File reference	W18FOI346
Key words	51 Infection-Related Incident Reports
Date of release	15/11/2018
Attachments	Yes

Freedom of Information Act Disclosure log - Reply Extract

You asked

There were 51 other infection-related incidents dealt with by the IPCT between April 2016 and March 2017. All ward closures and other Serious Untoward Incidents are reported to the Health Protection Agency and Strategic Health Authority as part of the mandatory surveillance of Healthcare Associated Infection. Reports on these incidents are available from the IPCT.

Is it possible to receive these 51 reports?

The Trust originally stated on the 22/10/2018

No - University Hospitals Plymouth NHS Trust is confirming in accordance with section 1 (a) of the Act that it holds the information requested, but is refusing to supply it in accordance with section 1(b), because section 40.-(2)(a) and (b) applies. This is by virtue of the first and second condition and avoids a breach of the first two Data Protection Act principles.

The reason this exemption applies is because it is personal and biographically identifiable information that cannot be released under the auspices of FoI in its current format. This is an absolute exemption and applies to all personal information. The legal exemption is described
here: http://www.legislation.gov.uk/ukpga/2000/36/section/40.

The Trust is also aware of its duty not to apply blanket exemptions to requested documents and ensure transparency and public accountability, whenever possible. It is currently considering whether any parts of the request could be released and made public with suitable redactions.

Whilst this process would fall outside the “appropriate limit” guidelines described in section 12 of the Act. It is *burdensome for us, in terms of *resources and *time to ensure both the contributions from specialist clinical and information experts in ensuring the appropriate redactions. We also need to consider the correct application of any exemptions, whilst ensuring the balance of any individual’s rights in compliance with the Information Laws, their guidance and Codes of Practice and ensuring health provisions.

The scope of this task; particularly in light of this and a **number of requests that you have made within the last 60 working days is currently being evaluated. This is to ensure that the workload involved in all these requests is appropriate, does not impose an unreasonable burden upon us, or draw the Act into disrepute.

The Trust will, if appropriate and able make public any further disclosures or decisions at the earliest opportunity before the 15th of November 2018 for this request.

Footnotes

***** See description in the Cabinet Office's 2018 Freedom of Information: Code of Practice – sections 7.12 to 7.15.

** The summary of requests received within the last 60 working days
18FOI346 due 15/11/2018
18FOI352 already disclosed 22/10/2018
18FOI360 already disclosed 04/10/2018
18FOI378 already disclosed 08/11/2018
18FOI383 already disclosed 01/11/2018

Part Two of our reply

Further to that response we are now providing this further response as promised above.

As previously confirmed the Trust holds 51 reports infection-related incidents. The Trust took additional time to consider both the scope of all of your requests and specifically for this case the redaction of such reports to ensure compliance with both the Freedom of Information Act 2000 and the Data Protection Act 2018

The Trust makes public annual Infection Prevention and Control Report and this is available here: https://www.plymouthhospitals.nhs.uk/our-publications
This report includes a table of the infection related incidents between April 2016 and March 2017 and is available on page 25. The table provides the Month/year – Incident type and area and the report type. As your request is for the specific report content the Trust has needed to consider the appropriateness of any disclosure.

The Trust is aware of both its duties to whenever possible be open, transparent and accountable. It is also aware of its duty to ensure personal information is not made public.

The Trust is also aware that through a mosaic effect biographical significant information can, when pieced together with other publicly available information identify persons involved.

The Trust considered this when preparing this reply and it is for this reason it is disclosing the information, but in a redacted format. That is to say we have removed any details that could, with any other information identify any person. This includes patients, staff and possibly other persons affected by the disclosure.

We have removed:

- Dates, but not the year
- Ward or unit details

- Treatments a person received
- Numbers of five or fewer
- Biographically significant person specific information

This is to reduce the likelihood of people pairing publicly available information (regardless of source) with these attached and redacted reports.

Legal notes
University Hospitals Plymouth NHS Trust is confirming in accordance with section 1 (a) of the Act that it holds the information requested. It is refusing to supply it in the form we hold it because it contains person information. We are however providing it in a redacted form. Where a redaction has been applied the text will state 40(2). This means it is personal information about other people and you do not have their permission to receive it. This is in accordance with section 1(b), because section 40.-(2)(a) and (b) applies. This is by virtue of the first and second condition and avoids a breach of the first two Data Protection Act principles.

