UNIQUE IDENTIFIER NO: C-30-2007
EQUIP-2019-047
Review Date: September 2022
Review Lead: Senior Infection Prevention and Control Nurse

Section Y
Control and Management of Clostridium difficile

Version 7

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Summary		
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Document Version Control	
Version 7	Processes for de-escalation and re-admissions have been added. EPR links and advice have been updated. CDI meds via NG advice given. Hyperlinks revised. Signage updated. Procedure for informing results to patients and staff has been added
Version 6	A sentence has been added to the ribotyping section along with a link to the SOP on how to complete a stool chart.
Version 5	The policy has been reviewed and updated and hyperlinked to the newly revised CDAD CHFT Clinical Guidelines and a section on ribotyping added. The RCA process has also been updated.
Version 4	The policy has been reviewed and updated and hyperlinked to the newly revised CDAD CHFT Clinical Guidelines.
Version 3	The policy has been reviewed and updated; a summary of the document & a hyperlink to the CDAD CHT Clinical Guidelines.

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1. Introduction

Public Health England (PHE, 2013) acknowledges the safety of patients is of paramount importance, continuing the zero-tolerance approach to all avoidable Health Care Associated Infections (HCAIs). Clostridium difficile infection (CDI) is associated with considerable morbidity and risk of mortality, occurring mainly in elderly and other vulnerable patient groups, especially those exposed to antibiotic treatment (NHS England 2019). Consequently, this policy reflects PHE and the Department of Health guidance in the ongoing challenge of reducing CDI.

A summary of this policy can be found in Appendix 4.

2. Purpose

The purpose of this policy is to:

- Promptly identify and manage the safe and appropriate care of patients diagnosed with CDI.
- Ensure the provision of a safe patient environment, to prevent the cross transmission of CDI to other patients.
- Provide operational guidance for prevention, control & management of CDI based on Public Health guidance (PHE 2013).
- In accordance with the Health & Social Care Act (Department of Health 2008), ensure effective prevention and control of HCAI is embedded in everyday practice and applied consistently by everyone at CHFT.

3. Definitions

AAD - Antibiotic associated diarrhoea
CDI - *Clostridium difficile* infection
CDTGD- Clostridium difficile toxin gene detected
DH - Department of Health
DIPC - Director of Infection Prevention & Control
HCAI - Health Care Associated Infections
HCW - Health Care Worker
IPCN - Infection Prevention & Control Nurse
IPCT - Infection Prevention & Control Team
PIR - Post Infection Review (PIR) (RCA process)
PMC - Pseudomembranous Colitis
PPE - Personal Protective Equipment
PPI - Proton Pump Inhibitors
NEWS - National Early Warning Score

4. Duties

The Chief Executive is responsible for ensuring that there are effective Infection Control arrangements in the Trust.

Managers' responsibilities are to ensure that:

- All staff understand how organisms spread in order to apply correct procedures.
- Staff are aware of, have access to and comply with this policy.
- Staff are adequately trained in all aspects of this policy.

Staff responsibilities are to ensure that they:

- Understand how organisms spread in order to apply correct precautions.
- Comply with the requirements of this policy.
- Attend training as required.
- All staff working on Trust premises, including contractors, agency and locum staff are responsible for adhering to this policy.
- Nursing staff must always comply with the Nursing and Midwifery Council Code of Professional Conduct 'The Code' and if a task is delegated "confirm that the outcome of any task you have delegated to someone else meets the required standard" (NMC 2018 11.3 p.12).
- All other registered HSCWs must abide by their own Professional Code together with the Trust's policies and guidelines.
- The Trust has vicarious liability for the actions of all appropriately trained staff, provided that agreed policies, procedures, guidelines and mandatory training have been followed / attended.

5. What is Clostridium difficile

- *Clostridium difficile (C.difficile)* is a spore forming bacterium, widely distributed in the soil and in the intestinal tracts of animals. The organism forms spores, which are resistant to heat, drying and chemical agents. This permits the organisms to survive easily in the environment.
- Up to 3% of healthy adults are colonised with *C.difficile*
- In a healthcare environment the spores survive very well
- Symptoms range from asymptomatic colonisation to diarrhoea of varying severity to life-threatening Pseudomembranous Colitis (PMC)
- Diarrhoea is defined as;
  i) Bowel motions that are abnormally frequent for that individual.
  ii) The faeces consist mostly of fluid (Types 5 to 7 on Bristol Stool Chart – See Appendix 1) [PHE 2013].

