CLOSTRIDIUM DIFFICILE (CDIFF) POLICY

Policy Type	Clinical Infection prevention and control
Directorate	Corporate Nursing
Policy Owner	Chief Nurse including Midwifery and Allied Health Professionals
Policy Author	Infection Prevention and Control Team
Next Author Review Date	1st May 2022
Approving Body	Policy Management Sub-Committee 9th October 2018
Version No.	5.0
Policy Valid from date	1st October 2018
Policy Valid to date:	31st October 2022

'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
6 Dec 12	3.2		Executive Directorate of Nursing & Workforce	Put into new Trust Format. Endorsed at	Quality & Patient Safety Committee
29 Jan 13	3.3		Executive Directorate of Nursing & Workforce	Endorsed at	Policy Management Group
2 Sep 13	3.4	02/0913	Executive Directorate of Nursing & Workforce	Approved at	Trust Executive Committee
Sep 15	3.5		Executive Director of Nursing	Revision	IPCC
4 Dec 15	3.5		Executive Director of Nursing	For Ratification	Clinical Standards Group
15 Dec 15	4.0	15/12/15	Executive Director of Nursing	For Approval	Policy Management Group
Aug 18	4.1		Director of Nursing	Put into current Trust Format and Revision and update.	
29/09/18	4.1		Director of Nursing	For ratification	Clinical Standards Group
09/10/18	5.0	09/10/18	Director of Nursing	Approved	Policy Management Sub-Committee
29/01/21	5.0	09/10/2018	Chief Nurse including Midwifery and Allied Health Professionals	12 month blanket policy extension due to covid 19 applied with author review date set 6 months prior to Valid to Date.	Quality & Performance Committee
13/05/21	5.0	09/10/2018	Chief Nurse including Midwifery and Allied Health Professionals	Extended policy uploaded and linked back with new cover sheet	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents **Page**

1 Executive Summary

This policy defines the actions required to reduce risk for healthcare associated infections (HCAI), by reducing risk for transmission of *Clostridium difficile* and preventing cross infection within the healthcare environment, in line with the requirements of the Health and Social Care Act Code of Practice and the Department of Health document "Updated Guidance on the management and treatment of *Clostridium difficile* infection" 2013. This provides detailed, evidence based guidance for NHS managers and clinicians involved in the prevention and control of *Clostridium difficile* infection (CDI), with the purpose of enabling them to deliver the NHS operating framework target to reduce CDI across the NHS.

This document provides local guidance on implementing these recommendations and includes information on diagnosis, management, treatment and prevention of CDI in all healthcare settings.

2. Introduction

2.1 *Clostridium difficile* (*C.difficile*) is a spore producing bacterium. It can be found colonising the intestine of a small percentage (less than 5%) of the healthy adult population and more commonly in babies and small children.

2.2 As a colonising organism in adults and children, *C.difficile* does not cause any symptoms and is not detectable by those who carry it. If a colonised individual has diarrhoea for any reason, there is an increased risk of transmission to others.

2.3 *C.difficile* infection was identified in the 1970's as a significant cause of diarrhoea and colitis following antibiotic therapy. Infection usually occurs because the normal resident gut flora which naturally suppresses overgrowth of *C.difficile* have been disrupted and decreased. Most commonly this can occur after use of broad spectrum antibiotics. Other risk factors include gastro-intestinal procedures, Percutaneous endoscopic gastrostomy (PEG) and Nasogastric (NG) feeding, age over 65 years, recent hospitalisation, living in a nursing home or long term care facility, transfer from another care facility, weakened immune system and Proton-pump inhibitors (PPI) use.

2.4 Active *C.difficile* infection (CDI) occurs when multiplication of the organism produces toxins which irritate the gut leading to loose stools which can be explosive and profuse and has a particularly distinctive odour. Frequently mucus is seen mixed with the stool. Symptoms of colitis are often present. Severe cases of infection can lead to pseudomembraneous colitis and toxic megacolon which can be fatal.

2.5 *C.difficile* spores may be released into the environment as loose stools are expelled and may travel some distance from the patient if explosive, contaminating the immediate environment. These spores are resistant to drying and will remain viable for long periods of time. If ingested by other vulnerable hosts with risk factors for developing CDI, transmission of infection can occur.

