



Policy for the Management of Clostridium difficile associated diarrhoea

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Author	Infection Control Nurse Consultant		
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Staff/Groups Consulted	Infection Control Doctor Consultant Microbiologist Director of Infection Prevention and Control Infection Control Team Associate Directors of Nursing Ward Managers Gastroenterology Consultants		
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CONTENTS

1. INTRODUCTION	4
2. AIM	4
3. DEFINITIONS	4
4. ROLES AND RESPONSIBILITIES.....	5
5. PREVENTION OF CLOSTRIDIUM DIFFICILE THROUGH ANTIBIOTIC PRESCRIBING	9
6. INFECTION CONTROL AND MANAGEMENT OF SUSPECTED OR CONFIRMED CASES.....	11
7. SURVEILLANCE AND REPORTING	12
8. MANAGING HIGH PREVALENCE OR OUTBREAKS	13
9. POST INFECTION REVIEW (PIR) OF TRUST APPORTIONED CASES OF CLOSTRIDIUM DIFFICILE INFECTION	13
10. DISCHARGE	14
11. DEATH CERTIFICATION	14
12. AUDIT AND MONITORING	15
13. APPLICABILITY	15
14. IMPLEMENTATION, MONITORING AND EVALUATION.....	15
15. REFERENCES	15
Appendix A – Diagnostic Algorithm For Clostridium difficile Infection (CDI).....	15
Appendix B – Clostridium Difficile Care Pathway	16
Appendix C – Isolation Policy	16
Appendix D – Terminal Clean Checklists: General Ward Area And Bed/Bay/Sideroom.....	16
Appendix E – Bristol Stool Chart	17
Appendix F - Equality Impact Assessment Tool	18

1. INTRODUCTION

- 1.1 Clostridium difficile infection can be a very serious and complications include relapsing diarrhoea, Clostridium difficile is an anaerobic infection that is present in the gut of up to 3% of healthy adults and 66% of infants (HPA 2009) and rarely causes a problem as it is kept in check by normal bacteria population of the intestine. However certain antimicrobials can disturb the balance of the normal gut bacteria and Clostridium difficile can multiply rapidly and produce toxins. Symptoms of Clostridium difficile infections can range from mild to severe diarrhoea, pseudo-membranous colitis, toxic megacolon, perforated colon, sepsis and death. Clostridium difficile can cause outbreaks in healthcare settings and these can be subject to a Care Quality Commission (CQC) inspection.
- 1.2 Clostridium difficile infections can be spread on the hands of healthcare workers and other people who come into contact with infected patients or via environmental surfaces contaminated with the bacteria or its spores. Spores are produced when the bacteria encounters unfavourable conditions such as being outside the body so it can survive for a long time.

2. AIM

- 2.1 The aim of these guidelines is to detail the infection prevention and control management for hospitalised patients with suspected or confirmed Clostridium difficile infections.
- 2.2 To ensure that healthcare workers are aware of the actions and precautions to care for patients with Clostridium difficile and minimise the risk of cross contamination / transmission between patients, staff and visitors.

3. DEFINITIONS

- **Clostridium difficile infection (CDI) Toxin positive** – Clostridium difficile toxin detected in a stool specimen, which is compatible with Clostridium difficile infection. Results must be reported to the Department of Health (DoH) via Public Health England (PHE) Healthcare Associated infection Data capture System (HCAIDCS)
- **Clostridium difficile detected by PCR but Toxin Not detected** – Evidence of Clostridium difficile colonisation (the patient is carrying the organism in their bowel). Patients may sometimes need treatment if symptomatic and other causes for diarrhoea are not apparent.
- **Diarrhoea** – defined as a stool loose enough to take the shape of a container used to sample it or as Bristol Stool chart types 5 – 7.
- **GDH** – Glutamate Dehydrogenase – An antigen that is produced in high amounts by Clostridium difficile, both toxin and non-toxin producing.
- **Outbreak of CDI** – 2 or more cases (either toxin positive / toxin negative / PCR positive result treated as a Clostridium difficile infection case) caused by the same strain related in time and place over a defined period that is based on the date of the onset of the first case.
- **Period of Increased Incidence (PII) of CDI** – 2 or more toxin positive or toxin negative / PCR positive cases which have been treated as a Clostridium difficile infection (where the specimen was taken on the fourth day or later from the

admission date, where the day of admission is day one) in a 28 day period on a ward.

