### Clostridium difficile Infection Policy

<table>
<thead>
<tr>
<th>Post holder responsible for Policy</th>
<th>Judy Potter, Lead Nurse Director of Infection Prevention &amp; Control</th>
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<tbody>
<tr>
<td>Author of Policy</td>
<td>Judy Potter, Lead Nurse/Director of Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Division/ Department responsible for Policy</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
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<tr>
<td>Contact details</td>
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<td>Date of original document</td>
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<td><strong>Yes</strong>/No</td>
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<td>Infection Control &amp; Decontamination Assurance Group: 24th January 2017</td>
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<td>June 2021 (every 5 years)</td>
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<td>Expiry date</td>
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Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

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<td>Integrated Community Pathways</td>
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<td>Monitor/Finance/Performance</td>
<td>Develop Acute services</td>
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<td>Infection Control ✓</td>
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Other (please specify): |

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Full History

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Associated Policies:
- Antimicrobial Policy
- Guidelines for Good Antimicrobial Prescribing
- Incident Reporting Analysing Investigating and Learning Policy
- Torridge ward Operational Guidance

Key Words
- Clostridium difficile, CDI, Cdiff

In consultation with and date:
- Infection Control Operational Group: 14th November 2016
- Community Professional Leads, Senior Nurses and Matrons: 19th December 2016
- Infection Control & Decontamination Assurance Group: 24th January 2017
- Policy Expert Panel: 1st February 2017

Contact for Review:
- Lead Nurse, Infection Prevention & Control

Executive Lead Signature:
(Only applicable for Strategies & Policies)

Medical Director
CONTENTS

1. INTRODUCTION ..................................................................................................................... 4
2. PURPOSE ................................................................................................................................. 4
3. DEFINITIONS (Dept. of Health/HPA, 2009) ........................................................................... 4
4. DUTIES AND RESPONSIBILITIES OF STAFF .................................................................... 5
5. DIAGNOSIS ............................................................................................................................ 7
6. SUSPECTED CDI - ACTION TO TAKE ............................................................................... 8
7. CONFIRMED CDI - ACTION TO TAKE ............................................................................... 8
8. TREATMENT AND CLEARANCE ....................................................................................... 8
9. STOPPING ISOLATION AND TERMINAL CLEANING ....................................................... 8
10. RELAPSE ............................................................................................................................. 8
11. TRANSFER .......................................................................................................................... 9
12. DISCHARGE ....................................................................................................................... 9
13. DEATH CERTIFICATION .................................................................................................... 9
14. SURVEILLANCE .................................................................................................................. 9
15. MANAGEMENT OF INCREASED INCIDENCE AND OUTBREAKS OF CDI ............. 10
16. ARCHIVING ARRANGEMENTS ......................................................................................... 10
17. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY ................................................................................................................................. 10
18. REFERENCES ..................................................................................................................... 11
APPENDIX 1: SUSPECTED CLOSTRIDIUM DIFFICILE INFECTION - ACTION TO TAKE .............................................................. 13
APPENDIX 2: CONFIRMED CLOSTRIDIUM DIFFICILE INFECTION - ACTION TO TAKE ................................................................................. 14
APPENDIX 3: TREATMENT AND CLEARANCE ................................................................ 15
APPENDIX 4: COMMUNICATION PLAN ............................................................................... 18
APPENDIX 5: EQUALITY IMPACT ASSESSMENT TOOL ...................................................... 19
1. INTRODUCTION

1.1 Clostridium difficile is a bacterium that produces two potent toxins that cause mucosal damage and inflammation of the large colon. It causes a diarrhoeal illness which can vary from mild to severe, and occasionally, particularly elderly patients may develop a severe life threatening form of the disease called ‘pseudomembranous colitis’. This condition is characterised by significant damage to the large bowel, and may lead to gross dilation with possible rupture or perforation of the bowel. C. difficile infection (CDI) is extremely unpleasant for the patient and has significant morbidity and both direct and indirect mortality, especially in elderly patients with multiple comorbidities.

1.2 CDI is often acquired in hospital and other communal care settings, and most patients who develop C. difficile diarrhoea are taking, or have recently been given antibiotic therapy. Nearly all antibiotics have been causally associated with C. difficile however, some such as cephalosporins (particularly oral cephalosporins), quinolones, clindamycin and antibiotic combinations such as cefuroxime and clarithromycin are more strongly associated whereas gentamicin, vancomycin, tetracyclines and trimethoprim are much less often associated.