3. Definitions

CDI	-	*Clostridium difficile* infection
GDH	-	Glutamate Dehydrogenase (enzyme produced by *C. difficile*)
IPCT	-	Infection Prevention and Control Team
IPCC	-	Infection Prevention and Control Committee

PII - Period of Increased Incidence
PPE - Personal Protective Equipment

4. Scope

This policy applies to all staff working in all healthcare settings of the Trust.

5. Purpose

This policy provides best practice guidance on prevention, management and treatment of patients with CDI.

6. Roles and Responsibilities

It is the responsibility of **all healthcare staff** to comply with the Trust's infection control polices to protect patients from Health Care Associated Infection including CDI.

- **Director of Infection Prevention & Control (DIPC)** has overall responsibility for ensuring Trust wide implementation and adherence to this policy takes place.
- **Leads of Clinical Services** Responsible for ensuring the policy is implemented and adhered to within their areas.
- **The Consultant responsible for the patient's care** is responsible for promoting adherence to this policy (including appropriate antibiotic use, medications review and infection control precautions) amongst their team and must actively participate in the RCA meeting to establish the root cause of hospital acquired (including community attributed with inpatient stay within 3 months) CDI cases.
- **Modern Matrons/Ward Managers** are responsible for promoting compliance with infection control policies. They should take the lead on root cause analyses (RCA) in their area, ensuring the investigation and the follow up of the actions take place in a timely manner. They should ensure appropriate audit implementation for hospital acquired CDI.
- **Site Co-ordinators** are responsible for identifying appropriate isolation rooms for patients with potentially infectious loose stools when no side room on the patient's ward can be made.
- **Ward clinical staff** are responsible for implementing this policy, including identification of patients with loose stools and acting appropriately in line with this and other relevant policies, checking and documenting the results and acting appropriately on results.
- **Microbiology laboratory staff** are responsible for processing *C.difficile* tests in line with the laboratory standard operating protocol.
- **Consultant Medical Microbiologists** are responsible for advising on diagnosis, prevention and management of *C.difficile* infections including appropriate antimicrobial use.
- **The Antimicrobial Management Team** is responsible for;
    - Reviewing, monitoring and advising on antibiotic use especially in respect of restricted broad-spectrum antibiotics
    - Ensuring local antibiotic guidance reflects national guidance
    - Developing, maintaining and using programmes to capture data on antibiotic use and reporting this information to relevant groups including IPCC.
- **Infection Prevention & Control Team (IPCT)** are responsible for advising on diagnosis, prevention and management (including isolation precautions) of *C.difficile*

infections, updating this policy and patient information. IPCT should ensure *C.difficile* colonised and infected patients have the appropriate flag on the electronic patient record, are responsible for reporting CDI cases (hospital and community acquired cases) to Public Health England (and CCG where appropriate) and prompting and supporting the RCA investigation process for Trust attributed CDI, as well as supporting investigation of potential incidents of CDI cross infection.

- **Cleanliness team** are responsible for instigating enhanced environmental cleaning in line with the Clean Patient Environment Policy and as advised by the Infection Prevention & Control team

7. Policy detail/Course of Action

7.1 CDI Prevention

- **Minimising CDI risk from antibiotic prescribing**

This organisation has restrictive anti-microbial policy and guidelines in place to avoid use of agents which might provoke CDI in vulnerable patients. These guidelines can be found at: http://it-intranet/anti-microbial

Caution must be taken in prescribing any antibiotics for patients known to be infected or colonised (GDH positive) with *C. difficile*. Contact the Consultant Microbiologist if unsure about which antibiotics would be appropriate.
All consultants are responsible for reviewing antibiotic prescriptions on all their ward rounds, stopping unnecessary prescriptions and changing those that do not comply with the guidelines, as should their juniors on all their own ward rounds.
Further guidance on antibiotic use can be obtained from the Consultant Medical Microbiologist (Ext 4807; via switch out of hours).

- **Infection control precautions**

Effective hand hygiene, use of appropriate personal protective equipment, appropriate isolation implementation and effective decontamination of equipment and environment are key measure to minimise the risk of *C.difficile* transmission in the Trust. Relevant policies should be consulted for further details.