- **PCR** – A molecular test used to detect the presence of *Clostridium difficile* and the genes that produce the toxins.
- **PCR Ribotyping** – A molecular typing method used to investigate whether the same strain of *Clostridium difficile* is implicated in a PII or suspected outbreak of *Clostridium difficile* infection.
- **Source Isolation** – Used for patients suffering from a communicable / infectious disease or carriers of a communicable / infectious disease, to prevent the spread of infection to others.
- **Hospital onset healthcare associated:** Cases that are toxin positive and detected in the hospital three or more days after admission where day of admission is day one.
- **Community onset healthcare associated:** Cases that are toxin positive and that occur in the community (or within two days of admission) where the patient has been an inpatient in the Trust reporting the case in the previous four weeks.
- **Community onset indeterminate association:** Cases that are toxin positive and that occur in the community (or within two days of admission) where the patient has been an inpatient in the Trust reporting the case in the previous twelve weeks but not the most recent four weeks.
- **Community onset community association:** Cases that are toxin positive and that occur in the community (or within two days of admission) where the patient has not been an inpatient in the Trust reporting the case in the previous twelve weeks.

4. ROLES AND RESPONSIBILITY

4.1 **Chief Executive** is responsible for:

- Ensuring that appropriate systems and resources are in place to manage infection prevention and control across the organisation.
- Designating an individual as the Director of Infection Prevention and Control (DIPC) with dedicated time to fulfil this role.
- Ensuring an appropriate Infection Control Assurance Framework is in place for reviewing incidence of alert organisms, outbreaks, Serious Untoward Incidents (SUI) and compliance/performance against the infection control audit programme in clinical areas.
- Ratification of the Infection Prevention and Control Annual Programme of Work.

4.2 **Director of Infection Prevention and Control** is responsible for:

- Infection prevention and control within the Trust and ensuring that national directives are implemented.
- Chairing the Infection Prevention and Control Strategic Group (IPS) and Infection Prevention and Control Committee (IPCC).

- Ensuring the development and implementation of strategies to prevent avoidable HCAI at all levels within the Trust.
- Production of the Infection Prevention and Control Annual Report on progress against the Annual programme of work in the reduction of HCAI in collaboration with the Nurse Consultant for Infection Prevention and Control and the Infection Control Doctor.
- Providing assurance to the Board of Directors that systems are in place. To ensure correct policies and procedures are adhered to across the Trust to ensure safer and effective healthcare and comply with the Health Act (2006) revised (2009).
- Production of reports and presentations to the Board of Directors as required, including a quarterly review of progress against Infection Prevention and Control Annual programme of Work.
- Reviewing statistics on incidence of alert organisms, conditions and serious untoward incidents.
- Production of a monthly report to the Board of Directors showing the Trust's position against key performance indicators.
- Ensuring Trust wide compliance with infection prevention and control policies and procedures.
- Providing evidence of appropriate actions taken following HCAI events.
- Attend the twice weekly antibiotic round when able or as requested by the Consultant Microbiologist, Antibiotic Pharmacist and IP&CT

4.3 **Antimicrobial Prescribing Group** is responsible for:

- Overseeing the antimicrobial stewardship programme.
- Promoting prudent antibiotic prescribing and overseeing the use of antimicrobial agents within the Trust.
- Monitoring compliance with Trust antibiotic guidelines by reviewing audit information and providing timely feedback of audits to clinicians and prescribers.
- Reviewing antimicrobial guidelines, making appropriate recommendations and changes to antibiotic guidelines as required in response to increased *Clostridium difficile* levels in the Trust.