The legal exemption is described here: http://www.legislation.gov.uk/ukpga/2000/36/section/40.

Section 16 advice
The Trust has whenever possible used five or fewer figures and provided links to the published information we make available, both in this letter and other correspondence to you.

Attachments included: Yes

MRSA cases on Section 40(2) 2017

Summary

- S40(2) Five or fewer cases of MRSA were noted in on S40(2) in S40(2) 2017.
- An Action Plan to enhance infection control practice, particularly around hand hygiene, hand care, aseptic technique and enhanced cleaning of the environment and equipment, was agreed.
- The strains were typed and found to be different, suggesting that cross-infection had not occurred.
- There have been no further cases since S40(2) 2017.

The cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, Meticillin-resistant *Staphylococcus aureus* (MRSA) was grown from S40(2) Five or fewer patients on S40(2). S40(2) Five or fewer grew MRSA from an operative sample and was MRSA-negative on admission to S40(2), and S40(2) Five or fewer had been previously been MRSA-negative. Molecular typing demonstrated that the isolates were different, suggesting that cross-infection had not occurred.

An outbreak meeting was held on S40(2) 2017 and a series of recommendations for enhanced infection control procedures were made, with particular attention to hand hygiene, aseptic technique and enhanced cleaning of S40(2) and equipment. Staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. There have been no further cases of this strain since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

MRSA cases on Section 40(2) 2016

Summary

- S40(2) Five or fewer cases of MRSA were noted in patients who were on or had been on S40(2) between S40(2) and S40(2) 2016.
- An Action Plan to enhance infection control practice, particularly around hand hygiene, hand care, the care of tracheostomies and enhanced cleaning of the environment and equipment, was agreed.
- The strains isolated from S40(2) Five or fewer patients were identical, suggesting that cross-infection had occurred. The S40(2) strain was distinct.
- There have been no further cases since S40(2) 2016.

The cases

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, Meticillin-resistant *Staphylococcus aureus* (MRSA) was grown from S40(2) Five or fewer patients who were on or had been on S40(2).

S40(2)

Outbreak meetings were held on S40(2) and S40(2) 2016 and a series of recommendations for enhanced infection control procedures were made, with particular attention to hand hygiene, aseptic technique, the care of tracheostomies and enhanced cleaning of S40(2) and equipment. S40(2) underwent a deep clean. Staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. Molecular typing revealed that the strains from S40(2) Five or fewer patients were identical, suggesting that cross-infection may have occurred. The strains from S40(2) Five or fewer were distinct. There have been no further cases of since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

MRSA on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of MRSA was identified on S40(2). Molecular typing confirmed it to be identical to previous strains isolated on S40(2).
- Enhanced infection control procedures were implemented.
- Staff involved in the care of the case and those on duty at the same time were screened for MRSA.
- Of 13 members of staff screened, none were colonised with the outbreak strain.
- No further cases of MRSA have been noted since S40(2) 2016.

The cases

In S40(2) 2016, MRSA was isolated from S40(2) Five or fewer patients on S40(2). Molecular typing confirmed that this was identical to 19 cases previously seen on S40(2) since S40(2). S40(2) Outbreak meetings were held on S40(2) and S40(2) 2016 to agree enhanced infection control procedures, with particular attention to hand hygiene, aseptic technique, line care and enhanced cleaning. All staff was reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. Those staff involved in the initial care and those on duty at the same time were screened for MRSA. In total, 13 members of staff were screened for MRSA and none were found to be colonised with the outbreak strain. S40(2). There have been no cases of MRSA on the S40(2) since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

MRSA on Section 40(2) 2016

Summary

- S40(2) 2016, S40(2) Five or fewer cases of MRSA were identified in S40(2)
- Enhanced infection control procedures were implemented.
- Staff involved in the care of the initial cases and those on duty at the same time were screened for MRSA.
- Of 104 members of staff screened, none were colonised with the outbreak strain.
- No further cases of MRSA have been noted since S40(2) 2016.

