Public – To be published on the Trust external website

Clostridioides Difficile Associated Diarrhoea (CDAD)

Ref: IPC-0001-004-v4.2

Status: Approved
Document type: Procedure
Overarching policy: IPC Policy

Contents

1 Introduction

This procedure supports the trust to control and manage any cases or incidence of Clostridioides Difficile Infection (CDI). Clostridioides difficile formerly known as Clostridium difficile known as *C.* difficile is an anaerobic, gram-positive spore forming bacillus. *C. difficile* spores are resistant to exposure to air, drying, and heat and they can survive in the environment without nutrients for long periods of time. They are also resistant to general detergents and higher levels of cleaning must be instigated when dealing with patients who are symptomatic.

C.difficile is a bacterium found in the intestines. C. difficile can be found in the gut of healthy people where it causes no symptoms. Statistics illustrate carriage in 3% of adults,10% of residents in long-term care facilities, 14-20% of older people on hospital wards and 66% of healthy children under 2 years.

CDI occurs when the normal bacterial flora of the bowel is altered this allows C. difficile to flourish and produce toxins which attack the intestines and cause diarrhoea.

The primary cause of CDI is antibiotic exposure. Gastro-intestinal surgery also increases a person's risk of developing the disease. All age groups can be affected; however, the elderly and other vulnerable patient groups are most at risk and people whose immune systems are compromised.

Children under the age of 2 years are not usually affected but they are frequently asymptomatic carriers. A long length of stay in healthcare settings and immuno-suppression leads to an increase in patients who are carriers. For most people this is a mild but uncomfortable illness, and patients will make a full recovery. Some elderly patients can become ill with dehydration caused by the diarrhoea C. difficile can lead to more serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis). C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients.

This procedure provides all staff employed by TEWV with the key processes and protocols.

required to enable them to care for patients with suspected/confirmed CDI and ensure that other patients are not put at undue risk.

This procedure supports Our Journey to Change as set out in the overarching Infection Prevention and Control Policy.

2 Purpose

This procedure is essential to patient and staff safety, following this procedure will help the Trust to minimise the spread of Clostridioides Difficile by: -

- Managing and treating patients with suspected / confirmed *CDI*
- Managing the cleaning of rooms that are in use / have been used by a patient with CDI
- Reducing the risk of transmission of CDI in the healthcare setting.

3 Who this Procedure Applies to

This procedure applies to all healthcare workers who undertake direct patient care within TEWV services.

4 Related Documents

The Standard (Universal) Precautions for Infection Prevention and Control defines the universal standards for IPC which you **must** read, understand, and be trained in before carrying out the procedures described in this document.

This procedure also refers to: -

- Hand Hygiene
- Waste Management Policy
- Outbreak
- Laundering and Safe Handling of Linen and Clothing
- Decontamination of equipment

5 Signs & Symptoms of CDI

- Diarrhoea unexplained with mucus or occult blood – The illness ranges from mild self-limiting diarrhoea to explosive watery, green coloured and foul-smelling diarrhoea.

Other symptoms include:

- abdominal swelling / abdominal pain
- high temperature
- lethargy
- loss of appetite.
- Nausea

*UNEXPLAINED diarrhoea:

1. Patient or carer states this is not normal for them
2. Patient does not have a known bowel condition i.e. ulcerative colitis, bowel Cancer
3. Patient has not recently consumed something (food/drink/meds/supplements) that is known to, or suspected could, upset their stomach/bowels
4. Patient has not recently had an enema or started on or on long term aperients / laxatives

5.1 Diagnosis in an Inpatient Setting

Diagnosis is confirmed by the laboratory following the testing of a faeces specimen (Appendix 3) which must be obtained should C. difficile be suspected. The testing algorithm for C. difficile involves a combination of tests. The first, an immunoassay detects the presence of C. difficile in the sample via the detection of the glutamate dehydrogenase enzyme (GDH). The second, another immunoassay, detects the presence of the C. difficile toxin in the sample. In cases where GDH is detected but the toxin is not detected in the sample, a PCR test is undertaken to identify whether the C. difficile strain carries the toxin gene.

CDI **must** be managed as a diagnosis.