4.4 **Antimicrobial Pharmacist** is responsible for:

- Reviewing all in-patients with *Clostridium difficile* with the microbiologist and a member of the Infection Prevention and Control Team (IPCT) on the twice weekly antimicrobial ward round.
- Carrying out regular audits of compliance with antimicrobial guidelines and providing feedback and education to clinicians and prescribers as required.

- Participating in the Post Infection Reviews (PIR) carried out for patients with Clostridium difficile infection, advising (in conjunction with the Microbiologist) on the appropriateness of any antibiotics given in the previous 12 weeks.

4.5 Consultants and Medical Staff are responsible for:

- Ensuring the appropriate medical management of patients with Clostridium difficile as detailed in the Trust guidelines.
- Ensuring that the patient is reviewed on a daily basis and the outcome of this review is clearly documented in the medical notes.
- Ensuring that they and their teams comply with the infection prevention and control management of Clostridium difficile patients and challenge any poor practice.
- Participating with the PIR investigation as required.

4.6 Consultant Medical Microbiologist (CMM) is responsible for:

- Advising clinical staff on the medical management of patients with Clostridium difficile.
- Reviewing all in-patients with Clostridium difficile on the twice weekly antibiotic ward round.
- Ensuring that positive Clostridium difficile test results are communicated promptly to the appropriate clinical team, the Infection Prevention and Control (IP&C) nurses and appropriate ward staff within the Trust.
- Participating in with the PIR as required and acting upon any recommendations.
- Disseminating and discussing the PIR findings amongst their teams.
- Together with the IP&C Team and the antimicrobial pharmacist reviewing all Clostridium difficile patients on the twice weekly antimicrobial ward round.

4.7 Infection Prevention and Control Team is responsible for:

- Educating and training Trust staff in the infection control management of hospitalised patients with suspected or confirmed CDI or colonisation.
- Auditing of isolation practice of patients isolated with suspected or confirmed Clostridium difficile.
- Reporting all laboratory confirmed cases of patients with CDI toxin positive on the PHE HCAIDCS.
- Leading on the PIR investigation of patients with hospital attributed Clostridium difficile and disseminate the findings.

- Ensuring PIR action plans are completed and the necessary actions are taken in response to the PIR.
- Reviewing all in-patients with Clostridium difficile on a daily basis Monday – Friday and reporting back to the CMM as the patient’s condition dictates.
- Reviewing all Clostridium difficile patients on the twice weekly antimicrobial ward round with the Antimicrobial Pharmacist and Consultant Microbiologist.
- Ensuring the Clostridium difficile pathway (appendix B) is commenced for every patient as required.
- Ensuring that the teams who are caring for the affected patient comply with the infection prevention and control management of Clostridium difficile patients as detailed in appendix B and noting good practice whilst always challenging poor practice.

4.8 Associate Directors of Nursing are responsible for:

- Ensuring that any actions are taken in response to any practice issues identified through PIR’s, PII’s and area’s for improvement highlighted in relevant audits.
- Participating in with the RCA investigations as required and ensuring action is taken on any recommendations.
- Ensuring that their teams comply with the infection control management of Clostridium difficile patients as detailed in appendix B and challenge any poor practice.
- Ensuring dissemination and discussion of the RCA findings amongst their teams
- Ensuring representation at the monthly Clostridium difficile review meetings.
- Participating in the weekly antibiotic ward round when invited.

4.9 Matrons and Ward managers are responsible for:

- Ensuring that enhanced cleaning arrangements are in place in their areas of responsibility for all patients with Clostridium difficile.
- Participating in with the PIR investigations as required and acting upon any recommendations.
- Disseminating and discussing the PIR findings amongst their teams
- Ensuring that any actions are put into place in response to any practice issues identified in audits, PIR’s or episodes of increased prevalence.
- Ensuring that they and their teams comply with the infection prevention and control management of Clostridium difficile patients as detailed in appendix B and challenge any poor practice.
- Ensuring that appropriate cleaning arrangements are in place in their areas of responsibility for patients with Clostridium difficile.