6. Risk factors for acquiring Clostridium difficile

- Advanced age (≥65yrs)
- Duration of hospitalisation
- Exposure to antibiotics. Greatest risk antibiotics are third generation cephalosporin's, quinolones and clindamycin. Both duration of antimicrobial exposure and multiple antibiotics increase the risk.
- Single dose of an antimicrobial (e.g. surgical prophylaxis)
- Proton pump inhibitors
- Cancer chemotherapy
- Immunosuppression (including HIV infection)
- Gastrointestinal surgery
- Manipulation of the gastrointestinal tract including tube feeding.

7. Transmission

- Transmission of *C. difficile* is via spores that survive in faecal matter
- Transmission can occur directly from patient-to-patient, on the hands and/or uniforms of healthcare staff or from the environment, especially if high standards of environmental cleanliness are not maintained
- Contamination of patient equipment i.e. commodes, drip stands etc. Also shared bathroom facilities will increase the risk of CDI being spread within the environment - effective cleaning and decontamination is vital

8. Diagnosis and Management

8.1 SIGHT

Clinicians (doctors and nurses) should apply the following mnemonic protocol when managing suspected potentially infectious diarrhoea (PHE 2013):

S	SUSPECT that a case may be infective where there is no clear alternative cause for diarrhoea.
I	ISOLATE the patient and consult with the Infection Control Team while determining the cause of the diarrhoea.
G	GLOVES and aprons must be used for all contacts with the patient and their environment.
H	HANDWASHING 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 toxin, by sending a specimen immediately.

Supportive care including attention to hydration, electrolytes and nutrition should be given. Antiperistaltic agents should be avoided in acute infection. Precipitating antibiotics should be discontinued where possible, antibiotics with less risk of inducing CDI may be substituted if an underlying infection still

requires treatment (PHE 2013). Please refer to The CDI CHFT Clinical Guidelines are available on the intranet via:
https://intranet.cht.nhs.uk/chft-documentation/view-document.php?docID=299

8.2 Taking Samples

If a patient has diarrhoea, not clearly attributed to an underlying condition (overflow) or therapy (laxatives, enteral feeding) then a stool sample should be sent as soon as possible for *C.difficile* testing. The date, time and reason for sample should be clearly indicated on a Bristol Stool Chart (Appendix 1).

8.3 Who to test

All diarrhoeal samples from inpatients ≥ 2 years and out-patients ≥ 65 years are tested for *Clostridium difficile* infection. Samples from outpatients <65 years are tested if there are relevant clinical details (recent antibiotic therapy/hospitalisation, colitis) or on clinical request.
ALL stool sample results should be followed up by the clinical team.

8.4 Limitations on sampling

Negative result: If the initial specimen is negative on the screen test (GDH), a repeat specimen will not be processed within 7 days. The GDH test has a high negative predictive value (98-99.7%) and a negative test indicates that CDI is unlikely. However, if there is a strong clinical belief that the patient has CDI discuss the case with the duty microbiologist.

Positive result: Do not send repeat stool specimens within 28 days of a confirmed CDI. If the patient has a suspected relapse after this time, a repeat sample is indicated.

8.5 Procedure for informing results

Routine testing for CDI is performed at 12 noon on a daily basis (7 days a week). Samples must be received into the laboratory at CRH by 11am to ensure results can be obtained the same day.

For inpatients with a positive CDI result an Infection Prevention and Control Nurse will:

- Notify the result to the ward during normal working hours. Any positive results on a weekend will be dealt with by the on call IPCN.
- On Monday to Friday visit the ward to discuss IPC related issues with staff, the patient and relatives if appropriate. Saturday and Sunday this advice will be delivered during the telephone conversation with ward staff.

- Deliver the alert card. For positive results received on a weekend the alert card will be given on a Monday. N.B. the information leaflet is available on the patient leaflet section of the repository.
- Review the patient and the environment.
- Add a FLAG alert and diagnosis to EPR, request isolation – even if the patient is already isolated. Document IPC advice on EPR.
- Complete the enhanced surveillance form for submission to PHE.
- Complete an orange datix for true post cases – this will trigger the PIR process (see appendix 4).
- Complete an orange datix for community onset healthcare associated (see appendix 4).
- Notify the duty Consultant microbiologist.
- Notify domestic services / ISS to ensure twice daily tristel cleaning is undertaken with HPV on transfer / discharge.