The cases

S40(2) 2016, an identical strain MRSA was isolated from S40(2) remainder of paragraph removed.

An outbreak meeting was held on S40(2) 2016, to agree enhanced infection control procedures, with particular attention to hand hygiene, aseptic technique, line care and enhanced cleaning. All S40(2) were screened for MRSA and staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. The decision was also made to screen all staff on S40(2). In total, 104 members of staff were screened for MRSA and none were found to be colonised with the outbreak strain. There have been no cases of MRSA on S40(2) since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

MRSA on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of MRSA were identified in S40(2).
- Enhanced infection control procedures were implemented.
- Staff involved in the care of the initial cases and those on duty at the same time were screened for MRSA.
- Of 46 members of staff screened, none were colonised with the outbreak strain.
- No further cases of MRSA have been noted since S40(2) 2016.

The cases

In S40(2) 2016, an identical strain MRSA was isolated from S40(2) Five or fewer S40(2) that were on or had been on S40(2). An outbreak meeting was held on S40(2) 2016 to agree enhanced infection control procedures, with particular attention to hand hygiene, aseptic technique, line care and enhanced cleaning. All S40(2) were screened for MRSA and were found to be negative. All staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. Those staff involved in the care of initial S40(2) and those on duty at the same time were screened for MRSA. In total, 46 members of staff were screened for MRSA and none were found to be colonised with the outbreak strain. Weekly screening of S40(2) was performed for 3 weeks and no further cases were identified. There have been no cases of MRSA on S40(2) since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

MRSA cases on Section 40(2) 2017

Summary

- S40(2) Five or fewer cases of MRSA were noted on S40(2) between S40(2) and S40(2) 2017. S40(2) Five or fewer of these were noted on admission to the ward.
- An Action Plan to enhance infection control practice, particularly around hand hygiene, hand care, aseptic technique and enhanced cleaning of the environment and equipment, was agreed.
- The strains were typed and found to be identical, suggesting that cross-infection had occurred.
- There have been no further cases since S40(2) 2017.

The cases

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2017, Meticillin-resistant *Staphylococcus aureus* (MRSA) was grown from S40(2)

An outbreak meeting was held on S40(2) 2017 and a series of recommendations for enhanced infection control procedures were made, with particular attention to hand hygiene, aseptic technique and enhanced cleaning of the ward and equipment. Staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. There have been no further cases of this strain since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

MRSA cases on Section 40(2) 2016

Summary

- S40(2) Five or fewer cases of MRSA were noted on S40(2) in S40(2) 2016. S40(2) Five or fewer of these was noted on admission to S40(2).
- An Action Plan to enhance infection control practice, particularly around hand hygiene, hand care, aseptic technique and enhanced cleaning of the environment and equipment, was agreed.
- The strains were typed and found to be identical, suggesting that cross-infection had occurred.
- There have been no further cases since S40(2) 2016.

The cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, Meticillin-resistant *Staphylococcus aureus* (MRSA) was grown from S40(2). S40(2) Five or fewer patients grew MRSA on admission to the ward and S40(2) Five or fewer had been previously been MRSA-negative. Molecular typing demonstrated that the isolates were identical, suggesting that cross-infection had occurred.

An outbreak meeting was held on S40(2) 2016 and a series of recommendations for enhanced infection control procedures were made, with particular attention to hand hygiene, aseptic technique and enhanced cleaning of S40(2) and equipment. Staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. There have been no further cases of this strain since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

MRSA on the Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of MRSA were identified on S40(2). Molecular typing confirmed this to be identical to S40(2) Five or fewer strains previously isolated on S40(2) between S40(2) 2015 and S40(2) 2016.
- Enhanced infection control procedures were implemented.
- Staff on S40(2) were screened for MRSA.
- Of 42 members of staff screened, S40(2)
- No further cases of MRSA have been noted since S40(2) 2016.