C difficile should be considered in any patient with 3 or more loose stools within 24 hours, particularly those with a recent history of hospitalization and antibiotic use within the last 3 months. Additionally, diarrhoea persisting for 48 hours or longer after hospital admission warrants consideration.

For people with suspected or confirmed *CDI*, assess:

- whether it is a first or further episode (relapse or recurrence) of C. difficile infection
- the severity of C. difficile infection
- individual factors such as age, frailty or comorbidities that may affect the risk of complications or recurrence.

5.2 How the Infection is Spread

- Transmission can be directly spread from patient to patient by the faecal oral route.
- Indirectly spread via the hands of healthcare workers.
- Or via environmental contamination including health care equipment (physiological monitoring equipment, beds, mattresses, chairs, hoists etc) and toilet facilities.

6 Management of Patients with CDI

Clinicians should apply the following mnemonic protocol (SIGHTED) when managing suspected potentially infectious diarrhoea:

S	Suspect that a case may be infective where there is no clear alternative cause of diarrhoea. Refer to Bristol Stool Chart (Appendix 4)
I	Isolate the patient and consult with the infection prevention and control team while determining the cause of diarrhoea
G	Gloves and aprons must be used for all contacts with the patient and their environment
H	Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment Alcohol hand gel is not effective in removing spores from hands.
T	Test the stool for toxin, by sending a specimen immediately
E	Educate the patient, family, and visitors
D	Document actions, including if patient will not isolate

For people with suspected or confirmed C. difficile infection, review existing antibiotic treatment, and stop it unless essential. If an antibiotic is still essential, consider changing to one with a lower risk of causing C. difficile infection.

For people with suspected or confirmed C. difficile infection, review the need to continue any treatment with (see Appendix 5):

- proton pump inhibitors
- other medicines with gastrointestinal activity or adverse effects, such as laxatives
- medicines that may cause problems if people are dehydrated, such as non-steroidal anti-inflammatory drugs, angiotensin-converting enzyme inhibitors, angiotensin-2 receptor antagonists and diuretics.

Each patient must be monitored daily for signs of increasing disease severity. Consideration will be given to the requests of the patients with regards to the gender of the staff member who may monitor their symptoms.

Each patient must be reviewed daily by a physical health practitioner and/or medical staff, fluid intake, electrolyte replacement and nutritional status must be included in the daily review.

All bowel movements must be recorded on the patient's bowel chart (Appendix 6)

Clinicians and Infection Prevention and Control Nurses (IPCN) caring for patients in a mental health/learning disability will review patients at least weekly.

Please refer to Appendix 7 – algorithm for the management of CDI.

6.1 Assessing the Severity Level of CDI

The clinician (Physical health practitioner and/or medical staff) **must** assess the severity of CDI **daily** and liaise regularly with the multidisciplinary team including the IPC team to ensure the patient receives holistic care and appropriate treatment.

Severity of CDI			
Mild CDI	**Moderate CDI**	**Severe CDI**	**Life-threatening CDI**
Is not associated with a raised White cell count (WCC).	Associated with a raised WCC that is <15,000.	Associated with a WCC >15,000 or a temperature of >38.5 degrees C or an acute rising serum creatinine (i.e., >50% increase above baseline), or evidence of severe colitis (abdominal or radiological signs)	Includes hypotension, partial or complete ileus or toxic megacolon or CT evidence of severe disease.
Typically associated with 3 or fewer type 5 – 7 stools per day using the Bristol Stool Chart	Typically associated with 3 – 5 type 5-7stools per day	The number of stools may be a less reliable indicator of severe disease but if the patient is passing >5 unformed (type 5-7)	Daily assessment must be documented in the medical notes.

(Appendix 4) as reference.		stools per day the disease should be classified as severity. **The patient does not necessarily have to have all the above criteria to be defined.**	

If any patient displays symptoms of severe or life-threatening CDI, medical staff must consult a microbiologist/gastroenterologist/surgeon for immediate advice.

6.2 Treating CDI According to Severity

Medical staff must consult a microbiologist, infectious diseases physician or gastroenterologist for prescribing advice. The below antibiotics are advised for adults aged 18years and over.