1.3 The sensible use of antibiotics is the key to the prevention of CDI. Unnecessary use of antibiotics must be avoided. Where possible, short courses of narrow-spectrum antibiotics, of only three to five days, are preferred to longer courses. All antibiotic prescriptions should be kept under review and follow Royal Devon & Exeter NHS Foundation Trust (hereafter referred to as “the Trust”) guidelines.

1.4 It has been firmly established that person to person transmission can occur in the hospital and other communal care settings and indeed major outbreaks have resulted. Staff hands are the most important mode of transmission, but studies have also demonstrated that C. difficile, as a spore forming organism, can survive for long periods of time in the environment and on contaminated equipment.

1.5 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 The purpose of this policy is to:

- reduce transmission of Clostridium difficile
- ensure that patients with CDI are managed appropriately
- patients are provided with accurate information about C. difficile infection.

This policy takes into consideration the prevalence of CDI both locally and nationally and takes into account national guidance (Dept of Health/Health Protection Agency, 2009; Dept of Health 2010; Dept of Health 2012; Public Health England (PHE) 2013)

3. DEFINITIONS (Dept. of Health/HPA, 2009)

3.1 Clostridium difficile infection (CDI): one episode of diarrhoea, defined either as stool loose enough to take the shape of a container used to sample it or as Bristol Stool Chart types 5–7 that is not attributable to any other cause including medicines and that occurs at the same time as a positive toxin assay (with or without a positive C. difficile culture) and/or endoscopic evidence of pseudomembranous colitis (Dept of Health/Health Protection Agency, 2009)
3.2 **Period of increased incidence** —: two or more new cases in a 28-day period on a ward/unit.

3.3 **Outbreak of *C. difficile* infection**: two or more cases caused by the same strain related in time and place over a defined period that is based on the date of onset of the first case.

3.4 **Acute Trust apportioned case of CDI**: *C. difficile* infections are apportioned to an acute Trust if the patient’s specimen date is on, or after, the fourth day of the admission (or admission date is null), where the day of admission is day 1.

4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 **Board of Directors**
The Board will support and encourage compliance through the Executive lead for healthcare associated infection and the Joint Directors for Infection Prevention and Control by:

- Regarding lapses in compliance this policy with as a serious issue.
- Supporting mandatory education at induction for all staff and appropriate updates for staff involved in direct patient contact.
- Ensuring consideration is given to the provision of facilities for the isolation of patients with suspected or confirmed CDI, e.g. suitable isolation facilities, hand wash basins.
- Involving the Infection Prevention and Control Team in the planning process for new construction and refurbishment work so that advice can be given on appropriate isolation facilities as emphasised by “*Infection Control in the Built Environment*” (Dept of Health, 2013) and the *Health and Social Care Act 2008* (Dept of Health 2010).
- Considering performance against national and local objectives monthly

4.2 **Joint Directors of Infection Prevention and Control**
The Joint Directors of Infection Prevention and Control are responsible for:

- Reporting performance against national or local targets and highlighting lapses in compliance with this policy to the Board of Directors through the governance structure
- Coordinating the provision of essential education for all staff at induction and annual updates
- Providing advice on infection control issues associated with facilities for isolation of patient with infectious conditions
- Ensuring that infection control expertise is provided in the planning process for new construction and refurbishment works

4.3 **Infection Control and Decontamination Assurance Group (ICDAG)**
ICDAG is responsible for:

- Ratifying the *Clostridium difficile* infection policy
- Using CDI surveillance data to review performance and identify areas for improvement
- Escalating issues and concerns about *Clostridium difficile* performance to the Safety and Risk Committee
4.4 Divisional Directors, Assistant Directors of Nursing and Associated Medical Directors
Each divisional management team has a responsibility to actively encourage compliance with the Policy by all staff groups.

- Ensure that all staff including junior medical staff undertake and complete infection control training and annual updates.
- Provide facilities and equipment for isolation of in-patients with suspected or confirmed CDI.
- Ensure the provision of infection control training and the release of staff to undertake training.
- Ensure that CDI surveillance and any root cause analysis action plans are discussed at Divisional Governance Group meetings as part of the infection control standing agenda item.

