEASE PROVIDE DETAILS OF TYPE OF STAFF HERE) WARD BASED MEDICAL, NURSING AND PHARMACIST TEAM; MANAGER; QUALITY AND SAFETY COMMITTEE	YES <input checked="" type="checkbox"/>	No <input type="checkbox"/>
CONTRIBUTORS TO THIS REVIEW	YES <input checked="" type="checkbox"/>	No <input type="checkbox"/>