Treatment	Antibiotic, dosage, and course length
First line antibiotic for a first episode of mild, moderate, or severe *C. diffcile* infection	Vancomycin: 125mg orally four times a day for 10 days • if patient unable to swallow discuss with clinical team alternative methods for administration
Second-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection if vancomycin is ineffective.	Fidaxomicin: 200mg orally twice a day for 10 days • Specific advice of an infectious diseases physician or consultant microbiologist must be sought prior to prescribing
Antibiotics for *C. difficile* if first- and second-line antibiotics are ineffective – seek specialist advice as the patient may need transferring to acute trust.	Specialist may initially offer: Vancomycin: Up to 500 orally four times a day for 10 days With or without Metronidazole: 500mg intravenously three times a day for 10 days
Antibiotic for a further episode of *C. difficile* infection within 12 weeks of symptoms resolution (relapse)	Fidaxomicin: 200mg orally twice a day for 10 days

Antibiotics for a further episode of *C. difficile* infection more than 12 weeks after symptom resolution (recurrence)	Vancomycin: 125mg orally four times a day for 10 days Or Fidaxomicin: 200mg orally twice a day for 10 days Refer to BNF for appropriate use and dosing in specific population.

(See Appendix 8 for the Treatment of CDI flowchart).

7 Management and Treatment of Clostridioides difficile carriers

Providing these patients are asymptomatic they may be nursed without isolation precautions.

Carriers of Clostridioides difficile will be at more risk of developing CDI therefore antibiotics should be avoided, if possible, in the three months after a positive sample. If antibiotics are essential to treat another infection during this period, a short course of a narrow spectrum agent is preferable.

Consult with Acute Microbiologists to discuss the best option if antibiotic therapy is required. Any intravenous treatment would be given in the Acute hospital.

If the patient develops diarrhoea for any reason, they will be infectious to others, whatever the cause of the diarrhoea. Therefore, if they are in any healthcare environment, they must be isolated immediately until 48 hours clear of diarrhoea and a formed stool passed.

8 Responsibilities of the Nurse in Charge

Who	What
Nurse in charge	Inform the IPCN and commence the *Clostridiodes difficile* pathway / C Difficile Pathway
Nurse in charge	Ensure that the patient is isolated in a single room with en-suite toilet facilities. This may require discussion /review with the infection control team depending on the patient's Mental health diagnosis
Nurse in charge	Make sure the correct Infection Prevention and Control (IPC) measures are implemented.
Nurse in charge	Instigate use of personal protective equipment i.e., disposable gloves and aprons / long sleeved gowns. For all contact with the patient and their immediate environment

Nurse in charge	If the ward does not have single rooms with ensuite facilities, then patients must be allocated their own toilet or commode – these **must** be cleaned after each use with a chlorine releasing agent
Nurse in charge	Inform domestic staff to ensure cleaning of the patient's room and toilet facilities is undertaken using a chlorine releasing agent at least daily
Nurse in charge	Ensure that a Bristol Stool Chart is commenced, maintained, and monitored to record all bowel movements.
Nurse in charge	Allocate designated medical equipment for the sole use of the patient that must still be thoroughly cleaned with a chlorine releasing agent / sporicidal wipes following each use. If designated equipment is not available, ensure all staff are informed to clean any multi use medical equipment immediately after use with a chlorine releasing agent / sporicidal wipes (these will be delivered by the infection control team.
Clinician	To review the patient's condition and assess severity daily in collaboration with the Multidisciplinary and Infection Prevention and Control teams.
Clinician	If patient dies complete a death certificate (examples Appendix 9).
IPCN/Nurse in Charge	Provide specialist advice in accordance with this procedure, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. The IPC team will ensure this procedure remains consistent with the evidence-base for safe practice. Review in line with the review date or prior to this in light of new developments. For individual cases and multiple outbreaks complete a Root Cause Analysis (RCA).

9 Infection Prevention and Control Measures

If symptomatic: **Single room accommodation**	• The patient must be nursed in single room accommodation with door closed and en-suite facilities. This may require further discussion with the infection control team. A risk assessment may need to be carried out and documented if a patient is at risk behind a closed door. • It is important to physically separate the symptomatic patient from other vulnerable patients in order to prevent the spread of CDI. This will be done in a respectful way that maintains the service user's privacy, dignity, and confidentiality.
Hand hygiene	• Staff and relatives must observe strict hand hygiene with liquid soap, water, and disposable hand towels before and after each patient contact or contact with the patient's immediate environment.