4.5 Infection Prevention and Control Team (IPCT)
The IPCT will:

- Ensure that CDI results are communicated to the clinical staff promptly.
- Provide advice on appropriate placement of patients with suspected or confirmed CDI.
- Update patient infection control alerts appropriately for PAS and Whiteboard.
- Produce timely feedback on surveillance of CDI for wards/units, divisions and Board of Directors.
- Produce reports to the Infection Control and Decontamination Assurance Group and for the Trust Board on CDI performance.
- Ensure that all patients over the age of two with a positive C. difficile toxin enzyme immunoassay are reported on the HPA mandatory enhanced surveillance system.
- Monitor the use of antimicrobial agents within the Trust and feedback on areas for improvement.
- Review the Clostridium difficile policy and making any necessary revisions in light of local surveillance and national evidence based guidance.

4.6 Microbiology staff

- Ensure that testing for CDI is available 7 days per week and is undertaken in accordance with national guidance (Dept of Health, 2012).
- Ensure that C.difficile laboratory results are communicated promptly to clinical teams.
- Provide timely advice to clinicians regarding appropriate treatment.

4.7 Matrons and other nursing staff

- Ensure that patients with suspected infective diarrhoea are identified promptly, reported to the infection prevention and control team and isolated in single room accommodation if they are in hospital.
- Obtain faecal sample for C.difficile testing promptly and send to microbiology laboratory.
- Record bowel movements using the Bristol Stool Chart.
- Ensure that hospital visitors are advised of any necessary infection control precautions required of them when visiting a patient with suspected or confirmed CDI.
• On laboratory confirmation of CDI arrange for transfer of the patient to *C. difficile* isolation ward, if appropriate (Acute Trust hospital patients only).
• Administer prescribed treatment for CDI.
• Ensure that hospital bed spaces/rooms vacated and associated equipment used by patients with suspected or confirmed CDI are terminally cleaned and disinfected prior to new admission

4.8 **Consultant and other medical staff responsibilities**

• Use antimicrobial agents prudently
• When antimicrobial use is necessary comply with the [Antimicrobial Policy](#) and [Guidelines for Good Antimicrobial Prescribing](#)
• Ensure that a plan is in place to ensure that patients with CDI, who are transferred to the isolation ward, receive the appropriate clinical care.
• Advise the IPCT if transfer of the patient to the isolation ward will compromise a patient’s clinical care.
• Commence treatment of patients with confirmed CDI in accordance with this policy or Microbiology advice.
• Ensure that all patients with CDI are kept under review by Microbiology and other specialists with an interest in *C. difficile*, especially if not managed on the isolation ward

4.9 **Site Management Team**

• Assist ward staff to identify single room accommodation for patients with suspected CDI
• Facilitate the prompt transfer of patients with confirmed CDI into the isolation ward, and transfer out on recovery, on the advice of the IPCT.

4.10 **Housekeeping/Domestic Services**

• Routinely maintain a clean environment to reduce level of environmental contamination with *C. difficile* spores
• Provide terminal cleaning of vacated bed spaces/isolation rooms on discharge/transfer of patients with suspected or confirmed CDI using products advised by the Infection Prevention and Control Team

4.11 **All Staff**

All staff have a personal and corporate obligation to comply with best practice in the prevention of infection and comply with this and all other infection control related policies.

5. **DIAGNOSIS**

5.1 Stool samples, loose enough to take the shape of the container, submitted from all hospital in-patients (excluding neonates and children under 2 years) will be tested routinely for the presence of toxigenic *C. difficile* in accordance with national guidance ([Dept of Health, 2012](#)).

5.2 In general practice, only diarrhoeal stool samples from patients over 65 years of age will be tested routinely for toxigenic *C. difficile*. If a GP requires a *C. difficile* test on a younger patient this must be specifically requested.
5.3 Samples of faeces taken within 7 days of a negative stool test for toxigenic *C. difficile* will not normally be tested for *C. difficile* unless agreed with a Consultant Microbiologist. Also it is not normally necessary to retest for toxigenic *C. difficile* in patients presenting with typical features of relapsing CDI, although such patients may be tested for other pathogens (e.g. norovirus) in some circumstances. Where a negative *C. difficile* test is reported and a patient remains symptomatic without other causes for the diarrhoea clinicians should seek advice from a Consultant Microbiologist as to whether repeat testing may be indicated.

