***Clostridium difficile* infection investigation and multidisciplinary team root cause analysis**

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Dear Editor

We were interested to read the paper by Saeed et al. (2017) that describes the use of on-the-spot investigation and monthly multidisciplinary root cause analysis (RCA) meetings to investigate cases of *Clostridium difficile* infection (CDI) in their hospital. At Great Western Hospital NHS Foundation Trust, we too look in depth at each of our hospital-acquired CDI cases and use a rapid method similar to the on-the-spot investigations used by Saeed et al (2017). Since December 2015, we have aimed to get relevant teams to meet soon after the incident to discuss the case and obtain rapid feedback to identify preventable factors that could help us limit cases and assist with local learning and education. The majority of our meetings lasting 30–60 min are held on the ward that the new case occurred and within seven days so that staff remember the case and, if needed, an action plan developed. Similar to the on-the-spot investigations (Saeed et al., 2017) we too have representation from infection prevention and control (IPC) nurses and ward staff and try to ensure that the latter consists of both nursing and medical staff, but also have attendance from the antibiotic pharmacist and microbiologist. We use a checklist approach to systematically investigate the case and have incorporated the tool from NHS England (2015). Like Saeed et al. (2017), we have learnt from the cases and we monitor for recurrent themes. Locally at ward level we too have noted delay in sending samples and isolation and this has been used for ward staff education. Another common lesson learnt is the inconsistent documentation of the indication why an antibiotic was prescribed which is discussed with the doctor(s) present at the meeting and suggested they feedback to their team. We have also identified possible risk factors such as low staff compliance with infection control training which have then been corrected at ward level. Organisational changes made include redesigning the stool chart to prompt consideration of CDI symptoms/risk factors and more information on when to send a sample. We have recently evaluated these meetings by using a questionnaire, and results from 15 attendees have been encouraging as they thought they were valuable. It was highlighted that we needed to ensure staff who were familiar with the patient's care attend, especially the original antibiotic prescribers as

this may add to the information that is available in the notes. Also, if relevant, we should discuss prior antibiotic choices with GPs. It was also suggested that the meetings would provide a good learning opportunity for junior staff and we are now trying to incorporate these suggestions.

Although we have not calculated the cost of our meetings we found them of value to obtain information on the cases and provide a comprehensive picture. This has enabled us to illustrate to the Clinical Commissioning Groups (CCGs) our investigation and action plans and determine if cases that are avoidable. In the financial year 2015–2016, we had 30 cases of CDI of which only five were categorised as avoidable; in 2016–2017 there were 21 cases of which only one was deemed avoidable. In both years, the threshold for the Trust was 20 cases (NHS England, 2015; NHS England, 2016).

In conclusion, as found by Saeed et al. (2017), our meetings have enabled a rapid investigation of cases, provided learning, and enabled action plan development. We have found they have educational value for staff by demonstrating the risk factors that contribute to these cases. The IPC team plan to continue with this format.

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