	• Patients **must** also be encouraged to wash and dry their hands before meals and after using the toilet. • Alcohol hand gel **must not** be used as an alternative to soap, as it is not effective against these bacteria. • Moist hand wipes can be offered if patients cannot access a wash hand basin. Patients may require assistance and or advice on how to wash their hands effectively and how to use the hand wipes.
Personal protective equipment & waste management	• Disposable gloves and aprons / long sleeved gowns must be worn for direct care for the patient, and for contact with the patient's immediate environment and body fluids. • These **must** be removed and disposed of as clinical waste immediately following the episode of care, and then hand hygiene performed using soap and water. All clinical waste should be disposed of in orange infectious waste bags.
Laundry	• Infected linen should be placed in an inner red alginate bag within a laundry bag and sent to the laundry for processing. • Patient's clothing must be washed separately on the hottest wash the material can withstand.
Environmental cleaning	**Clostridioides difficile spores may survive for many months. They are also resistant to many disinfectants. Patients' hands, care equipment and the environment can easily become contaminated with the organism.** • Environment cleaning must be completed daily. • Horizontal surfaces **must** be cleaned with Chlorclean solution in line Hotel Services policy. • Attention **must** be paid to all patient contact areas such as tables, chairs, door handles etc. • Toilet seats **must** be thoroughly cleaned with a chlorine releasing agent after each use. • Once the patient has been symptom free for 48 hours the room **must** be terminally cleaned, and curtains changed. • This **must** take place even if the patient will continue to be cared for in this room.
Equipment Decontamination	Monitoring and physiological equipment such as blood pressure cuffs, oxygen saturation monitor, thermometer, stethoscope must be disposable or designated where possible. • Any equipment which cannot be disposable or designated must be thoroughly decontaminated with Chlorclean between each and every use
Visitors	Visitors should be made aware patient has an infection. • Only take in bedroom items that you really need • You may be asked to wear apron and or gloves if this is deemed necessary • Please wash your hands with soap and water before and immediately after the visit. • Please do not use the patient toilet Please speak to a member of the clinical team if you have any questions.

9.1 Length of Isolation and Period of Infectivity

Isolation precautions may be discontinued when the patient has been symptom-free for 48 hrs and bowel movements have returned to normal. Hotel services staff must then be advised to undertake a terminal clean.

Infectivity occurs whilst symptomatic and as a general principle until 48 hours after cessation of symptoms. Note – some people will continue to shed spores once they are no longer symptomatic.

9.2 Patient Information

Patients should receive comprehensive education regarding the course and treatment of C difficile infection, potential recurrence, the judicious use of antibiotics, and preventive measures to contain its spread. Adhering to the prescribed treatment duration and abstaining from other antibiotics during C difficile treatment are crucial. Patients must understand that symptoms should gradually resolve and prompt reporting to their clinician is warranted if symptoms persist, worsen, or reappear, as this may indicate recurrence or exacerbation of the original episode.

Additionally, advise drinking enough fluids to avoid dehydration.

Preventing the spread of infection patients should be instructed to wash their hands thoroughly with soap and water to eliminate C difficile spores. Ensure the patient is offered the patient information leaflet that is available via the IPC intranet page.

9.3 Clostridioides Difficile Relapse

Recurrent disease occurs in about 20% of patients treated initially with either metronidazole or vancomycin (Teasley et al., 1983; Bartlett, 1985; Wenisch et al., 1996). The same antibiotic that had been used initially can be used to treat the first recurrence (Pépin et al., 2006). A variable proportion of recurrences are reinfections (20-50%) as opposed to relapses due to the same strain; relapses tend to occur in the first two weeks after treatment cessation (Wilcox et al., 1998; Figueroa et al., 2012).

After a first recurrence, the risk of another infection increases to 45–60% (McFarland et al., 1999). If Symptoms resolve then recur, repeat testing is justified to diagnose relapse of condition or new infection. Consult with the IPC team for further advice.

If a patient tests positive for C. difficile, they will not be re-tested by the laboratory within a 28-day period following this result. unless another cause of diarrhoea is suspected or requested by the Infection control team or infection control doctor.