5.4 Sudden increases in the number and/or severity of cases detected in a ward or across several units within a hospital are legitimate reasons for typing *C. difficile* in order to detect outbreaks or appearance of virulent strains. Typing is undertaken by the *Clostridium difficile* Ribotyping Network for England and can only be requested with the agreement of the Public Health England Regional Microbiologist. To facilitate investigations a sample from all stools positive for toxigenic *C. difficile* is stored for a minimum of 2 years.

6. SUSPECTED CDI - ACTION TO TAKE

Refer Appendix 1

7. CONFIRMED CDI - ACTION TO TAKE

Refer Appendix 2

8. TREATMENT AND CLEARANCE

Refer Appendix 3

9. STOPPING ISOLATION AND TERMINAL CLEANING

9.1 Once the patient is considered non infectious the housekeeping/domestic supervisor should be notified, and given early warning if possible, so that the room, and associated equipment, can be decontaminated, usually using hydrogen peroxide vapour.

10. RELAPSE

10.1 If further diarrhoea occurs after recovery, suspect a relapse, isolate the patient. Repeat testing for *C. difficile* is not always necessary if symptoms are typical, and can be misleading as patients can remain toxin positive for some time after clinical infection. Testing for other pathogens to exclude alternative infection may be required. Investigation and management of relapses should be discussed with the clinical team on Torridge Ward or Medical Microbiologist.
11. TRANSFER

11.1 If transfer of a patient with CDI is confirmed or suspected, the receiving area must be informed prior to transfer.

11.2 The Infection Prevention and Control Team should be informed of the transfer as soon as possible.

11.3 When a patient has been positive but symptoms have resolved, the receiving area should be informed as part of the normal handover process. This will ensure that the diagnosis of *C. difficile* is considered if the patient has any further diarrhoea.

12. DISCHARGE

12.1 Staff must ensure that the diagnosis of CDI is noted on the information sent to the patient’s General Practitioner, and the patient should be advised to report to their GP if they experience further diarrhoea. If there is planned follow up by community nursing teams they should also be informed at the time of referral as a matter of course.

12.2 If a patient still has symptoms on discharge, agencies that will provide care for the patient must be informed as part of normal discharge communication.

13. DEATH CERTIFICATION

13.1 If a patient with CDI dies, the death certificate should state whether CDI was part of the sequence of events leading directly to death or whether it was the underlying cause of death. If either case applies CDI should be mentioned in Part 1 of the certificate.

13.2 If CDI was not part of the sequence of events leading directly to death but contributed in some way to it, this should be mentioned in Part 2.

13.3 If a doctor is in doubt about the circumstances of death when writing the certificate, they should consult with the trust’s multidisciplinary clinical review team for CDI.

13.4 It is considered a serious incident requiring investigation if CDI is recorded on Part 1 of the death certificate or CDI results in colectomy and is reportable externally to the commissioners in accordance with the *Incident Reporting, Analysing, Investigating and Learning Policy and Procedures*.

14. SURVEILLANCE

14.1 The Infection Prevention and Control team (IPCT) will undertake continuous surveillance of CDI.

14.2 Weekly reports will be made to the Executive Team identifying acute trust apportioned cases and performance against the annual objective.

14.3 The IPCT will provide wards with charts showing new cases of CDI on a monthly basis via the Ward to Board report.
14.4 Outbreaks and period of increased incidence will be discussed at Divisional Governance Group meetings

14.5 Trust wide surveillance data will be reported to the Infection Control and Decontamination Assurance Group, Safety and Risk Committee and the Board of Directors.

15. MANAGEMENT OF INCREASED INCIDENCE AND OUTBREAKS OF CDI

15.1 A period of increased incidence (PII) of CDI is defined as two or more new ward acquired cases in a 28-day period on a ward/unit.

15.2 The IPCT will inform the relevant Associate Medical Director, Assistant Director of Nursing and Divisional Director urgently when a PII is identified in a particular ward area and advise on action required.

15.3 Depending on the size and rate of growth of the PII action required may include:
- Holding an incident meeting
- Partial closure of a bay to new admissions
- Closure of a ward to new admissions
- Deep cleaning of an area or entire ward using a chlorine containing agent or hydrogen peroxide vapour
- Review of antimicrobial prescribing
- Review of patient equipment cleaning
- PCR Ribotyping

15.4 Ribotyping may confirm that a PII represents an outbreak of CDI. If so, this will be reported on the electronic incident reporting system as an outbreak.