Clinical Guidelines:

It is the clinician's responsibility to assess the severity of CDI and ensure **management as a diagnosis in its own right** with a daily review (DH, 2008).

The CDI CHFT Clinical Guidelines are available on the intranet via:
https://intranet.cht.nhs.uk/chft-documentation/view-document.php?docID=299

N.B. Metronidazole liquid should be avoided for patients with CDI who have a nasogastric tube, instead the tablets should be crushed. Also, vancomycin capsules should not be used nasogastrically as they block the tube, use the IV preparation diluted.

9. Infection prevention and control management

9.1 General Management

- Patients who have diarrhoea of unknown cause must be isolated in a side room, **with door closure** within 2 hours from onset of symptoms.
- The single room should have en-suite toilet facilities or its own designated commode; and cleaned appropriately after each use with a chlorine-based disinfectant, for example Tristel.
- A 'Red Contact Isolation' sign must be displayed on the external side of the side room door.
- The red 'standards' signage must be displayed on the wall **inside the side room.**
- A stool sample must be sent for *C. difficile* toxin testing in accordance with section 8.2 of this policy.
- All patients who are diagnosed with CDI must remain in side room isolation throughout their hospital stay – for de-escalation refer to section 9.8 (page 11).
- Environmental cleanliness – refer to section 9.6 (page 8).

- All linen must be considered infectious and managed in accordance with the CHFT linen policy.
- All isolation rooms must have a 'domestic' bin and an 'orange' infectious waste bin in accordance with the waste policy.
- The CDI care plan must be commenced. This is available via the 'Clinical Documentation Repository' in 'Trustwide Nursing Documents'.
- All patients diagnosed with CDI must have a daily wash, full change of bed wear and bed linen.
- All patients diagnosed with CDI must be given an information leaflet and a CDI identification card. These are available from the IPCN's.
- On discharge/transfer - the room requires a terminal clean followed by HPV (Hydrogen Peroxide Vapour) decontamination via cleaning services. This clean should include any dedicate equipment use for the patient.
- If a patient is readmitted with a previous history of *C. difficile* they would only require isolation if symptomatic with loose stools. If unsure discuss further with an IPCN.

9.2 Stool Chart Documentation

Patients must be monitored **during each shift** for frequency and severity of diarrhoea. All bowel action must be recorded on every shift i.e. early, late and night (including when BNO) in the gastrointestinal section of the Adult Detailed Assessment on EPR, together with all intake and output on the EPR fluid balance section. Those patients whom are independent with their toileting requirements may be asked to complete a paper copy of the Bristol Stool Chart – see Appendix 1, this is to assist with accurate documentation. 'How to record bowel care for adult inpatients' standard operating procedure (SOP) can be found by following the link: https://epr.this.nhs.uk/document-repository/ptr-view-subcategory.php?cat=25

9.3 Ribotyping

All post case clostridium difficile toxin positive or gene detected cases will be sent to the Leeds Reference Laboratory for ribotyping. All other positive samples will be risk assessed by the IPCNs to establish if ribotyping is required.

When two or more cases of C. difficile are epidemiologically linked and have the same ribotype, the Infection Prevention and Control Doctor (IPCD) will arrange for enhanced MVLA typing if required to confirm that the cases are linked. This may not be required if the ribotype is considered to be unusual in Calderdale and Huddersfield NHS Foundation Trust. The C. difficile Ribotyping Network housed by Leeds Teaching Hospitals are the ultimate gatekeeper to this service.

9.4 Hand Hygiene

Staff Hand Hygiene: If CDI is suspected or proven, all healthcare workers must wash their hands thoroughly with soap and water:

1. Prior to entry/exit of a patient's room,
2. Before and after contact with patients, their blood/body fluids and their immediate environment.
3. Before applying PPE and after removal of PPE

Patient Hand Hygiene: patients must be offered the opportunity to undertake hand hygiene with soap and water or detergent hand wipes before meals and after using the toilet/commode, and if their hands are visibly dirty.