9.4 Continue Local Surveillance

The Trust will record the number of patients with Clostridioides difficile for Inpatient facilities. This information will be discussed at the Infection Prevention and Control Committee and forms part of the Quarterly Surveillance reports.

10 Definitions

Term	Definition
CDAD	*Clostridioides difficile* Associated Diarrhoea.
Clostridioides difficile diarrhoea	One or more episodes 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. This includes medicines and that occurs at the same time as a positive toxin assay (with or without a positive C-difficile culture and / or evidence of pseudo membranous colitis.
CDI	*Clostridioides difficile* Infection.
IPC	Infection Prevention and Control.
IPCN	Infection Prevention and Control Nurses.
Pseudo membranous colitis	Severe bowel infection which could be life threatening.
QDS	Four times per day.
TDS	Three times per day.
WCC	White Cell Count.

11 How this Procedure will be Implemented

This procedure will be published on the Trust's intranet and external website.

Line managers will disseminate this procedure to all Trust employees through a line management briefing.

11.1 Training Needs Analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All health care staff	On-line national mandatory training	30mins	Yearly
All clinical staff	Support Infection Prevention Specialist (SIPS) programme	20 mins	Rolling programme

12 How the Implementation of this Procedure will be Monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	IPC quarterly report	IPC	IPCC

13 References

Department of Health and HPA (2008) Clostridium difficile infection: How to deal with the problem. London. Department of Health. Available at

http://www.gov.uk/government/publications/clostridium-difficile-infection-how-to-deal-with-the-problem

https://www.nice.org.uk/advice/esmpb1/chapter/full-evidence-summary-medicines-and-prescribing briefing.

Wilcox M (2013) Updated Guidance on the management and treatment of Clostridium difficile infection. Public Health England London

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321891/Clostridium_difficile_management_and_treatment.pdf

Department of Health and HPA (2008) Clostridium difficile infection: How to deal with the problem. London. Department of Health. Available at

http://www.gov.uk/government/publications/clostridium-difficile-infection-how-to-deal-with-the-problem

National Institute for Health and care Excellence 2021. Clostridioides difficile infection: antimicrobial prescribing

NHS England (2021) NHS Standard Contract 2021/22: Minimising Clostridioides difficile and

Gram-negative Bloodstream Infections.

NICE (2021) Clostridioides difficile infection: antimicrobial prescribing.

https://www.nice.org.uk/guidance/ng199 Accessed August 2024

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

14 Document Control (External)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	29 October 2024
Next review date	29 October 2027
This document replaces	**Clostridium** Difficile Associated Diarrhoea (CDAD) CLIN-0001-004-v4.1
This document was approved by	IPCC (virtual approval)
This document was approved	29 October 2024
This document was ratified by	IPPC (pending retrospective formal approval)
This document was ratified	January 2025 (pending)
An equality analysis was completed on this policy on	September 2024 (AH)
Document type	Public
FOI Clause (Private documents only)	n/a

Change Record

Version	Date	Amendment details	Status
4	22 Oct 2021	Full review with minor changes including transfer to new template and Antimicrobial treatment changes.	Withdrawn
4.1	19 Jan 2023	Information regarding safe labelling and transportation of specimens added to Appendix 3, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection. Link to faecal specimen collection procedure within the Royal Marsden Online Manual added into Appendix 3. Royal Marsden online added to references.	Withdrawn
4.2	29 Oct 2024	Replaced name Clostridium difficile with Clostridioides difficile to reflect changes in microbial taxonomy (UKHSA 2024). Full review with additional information for educational purposes, amended flowchart, references updated	Approved

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/Infection Prevention and Control Team
Title	Clostridioides Difficile Associated Diarrhoea (CDAD) Ref: IPC-0001-004-v4.2
Type	Procedure/guidance*
Geographical area covered	Trust wide
Aims and objectives	To set standards in practice to minimise the spread of Clostridioides Difficile
Start date of Equality Analysis Screening	21/10/2024
End date of Equality Analysis Screening	29/10/2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	The Trust, staff, patients & visitors
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	**Race** (including Gypsy and Traveller) **NO** **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** **Sex** (Men and women) **NO** **Gender reassignment** (Transgender and gender identity) **NO** **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** **Age** (includes, young people, older people – people of all ages) **NO** **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** **Human Rights Implications** **NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	N/A
Describe any positive impacts / Human Rights Implications	N/A