16. ARCHIVING ARRANGEMENTS
The original of this policy will remain with the author, Lead Nurse/Director for Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet, (A-Z) P – Policies (Trust-wide) – C- Clostridium difficile Infection Policy. Archived copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy, where one exists, will be held for 10 years.

17. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

17.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

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<th>Minimum Requirements</th>
<th>Evidenced by</th>
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<tr>
<td>1.</td>
<td>Laboratory testing for C.difficile will be undertaken in accordance with national guidance</td>
<td>Laboratory standard operating procedure</td>
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<tr>
<td>2.</td>
<td>All cases of CDI will be reported to Public Health, England in accordance with national mandatory surveillance requirements</td>
<td>Reported data can be viewed on the PHE website.</td>
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3. Patients with CDI will be reviewed by the IPCT to review isolation precautions and monitoring of symptoms

4. In-patients with confirmed CDI will be isolated appropriately

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<td>In each financial year, the Lead Nurse/Director of Infection Prevention and Control (DIPC) will ensure that results of the auditable standards are included in the annual report of the Joint Directors of Infection Control which is presented to the Board of Directors.</td>
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<th>17.3 Undertaken by</th>
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<tr>
<td>Lead Nurse/Joint DIPC</td>
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<th>17.4 Dissemination of Results</th>
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<td>Results from reporting will be discussed at Infection Control Operational Group meetings, through Divisional Governance Group meetings and escalated to the Infection Control and Decontamination Assurance Group if compliance with the minimum standards not achieved.</td>
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<th>17.5 Recommendations/ Action Plans</th>
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<td>Implementation of the recommendations and action plans will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly.</td>
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| 17.6 Any barriers to implementation will be risk-assessed and added to the risk register. |

| 17.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system. |

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<th>18. REFERENCES</th>
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Bristol Stool Chart. Available at: http://en.wikipedia.org/wiki/Bristol_stool_scale
APPENDIX 1: SUSPECTED CLOSTRIDIUM DIFFICILE INFECTION - ACTION TO TAKE

1. Obtain and send a faecal sample for toxigenic *C. difficile* testing. Ensure that microbiology request form is completed appropriately and that specimen container is closed securely to avoid leakage.

2. Inform the Infection Prevention and Control Team

   **In hospital:**

3. Move patient into a single room, with *ensuite* facilities where possible. Where *en suite* facilities are unavailable, a dedicated commode should be allocated. Source isolation procedures as per the Source Isolation Procedures should be followed.

4. Ensure vacated bed space is terminally cleaned prior to admitting the next patient as per instructions for terminal cleaning in Source Isolation Procedures.

5. Ensure that the following precautions are in place:

   5.1 **Hand Hygiene:** Staff hands are the most important mode of transmission of microbes from patient to patient. Soap and water must be used for hand hygiene after contact with a patient who has CDI as this is the most effective method for removal of spores. However, alcohol hand rub must be available for hand hygiene before contact with the patient and between tasks on the same patient.

      Patients must also be encouraged to wash their hands. If the patient is bed bound, wet patient wipes can be offered for hand hygiene as an alternative to soap and water.

   5.2 **Protective Clothing:** Gloves and aprons must be worn for direct patient contact with the symptomatic patient or when cleaning the isolation room/bay. Hands must be washed with soap and water following removal of protective clothing.

   5.3 **Staff exclusion:** Staff very rarely suffer from symptoms related to *C. difficile*. However, should staff be receiving antibiotics then they may be at some risk of infection, and therefore should avoid contact with known cases of *C. difficile* infection.

   5.4 **Family, visitors and social contact:** Protective clothing is unnecessary unless involved in personal care. Advise visitors to wash their hands immediately prior to leaving the isolation room. Advise visitors not to eat or drink within the room. If visitors disclose the fact that they are taking antibiotics, they should be advised of the increased risk of infection.

6. Do NOT give anti-motility agents such as Loperamide (risk of toxic megacolon).

7. Objective assessment of the patient’s bowel movements must be undertaken every time the patient opens their bowels and recorded on a stool chart. The use of the *Bristol Stool Scale* is required for this purpose.
APPENDIX 2: CONFIRMED CLOSTRIDIUM DIFFICILE INFECTION - ACTION TO TAKE

1. If patient is on the RD&E (Wonford) site, arrange transfer to designated C. difficile isolation facilities via the infection control team (also refer Torridge Ward Operational Guidance). Precautions as described in Appendix 1 Section 5 will continue.