4.10 **Ward / Clinical Staff** are responsible for:

- Ensuring that any patient suspected or with a confirmed diagnosis of Clostridium difficile is placed into isolation immediately.
- Informing the IP&C Team and the Clinical Site Managers (CSM) out of hours) if for any reason a patient with suspected or confirmed diagnosis of Clostridium difficile cannot be isolated and completing an incident report.
- Ensuring that they communicate the patient's infectious condition to all necessary parties that have contact with or treat the patient.

4.11 **Domestics / Housekeepers** are responsible for:

- Ensuring that they comply with the infection prevention and control management of Clostridium difficile patients as detailed in appendix B and that they challenge or report any poor practice.
- Ensuring that appropriate cleaning is carried out for all Clostridium difficile patients in their area (see appendix D)

5. PREVENTION OF CLOSTRIDIUM DIFFICILE THROUGH ANTIBIOTIC PRESCRIBING

5.1 Text Antimicrobial management is a key component of infection prevention and control and prudent antimicrobial prescribing is essential in reducing the prevalence of Clostridium difficile. All clinicians and nurse prescribers must comply with the Antimicrobial Policy and they should also follow the Antimicrobial Prescribing Guidelines.

General principles of antimicrobial prescribing include: -

- Antimicrobials should only be prescribed for a specific indication which should be documented in the patients' notes.
- Antimicrobials with the narrowest possible spectrum should be used.
- Once a pathogen has been identified, antimicrobial therapy should be tailored to the narrowest spectrum suitable agent.
- Antimicrobial medication should be reviewed daily with a senior review between 24 to 72 hours where decisions regarding iv to oral switch, reasons for continuing antibiotics and the next review date should all be documented.
- The prescription should have a review date or stop date documented in the notes and on the drug chart and the length of course should be limited to the shortest possible time.

5.2 Diagnosis and Testing

- If a patient presents with unexplained diarrhoea a stool specimen should be sent to the laboratory for investigation. Recent and current antibiotic history must be highlighted on the microbiology request form. Only stools that are loose enough to take the shape of the pot will be tested. Clostridium difficile is detected by a

3-stage testing protocol, which includes a GDH screening test, a toxin test and PCR for the toxin gene.

- Diarrhoeal specimens for all hospital in-patients 2 years of age or above will be routinely tested for Clostridium difficile toxin (unless positive within the last 28 days) by the laboratory as part of the National Healthcare Associated Infection Screening Programme.
- Children below the age of 2 years will not be tested without prior agreement of the Consultant Microbiologist, as Clostridium difficile is a commensal organism in this age group.
- Clearance specimens are not required for any patient diagnosed with Clostridium difficile infection or colonisation.
- If the GDH screening test is negative, it will be reported as 'Clostridium difficile screening test negative. Clostridium difficile is very unlikely to be present, but if clinical suspicion is high, please send a repeat sample'.
- If the GDH screening test is positive, the laboratory then uses a toxin test to look for Clostridium difficile toxin production.
- If the test is positive it will be reported as 'Clostridium difficile toxin detected. Compatible with Clostridium difficile infection'
- If the toxin test is negative a PCR test will be performed. If the PCR test is positive it will be reported as 'Clostridium difficile detected by PCR but toxin not detected. Evidence of Clostridium difficile colonisation'. These patients may sometimes need treatment as though they have true Clostridium difficile infection, dependent on symptoms.
- Following treatment for Clostridium difficile infection, relapse of symptoms can occur in 20 -30% of patients. If the patient has had a positive Clostridium difficile result within the last 28 days, a further sample should not be submitted for testing.
- Clostridium difficile positive isolates (toxin positive or toxin negative / PCR positive) from patients on the ward should be sent for PCR Ribotyping. The IP&C Team will make the request via the Clostridium difficile Ribotyping network (CDRN) and the laboratory will submit the specimen.

5.3 Treatment and Medical Management

- For guidance on assessment of severity and treatment of CDI refer to Trust guidelines for The Medical Management of Clostridium difficile Infection.
- In addition, advice concerning management can be sought from the CMM.

5.4 Transmission

- Clostridium difficile is spread by the faecal – oral route. Direct and indirect contact results from faecal spores contaminating the patients' skin and hands, the hands of the health care workers and heavily contaminating the immediate environment around the symptomatic patient.