The cases

S40(2) Place removed to avoid biographical identification. Between S40(2) 2015 and S40(2) 2016, S40(2) were noted on the ward. In S40(2) 2016, S40(2)..
Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, line care and enhanced cleaning. All staff were reviewed for the presence of any skin condition, with referral to the Occupational Health and Wellbeing Department as required. S40(2)

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was identical for S40(2) Five or fewer strains, suggesting that cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was identical for S40(2) Five or fewer strains, suggesting that cross-infection had occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2), 2016 - 2017

Summary

- Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, six cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that S40(2) Five or fewer of the strains were identical, suggesting that cross-infection may have occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, six cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated S40(2) Five or fewer of the strains were identical, suggesting that cross-infection may have occurred between these patients (who were on S40(2) at the same time). There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was only available for S40(2) Five or fewer of the strains, so it was not possible to conclude whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2) ward. Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was only available for S40(2) Five or fewer of the strains, so it was not possible to conclude whether cross-infection had occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was available for S40(2) Five or fewer of the strains and was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was available for S40(2) Five or fewer of strains and was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- The reference laboratory were unable to confirm the ribotypes of the strains so it was not possible to conclude whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

The reference laboratory were unable to confirm the ribotypes of the strains so it was not possible to conclude whether cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016- 2017

Summary

- Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was available for S40(2) Five or fewer strains and was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
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3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was available for S40(2) Five or fewer strains and was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

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5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was available for S40(2) Five or fewer strains and was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

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5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was available for S40(2) Five or fewer strains and was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

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3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- The reference laboratory were unable to confirm the ribotypes of the strains so it was not possible to conclude whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

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3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

The reference laboratory were unable to confirm the ribotypes of the strains so it was not possible to conclude whether cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping of the S40(2) Five or fewer the strains was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was available for S40(2) Five or fewer of the S40(2) Five or fewer strains and these were identical, suggesting that cross-infection may have occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was available for S40(2) Five or fewer of the S40(2) Five or fewer strains and these were identical, suggesting that cross-infection may have occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016- 2017

Summary

- Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- The ribotype of the S40(2) Five or fewer of the strains was identical, suggesting that cross-infection may have occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. Between S40(2) 2016 and S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

The ribotype of S40(2) Five or fewer of the strains was identical, suggesting that cross-infection may have occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- Between S40(2) and S40(2) 2017, six cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2) ward.
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- The ribotype of the S40(2) Five or fewer of the strains was identical, suggesting that cross-infection may have occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification, six cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

The ribotype of S40(2) Five or fewer of the strains was identical, suggesting that cross-infection may have occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was only available S40(2) Five or fewer of the strains so it was not possible to conclude whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was only available for S40(2) Five or fewer of the S40(2) of strains so it was not possible to conclude whether cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- As ribotyping of the strains was not available, it was not possible to determine whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

As ribotyping of the strains was not available, it was not possible to determine whether cross-infection had occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was available for S40(2) Five or fewer strains and these were identical, suggesting that cross-infection may have occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was available for S40(2) Five or fewer strains and these were identical, suggesting that cross-infection may have occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2017.

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping of the two strains was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping demonstrated that the strains were different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. Between S40(2) and S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

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2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping demonstrated the strains were different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping of the S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
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3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping of S40(2) Five or fewer strains was different, suggesting that cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- Ribotyping was only available for S40(2) Five or fewer of the strains, so it was not possible to conclude whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on or had been on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

Ribotyping was only available S40(2) Five or fewer, so it was not possible to conclude whether cross-infection had occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

Clostridium difficile-associated disease on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients on S40(2).
- The patients were nursed in single rooms and treated with S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- As ribotyping was only available for S40(2) Five or fewer of the strains, it was not possible to determine whether cross-infection had occurred between these patients.
- There have been no further cases since S40(2) 2016.

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of *Clostridium difficile*-associated disease were noted in patients who were on S40(2). Meetings were held for each case to review the situation and implement appropriate control measures.

The following control measures were taken:

1. Symptomatic patients were isolated in side rooms and the ward remained open
2. The patients were treated with oral S40(2). All recovered
3. Enhanced infection control procedures were reinforced and implemented
4. An enhanced cleaning regimen using bleach and detergent was implemented including the cleaning of patient equipment. Microfibre cloths were disposed of
5. A review of antimicrobial prescribing was performed by the Antibiotic Control Team
6. Following discharge, the rooms were deep cleaned and fogged with hydrogen peroxide vapour.