- **Isolation**

All hospital in patients with potentially infectious loose stools should be isolated immediately **or at the very latest within 2 hours of loose stools symptoms becoming apparent.** This also applies if loose stools symptoms develop overnight. In the event that it is not going to be possible to isolate within this time frame, an incident form must be submitted by the nurse in charge of the ward at the time and the issue escalated to the site coordinator. The Infection Prevention & Control Nurses (IPCNs) or on call Medical Microbiologist (out of hours) may be contacted to support with side room risk assessments where a side room cannot be identified by the site co-ordinator.

- **Proton-Pump Inhibitors (PPIs)** should only be prescribed for a defined and appropriate indication as their use is associated with increased CDI risk.

7.2 Diagnosis

A faecal specimen must be sent if a patient has one episode of loose stools (Bristol Stool Chart types 5-7).) It should be borne in mind that even if loose stools are thought to be due to other causes, *C.difficile* could also be present (infection or colonisation). Act on the first episode of loose stools, do not wait for further episodes to obtain sample**.**

The following “SIGHT” mnemonic (adapted for local use) should be used when managing potentially infectious loose stools;

S	Suspect that a case may be infective
I	Isolate the patient at the very latest within 2 hours of loose stools becoming apparent (until *C. diff* status is known and no other infectious cause suspected).
G	Gloves and aprons/long sleeved gowns must be used for all contacts with the patient and their environment (See section 6.3 for details)
H	Hand washing with soap and water should be carried out before and after each contact with the patient and the patient’s environment
T	Test the stool for *C. difficile* by sending a specimen immediately – speed is essential. Faecal specimens contaminated with urine can be tested in the laboratory.

More than one test may be required if the first test is negative but there is a strong clinical suspicion of CDI and loose stools persist (discuss with the consultant microbiologist).

Laboratory diagnosis
Testing is available seven days a week at the following times;

- Mon - Sun: 9am - 4.30pm: samples processed within 1-2hrs of receipt in the lab but there may be delays at busy times - if needed urgently (i.e where you have been unable to isolate) please contact the laboratory during the above times (no evening or overnight processing available).

All loose stools specimens received in the laboratory from hospital inpatients over the age of 2 years will be routinely tested for CDI unless they have already been tested recently.

All community-based patient specimens from patients 65 and over will routinely be tested for *C.difficile*. Specimens from community patients under 65 years of age will only be tested for *C.difficile* if clear clinical indication is present on the laboratory request form.

The two-stage testing process performed on site involves testing for:

1) GDH (glutamate dehydrogenase) – a highly sensitive test for the presence of *C.difficile*
2) *C.difficile* toxin - only if the first (GDH) test is positive

Only if positive in both tests i.e. GDH and toxin positive will the case be considered as active CDI (requiring treatment) and included in mandatory reporting figures.

Interpretation of test results;

Report Result	Interpretation	Clinical significance
GDH EIA: **Negative** (Toxin testing not required)	CDI is very unlikely	**Treat as negative.** Do **not** routinely send any further samples. If symptoms worsen, clinical condition deteriorates or medical microbiologist advises then resend specimen. Isolation care can be discontinued where there is no suspicion of other infective cause.
GDH EIA: **Positive*** C.difficile toxin (EIA): **Negative**	Consistent with **colonisation** with C.difficile	C.difficile present in faeces but no toxin detected; potential for spore production and possible cross-transmission

		Loose stools likely to due to another cause - does **not** usually require specific treatment for CDI. Discuss with CM if high clinical suspicion of CDI e.g. if symptoms worsen or persist without other explanation especially if recent antibiotic therapy. **Isolation care is essential for those with loose stools symptoms who are GDH positive.** *Caution must be taken with future antibiotic prescriptions as will be at risk of developing CDI
GDH EIA: **Positive** C.difficile toxin (EIA): **Positive***	Consistent with **diagnosis** of CDI	Both C.difficile and toxin have been detected. Treat as CDI and follow treatment guideline. The IPCT will advise on re-sending specimens. Isolation care is essential for those with loose stools symptoms who have CDI. *Caution must be taken with future antibiotic prescriptions as will be at risk of developing CDI

To reduce the risk of false negatives from toxin breakdown, it is important that stool samples are transported to the laboratory as soon after collection as possible where they should be refrigerated if not tested immediately. A negative result may also indicate that the sample was not transported, stored, or processed promptly. If there is a concern that a stool specimen has not been collected and processed properly, a second specimen may be submitted for testing after discussion with the laboratory.

