POLICY FOR THE PREVENTION AND CONTROL OF *CLOSTRIDIOIDES DIFFICILE* INFECTION (CDI)

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Purpose of Agreement	To provide clear guidance and direction to staff within Solent NHS Trust on the management of CDI
Document Type	X Policy
Reference Number	Solent NHST/Policy/ IPC11
Version	7
Name of Approving Committees/Groups	Policy Group & Clinical Executive Group
Operational Date	March 2022
Document Review Date	March 2025
Document Sponsor (Job Title)	Chief Nurse & Director of Infection Prevention and Control
Document Manager (Job Title)	Head of Infection Prevention and Control Team
Document developed in consultation with	Infection Prevention & Control Team Infection Prevention & Control Group NHSLA Policy Group
Intranet Location	Business Zone > Policies, SOPs and Clinical Guidelines
Website Location	N/A
Keywords (for website/intranet uploading)	Cdiff, Clostridioides difficile, CDI, Diarrhoea, Policy, IPC11

Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
1	Dec 14	5	Updated the recognised risk factors	Immediate
2	Dec 14	10	Clarified CDI care in community	Immediate
3	Dec 14	12	Incorporated e-learning requirements	Immediate

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	07/14	E Hore	Policy Sub Committee	Review met
3 / 4	05/18	N Mounter	Policy Sub Committee	Review date
5	June 2021	Debbie Larkins	Chair's action approved extension request to October 2021 to allow time to review. Content remains current.	No changes made to policy.
6	August 2021	Debbie Larkins	Chair's action approved extension request to March 2022 to allow time to review. Content remains current.	No changes made to policy.
7	September 2021	Debbie Larkins	Policy Review	Review met

SUMMARY OF POLICY

Clostridioides difficile infection; formerly known as Clostridium *difficile* (CDI), C.*difficile*) causes serious illness and outbreaks among hospital service users, affecting the elderly & debilitated. Antibiotic use and environmental contamination contribute to the risk. Service users in the community setting can also be affected. This policy defines the actions to be taken by the Trust to reduce the transmission of *C. difficile* infection and improve the management of affected service users.

Clinical staff must apply the following mnemonic protocol (SIGHT) when managing suspected potentially infectious diarrhoea:

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea.
I	Isolate the patient and consult with the infection prevention team (IPT) while determining the cause of the diarrhoea.
G	Gloves and aprons must be used for all contacts with the patient and their environment.
H	Hand washing with soap and water must be carried out before and after each contact with the patient and the patient's environment.
T	Test the stool for toxin, by sending a specimen immediately

(Public Health England, 2013)

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1. INTRODUCTION & PURPOSE

1.1 *Clostridioides difficile (C.difficile)* are spore forming, gram-positive anaerobic bacilli that produce endotoxins, cause gastrointestinal infections in humans and are shed in faeces. *C.difficile* may be found in the large intestine of approximately 3% of the population (ONS 2015) and up to 20% of patients following contact with healthcare facilities

1.2 *C.difficile* has the potential to cause serious illness and death, therefore *Clostridioides difficile* Infection (CDI) should be managed as a diagnosis in its own right (Healthcare Commission 2007a).

1.3 Factors that increase the risk of CDI include antibiotic treatment, being age 65 or over and an underlying morbidity such as abdominal surgery, cancer, chronic renal disease and enteral feeding. Antimicrobials suppress other gut bacteria allowing C.difficile to proliferate and produce toxins resulting in CDI. Any antibiotic may be associated with CDI but broad spectrum antibiotics, such as cephalosporins and fluroquinolones are most often associated.

2. SCOPE & DEFINITIONS

2.1 This policy applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the trust, and secondees (including students), volunteers (including associate Hospital Managers), Non-Executive Directors, governors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Right's Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wide community and our staff.

2.3 **Definitions**

2.4 **Antigen:** A toxin or other foreign substance which induces an immune response in the body, especially the production of antibodies.

2.5 **C.Difficile:** abbreviation for Clostridioides difficile

2.6 **Endotoxin:** A toxin that is not secreted in soluble form by live bacteria but is a structural component in the bacteria which is released mainly when bacteria are destroyed.