Visitors: Refer to section 9.10 (page 10).

N.B Effective hand hygiene with soap & water is vital to ensure the physical removal of C. difficile spores as they are not effectively removed by alcohol gel (refer to Appendix 2 for correct soap and water hand washing technique).

9.5 Personal Protective Equipment (PPE)

Disposable gloves and aprons must be worn for all patient contact, including their environment. **All** staff leaving the isolation room must dispose of apron and gloves in the 'orange' infected waste stream, then proceed with hand hygiene before leaving. Hand hygiene paper towels require disposal in the domestic waste stream in accordance with the waste policy.

9.6 Environmental Cleanliness

- **The patient's room** must be kept clutter free and cleaned twice daily with a chlorine-based disinfectant, for example Tristel. Domestic Services need to be informed immediately of this request
- **All equipment** and room furniture must be decontaminated daily. Any equipment required for patient management should be disposable or dedicated for that patient only. These should be thoroughly cleaned with Tristel after use or when no longer required. This includes BP cuffs, moving and handling equipment, physiotherapy equipment, etc. This equipment should also be HPV cleaned within the side when the patient is transferred / discharged
- **Bed space cleaning** - adhere to CHFT protocol
- **Commodes -** must be thoroughly decontaminated **after every use** with a chlorine-based disinfectant, for example Tristel
- **Patient transfer/discharge -** a full terminal clean and curtain change by cleaning services is required to remove *C.difficile* spores. The order of cleaning is to remove curtains and linen, clean high surfaces first and work downwards. This should be followed by HPV decontamination of the room

- **Mattress cleaning** – Mattresses must be unzipped and visually checked for any indication of ‘strike through’ or damage to the mattress cover. Foam mattresses should be disposed of if there are any visible signs of contamination

9.7 Transfer to other Departments within the hospital

Transfer and movement of patients must be reduced to an operationally effective minimum. Where patients need to attend departments for essential investigations, they should be ‘last on the list’, unless earlier investigation is clinically indicated. Staff in the receiving department should be made aware of the patient’s CDI status. All staff must adopt appropriate infection control precautions when in contact with the patient. These include:

- Strict hand hygiene with soap and water for all staff involved with the transfer (see Appendix 2)
- All healthcare workers must use disposable apron and gloves for all physical contact, contact with body fluids or contact with the patient’s immediate environment. Portering staff do not necessarily need to wear PPE for transporting purposes alone, and this needs to be risk assessed according to individual circumstances
- Where possible ensure the patient is last on the list for the procedure.
- Avoid patient waiting in the department for any longer than necessary (department to phone through when ready for patient to avoid waiting in a communal waiting area)
- Ensure environmental cleaning using a chlorine-based disinfectant, ie Tristel after the patient has left the department
- De-escalation of isolation will only be considered by the IPC nurses **and** microbiologist on a case by case basis. If de-escalation is approved the side room would still require an HPV clean

9.8 Transfer to other health care setting and/or discharge planning

- Whilst symptomatic, patient transfers to other wards 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 to enable side room accommodation to be identified
- Cleaning services must be informed of any transfer to facilitate ongoing cleaning
- The transfer of symptomatic patients to another hospital or facility including care homes should be avoided if possible. If it is necessary there should be prior liaison with medical staff and the consultant microbiologist. The receiving hospital or care home must be informed both verbally and via a written handover/transfer form and discharge summary to ensure continuity of care in the community

9.9 Precautions for handling deceased patients

- Standard precautions are the same as for when a patient is alive including hand hygiene with soap and water and use of PPE
- Faecal soiling around the body should be removed with a chlorine based combined detergent/disinfectant, for example Tristel (DH, 2008)
- Please refer to Care of the Deceased Body policy (section P) for management of the cadaver. Body bags should only be used in accordance with the policy

9.10 Visitors and relatives

- Visitors do **NOT** need to wear PPE **unless** participating in care of the patient or having contact with the immediate environment
- All visitors must be advised to decontaminate their hands with alcohol gel prior to room entry and with soap and water before leaving the room
- Visitors should not eat or drink in the vicinity of the patient
- Visitors should be discouraged from bringing in food products
- A patient/visitor information leaflet should be made available
- If patient belongings require laundering at home water soluble bags, with instructions for use, should be made available for relatives, Any soiled items must be washed separately from other washing, in a washing machine at the highest temperature possible for that fabric (60 degrees or above if possible)

10. Actions following a hospital acquired CDI case

If a hospital acquired CDI is identified, the Infection Prevention and Control Team (IPCT) will inform the relevant clinical area/team and initiate the CDI post infection review (PIR) process (refer to Appendix 3). The IPCT will complete a CDI surveillance document and undertake a regular case review involving the designated matron (or nurse in charge if the matron is not available).