6. INFECTION CONTROL AND MANAGEMENT OF SUSPECTED OR CONFIRMED CASES

- 6.1 Source isolation procedures as per the Isolation Policy must be put into place if a patient presents with diarrhoea, and an infectious cause cannot be excluded. All patients who are suspected *Clostridium difficile* or have a stool sample must be placed in isolation.
- 6.2 **Single Room** – patients should be moved into a single room within 4 hours of onset of symptoms, with en-suite facilities where possible. If en-suite facilities are not available a dedicated commode should be allocated. If the patient uses a bedpan a dedicated bedpan holder should be identified and used.
- 6.3 **Isolation Notice** – A BLUE isolation sign should be clearly displayed on the door.
- 6.4 **Hand Hygiene** – After contact with the patient or their environment, soap and water must be used for hand hygiene rather than alcohol gel. Patients must also be encouraged and offered the opportunity to wash their hands before eating and after the toilet. Please see the Hand Hygiene Policy.
- 6.5 **Personal Protective Equipment (PPE)** – A disposable apron and gloves must be worn when entering the room. PPE should be worn at all times during contact with the patient or the environment. Aprons and gloves must be disposed of before leaving the isolation area and hands washed with soap and water. If bodily fluids need transporting and disposing of in the main ward sluice then new gloves and aprons must be changed into before leaving the side room. Hands should be washed with soap and water after removal. Please see PPE guidelines.
- 6.6 **Cleaning** – The room will be cleaned on a daily basis with TECcare Ultra this will also include the toilet / commode. Once the patient has been identified as asymptomatic a terminal clean of the room will take place using TECcare Ultra and Ultra V machine. The purpose of this is to eliminate any *Clostridium difficile* spores present which could re-infect the patient.
- 6.7 **Equipment** – Only essential equipment should be taken into the isolation room. Where possible disposable equipment or equipment dedicated for the use of the isolated patient should be used. If the use of shared equipment is unavoidable, it must be cleaned with a sporicidal cleaning agent before being used for another patient (i.e. Clinell Sporicidal wipes). Crockery and cutlery does not need to be dedicated for the use of the isolated patient, but must go through the dishwasher before being used for another patient.
- 6.8 **Linen** – Used linen should be sealed in a red water-soluble linen bag before being placed into a white plastic linen bag. Please see the Linen policy.
- 6.9 **Waste** – The normal rules of segregation of domestic and clinical waste apply. Items such as newspapers and flowers may still be disposed of as domestic waste in black bags, or segregated for recycling when appropriate. Used PPE such as gloves and aprons should be disposed of as clinical waste in an orange bag. Please see the Waste Management Policy.

- 6.10 **Stool Chart** – The stool chart section of the Clostridium difficile pathway must be completed and maintained at all times following the definitions from the Bristol stool chart (see appendix E).
- 6.11 **Documentation** – All documentation must be kept outside the patient's side room, unless this constitutes a risk to patient confidentiality due to the heavy footfall of visitors and reduced staff visibility (e.g. side wards 5&6).
- 6.12 **Visitors** – Protective clothing is not required unless assisting with the patient's personal care. Visitors must be advised to wash their hands immediately after leaving the isolation room.
- 6.13 **Attendance at Other Department** – If the patient needs to attend a department for investigation, they should be 'last on the list' wherever possible, unless earlier investigation is clinically needed. The receiving area should be notified and arrangements put into place to minimise the patient's waiting time and hence contact with other patients.
- 6.14 **Transfers** – Patient transfer to other wards whilst the patient is symptomatic should be avoided unless essential. Should the patient require transfer for clinical reasons the receiving ward must be informed of the patient's infection status and single room accommodation identified.
- 6.15 **Termination of Isolation Precautions** – As skin carriage and environmental shedding can continue for a number of weeks in recovered patients, isolation precautions should be maintained for all patients with a positive test result for Clostridium difficile for the duration of the patient's hospital admission. However, the decision to keep the patient in isolation for the duration of their hospital stay must be balanced against their clinical and rehabilitation needs. If it is thought that keeping the patient isolated for the duration of their stay would be detrimental, infection prevention and control advice should be sought and a risk assessment undertaken.
- 6.16 **Maintenance of Isolation** – For duration of stay is a special measure employed at this Trust. Therefore, when transferring patients to other institutions, if the patient has been symptom-free for 48 hours or more, isolation will no longer be required unless specified by the receiving institution.