2.7 **GDH:** The glutamate dehydrogenase test detects the antigen that is produced in high amounts by C*.difficile. This may be also referred to as C.difficile carriage.*

2.8 **Outbreak of CDI:** Two or more cases of the same strain related in time and place.

2.9 **Period of Increased Incidence (PII):** Two or more new cases within a ward in a 28 day period.

2.10 **Pseudo-membranous colitis:** An infection of the colon, frequently, but not exclusively caused by C.*difficile*. In severe cases, life-threatening complications, such as toxic mega-colon, can occur.

2.11 **Spores:** Spores are produced when *Clostridium difficile* bacteria encounter unfavorable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

2.12 **Toxic mega colon:** A life-threatening complication of several intestinal conditions. It is characterized by a very dilated colon (mega colon) accompanied by abdominal distension, and sometimes fever, abdominal pain or shock.

3 PROCESS/REQUIREMENTS

3.1 RISK FACTORS FOR CDI

3.1.1 These include:

- Over 65 years of age
- Antibiotics therapy in previous 1-3 months Particularly high risk antibiotics are the 4C's – Cephalosporins, Ciprofloxacin & Quinolones, Co-amoxiclav, and Clindamycin
- Immuno-compromised patients
- Hospital admission within previous one to three months
- Past infection with CDI or previous *C.difficile* carriage
- Presence of co-morbidity
- Existing bowel problems, such as inflammatory bowel disease or colon cancer
- Bowel surgery
- Oncology
- Proton pump inhibitors (PPI)

3.2 CLINICAL PRESENTATION

3.2.1 Infection with *C. difficile* results in a wide spectrum of disease ranging in severity from mild diarrhoea, through moderately severe disease, to life-threatening pseudo-membranous colitis with toxic mega colon, electrolyte imbalance and bowel perforation. Pseudomembranous colitis may occur without diarrhoeal symptoms.

3.2.2 *C.difficile* ribotypes 015, 027 and 078 are amongst the more virulent strains capable of producing greater amounts of toxin resulting in more severe disease, increased therapeutic failure and higher mortality (Commission for Healthcare Audit and Inspection 2006; 2007).

3.3 MANAGEMENT OF CDI

3.3.1 Clinical staff must apply the following mnemonic protocol (SIGHT) when managing suspected potentially infectious diarrhoea.

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea.

I	Isolate the patient and consult with the infection prevention team (IPT) while determining the cause of the diarrhoea.
G	Gloves and aprons must be used for all contacts with the patient and their environment.
H	Hand washing with soap and water must be carried out before and after each contact with the patient and the patient's environment.
T	Test the stool for toxin, by sending a specimen immediately.

(Public Health England, 2013)

Suspected Infectious diarrhoea

CDI should be suspected in patients with diarrhoea in the following situations:

- The patient is on or has been on antibiotics in the past 3 months
- There is explosive, watery, offensive diarrhoea, fever, bloody stools or severe abdominal cramps
- The patient has previously tested positive for *C.difficile* (GDH or Toxin)
- The patient developed diarrhoea on a ward where there was a known case of CDI
- In suspected cases of 'Silent' CDI such as ileus, toxic megacolon of pseudomembranous colitis without diarrhoea other diagnostic investigations should be undertaken such as white cell, count, serum creatinine, colonoscopy and abdominal computerised tomography (CT) may be required

Isolation

- Patients with diarrhoea should be isolated immediately unless their diarrhoea is known to have a non-infective cause
- Isolation of patients with suspected infectious diarrhoea should occur as soon as possible. If this cannot occur within two hours of onset of symptoms the situation must be escalated as the risk of onward transmission is high
- Isolation must be within a single room, preferably with its own ensuite bathroom. Where an ensuite bathroom is not available isolation can occur within a single room with a dedicated commode in situ
- If isolation is not possible this must be escalated to the Infection Prevention Team (IPT) or out of hours to the Duty Manager. In order to maintain the safety of other patients it may be necessary to transfer the patient to an appropriate environment
- Isolation room doors must remain closed (when safe to do so) and an isolation notice placed on the door
- A patient with C.*difficile* is permitted to leave the room for clinically urgent diagnostic or treatment purposes. The clinician must ensure the privacy and dignity of the patient is maintained and infection prevention practices are followed to prevent onward transmission to others. Please contact IPT for additional advice