11. Period of Increased Incidence and Outbreaks

Two cases of C. difficile in the same ward within a 28-day period is defined as a period of increased incidence (PII). An outbreak may be declared in response to this, at the discretion of the IPCT in discussion with the DIPC. The decision whether or not to call an outbreak meeting in this context may be influenced by ribotyping results. The IPCT will undertake a full case review. If three or more cases are epidemiologically linked:

- IPCT will inform the Director of Infection Prevention and Control (DIPC), Infection Control Doctor, Director of Nursing, Medical Director, relevant

divisional clinical leads, senior nurses & managers and an outbreak meeting convened

- The IPCT will instigate enhanced patient monitoring within the affected area to identify other potential cases, with a daily report to DIPC, Infection Control Doctor and Director of Nursing
- Staff and patient hand hygiene awareness must be emphasised
- Staff deployment to other areas will be assessed, to ensure adequate staffing levels are present and to prevent transmission of CDI
- Restriction of all patient transfers and admissions to/from the affected area (ward/bay) to prevent spread of infection to other areas
- Patients in the affected area who develop diarrhoea/loose stools must have faeces specimens sent for *C. difficile* toxin testing. Ribotyping of *C. difficile* isolates will be arranged by the IPCT
- Additional outbreak cleaning will be arranged with Cleaning Services.
- HPV cleaning as advised by IPCT

12. Investigation of Cases

The PIR forms the basis of investigation of all cases of CDI.
Healthcare onset healthcare associated – cases detected in the hospital $\geq$2 days after admission - the PIR is led by the divisional Clinical Team and identified action points implemented, monitored and audited.
Community onset healthcare associated – cases that occur in the community when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks – the PIR is led by the IPCT. The learning from these investigations must be disseminated throughout the Divisions.

13. Training and Implementation

The IPCT will facilitate training for all Trust staff via mandatory training and bespoke educational sessions.

14. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnerships.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

15. Monitoring Compliance with this Procedural Document

Compliance with the policy will be monitored through audit and surveillance on an on-going process.

16. Associated Documents

This policy should be read in conjunction with the following:

- Department of Health (DH) Health protection Agency (HPA) (2008) Clostridium Difficile infection: How to deal with the problem. DH: London
- Public Health England (PHE) (2013) Updated guidance on the management and treatment of Clostridium difficile infection. PHE London

And the following IPC policies:

- Section C – Standard Precautions (Trust Intranet)
- Section F – Decontamination and disinfection policy (Trust intranet)
- Section H – Hand Hygiene (Trust Intranet)
- Section K – Isolation Policy (Trust intranet)
- Section P – Care of the deceased body (Trust intranet)
- Section R – Specimen collection, handling & transportation (Trust intranet)
- Section W – Bed management and movement of patients (Trust intranet)

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APPENDIX 1

Unique Identifier NO: TW/006/2011v3 **Bristol Stool Chart – Stool Assessment** **Status:** Draft 1 **Ordering Code:** WQN570X	(Patient ID Label) Name: DOB: NHS Number: Hospital Number:	Ward

ristol Stool Chart – Stool Assessment

Bristol Stool Chart (Heaton, 1999)

Type 1 **Separate hard lumps – like nuts (hard to pass)**	**Type 4** **Like a sausage or snake, smooth and soft**
Type 2 **Sausage-shaped but lumpy**	**Type 5** **Soft blobs with clear cut edges (passed easily)**
Type 3 **Like a sausage but with cracks on its surface**	**Type 6** **Fluffy pieces with ragged edges, a mushy stool**

Type 7

Watery, no solid pieces – ENTIRELY LIQUID

- Please note that types **5, 6 & 7** are classed as diarrhoea (DH 2012; 2009).
- When obtaining a sample, the stool should take on the shape of the container, if the stool has come into contact with urine, this can still be sent for testing.
- If a patient has diarrhoea, **not clearly** attributable to an underlying condition e.g. colitis or overflow or therapy e.g. laxatives or enteral feed then a **sample should be obtained** to determine if due to an infective cause.
- Advice should be sought from the patient's Consultant if there is any doubt.