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Nice guidance & best practice
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Not relevant to this procedure
If you answered Yes above, describe the engagement and involvement that has taken place	N/A
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Yes
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	IPCC members
Is there evidence of consultation with stakeholders and users?	N/A	
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	

Are key references cited?	Yes	
Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	Sep 2024 ah
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	
Does the document identify whether it is private or public?	Yes	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	

Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like ‘click here’)	Yes	

Appendix 3 - Specimen Collection and Transportation

Follow the Royal Marsden Manual online procedure for specimen taking: Faecal sampling - Royal Marsden Manual (rmmonline.co.uk)

Safe labelling of specimens

Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location eg. ward name.

The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.

Ensure the laboratory request form is also signed by the clinician who has requested the specimen.

The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.

Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as 'high risk' (high risk stickers can be ordered via cardea).

Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

Transportation of laboratory specimens

All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.

Specimen transport containers must not be left unattended in a patient access area.

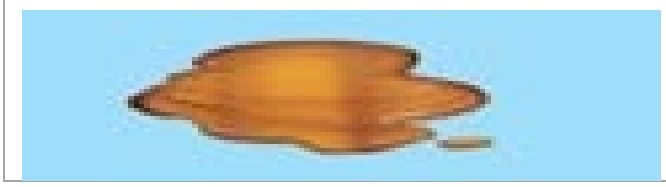
Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.

Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.

Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen.

Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

Appendix 4 – The Bristol Stool Chart

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

Appendix 5 - Medicines that can Cause Diarrhoea

Diarrhoea is a common adverse drug reaction (ADR) with many medicines.

Antimicrobials account for about 25% of drug-induced diarrhoea though most cases are benign (Lee, 2006)

While diarrhoea has been seen with most medicines, the ones that are most commonly implicated are:

- Acarbose
- Antimicrobials
- Bile salts
- Colchicine
- Cytotoxics
- Dipyridamole
- Iron preparations
- Laxatives
- Leflunomide
- Magnesium preparations e.g. antacids
- Metformin
- Metoclopramide
- Misoprostol
- Non-steroidal anti-inflammatory drugs (NSAIDS) e.g. aspirin, ibuprofen
- Olsalazine
- Orlistat
- Proton pump inhibitors
- Sodium Aurothiomalte
- Ticlopidine

Please refer eBNF for up-to-date information.

Clinician to review medication in conjunction with pharmacist and consultant microbiologist.

Careful attention **must be** paid to how much time has passed between the time that the medicine is first taken and when the diarrhoea first appears.

Further information on adverse effects is available from local medicines information centres or by using the 'search by section' at http://emc.medicines.org.uk.