As ribotyping was only available for S40(2) Five or fewer of the strains, it was not possible to determine whether cross-infection had not occurred between these patients. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016.

S40(2) on Section 40(2), 2016

Summary

- S40(2) Five or fewer patients who had been nursed in a bay on S40(2) in S40(2) 2016 S40(2).
- S40(2) Five or fewer patients identified as having had significant exposure were informed of the incident and invited for follow up at S40(2).
- A list of 8 staff contacts was sent to Occupational Health and Wellbeing for follow up.
- Monitoring for secondary cases of S40(2) will continue.

Description of the incident

S40(2) Whole paragraph

Monitoring for secondary cases of S40(2) will continue.

Infection Prevention and Control Team, S40(2) 2017.

Plymouth Hospitals NHS
NHS Trust

S40(2) on Section 40(2) 2016

Summary

- S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The organisms were both isolated from wound swabs and the patients were on the ward at the same time.
- A series of recommendations regarding infection control practice, aseptic technique and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. S40(2) 2016, S40(2) Five or fewer cases of S40(2) with a similar antibiotic-susceptibility pattern were noted in patients who were on S40(2) at the same time. An outbreak meeting was held on S40(2) 2016 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique and enhanced cleaning of the environmental and equipment. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016

Plymouth Hospitals NHS
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S40(2) on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- Five or fewer of the isolates had similar antibiograms, but as none of the strains were available for typing, it was not possible to confirm whether they were related.
- A series of recommendations regarding infection control practice, aseptic technique and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) was isolated from S40(2) Five or fewer different patients. S40(2) Five or fewer of these were S40(2) and S40(2) Five or fewer had S40(2). Unfortunately none of the strains were available for typing, so it was not possible to determine whether cross infection had occurred.

An outbreak meeting was held on S40(2) 2016 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, airway management, urinary catheter care and enhanced cleaning of the environment and equipment. An Infection Control Week was held on the Unit to provide additional education and raise awareness of the consistent application of standard infection control practices.

Infection Prevention and Control Team, S40(2) 2016

Plymouth Hospitals NHS
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S40(2) on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The organisms were all isolated from urine samples and the patients were on the S40(2) at the same time.
- A series of recommendations regarding infection control practice, urinary catheter management and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of S40(2) with a similar antibiotic-susceptibility pattern were noted in patients who were on S40(2) at the same time. The organisms were all isolated from urine samples. An outbreak meeting was held on S40(2) 2016 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to the use of hand hygiene, isolation care plans, urinary catheter management and enhanced cleaning of the environmental and equipment. The S40(2) received a bay-by-bay deep clean and the rooms were fogged with hydrogen peroxide vapour. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016

Cases of S40(2)on Section 40(2) 2016

Summary

- S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The S40(2) Five or fewer strains had the same antibiotic susceptibility pattern. They were sent for typing and were found to be identical.
- Enhanced infection control procedures were reinforced and implemented.
- Surveillance of S40(2) continues across the Trust.

S40(2) Place removed to avoid biographical identification. S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted in patients who were on S40(2) at the same time. S40(2) Five or fewer were associated with soft tissue infections. S40(2) Five or fewer isolates had the same antibiotic susceptibility pattern. These were sent for typing and were found to be identical strains.

The following control measures were taken:

1. The patients were nursed with standard isolation precautions and treated according to national guidelines
2. Enhanced infection control procedures and the management of medical devices were reinforced and implemented
3. A review of the cleaning of the environment and clinical equipment was performed. Enhanced cleaning of common areas was performed
4. Staff who had provided care to the patients were asked if they had symptoms consistent with S40(2). None were identified
5. Enhanced surveillance of S40(2)continues across the Trust.

Infection Prevention and Control Team, S40(2) 2016.

Plymouth Hospitals NHS
NHS Trust

S40(2)on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The S40(2) Five or fewer organisms were isolated from urine samples and the patients were on S40(2) at the same time.
- A series of recommendations regarding infection control practice, urinary catheter management and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) Five or fewer cases of S40(2) with a similar antibiotic-susceptibility pattern were noted in patients who were on S40(2) at the same time. An outbreak meeting was held on S40(2) 2016 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, urinary catheter care and enhanced cleaning of the environmental and equipment. There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016

S40(2) on Section 40(2) 2016

Summary

- S40(2) 2016, S40(2) was grown from S40(2) Five or fewer patients who were on or had been on S40(2).
- Enhanced infection control procedures were reinforced and implemented.
- The linked sink outlets were hyper-chlorinated.
- Molecular typing revealed no evidence of cross-infection or acquisition from the clinical environment.