N.B. All patients with diarrhoea should be isolated until a non- infective cause has been established (discuss with Infection Prevention and Control if required).

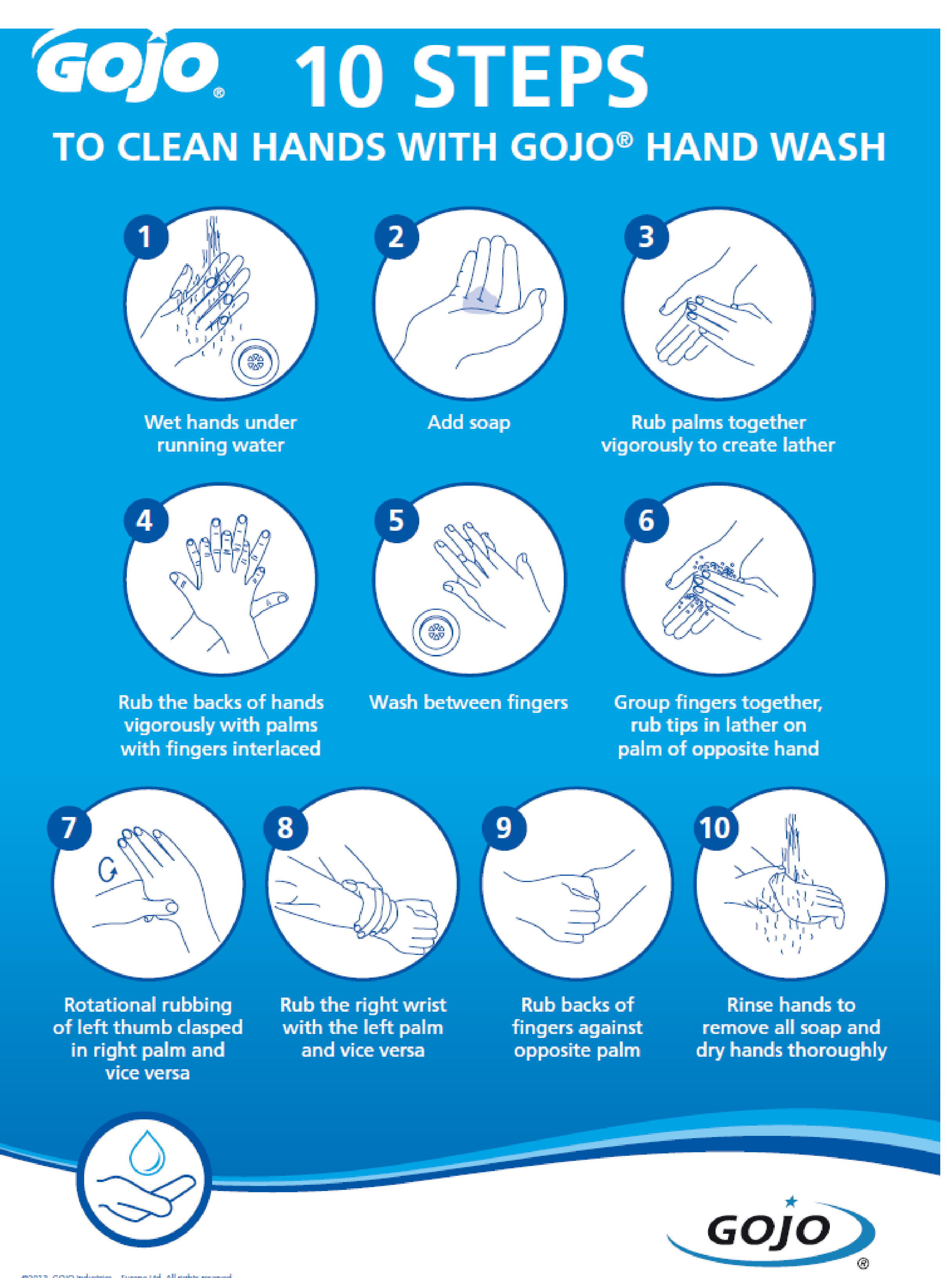
Patient's usual bowel pattern on admission: **Type:** **Frequency:**

