VERSION 01 JANUARY 2021

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 REOCCURRANCE. 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		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.

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	
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐
	CLICK HERE TO ENTER A DATE.	CLICK HERE TO ENTER A DATE.		YES☐	NO☐

IF ANTIBIOTICS WERE NOT COMPLIANT WITH HOSPITAL GUIDELINES PLEASE PROVIDE REASONS FOR VARIATION FROM GUIDELINE:		
COLLECTION DATE OF 1ST POSITIVE STOOL SAMPLE	Click here to enter a date.	
IS PATIENT CONSIDERED PART OF AN OUTBREAK/CLUSTER OF CDI?	YES☐	NO☐

(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	
DATE RECEIVED	
PRIMARY DIAGNOSTIC TEST	
SECONDARY (CONFIRMATORY) TEST	
IF TYPING PERFORMED PROVIDE DETAILS	

(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☐	NO☐
PREVIOUS HOSPITAL ADMISSIONS	YES☐	NO☐
PREVIOUS HISTORY OF CDI	YES☐	NO☐
RECENTLY ON WARD/UNIT WITH OTHER CASES OF CDI	YES ☐	NO☐
PROTON PUMP INHIBITOR	YES☐	NO☐
LAXATIVE USE	YES☐	NO☐
IMMUNOSUPPRESSION	YES☐	NO☐
INFLAMMATORY BOWEL DISEASE	YES☐	NO☐
NG FEEDING	YES☐	NO☐
GI SURGERY	YES☐	NO☐
ASSESSING IMPACT OF CDI		
DID PATIENT REQUIRE ICU ADMISSION FOR CDI?	YES☐	NO☐
DID PATIENT REQUIRE COLECTOMY FOR CDI?	YES☐	NO☐
DID THE PATIENT SURVIVE (ASSESSED AT TIME OF DISCHARGE/TRANSFER OR AT 30 DAYS FROM ONSET?	YES☐	NO☐
IF PATIENT SURVIVED WAS PATIENT DISCHARGE DELAYED?	YES☐	NO☐
IF PATIENT DECEASED, WAS CDI IDENTIFIED ON THE DEATH CERTIFICATE AS A PRIMARY OR CONTRIBUTORY CAUSE OF DEATH?	YES☐	NO☐
FURTHER COMMENTS:		

(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☐	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 a CDI?	Yes ☐	No ☐
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 ☐	No ☐
If this episode of CDI is part of an outbreak was the patient/relevant person informed of this?	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).*

(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 BASED MEDICAL, NURSING AND PHARMACIST TEAM; MANAGER; QUALITY AND SAFETY COMMITTEE	YES ☐	NO☐
CONTRIBUTORS TO THIS REVIEW	YES ☐	NO☐
SIGNED BY: CONSULTANT OR NOMINEE		