7. SURVEILLANCE AND REPORTING

- 7.1 The CMM will inform the doctor / ward and the IP&C Team of any toxin positive or toxin negative Clostridium difficile test results taken from patient in the hospital. Positive Clostridium difficile results are also reported electronically to the IP&C Team via the ICNET Healthcare Associated Infection Case Management and Surveillance System.
- 7.2 The IP&C Team will follow up all in-patient cases to ensure the patient is isolated and appropriate precautions are in place. Out of normal office hours the on-call CMM will give infection control advice to the wards as required.
- 7.3 All NHS Trusts in England are required to participate in the DoH mandatory Clostridium difficile infection reporting system and to report details of all toxin positive results in patients aged 2years or more via the Public Health England Healthcare Associated Infection Data Capture System. This reporting is carried out monthly.

- 7.4 Positive results on the same patients more than 28 days apart should be reported as separate episodes, irrespective of the number of specimens taken in the intervening period. The IP&C Team are responsible for reporting this data.
- 7.5 The total number of Clostridium difficile tests performed by the laboratory and the number of toxin positive results must be reported on the healthcare Associated Infection Data Capture System quarterly. The information is provided by the laboratory to the IP&C Team, who are responsible for inputting this data.
- 7.6 The number of toxin positive Clostridium difficile cases for each ward is reported internally in the Trust to the Trust board every month via the Board monthly reports.
- 7.7 Deaths due to Clostridium difficile infection should be reported as a serious incident requiring investigation via the Trust's incident reporting system.

8. MANAGING HIGH PREVALENCE OR OUTBREAKS

- 8.1 The IP&C Team will identify any Period of Increased Incidence (PII) of Clostridium difficile infection. A PII is defined as 2 or more toxin positive or toxin negative / PCR positive cases which have been treated as a Clostridium difficile infection (where the specimen was taken on the fourth day or later from the admission date where the admission date is day 1) in a 28 day period on a ward. If a PII occurs the following actions should be put into place: -
- A meeting will be convened with the Ward manager / Matron for the area, a member of the medical team and the IP&C Team to investigate and agree actions.
 - Meetings will be held weekly thereafter to review progress and actions, until there are no symptomatic patients on the ward.
 - An environmental audit of the ward will be completed by the Matron, ward manager and a member of the IP&C Team. Any actions required will be the responsibility of the ward manager.
 - The IP&C Team will carry out weekly isolation, hand hygiene and PPE audits of the ward until there are no symptomatic patients with CDI. Areas identified for improvement will be escalated to the ward manager at the time.
 - A terminal clean of the ward using TECcare Ultra and then daily enhanced cleaning with TECcare Ultra until there are no symptomatic patients with CDI.
 - A weekly review of all patients on the ward should be carried out by the Antimicrobial Pharmacist and the CMM to ensure judicious antimicrobial prescribing is in place. This should continue until there are no further CDI symptomatic patients on the ward.
 - The PII can be classed as closed when there are no symptomatic cases on the ward and no new Trust apportioned cases identified for 28 days.
- 8.2 Outbreaks of Clostridium difficile infection are defined as 2 or more cases (either toxin positive or toxin negative / PCR positive cases treated as Clostridium difficile) caused by the same strain related in time and place over a defined period (28 days) that is based on the onset of the first case. In the event that an outbreak is confirmed the Hospital Management of Outbreaks Policy should be followed.

9. POST INFECTION REVIEW (PIR) OF TRUST APPORTIONED CASES OF CLOSTRIDIUM DIFFICILE

9.1 The Trust is required to undertake a review of each Trust apportioned CDI case. The purpose of this review will be to determine whether the infection was associated with a lapse in the quality of care provided to the patient and identify if there was any part of that care that could have been done differently and therefore might have led to a different outcome. Where lapses of care are identified actions should be agreed to improve patient safety.