Does the patient take regular laxatives? **Yes / No**

Date	Ward/Bed space	Time	Type	Colour	Amount	Comments – Blood, mucous, Reason specimen sent	Initials

`

APPENDIX 2



APPENDIX 3

<u>RCA Process – Clostridium Difficile</u>

<table>
<tr><td>First working day of positive result</td><td colspan="2">IPCN
Inform ward of positive result
Review of patient and environment
Complete enhanced surveillance form for submission to PHE
Notify duty microbiology consultant

Fact find to determine Pre- Post- or COHA status
Record on Datix as follows:
<table><tr><td>Pre-</td><td>Record as Green</td></tr><tr><td>Post -</td><td>Record as Orange</td></tr><tr><td>COHA</td><td>Record as Orange</td></tr></table>
Identify any immediate actions required to mitigate risk to the patient, other patients, visitors and staff and ensure these are carried out.

Make a decision to involve community representatives in RCA (COHA case)</td></tr>
<tr><td></td><td>Post- case</td><td>COHA case</td></tr>
<tr><td>Within 7 working days of positive result</td><td>Ward Manager to
Gather information on RCA tool
Complete Duty of Candour
Schedule RCA meeting and send out invite to hold diaries at the earliest opportunity
Distribute the completed RCA tool at least 24 hours before the meeting</td><td>IPCN to
Collate information on RCA tool liaising with other providers as appropriate
Discuss with Infection Control Director (ICD) and Community IPC Team to agree level of investigation
Schedule RCA meeting and send out invites to hold diaries
Distribute the completed RCA tool at least 24 hours before the meeting</td></tr>
<tr><td>RCA meeting</td><td>Ward Manager to chair and to invite:
▪ Matron
▪ Consultant responsible for the patient
▪ Consultant Microbiologist
▪ IPCN
▪ CCG representative

Consider:
▪ Pharmacist
▪ Other relevant services</td><td>Attendees to be determined by level of investigation but will always include:
▪ IPCN
▪ Community IPCN
▪ Consultant Microbiologist - Chair

To co-opt as required:
▪ Matron
▪ Ward Manager (relevant wards)
▪ Consultant responsible for the patient
▪ Pharmacist</td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td colspan="2">Terms of Reference
To ensure all present are clear on the purpose and scope of the RCA meeting the following should form the basis for the Terms of Reference for the meeting:

▪ Conduct a thorough and proportionate review, examining the care, treatment and compare this to best practice guidance.
▪ Consider the information collated in respect of patient history, Isolation and stool sampling, infection markers, contacts, antimicrobial prescribing, environmental factors and other factors specific to the case in order to identify contributory factors and any other key issues that require addressing
▪ Identify a root cause
▪ Develop a measurable action plan for improvement, with clear leads, agreed delivery date and required evidence of completion
▪ Ensure learning is shared within the team, division and across the Trust and across the CCG as indicated</td></tr>
<tr><td>Post- case</td><td>COHA case</td></tr>
<tr><td>Chair to:
▪ ensure terms of reference are understood and followed
▪ facilitate discussion enabling appropriate contributions from all participants
▪ Capture discussions recording agreed contributory factors, root cause and actions
▪ Complete the RCA tool by documenting contributory factors, root cause and the action plan, including action lead and timescale
▪ Distribute the draft completed RCA tool to meeting participants for comments
▪ Finalise RCA tool and save to Datix incident.
▪ Add the actions to the incident

Submit for Orange Panel</td><td>Chair to:
▪ ensure terms of reference are understood and followed
▪ facilitate discussion enabling appropriate contributions from all participants
▪ Confirm the final risk grading for CHFT of the case (Orange/Green)
IPCN to:
▪ Capture discussions recording agreed contributory factors, root cause and actions
▪ Complete the RCA tool by documenting contributory factors, root cause and the action plan, including action lead and timescale
▪ Distribute the draft completed RCA tool to meeting participants for comments
▪ Finalise RCA tool and save to Datix incident.
▪ Add the actions to the incident