Gloves and Aprons (Personal Protective Equipment)

- On entering the room, staff must wash hands with soap and water and wear an apron and gloves for the management of CDI. Additional PPE may be required during the pandemic
- Visitors who do not assist in patient care and who have minimal patient contact do not need to wear gloves and an apron
- Visitors assisting with patient care should wear gloves and an apron
- All visitors and staff should wash their hands with soap and water before they leave the room
- Visitors and staff should not eat or drink in the vicinity of the patient
- Before leaving the room all staff or visitors (who wear gloves and aprons) must remove and dispose of apron and gloves into the clinical waste bin and wash hands using soap and water

Enhanced Environmental Cleaning

- For cleaning and disinfection in the presence of CDI, all surfaces and equipment should be cleaned and disinfected minimum of twice daily using Actichlor Plus and allowed to air dry
- Commodes and raised toilet seats must be cleaned after each use with Actichlor Plus
- Clinical staff must ensure the room remains clutter free to enable effective cleaning. This must be communicated to the patient and visitors
- All open food such as fruit bowls should be removed due to high risk of contamination from the environment
- Clinical staff are responsible for the daily cleaning within the isolation room of clinical equipment
- Domestic Services are responsible for floors, sinks, touch points i.e. door handles, light switches, chairs and base of bed frame (see Decontamination Policy)

Hand Hygiene

- Alcohol hand rubs are not effective against *C.difficile* spores. Hands must always be cleaned with soap and water to facilitate the physical removal of spores. If staff visit a patient in their own home without access to soap and running water then a moist hand wipe (such as a Clinell hand wipe) must be used before using alcohol hand rub

Testing

- In the case of unexplained diarrhoea (Bristol Stool Chart type 6 or 7, see Appendix A) a stool sample must be taken and sent to the microbiology lab ASAP.
- Clinical details should include duration of symptoms, any current or recent antibiotic therapy and any recent hospital admission (if known)
- If strong clinical suspicion remains following a negative result resent a further specimen 24 hours late
- It is not necessary to repeat tests to confirm clearance of C.difficile

A two stage test is used to detect presence of glutamate dehydrogenase (GDH) and *C.difficile* toxins.

Possible results are outlined below:

1st Stage GDH test	2nd Stage Toxin Test	Interpretation	Action
Negative	(not required)	*C.difficile* negative	Proceed to full enteric screen with transmission precautions if diarrhoea persists
Positive	**Negative**	*C.difficile* carriage	Potential for transmission requiring transmission precautions. Potential for future active infection
Positive	**Positive**	*C.difficile* positive	Active infection requiring treatment and full transmission precautions

- GDH Positive patients who are symptomatic have the potential to spread infection.
- GDH has a high negative predictive value. In GDH negative patients, *C.difficile* can reasonably be excluded
- If a GDH positive, toxin negative sample is obtained but clinical symptoms of *C.difficile* persist a repeat stool sample should be taken, and advice sought from Infection Prevention & Control Team or Microbiology
- Do not retest stool specimens within 28 days of original positive result unless symptoms resolved and recurred

3.4 TREATMENT OF CDI – First episode Refer to NICE Guidelines NG199 for complete guidance

3.4.1 Treat according to severity:

Mild disease: 3 or fewer type 5-7 stools on Bristol Stool Chart per day and a normal white cell count (WCC).

Moderate disease: 3 to 5 stools of type 5-7 per day and a raised WCC (but less than 15).

Severe disease: WCC greater than 15, ***OR*** a temperature greater than 38.5, ***OR*** an acutely rising serum creatinine (e.g. greater than 50% increase above baseline) with evidence of severe colitis (abdominal, endoscopic or radiological signs). (The number of stools may be a less reliable indicator of severity).

Life threatening disease: complete ileus or toxic megacolon with a systemic inflammatory response or septic shock.

Recommendations for treatment include the following:

- Patients should be reviewed daily for fluid resuscitation, electrolyte replacement, nutritional status and monitored for signs of increasing disease severity
- Consideration should be given to stopping precipitating antibiotic if safe to do so or switching to a lower risk antibiotic
- Stopping laxatives and anti-motility drugs due to risk of ileus and toxic megacolon. However, anti-motility drugs may be appropriate for a patient who is receiving

palliative care who is very symptomatic or very distressed with the diarrhoea. In these circumstances the decision to prescribe anti-motility medications to control symptoms is a clinical one based upon risk versus benefit for the individual patient. Please liaise with the Consultant Microbiologist or the Infection Prevention Team if further advice is required.