   The benefits of transfer to the designated ward include:
   • Reduces risk to other patients in original ward
   • Specialist medical management of CDI
   • Daily multidisciplinary review of patients

2. If the clinical condition of the patient suggests that the patient should remain in a specialist area, rather than being transferred to the designated isolation facilities, a member of the Infection Control Team will discuss and confirm appropriate placement with the relevant Consultant. Precautions as described in Appendix 1 Section 5 will continue.

3. If the patient is not on the RD&E (Wonford) site, the patient will be isolated in a single room with precautions as described in Appendix 1 Section 5.

4. If the patient is in their own home, health and social care providers should practice standard infection control precautions

5. Ensure patient is provided with an explanation of C. difficile infection and an information leaflet.
APPENDIX 3: TREATMENT AND CLEARANCE

1. Treatment will depend on the severity of the CDI. All in-patients must be assessed by a senior member of medical staff (refer point 3 below regarding severity assessment). Advice should be sought from the duty Medical Microbiologist or specialist team based on Torridge ward.

2. All confirmed cases should have medication review.
   - Stop any antibiotics that may have precipitated the acquisition of CDI, if possible. This may suffice to prevent diarrhoea developing further.
   - DO NOT give anti-motility agents such as Loperamide (risk of toxic megacolon).
   - If on acid suppressing drugs eg H2antagonists or PPI (Proton Pump Inhibitors) then these should be withheld unless there is a good indication to continue them (eg Duodenal ulcer, use of NSAIDs & steroids). Acid suppressing drugs can double the risk of acquiring C.difficile in the first place & than double the risk of relapse if continued.

3. Assess the severity of CDI each day. Assessment should include clinical examination and monitoring of severity of diarrhoea. Laboratory markers should include full blood count, renal function and C reactive protein. Blood lactate may be helpful in severe disease. Abdominal x-ray or CT assessment may also be indicated especially in assessment of severe disease. Categorisation of severity (Public Health England (PHE), 2013) is as follows:
   - **Mild CDI** is not associated with a raised WCC; it is typically associated with <3 stools of types 5–7 on the Bristol Stool Chart per day.
   - **Moderate CDI** is associated with a raised WCC that is <15 x 10⁹/L; it is typically associated with 3–5 stools per day.
   - **Severe CDI** is associated with a WCC >15 x10⁹/L, or an acute rising serum creatinine (i.e. >50% increase above baseline), or a temperature of >38.5°C, or evidence of severe colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity.
   - **Life-threatening CDI** includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.

3.1 Severity Score. All patients should have an initial assessment for disease severity. In addition to established PHE (2013) classification there are a number of parameters that help assess severity and associated mortality risk.

CRP >250 then score 1 point, Albumin <25 score 1 point, Combined Respiratory Rate >17 & White Cell Count >12 then score 1 point.

30 day mortality can then be predicted:

Score 0 = 9.5%
Score 1 = 36%
Score 2 = 66%
Score 3 = 100%
4. **Treatment for mild to moderate CDI**

- **1st line:** Oral metronidazole 400mg 8 hourly for 10 days.
- **Second line:** Oral vancomycin if metronidazole intolerant/allergic reaction or alcoholic, or after discussion with a Medical Microbiologist or specialist.

**After 5 days** treatment with metronidazole or vancomycin, if the patient still has diarrhoea, review diagnosis.

4.1 If severity increases while on treatment obtain urgent review from Microbiology or specialist based on Torridge ward

5. **Treatment for severe CDI**

Oral vancomycin 125 mg qds for 10–14 days.

5.1 In severe CDI cases not responding to oral vancomycin 125 mg qds, additional measures including the addition of intravenous (iv) metronidazole 500 mg tds, and rectal vancomycin should be considered.

5.2 The addition of oral rifampicin (300 mg bd) or iv immunoglobulin (400 mg/kg) may also be considered.

6. **Treatment for Life-threatening CDI**

6.1 It is essential that all patients are managed by a multidisciplinary team including a physician with experience in management in *C. difficile* disease, a Medical Microbiologist and a colonic surgeon.