Submit to Orange panel if indicated</td></tr>
</table>

<table>
<tr><td>Sharing learning</td><td>Ward Manager to complete a learning summary and distribute to:
▪ the RCA group
▪ the ward(s) / areas involved
▪ IPC Committee

Save to Datix incident record

Complete investigation section on Datix and move status to ‘Actions ongoing’ or to ‘Awaiting Final Approval’ if no actions required</td><td>IPCN and/or Community IPCN to complete a learning summary and distribute to:
▪ the RCA group
▪ identified community services
▪ the ward(s) / areas involved (if appropriate)
▪ IPC Committee

Save to Datix incident record

Complete investigation section on Datix and move status to ‘Actions ongoing’ or to ‘Awaiting Final Approval’ if no actions required</td></tr>
<tr><td>Assurance</td><td colspan="2">Report to
▪ IPC Performance Board
▪ PSQB

Summary of learning and assurance of delivery of actions to mitigate risk</td></tr>
</table>

APPENDIX 4

FOR DISPLAY IN STAFF AREAS ONLY

Sharing Learning following a Clostridium Difficile Root Cause Analysis

WHAT HAPPENED?

This should be 2 short sentences, not the full chronology

WHY DID IT HAPPEN?

Should summarise root cause and contributory factors

WHAT DID WE LEARN?

ISSUES FOR YOUR TEAM TO CONSIDER TO REDUCE THE RISK OF THIS INCIDENT HAPPENING AGAIN?

This section should be used to prompt discussion, questions are a good way of beginning this conversation, an example could be

How do you ensure equipment is properly cleaned?

What should you do if isolation was not immediately possible?

Staff groups the learning identified is applicable to:.

APPENDIX 5

New 2019/20 CDI objectives for NHS organisations

From April 2019 cases reported to the HCAI Data Capture System (DCS) will be assigned by DCS as follows:

A) Healthcare onset healthcare associated: cases detected in the hospital 2 or more days after admission.
B) Community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
C) Community onset indeterminate association: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
D) Community onset community associated: cases that occur in the community (or within 2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

"Guidance for testing and reporting CDI cases remains unchanged and the safety and care of patients must be the over-riding concern for everyone". (NHS Improvement 2019). Financial sanctions will continue to be applied. The key change is a shifting of the culture from sanctions to learning and improving patient safety (NHS Improvement 2019).

APPENDIX 6

Policy Summary

Infection Prevention and Control

- Prompt isolation within 2 hours onset of loose stools
- En suite facilities where possible
- Red Contact Isolation signage
- Red 'standards' signage to the wall in the side room
- Strict adherence to the Hand Hygiene policy
- Strict adherence to the Isolation Policy
- Strict PPE: disposable apron/gloves for all patient and/or environment contact
- Environmental cleaning with a chlorine-based disinfectant
- Reduction of environmental clutter
- Adherence to bed space cleaning protocol
- Linen and waste management according to hospital policy.
- Decontamination of patient equipment
- Prompt stool specimen collection and delivery to microbiology.
- Patient and visitor advice
- Review by IPCN and Matron – frequency dependent on individual patient risk assessment
- Red clean followed by HPV clean on Transfer/Discharge

Clinical Management

- Treatment as per regime – (see CDI CHT Clinical Guidelines).
  https://intranet.cht.nhs.uk/chft-documentation/view-document.php?docID=299
- Daily review by clinical team
- Prompt liaison with the Consultant Microbiologist and Gastroenterologist.
- Daily review/adherence to antibiotic prescribing policies
- Use of Proton Pump Inhibitors are reviewed by the clinical team
- Appropriate/timely blood tests
- Fluid and electrolyte replacement
- Observe abdomen
- Daily review by pharmacist
- Review by Dietician

Nursing Management

- Ensure the CDI care plan is utilised and evaluated daily.
- Observe abdomen for signs and symptoms of pseudomembranous colitis
- Monitor:
  - Bowel activity – frequency/severity documented on the bowel chart on EPR (even if BNO) **every shift** i.e. early/late/nights**.**
  - News
  - Temperature
  - Pressure ulcer risk assessment
  - Nutritional status
  - Fluid balance
- Daily bed bath/hygiene care
- Bed linen and patient clothing to be changed at least daily
- Keep the environment clutter free.

PIR Process

- Updated RCA Process – See Appendix 3