9.2 The IP&C Team will co-ordinate the review and assessment will include the following:

- Antimicrobial therapy for the last 3 months
- Any other relevant information from the last 3 months
- Treatment for Clostridium difficile infection and outcome
- Environmental factors
- Organisational issues
- Lessons learned.
- Preventability

9.3 In order to conduct the review a meeting should be convened to determine the cause, and should include the relevant clinical team such as: -

- Consultant responsible for the patient.
- Ward Manager
- IP&C Team
- CMM
- Antimicrobial Pharmacist

9.4 Completed PIR and action plans will be submitted to and reviewed by the Trust Infection Prevention and Control Committee (IP&CC). Action plans should be monitored via the relevant Directorate's Governance meetings until completed.

9.5 As well as internal review, the PIR will be reviewed again by a team from or acting on behalf on the relevant commissioner (i.e. Somerset Clinical Commissioning Group). The purpose of this review is to assess whether the relevant commissioner accepts the findings of the Trust's internal review regarding identification of lapses of the quality of care. Where no lapses in care are identified that could have led to the cases, then that case will not count towards the total number of actual CDI cases on which any sanction will be based.

10. DISCHARGE

10.1 Once a patient has been discharged the room and all equipment should have a

terminal clean with TECcare Ultra.

11. DEATH CERTIFICATE

11.1 Doctors have a legal duty to mention CDI on a death certificate if it was part of the sequence of events directly leading to death or contributed in some way.

11.2 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 death certificate. 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.

12. AUDIT AND MONITORING

12.1. The IP&CT will carry out quarterly audit of isolation practice as per the Infection Prevention and Control Audit Programme. Any issues identified from the audit will be highlighted by the IP&CT to the ward manager who will then formulate an action plan. Audit results will be reviewed at the IP&CT meetings, the appropriate Peer review and escalated to the Infection Prevention and Control Committee as necessary.

12.2. The Antibiotic Pharmacist will carry out regular audits of compliance with the Antibiotic Guidelines audits, and feedback results to clinicians and prescribers. Results of audits are reviewed at the Antimicrobial Prescribing group meetings, at which there is IP&C representation. The Antibiotic Pharmacist is a member of the IP&CT meetings, monthly Clostridium difficile group and the Infection Prevention and Control Committee and any concerns will be highlighted at these groups.

12.3. The IP&C Team will audit every CDI and Clostridium difficile colonisation patient upon discharge to monitor compliance with the Clostridium difficile pathway. Results of the audits will be reviewed at the Trust's IP&CC, monitored via the relevant Directorate's Governance meetings.

12.4. The IP&C Team will audit every CDI and Clostridium difficile colonisation patient upon discharge to monitor compliance with the Clostridium difficile pathway. Results of the audits will be reviewed at the Trust's IP&CC, monitored via the relevant Directorate's Governance meetings.

13. APPLICABILITY

13.1. These guidelines apply to staff employed by the Trust. Patients, visitors and the general public will be made aware of this guideline as required.

14. IMPLIMENTATION, MONITORING AND EVALUATION

14.1. Implementation monitored and evaluated under the requirements of the Policy for the Procedure and Management of Documents Policy. Monitoring and evaluation will be the remit of the IP&CT.

15. REFERNCES

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16. **APPENDIX A**
- 16.1. [Diagnostic Algorithm for Clostridium difficile Infection \(CDI\)](#)

17. **APPENDIX B**
- 17.1. [Clostridium Difficile Care Pathway](#)

18. **APPENDIX C**
- 18.1. [Isolation Policy](#)

19. **APPENDIX D**
- 19.1. [Terminal Clean Checklist](#)

20. APPENDIX E – BRISTOL STOOL CHART

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Text

21. ANNEX F – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes / No / N/A	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	N/A	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust's lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust's lead for Equality & Diversity.

Signed – Peter White

Date – 1 August 2019