- Stopping or reviewing proton pump inhibitors (PPIs) should be considered
- Medical staff should follow the appropriate guidance on Antibiotic prescribing according to their location, this differs in Southampton and Portsmouth
- Note: First episode of CDI patients who fail to respond to first line treatment within 7 days should be switched to Vancomycin therapy. Patients who have recently received Metronidazole for other infections should start on oral Vancomycin
- Patients unable to take Metronidazole including during pregnancy and breastfeeding should follow specific Vancomycin regime
- Further advice on the medical management can be sought from a microbiologist or the IPT

3.4.2 Recurrent CDI

If diarrhoea persists or reoccurs repeatedly alternative treatment options are available and can be discussed with microbiologists. This may include Fidaxomicin, tapering Vancomycin regimes of Faecal Microbiota Transplants (FMT)

3.4.3 Post Infective Irritable Bowel Syndrome

If diarrhoea persists despite 20 days treatment but the patient is stable, the daily number of type 5-7 stools has decreased, WCC is normal and there is not abdominal distension or pain the diagnosis of post infection irritable bowel syndrome should be considered

3.5 INFECTION PREVENTION TEAM

3.5.1 The ward will be advised of a positive *C.difficile* result either directly from the laboratory or from IPT.

3.5.2 The IPT will visit the clinical inpatient area as a matter of priority and discuss treatment and appropriate infection control precautions with staff.

3.5.3 IPT will ensure staff have commenced a *C.difficile* Care pathway (*Appendix A*).

3.6 C.*difficile care pathway*

3.6.1 This must be initiated ASAP following a positive C.*difficile* toxin or GDH result when symptomatic.

- The consistency of stools should be assessed and recorded using the Bristol Stool Chart
- Stool charts should be recorded accurately after each bowel motion. It is recommended that bowels not opened is recorded for completeness

- All urine or faeces must be disposed of as rapidly as possible down sluice or toilet
- All waste must be placed in an orange clinical waste bag
- All linen must be placed in a red water soluble/ alginate bag before being placed in a secondary laundry bag (as per local practice)
- Equipment such as blood pressure monitors, commodes, temperature probe, etc. should be used only on that patient. If the equipment is taken for use elsewhere it should be effectively decontaminated with a chlorine based detergent/disinfectant i.e. Actichlor Plus
- Use normal crockery and cutlery and wash in dishwasher

3.7 ENVIRONMENTAL CLEANING

3.7.1 Daily environmental cleaning of rooms of *C.difficile* patients must be carried out at least twice daily using chlorine releasing agents i.e. Actichlor Plus (with 1,000 ppm available chlorine). The infection prevention team may request additional frequency of cleaning based upon a risk assessment.

3.7.2 Patient's toilets or commodes must be cleaned after each use with a chlorine releasing agent i.e. Actichlor Plus (with 1,000 ppm available chlorine).

3.7.3 Terminal Environmental Cleaning

Once the patient is 72 hours clear of symptoms CDI, the patient environment must be thoroughly cleaned and disinfected with Actichlor Plus, with careful attention to toilets, bathrooms and sluices, beds, commodes and bedpans.

The correct order of terminal cleaning is as follows:

- Strip beds and remove linen placing in a red water soluble/alginate bag before being placed in a secondary laundry bag as per local protocol
- Disinfect equipment (including beds) with Actichlor Plus
- Dispose of unused consumables i.e. gloves and wipes into orange clinical waste bag, unless stored in sealed apron and glove dispenser (Dani centre) which can be disinfected externally with Actichlor Plus
- Arrange terminal clean via domestic department
- Disposable curtains must be removed bagged and discarded as clinical waste. Washable curtains must be removed bagged and laundered as infected
- Cleaning should always start with high surfaces leaving the floor until last

Please refer to The NHS Cleaning Manual 2022 for further guidance on terminal cleaning.

3.8 C.difficile IN THE COMMUNITY

3.8.1 All unexplained cases of diarrhoea in the community (patients aged 2 years and above) should be investigated for CDI. If necessary refer patient to GP to arrange stool testing. Samples should clearly state who to inform with results.