The current protocol for testing and diagnosing CDI (March 2012) is based on peer-reviewed, published research: https://www.gov.uk/government/publications/updated-guidance-on-the-diagnosis-and-reporting-of-clostridium-difficile

It is important to recognise that no test, or combination of tests, is infallible and the clinical condition of the patient should always be taken into consideration when making management and clinical choices.

7.3 **Management of CDI**

- A confirmed diagnosis of CDI will be reported to the ward and clinician providing care of the patient.
- All antibiotic therapy and other drugs that might cause loose stools should be reviewed in any patient suspected or diagnosed with CDI.
- Anti-gut motility medication should never be given to patients with active CDI.

CDI must be managed as a disease in its own right, with patients reviewed daily regarding fluid balance, electrolyte replacement and nutritional status. Severity of symptoms should be assessed and managed by clinicians on a daily basis using the appropriate C. difficile care pathway/severity score chart.
(see Intranet > Home > Corporate > Infection Prevention & Control > Clostridium difficile)

In all cases treat as per antimicrobial guidelines accessible via intranet home page or hyperlink below.

http://it-intranet/Anti-microbial

An accurate record of bowel activity using the Organisational stool chart must be maintained for all patients.

Infection Prevention Measures

- **GDH positive, toxin positive (CDI)** - Isolation must continue until loose stool symptoms are fully resolved for a minimum of 48 hours, patient is having formed stools, treatment has been completed for at least 48 hours and appropriate 'RED' barrier cleaning of the room with Hydrogen Peroxide Vaporisation (HPV) has been undertaken. Resolved CDI patients should ideally stay in a side room for the duration of their hospital stay to facilitate rapid isolation care implementation in the event of relapse.
- **GDH positive, toxin negative (C.difficile colonisation)** - Isolation must continue in the single room until loose stool symptoms are fully resolved for a minimum of 48hours, patient is having formed stools and appropriate 'RED' barrier cleaning of the room has been undertaken.

Isolation facilities must have:

- An isolation sign that is clearly visible and the isolation room door closed for the period of isolation. If safety reasons mean the door cannot remain closed, this must be clearly documented in the patient record and every effort made to maintain the isolation area.
- En-suite toilet or a commode, designated for the sole use of that patient which must remain in the room at all times.
- Detergent and chlorine wipes must be available in the isolation room.
- Patients must be given clear verbal and written information about the reason for isolation.
- Visitors must be given clear instructions regarding precautions.

PPE – All staff and visitors entering the isolation room must wear appropriate protective equipment.

- For hands on personal care delivery (e.g. assisting with washing, dressing, toileting needs or clinical examination) or undertaking environmental cleaning, a long sleeved disposable gown and disposable gloves should be worn.
- When entering an affected room, if not providing hands on personal care or undertaking environmental cleaning (e.g. delivering meals, porters assisting with basic transfers or basic observation monitoring), a disposable yellow apron and disposable gloves should be worn
- For relatives spending long periods of time with seriously ill patients, it may not be appropriate to wear gloves for long periods. Please contact the IPCNs for advice.
- Before leaving the isolation room, personal protective equipment must be removed and hands washed thoroughly with soap and water. It is the responsibility of ward staff to ensure that visitors are given appropriate information to minimise risk of transmission of infection.

Hand Hygiene – Hands must be washed with soap and water when dealing with any patient with potentially infective diarrhoea. Hand sanitiser is not effective against *C.difficile* spores and some other enteric organisms such as norovirus.

- The affected patient should be advised and supported to clean their hands after using WC or commode and before eating. Advice should be given about importance

of effective personal hand hygiene. This is particularly important for frail elderly who may need support.
- Visitors should be advised about the importance of effective hand hygiene.
- Equipment – Any observation monitoring equipment, infusion pumps, drip stands, commode, manual handling aids etc.; should be designated for that patient's sole use wherever possible and remain within the isolation room. These items and other equipment in the room must be routinely cleaned and disinfected on a daily basis, after each use and before leaving the room. Detergent and chlorine wipes must be available in the isolation room.

Environmental Cleaning

- The isolation room and furniture such as table, locker and bed frame must be cleaned daily and when visibly soiled.
- When there is a case of *C.difficile* on the ward, the whole ward (including bathrooms, toilets and dirty utility) is to be routinely cleaned daily using a chlorine releasing agent ("Actichlor plus") and disposable mop-heads/cloths.
- Specialist barrier clean of the isolation room with Hydrogen Peroxide Vaporisation in line with the Clean Patient Environment Policy and as indicated by the 'RAG' environmental cleaning guideline must be undertaken at the end of the isolation period before the room is returned to general use.