S40(2) 2016, S40(2) was grown from respiratory samples from S40(2) Five or fewer patients who were on or had been on S40(2). Water controls (temperatures of hot and cold water, copper/silver levels and flushing logs) were within recommended limits. Recent routine water testing had not revealed any concerns with Total Viable Counts, S40(2) Safe water practice was already implemented on the S40(2) with clinical sinks used for hand-washing only.

An incident meeting was held on S40(2) 2015. Cleaning and enhanced infection control procedures, including the airway management and the safe use of water on the S40(2) were reinforced and implemented. The Site Services Team arranged for hyper-chlorination of all the effected outlets.

Sampling of the water supply was performed and swabs were taken from the hand wash basins from each of the bed spaces. S40(2) was grown from the environmental samples linked to each patient. S40(2) Five or fewer of the patient isolate were available for typing and were different to each other. The environmental strains were identical to previous strains isolated from the S40(2) environment, but were distinct to those grown from the patients. There was no therefore no evidence of cross-infection or acquisition from the environment.

Infection Prevention and Control Team, S40(2) 2016

Plymouth Hospitals NHS
NHS Trust

S40(2) on Section 40(2) 2016

Summary

- In S40(2) 2016, S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The S40(2) Five or fewer strains had identical antibiograms, but molecular typing subsequently showed them to be different to each other and other isolates S40(2).
- A series of recommendations regarding infection control practice, aseptic technique, airway management and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2016, S40(2) was isolated from S40(2) five or fewer patients in S40(2). The S40(2) Five or fewer strains had identical antibiograms.

An outbreak meeting was held on S40(2) 2016 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, airway management, and enhanced cleaning of the environmental and equipment. Molecular typing demonstrated that the S40(2) Five or fewer strains were different to each other and previous isolates S40(2). There have been no further cases since S40(2) 2016.

Infection Prevention and Control Team, S40(2) 2016

Plymouth Hospitals NHS
NHS Trust

S40(2) on Section 40(2) 2017

Summary

- In S40(2) 2017, S40(2) Five or fewer of S40(2) were noted on S40(2).
- The strains had identical antibiograms, but molecular typing subsequently showed them to be different to each other and other isolates from the S40(2).
- A series of recommendations regarding infection control practice, aseptic technique, airway management and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. In S40(2) 2017, S40(2) with identical antibiograms was isolated from S40(2) Five or fewer on the S40(2). All S40(2) Five or fewer patients were on the S40(2) at the same time and S40(2) Five or fewer had been in the same bed space. The S40(2) had recently undergone a deep clean and recent equipment ATP results had been satisfactory.

An outbreak meeting was held on S40(2) 2017 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, airway management, and enhanced cleaning of the environmental and equipment. Molecular typing demonstrated that all S40(2) Five or fewer strains were different to each other and previous isolates from the S40(2). There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2016

Plymouth Hospitals NHS
NHS Trust

S40(2) on Section 40(2) 2017

Summary

- S40(2), S40(2) Five or fewer cases of S40(2) were noted on S40(2).
- The strains were sent for molecular typing and S40(2) Five or fewer were found to be identical to each other.
- A series of recommendations regarding infection control practice, aseptic technique, airway management and environmental cleaning were made.

Description of the cases

S40(2) Place removed to avoid biographical identification. S40(2) 2017, S40(2) was isolated from S40(2) Five or fewer patients on S40(2). The patients were all nursed in the same area of the ward.

Outbreak meetings were held on S40(2) and S40(2) 2017 to review the situation and implement appropriate control measures. Enhanced infection control procedures were reinforced, with particular attention to hand hygiene, aseptic technique, airway management, and enhanced cleaning of the environmental and equipment. Molecular typing demonstrated that S40(2) Five or fewer of the strains were identical. There have been no further cases since S40(2) 2017.

Infection Prevention and Control Team, S40(2) 2017.