Clostridium Difficile Policy.

Precautions to be observed when caring for
ECCH in-patients colonised or infected with Clostridium Difficile (C.difficile)

Includes GP flow chart & out of hours protocols

Document Control Sheet

Name of document:	Clostridium Difficile Policy. Precautions to be observed when caring for in-patients colonised or infected with Clostridium Difficile (C.difficile)
Version:	9
Status:	Approved
Owner:	Infection Prevention and Control Team
File location / Filename:	
Date of this version:	September 2018
Produced by:	Infection Prevention and Control Team
Synopsis and outcomes of consultation undertaken:	IPACC. Joint Infection Control Committee – reference to key guidance documents.
Synopsis and outcomes of Equality and Diversity Impact Assessment:	No specific issues. National EIA gives more details on measures to reduce HCAIs.
Approved by (Committee):	IPACC
Date ratified:	Via IPACC members by email consultation, to be minuted at next meeting on 17/03/2015. 29/11/2016 04/09/2018
Copyholders:	Infection Prevention and Control Team
Next review due:	September 2020
Enquiries to:	ecch.infectionprevention@nhs.net

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
March 2010	Further clarity regarding antibiotics	IPCT	5
March 2013		IPCT	6
November 2016	Out of hours flow charts added	IPCT	7
September 2018		IPCT	9

Approvals

This document requires the following approvals either individual(s), group(s) or board.

Name	Title	Date of Issue	Version Number
JICC		March 2011	5
IPACC		18/02/2013	6
		January 2015	7
IPACC		November 2016	8
IPACC		September 2018	9

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

- ❑ All ECCH policies, procedures, protocols and guidelines (clinical and non-clinical)
- ❑ Service developments
- ❑ Estates and facilities developments

Name of Policy / Procedure / Service	Policy on precautions to be observed when caring for in- patients colonised or infected with Clostridium Difficile (C. difficile)
Manager Leading the Assessment	Teresa Lewis
Date of Assessment	02/12/2014

STAGE ONE – INITIAL ASSESSMENT

Q1. Is this a new or existing policy / procedure / service?
√ **Existing**

Q2. Who is the policy / procedure / service aimed at?
☐ **Patients**

√ **Staff**
☐ **Visitors**

Q3. Could the policy / procedure / service affect different groups (age, disability, gender, race, ethnic origin, religion or belief, sexual orientation) adversely?
Yes Sufficient national protocols that this policy takes into consideration can be applied if relevant
No
If the answer to this question is NO please sign the form as the assessment is complete, if YES, proceed to Stage Two.

Analysis and Decision-Making

Using all of the information recorded above, please show below those groups for whom an adverse impact has been identified.

Adverse Impact Identified?

Age	No
Disability	No
Gender	No
Race/Ethnic Origin	No
Religion/Belief	No
Sexual Orientation	No

- Can this adverse impact be justified? NA
- Can the policy/procedure be changed to remove the adverse impact? NA

If your assessment is likely to have an adverse impact, is there an alternative way of achieving the organisation's aim, objective or outcome

What changes, if any, need to be made in order to minimise unjustifiable adverse impact?

Contents

1. Introduction

Clostridium difficile was first recognised in the late 1970's as being the cause of pseudomembranous colitis. It is now recognised as a cause of a wide spectrum of enteric diseases ranging from mild diarrhoea to life-threatening colitis. C.difficile spores are ubiquitous, widely present in the gut of both humans and animals, and in the environment. They are highly resistant both to harsh environmental conditions and to antiseptics. Spread is by faecal-oral route.

3-5% of healthy people can be carriers of C.difficile it can be spread however after cross infection from another patient, either through direct patient to patient contact, via healthcare staff or via a contaminated environment.

It should be remembered that the presence of this organism in a patient's faeces is not always significant. The detection of cytotoxins in the stool indicates potential damage to the bowel. This is more likely to occur in patients receiving antibiotic therapy. Most of those affected are elderly patients with serious underlying illnesses. Most occur in hospitals (including community hospitals), nursing homes etc, but it can also occur in primary care settings.