3.8.2 There should be no restrictions on institutions such as care homes receiving patients who have had CDI and are now clinically asymptomatic. IPT can assist if additional reassurance is required regarding perceived risks.

3.8.3 Staff working in the community who have contact with people with diarrhoea must wear gloves and aprons for all contact with them and their environment.

3.8.4 All staff in contact with patients with diarrhoea must wash their hands with soap and water even if hands are not visibly soiled. If soap and water are not available a moist hand wipe must be used before using alcohol hand rub.

3.9 OUTBREAKS

3.9.1 An outbreak of *C.difficile* is classified as two or more patients with the same strain related in time and place.

3.9.2 Guidance described above must be followed and the following additional measures should be implemented if an outbreak of *C.difficile* is suspected.

- Director of Infection Prevention and Control (DIPC) and Infection Prevention Team in consultation with a microbiologist should consider the need to form an outbreak committee. The Chief Executive is to be informed of their decision
- Any potential outbreak of CDI must to be reported to Public Health England (PHE) and relevant CCG (Clinical Commissioning Group)
- The ward will complete an online incident report and the Quality and Safety team will determine the level of investigation
- Restriction on admissions to and transfer from all affected areas
- Resolution of the cluster/outbreak will be confirmed by the outbreak committee
- Following confirmation, the affected area and all patient equipment will undergo a 'terminal' clean
- Patients may not be admitted to the ward until the 'terminal' clean is completed and the nurse in charge/IPT is satisfied with the standard of cleanliness
- An outbreak report will be prepared and submitted to the Infection Prevention and Control Group (IPCG) and other relevant authorities
- Any subsequent Post Infection Review (PIR) will be presented to Learning from Incident and Deaths panel along with recommendations

3.10. DISCHARGE PLANNING

3.10.1 Patients should not be discharged to other healthcare environments with symptoms of diarrhoea which are considered abnormal for the patient unless clinically imperative; and only following detailed communications ensuring adequate precautions are established before the patient arrives.

3.10.2 Patients diagnosed with CDI may be discharged to their own home as soon as considered clinically fit and able to manage. If external care agencies in place they must be advised of transmission risk. If discharged to own home with CDI the GP should be advised by telephone by ward staff

3.10.3 There should be no restrictions on community institutions i.e. care homes, care agencies or community nursing services receiving patients who have had CDI where symptoms are now resolved. However good communication is imperative **before** the patient is transferred, this should be supported by written information e.g. discharge letter or the Inter Health Care Transfer Form (*Appendix B)*.

3.10.4 Persistent diarrhoea after recommended course of antibiotics may be due to a) relapse or b) post infective irritable bowel syndrome. Advice on clinical management must be sought from microbiology (services in the east of the county to contact Portsmouth Hospital University

Trust microbiology team and services in the west to contact University Hospital Southampton's microbiology team).

3.11. DEATH CERTIFICATION

3.11.1 If *C.difficile* is believed to have directly caused or contributed to the death of the patient this must be recorded on Part 1of the death certificate. These cases will then be treated as a SIRI. A full PIR will be carried out by the IPT in conjunction with clinical staff. A summary of the case and findings will be disseminated via IPCG.

3.11.2 If *C.difficile* contributed, but was not part of the direct sequence leading to the patient's death this must be recorded in part 2 of the death certificate (DOH, 2007).

4. ROLES & RESPONSIBILITIES

4.1 The Chief Executive and Trust Board have a collective responsibility for infection prevention and control within the Trust.

4.2 The Director of Infection Prevention and Control (DIPC) (Chief Nurse) is responsible for ensuring that this policy is implemented and adhered to across the organisation.

4.3 The Infection Prevention Team (IPT) are responsible for maintaining this policy. The IPT will support the provision of training provided by the Learning and Development Team.

4.4 The Learning and Development Team are responsible for ensuring that staff have access to Induction training on Infection Prevention upon joining the organisation and e-learning modules according to learning & development policy.

4.5 Infection Prevention Link Advisors are healthcare staff selected by their managers to receive additional training in infection prevention and control. The key role of link staff is to promote best practice within their clinical area.