Under no circumstances can isolation precautions be lifted and the room re-used if this clean has not taken place as the environment will still be contaminated.

7.4 CDI outbreak identification

- A Period of Increased Incidence (PII) of CDI is defined as two or more new cases (96 hrs or more post-admission and not relapses) identified in a 28-day period in a ward. On identification of a PII, the following actions should be undertaken
- CM request that ribotyping is performed
- Review of RCA findings from cases within timeframe to ascertain any common factors and ongoing risk
- Review meeting to take place with IPCT, Director of Infection Prevention and Control, ward clinician and ward matron and manager to ensure appropriate measures in place to mitigate further risk and assess need for convening a wider outbreak management group

An outbreak of CDI is defined as two or more cases caused by the same strain, related in time and place over a defined period based on the time of onset of the index case.

7.5 CDI Reporting

National reporting of CDI to Public Health England (PHE) will be carried out by IPCNs in line with policy for mandatory reporting of healthcare associated infections (HCAI) (http://www.iow.nhs.uk/guidelines/IPC_Reporting%20of%20HCAI%20Policy.pdf)

For patients admitted to an acute trust, where day 0 is defined as the day of admission, if the test specimen was taken on day 3 or later the report is classified as an acute trust apportioned case.

The infection control lead for the Clinical Commissioning Group (CCG) will be notified by the IPCT of any community acquired cases reported via the laboratory.

NHS Improvement published in March 2018 the *Clostridium difficile* infection objectives for NHS organisations in 2018/19 guidance on sanction implementation and notification of changes to case attribution definitions from 2019.
https://improvement.nhs.uk/documents/808/CDI_objectives_18_19_FINAL_5_july.pdf

The changes to the CDI reporting algorithm for financial year 2019/20 are:

- Reducing the number of days to identify hospital onset healthcare associated cases from ≥3 to ≥ 2 days following admission
- Adding a prior healthcare exposure element for community onset cases.

For 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

- healthcare onset healthcare associated: cases detected three or more days after admission
- community onset healthcare associated: cases detected 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 detected within two days of admission where the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
- community onset community associated: case detected within two days of admission where the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Root Cause Analysis (RCA)
In the event of notification of a hospital acquired case of CDI, the IPCNs will complete an incident (Datix) form) and instigate the root cause analysis process The IPCNs will also send a hyperlink to a patient named copy of the NHS Improvement Clostridium difficile infection assessment tool and action plan guidance documentation : https://www.gov.uk/government/publications/updated-guidance-on-the-diagnosis-and-reporting-of-clostridium-difficile stored in the IPC Shared drive RCA folder.

The RCA must be undertaken by the clinical team (both medical and nursing staff i.e. Matron, Ward Sister/Charge Nurse and Consultant) as well as any relevant Allied Health Professionals/ Support services staff) responsible for the patient at the time the infection was acquired, within the designated time frame (2 weeks) and actions identified, implemented and reviewed. There will be an escalation process to IPC committee if the RCA or actions are not completed in a timely manner.

Lessons to be learned must be shared throughout the Organisation following root cause analysis. Clinical leads must share amongst their teams. The IPCNs will include lessons to be learned in the monthly IPC newsletter and include in mandatory IPC training as standard.

7.6 **Death of a patient with CDI**

Where CDI is mentioned on part 1 of the death certificate, it must be recorded as a serious incident (SI) and be subject to SI RCA. In such situations, an investigating officer will be appointed.

Doctors are reminded of their responsibility for death certification and to ensure that entries best reflect the cause of death and other contributory factors. The consultant responsible for the patient should be in agreement before CDI is entered on the death certificate. Where there is doubt about how to complete a death certificate in a case of CDI, advice can be obtained from the Consultant Microbiologist.

Last offices should be undertaken in the usual way.

7.6.1 CDI mortality review

30 day CDI mortality will be routinely reported at each IPCC. Cases of CDI with 30 day mortality must also have death certificate findings reported to IPCC. The infection control doctor should ensure typing is performed for deaths associated with CDI and further investigation carried out in conjunction with the clinical team to identify underlying factors.