journey to change

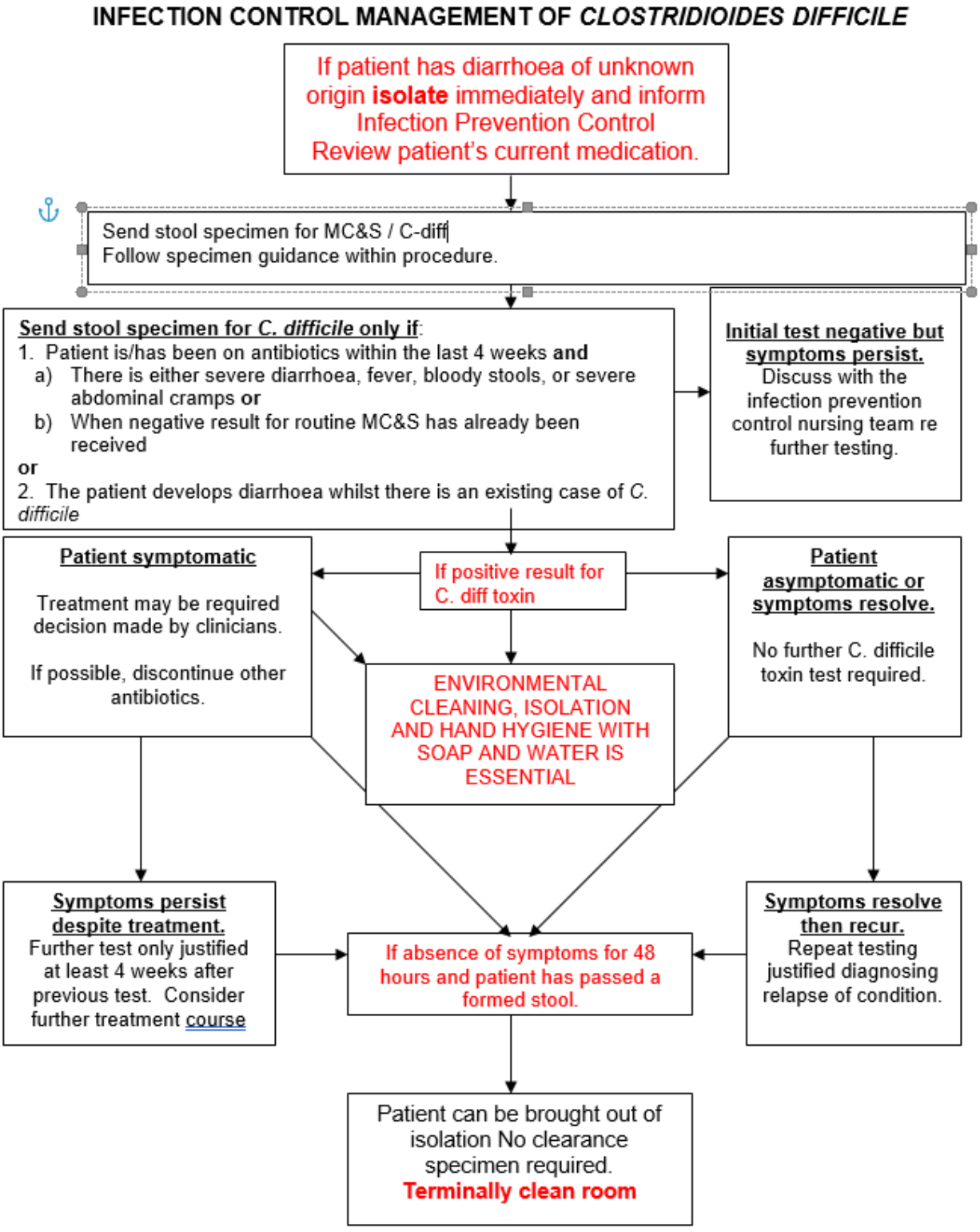
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix 6 - CDI Patient Bowel Movement Record Chart