4.6 Housekeeping routinely maintain a clean environment to reduce possibility of environmental contamination with C difficile spores. To provide enhanced cleaning during or upon discharge from stay.

4.7 All staff have individual responsibility to comply with this policy.

5. TRAINING

5.1 All new staff receive infection prevention induction at local level. Staff are responsible for ensuring they are familiar with IPC practices to maintain patient and staff safety.

5.2 All staff are expected to carry out a hand hygiene competency assessment six monthly, a record of this competency updated using the link to Learning and Development.

5.3 Infection Control training is an annual mandatory requirement for clinical staff and non-clinical staff as per Learning and Development policy and is assessed via e-learning modules.

5.4 Managers need to ensure all staff are up to date with Essential Training in accordance with the Learning and Development policy.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 This policy aims to improve safety and reduce risk of onward transmission of infections and consequently improve patient/service user care and outcomes and staff safety. As part of Trust Policy an equality impact assessment (Steps 1 & 2 of cycle) was undertaken. The Infection Prevention and Control Team are not aware of any evidence or concern that this Policy may discriminate against a particular population group. (See Appendix C).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The Infection Prevention and Control service will ensure the policy has been implemented and that it has been effective in practice, by undertaking the following measures:

- The IPT will use the HII tool for any CDI within Solent NHS Trust inpatient beds to identify compliance or highlight practice in need of improvement
- Report to Infection Prevention Group Ongoing daily surveillance by IPT
- Learning that is identified when analysing all cases of CDI as per current service specifications with local CCGs

7.2 Non-compliance of this policy must be reported to the IPT and any other appropriate persons.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

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National Institute for Clinical Excellence (2014) *Faecal Microbiota transplant for recurrent Clostridium Difficile Infection*
https://www.nice.org.uk/guidance/ipg485

National Institute for Clinical Excellence (2021) Clostridioides Difficile Infection: Antimicrobial Prescribing
https://www.nice.org.uk/guidance/ng199

National Standards of Healthcare Cleanliness (2021) NHS London

Public Health England (2013) Updated guidance on the management and treatment of Clostridium difficile infection
Links to:

- Policy on Infection Prevention and Control Framework
- Hand Hygiene Policy
- Isolation Policy
- Decontamination Policy
- Standard Precautions Policy
- Policy for Diarrhoea and Vomiting
- Policy for the Safe Handling and Disposal of Healthcare Waste

10. GLOSSARY

C. difficile	Clostrioides Difficile
CDI	Clostrioides Difficile
PII	period of increased incidence
IPT	Infection Prevention Team
GDH	glutamate dehydrogenase
WCC	white cell count
PPI	proton pump inhibitors
HII	high level intervention
PHE	Public Health England
CCG	Clinical Commissioning Group

SI	Serious Incident
PIR	Post Infection Review

Clostridium difficile (C.diff)
Care Pathway
For use in patients with suspected or confirmed C.difficile

Name:

DOB:

Hospital No:

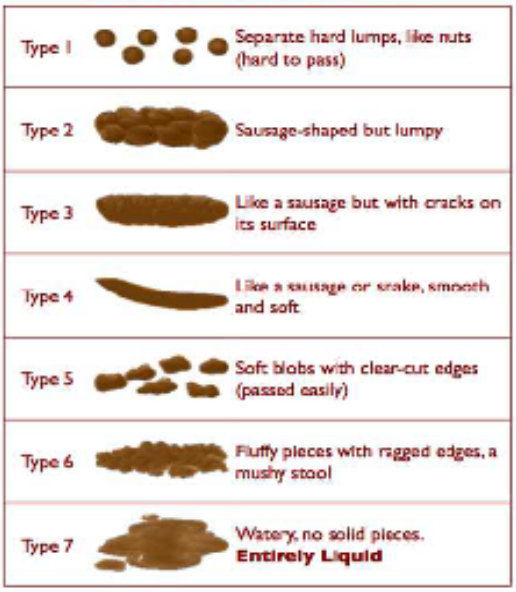
Ward:

Date C.diff Isolated	

Severity		WCC	Stools (24hr period)	Other
Mild		Not Raised	< 3 stools of type 5-7	
Moderate		<15x10^9/L	3-5 stools of type 5-7	
Severe		>15x10^9/L	Unreliable indicator of severity	**OR** acute rising serum creatinine (>50% above baseline) **OR** temperature >38.5℃ **OR** evidence of severe colitis
Life Threatening		As Above	As Above	includes hypotension / septic shock **OR** complete ileus or toxic megacolon **OR** CT evidence of severe disease
Carriage				incidental isolation of C.difficile toxin

Date	Stool Type	Quantity (S / M / L)

Bristol Stool Chart



Further repeat stool samples should not be sent to the laboratory within 28 days of a C.difficile toxin positive result, unless another pathogen is suspected

Infection Prevention & Control ext. 6261, bleep 0064

See over for Intervention Care pathway and Saving Lives – High Impact Interventions

Appendix A

Intervention		Initials	Date	Variance (Reason & Action Taken)
Stool Chart	Bristol Stool Chart commenced			
Isolation	Patient source isolated in single room within six hours? If not achieved raise incident form			
	Transmission precautions available (gloves, aprons, hand hygiene with soap and water) **No alcohol gel**			
	Patient / relatives informed of result and need for isolation and hand hygiene			
	Patient has personal toilet or commode with access to hand hygiene facilities			
	Standard Source Isolation card displayed at room entrance			
Medical Interventions	Antibiotic treatment for C.diff started for symptomatic patient. Rationalisation of laxatives, PPI and broad spectrum ABx			
	Referral for nutritional assessment. Regular monitoring of hydration (adequate oral / IV intake, urine output)			
	Regular monitoring of WCC/CRP/Serum Creatinine/Albumin			
Cleaning	Domestic team completing enhanced cleaning with actichlor plus and following transmission precautions			
	All horizontal surfaces and equipment (including commode) cleaned twice daily by nursing staff with actichlor plus			
	Fresh solution of actichlor plus made up every 24 hours (one 1.7G tablet diluted in one litre of warm water)			
	Terminal scrub with actichlor plus arranged on discharge of patient Carillion Job number :			

Discontinuation of Care Pathway	Initials	Date
Pathway discontinued – patient passing formed* stool for 72 hours OFF antibiotic treatment (*no stool passed does not imply formed stool)		

High Impact Intervention "Saving Lives" Care Bundle – Complete Daily

Day	Correct Hand Hygiene *(cleaned before & after patient contact with soap & water)*	Correct Environmental Decontamination *(chlorine cleaning of room & all items)*	Prudent Antibiotic Prescribed *(agreed by Microbiology)*	Correct Personal Protective Equipment *(gloves/aprons single use, removed before leaving cubicle unless going to sluice)*	Correct Isolation Maintained *(single room isolation with signage, door closed)*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Appendix B

Inter-healthcare infection control transfer form

Patient/client details: (insert label if available) Name: Address: NHS number: Date of birth:	**Consultant:** **GP:** **Current patient/client location:** **Transferring facility – hospital, ward, care home, other:** **Contact no:** Is the ICT aware of transfer? Yes/No
Receiving facility – hospital, ward, care home, district nurse **Contact no:** Is the ICT/ambulance service aware of transfer? Yes/No	Is this patient/client an infection risk? ***Please tick most appropriate box and give confirmed or suspected organism*** ☐ Confirmed risk Organism: ☐ Confirmed risk Organism: ☐ Suspected risk Organism: ☐ No known risk Patient/client exposed to others with infection eg D&V Yes/No

If patient/client has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol stool form scale, see previous page)

Is the diarrhoea thought to be of an infectious nature? Yes/No

Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP, *C. difficile*, multi-resistant *Acinetobacter* SPP) and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment information:

Other information:

Is the patient/client aware of their diagnosis/risk of infection? Yes/No

Does the patient/client require isolation? Yes/No

Should the patient/client require isolation, please phone the receiving unit in advance.

Signature of staff member completing form: .....

Print name:

Contact number:

For further advice, please contact your infection control team/adviser

Equality Impact Assessment

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

You can find further information via the e-learning module here

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Infection Prevention	
Title of Change:	Policy Review	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes		

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*

Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	
Have you taken into consideration any regulations, professional standards?	Yes	

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	N/A		
Who will be responsible for monitoring and regular review of the document / policy?	N/A		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	B S Carter	*Date:*	15/03/2022

Appendix C

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team