6.2 In addition to medical measures, colectomy should be considered.

7. **Persistent Diarrhoea**

7.1 If diarrhoea persists despite 20 days’ treatment but the patient is stable and the daily number of type 5–7 motions has decreased, the WCC is normal, and there is no abdominal pain or distension, the persistent diarrhoea may be due to post-infective irritable bowel syndrome.

7.2 At this stage, the patient may be treated with an anti-motility agent such as loperamide 2 mg prn (instead of metronidazole or vancomycin). The patient should be closely observed for evidence of a therapeutic response and to ensure there is no evidence of colonic dilatation.

8. **Treatment for Recurrent CDI**

8.1 Recurrence or relapse following an episode of CDI is common and may be due to an infection with the same strain, or a different strain of *C. difficile*. A proportion of patients may have multiple recurrences. Recurrence does not occur because of resistance to metronidazole / vancomycin, but because of the disturbance of normal gut flora in *C. difficile* patients.

8.2 For first recurrence, repeat the same antibiotic used to treat the initial episode in the first instance, or manage as appropriate to the severity of infection.
8.3 For subsequent recurrences, a tapering course of vancomycin may be used. Occasionally iv immunoglobulin is used for multiple recurrences. Specialist advice should always be obtained.

8.4 Fidoxamicin is a new class of antibiotic for CDI. It is equally effective in treating a first case of CDI as standard oral vancomycin but may have a lower relapse rate. It’s an additional drug to consider in patients who are relapsing or who are considered very high for relapse initially. It should only be prescribed on the advice of a Consultant microbiologist or by the Isolation Ward (Torridge Ward) Consultant.

8.5 In selected patients with recurrent *C. difficile* faecal donation treatment will be considered.

9. **Clearance**

9.1 **DO NOT** send specimens to confirm a patient is negative for *C. difficile* toxin unless asked to by a member of the infection prevention and control team. **Follow up stool samples are of no value since they often remain positive even in patients who have recovered symptomatically.**

9.2 Once a patient has had 48 hours without diarrhoea and a return to normal bowel habits they can be considered non-infectious. Source isolation precautions can then be stopped with the agreement of the Infection Prevention and Control Team.
The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the strategy/policy</th>
<th>All staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key changes if a revised policy/strategy</td>
<td>Adapted to take community services into consideration</td>
</tr>
</tbody>
</table>
| The key objectives                                            | The purpose of this policy is to:  
• reduce transmission of *Clostridium difficile*  
• ensure that patients with CDI are managed appropriately  
• patients are provided with accurate information about *C.difficile* infection. |
| How new staff will be made aware of the policy and manager action | Induction |
| Specific Issues to be raised with staff                      | No new issues |
| Training available to staff                                  | Induction and infection control updates |
| Any other requirements                                       | N/A |
| Issues following Equality Impact Assessment (if any)         | No negative impacts |
| Location of hard / electronic copy of the document etc.      | Infection Control Team Office and Site Management Office |
APPENDIX 5: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Clostridium difficile Infection Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services, Infection Control</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Judy Potter Lead Nurse/Joint Director for Infection Prevention and Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>20/10/2016</td>
</tr>
</tbody>
</table>

The purpose of this tool is to:

- identify the equality issues related to a policy, procedure or strategy
- summarise the work done during the development of the document to reduce negative impacts or to maximise benefit
- highlight unresolved issues with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

The purpose of this policy is to:
- reduce transmission of *Clostridium difficile*
- ensure that patients with CDI are managed appropriately
- patients are provided with accurate information about *C.difficile* infection.

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*

Carers ☐ Staff ☐ Patients X Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*

*Please insert an “x” in the appropriate box (x)*

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td>☐</td>
</tr>
<tr>
<td>Disability</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>X</td>
</tr>
</tbody>
</table>
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

N/A

5. Do you think the document meets our human rights obligations? X

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The content of this policy is not new but now makes specific reference to community services. Previous discussions with the Equality and Diversity Manager did not identify any issues relating to equality, diversity and inclusion commitments other than a positive impact on older people who are more vulnerable to C. difficile infection. The policy has been circulated to all members of the Infection Control which includes Specialist Nurses and Medical Microbiologists for consultation, including those working in the community setting, and has been considered by the Infection Control Operational Group which includes widespread representation from clinical, managerial and support staff.

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protect charactertistic”:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue:</td>
<td></td>
</tr>
<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
<td></td>
</tr>
<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
<td></td>
</tr>
</tbody>
</table>