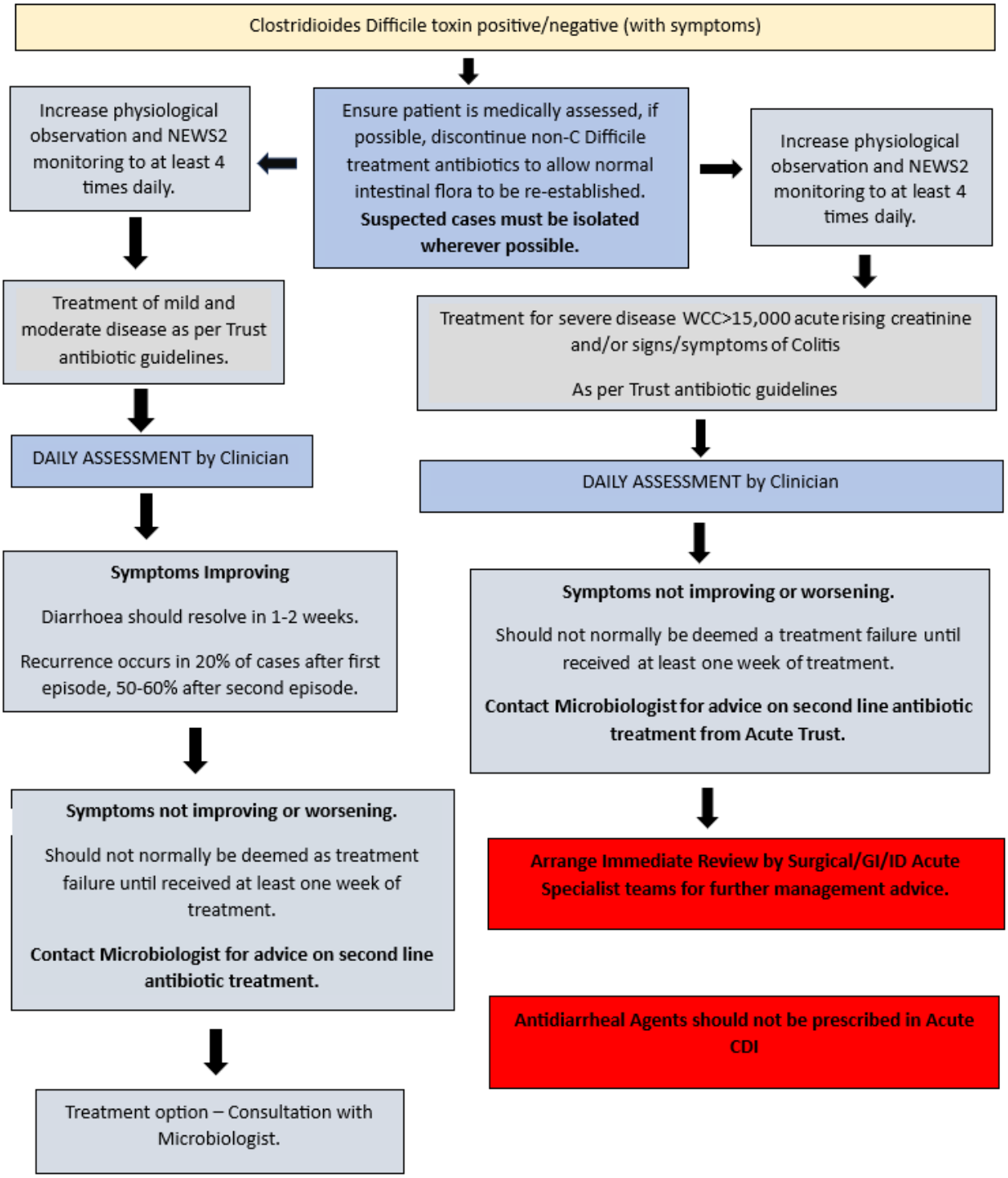
Please attach patient sticker here or record: Name: …… Date of Birth: …… Cito No: …… NHS No: …… Consultant: ……..	Clostridium difficile specimen result date: Toxin positive / toxin negative (please circle)	**Record every bowel movement.** **Also record if bowels are not opened in 24hours.** **Isolation to continue until 48hours symptoms free and a formed stool is passed.**

Date	Time	Comments Please state: Blood Mucus Offensive smell Colour Bowels not open	**Type 1** **Separate hard lumps (hard to pass)** 	**Type 2** **Sausage shaped but lumpy** 	**Type 3** **Like a sausage but with cracks on the surface** 	**Type 4** **Like a sausage or snake, smooth and soft** 	**Type 5** **Soft blobs with clear cut edges** 	**Type 6** **Fluffy pieces with ragged edges, a mushy stool** 	**Type 7** **Watery, no solid pieces (entirely liquid**) 	Staff Initials

Appendix 7 - Infection Control Management of Clostridioides Difficile



Appendix 8 - CDI Treatment Management Flowchart



Appendix 9 - Example Death Certificate for CDI Patients

If a healthcare-associated infection (HCAI) was part of the sequence leading to death, it must be in Part 1 of the certificate.

Include all the conditions in the sequence of events back to the original disease being treated.

Examples:

Ia. Clostridium difficile pseudo membranous colitis

Ib. Multiple antibiotic therapy

Ic. Community-acquired pneumonia with severe sepsis

II. Immobility, polymyalgia rheumatica, osteoporosis

If your patient had an HCAI which was not part of the direct sequence, but which you think contributed at all to their death, it must be mentioned in Part 2 of the certificate.

Examples:

Ia. Bronchopneumonia

Ib. Carcinomatosis and renal failure

Ic. Adenocarcinoma of the prostate

II. Clostridium difficile infection secondary to antibiotic therapy for recurrent bronchopneumonia