Learning through action to reduce infection

What is this for?
This is a quick, simple action tool to use when a patient has a confirmed infection such as an MRSA bacteraemia, *Clostridium difficile* (C.Diff) and other life threatening infections.

It is based on the Root Cause Analysis (RCA) approach and it is primarily a learning exercise.

Why use it?
To find out what factors or events led to the infection, and how you can reduce the risks of it happening again.

The results will help your organisation to gain a better overall understanding of the source and contributory factors associated with severe infections and take action to reduce the risks of them occurring elsewhere in the future.

Who will use it?
• the whole clinical team with the support of Risk Managers and infection control teams;
• and anyone else interested in learning from infections such as MRSA bacteraemias to reduce future occurrences.

How does it work?
The process is organised as an action checklist in three stages:

1 React
2 Record
3 Respond

| What were the critical problems? | What were the main contributory factors/root causes? | What needs to be done? |

You can write your findings on this form as you progress. When it is complete, the results of your analysis can be recorded in your organisation's RCA data collection template or fed into your local governance arrangements.

Begin here by recording:

Incident/type of infection:

Date of incident/awareness:

Patient location:

Patient name: Patient date of birth:

Patient NHS Number:

Name of the person coordinating the review: Their job title:

Date of beginning this process:

Where this form should be sent within the organisation when complete:

Stage 1: React

You have been notified that a patient(s) has an infection

Inform and report

- ☐ Inform the multidisciplinary team, including the infection control team and doctors.
- ☐ Report the infection through your organisation's reporting system.
- ☐ Tell the patient. Explain what is being done.
- ☐ Ensure that immediate actions and controls to manage risk are implemented.
- ☐ Record these in the patient's treatment plan and medical records.
- ☐ Assess severity and risk.

- Consider using Being Open to assist you. Further advice can be found at **www.mnpsa.nhs.uk/boa**
- Consult your organisation's risk matrix to help you judge 'severity'.

Stage 2: Record

A Finding out **what happened** – gathering information

- ☐ Write a brief story of the patient's journey up to this point. A simple timeline can be used to represent this information or use the box below.

Consider:
- How and where was the patient admitted?
- Were there any transfers/movements after admission?
- Did the patient receive any interventions? (for example, intravenous line or catheter inserted)
- Is the documentation related to isolations completed?
- Was the patient screened for MRSA or other infections? And when?
- If screening showed positive result, when was this confirmed?
- Did the patient receive any decolonisation treatment?
- What other treatment has the patient received?
- Was the patient isolated? Cohorted?
- Did the patient receive antibiotics? What were they? Why were the receiving them? Were relevant policies and protocols followed?

What happened?

Date and Time	Events/Interventions	Outcome if known

B   Finding out why it happened

☐ What were the critical problems or issues?
☐ Use the patient journey story to identify the critical problems/issues (care or service delivery problems) i.e. things that weren't done which should have been or things that were done which shouldn't have been done. For example, did treatment take place in a timely manner?

- Asking "why?" is a good way of understanding what has influenced the critical problem/issue
- You can use the following prompts to help assess why the problem/infection occurred:
- the condition of the patient
- the environment
- staff knowledge and competency, including assessment frameworks and compliance audit
- any treatment
- contamination of equipment
- procedures and protocols
- equipment and supplies
- compliance with hand hygiene
- protocols for hand hygiene observation/auditing

Critical problems/issues	Main contributory factors/root causes
Example:	Example:
- Unused venflon left in-situ for 5 days	- Poor documentation regarding inserted devices
	- Staff knowledge regarding national guidance

C   Reflect on what the information you've gathered is telling you

- For each of the most significant critical problems/issues, consider: what has contributed, influenced or caused that problem/issue?

- You may have a long list of contributory factors. Review it and identify the main contributory factors (root causes) which have had the greatest impact on the incident/infection and would help reduce the chances of it happening again.

Stage 3: Respond

Acting to help reduce the chances of it happening again

☐ Identify and record any areas and examples of good practice.
☐ Develop a list of targeted recommendations/solution(s) to address each root cause/main contributory factor.
☐ Write up an action plan to implement the recommendations.
☐ Implement plan.
☐ Communicate and record the results of this exercise through the relevant local directorate and governance committees, or your local trust arrangements.
☐ Tell the patient what you plan to do to reduce the chances of this happening again in the future.
☐ Feed back the examples and areas of good practice to staff.

Consider
• What controls, and changes will you implement to reduce the chances of the infection occurring in the future?

Areas of good practice
_____
_____
_____

Recommendations/solutions What changes need to be made?	Actions and steps How will you make the changes?	Person responsible for change Who will be the lead person responsible for ensuring that each step or action happens?		Timescale/Milestones What is the due date for completion of each step or action?	Date completed/ achieved

Record here what the patient has been told:

When you have completed this process:

Check that each stage has been completed and recorded

Record the details of other key staff who have participated and ensure that the outcome is fed back to all of them

Name(s)	Designation	Date informed