8. Consultation

This policy revision has been consulted on with:

- Infection Prevention & Control Committee (IPCC)

9. Training

This policy will be published to all areas using the organisation's communications system (E-bulletin or the equivalent).

The policy will be placed on the organisation Intranet system alongside other Infection Prevention & Control policies.

This *Clostridium Difficile* has a mandatory training requirement which is delivered via the Infection Prevention and Control mandatory training sessions as detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis. The following non-mandatory training is also recommended for clinical staff:

- Training Tracker module – *C difficile* E-learning package

10. Monitoring Compliance and Effectiveness

- All NHS Trusts are required to participate in the Department of Health's mandatory CDI reporting system and to report all cases of *C.difficile* toxin positive diarrhoea in patients over 2 years of age. The IPCN team in collaboration with the Consultant Microbiologist are responsible for this. The RCA investigation for each Trust attributed case will review compliance with all aspects of this policy and an appropriate action plan must be produced to address non compliances.
- CCG representation is requested at all *C.difficile* RCA meetings to inform decision making in regard to identification as to whether cases are designated preventable or non-preventable. Preventable cases attract a financial sanction of £10,000 per case reported in excess of annual set PHE trajectory.

- Local monitoring of CDI incidence and 30 day mortality will be carried out by the IPCNs, Consultant Microbiologist and Director of Infection Prevention & Control. This will be an agenda item for review at Infection Prevention & Control Committee.
- CDI audits will be completed by ward staff when an inpatient is diagnosed with CDI, these audits will be monitored via the clinical directorate affected, reported on intranet dashboard and discussed at IPCC.

11. Links to other Organisational Documents

These documents can be found on the local intranet by following the links below.

Infection Prevention & Control Outbreak Policy *(Outbreak including bed closure)*

Infection Prevention & Control Isolation Policy

Infection Prevention & Control Hand Hygiene Policy *(due for update/review)*

Infection Prevention & Control Personal Protective Equipment Policy

Infection Prevention & Control Clean Patient Environment Policy

Infection Prevention & Control Patients with Diarrhoea Policy

Trust antimicrobial guidelines:
http://it-intranet/Anti-microbial

12. References

NHS Improvement (March 2018) Clostridium difficile infection objectives for NHS organisations in 2018/19 guidance on sanction implementation and notification of changes to case attribution definitions from 2019. Available at:
https://improvement.nhs.uk/documents/808/CDI_objectives_18_19_FINAL_5_july.pdf

Updated guidance on the management and treatment of Clostridium difficile infection. Public Health England 2013. Available at:

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

Updated Guidance on the Diagnosis and Reporting of Clostridium difficile. May 2013. Public Health England. Available at:

https://www.gov.uk/government/publications/updated-guidance-on-the-diagnosis-and-reporting-of-clostridium-difficile

Department of Health (2009) The Health and Social Care Act 2008. Code of practice for health and adult social care on the prevention and control of infections and related guidance. London. Available at:

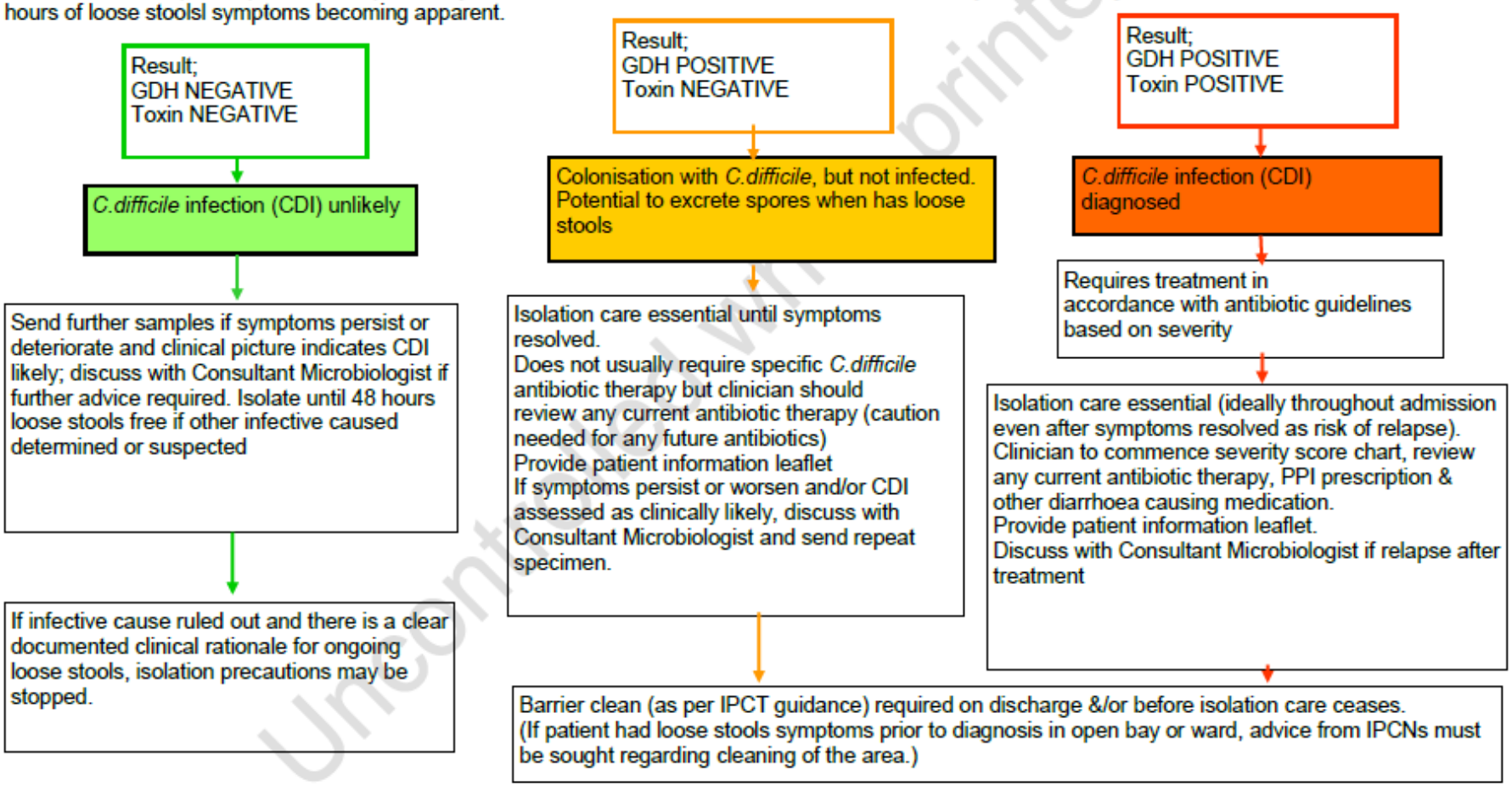
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf

13. Appendices

Appendix A Clostridium difficile management algorithm
Appendix B Financial and Resourcing Impact Assessment
Appendix C Equality Impact Assessment

Appendix A

Isolation - All hospital in patients with potentially infectious loose stools should be isolated immediately or at the very latest within 2 hours of loose stoolsl symptoms becoming apparent.



Appendix B

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	Clostridium Difficile Policy

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs			
Training Staff			
Equipment & Provision of resources			

Summary of Impact: No increased requirement to existing arrangements

Risk Management Issues:

Benefits / Savings to the organisation:

- Reduction of protracted stays for patients
- Release of occupied bed days
- Reduction in level of HCAI fines from CCG

Equality Impact Assessment

- Has this been appropriately carried out? YES/~~NO~~
- Are there any reported equality issues? ~~YES~~/NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:		

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix C

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Clostridium Difficile Policy
Purpose of document	This policy provides best practice guidance on prevention, management and treatment of patients with CDI.
Target Audience	All staff working in all healthcare settings of the Trust
Person or Committee undertaken the Equality Impact Assessment	*Head of Infection Prevention and Control*

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

No – does not discriminate against any of below groups.
Good Infection Control benefits all patients, staff and visitors.

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men		*No*	
	Women		*No*	
Race	Asian or Asian British People		*No*	
	Black or Black British People		*No*	
	Chinese people		*No*	
	People of Mixed Race		*No*	

	White people (including Irish people)		*No*	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues		*No*	
Sexual Orientation	Transgender		*No*	
	Lesbian, Gay men and bisexual		*No*	
Age	Children		*No*	
	Older People (60+)		*No*	
	Younger People (17 to 25 yrs)		*No*	
Faith Group			*No*	
Pregnancy & Maternity			*No*	
Equal Opportunities and/or improved relations			*No*	

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
N/A
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
N/A

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
N/A	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	