Prevention and control are viewed as essential of which there are 3 components:-

1. prudent antibiotic prescribing to reduce the use of broad spectrum antibiotics.
2. isolation of patients with C.difficile diarrhoea and good infection control nursing including hand washing (not relying on hand sanitiser as this does not kill the spores) and the use of appropriate personal protective equipment (gloves and aprons).
3. enhanced environmental cleaning and the use of a chlorine containing disinfectant where there are cases of C.difficile to reduce environmental contamination with the spores.

2. Purpose and scope

This document applies to all staff either employed or contracted by East Coast Community Healthcare CIC (ECCH). These staff may work within ECCH premises, patients own homes, or care settings owned by other agencies.

3. Policy Statement

This policy will be implemented to ensure adherence to safe practice.

4. Responsibilities

It is the responsibility of all staff to ensure that they adhere to best practice

5. Policy monitoring

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy

6. Review

This policy will be reviewed by the Infection Prevention and Control Team.

7. Precautions to be observed when caring for a patient colonised or infected with Clostridium Difficile

- Please refer to attached flow charts for management of patient either inpatient areas or in patients own home. Pages 8 & 9 of this policy.
- The patient should be transferred to a single room if possible, and full enteric / standard precautions commenced (source isolation). The room door must be kept closed at all times. If a side room is not available a risk assessment and Datix entry must be performed it may be possible to cohort nurse cases of confirmed C. difficile, advice must be sought form the infection control team. 01502 445251

- An information leaflet should be given to the patient and a stool chart must be commenced information must be recorded as to the consistency with reference to a 'Bristol Stool Chart' see page 7 of this policy.
- Strict hand washing is essential after any nursing or invasive procedure or when dealing with body fluids, soiled linen, soiled equipment.
- After contact with the patient all equipment must be cleaned and disinfected in accordance with the disinfection policy.
- After the side room is vacated the bed, mattress, chair, locker, table and all other equipment must be cleaned and disinfected in accordance with the disinfection policy. All curtains must be changed.
- It is unnecessary to send any further stool samples once C. difficile has been detected unless requested by the Infection Prevention and Control Team / or clinically indicated.
- Patients must not be moved to another area within the hospital, outlying hospital, and residential/nursing home until they are 48 hours clear of any signs and symptoms.
- The infection prevention and control team will complete a root cause analysis on each case of C. difficile.
- Antimotility agents are contraindicated in cases of antimicrobial associated diarrhoea.
- The patient must be reviewed daily regarding fluid management, monitoring for signs of increasing severity of disease, such as colitis or toxic megacolon. On suspicion of these complications, the Doctor should contact the Consultant Microbiologist urgently.

8. References

Bartlett J.G. et al.(1978) Role of Clostridium Difficile in antibiotic associated pseudomembranous colitis: Gastroenterology 75: p778-782.

Brazier JS and Durden BI (1998) Guidelines for optimal surveillance of Clostridium difficile infections in hospitals. Communicable Disease and Public Health 1(4): 229-230.

Department of Health/Health Protection Agency (2009) Clostridium difficile infection: how to deal with the problem. DoH London_093220

Department of Health (2010) The Health and Social Care Act 2008 . DoH London_ 13072

Department of Health (2007) *Essential Steps to Safe Clean Care.* DoH London _4136212

Department of Health (2005) Infection caused by Clostridium difficile. DoH London_4124989

Department of Health and Health Protection Agency (2009) Clostridium difficile infection: How to deal with the problem. DoH London 287860

Health Protection Agency (2003) National Clostridium difficile standards group, report to the Department of Health. HPA. London. HPA web_C/1194947372533

Larson H.E. et al. (1978) Clostridium difficile and the aetiology of pseudomembranous colitis: Lancet:1063-1066

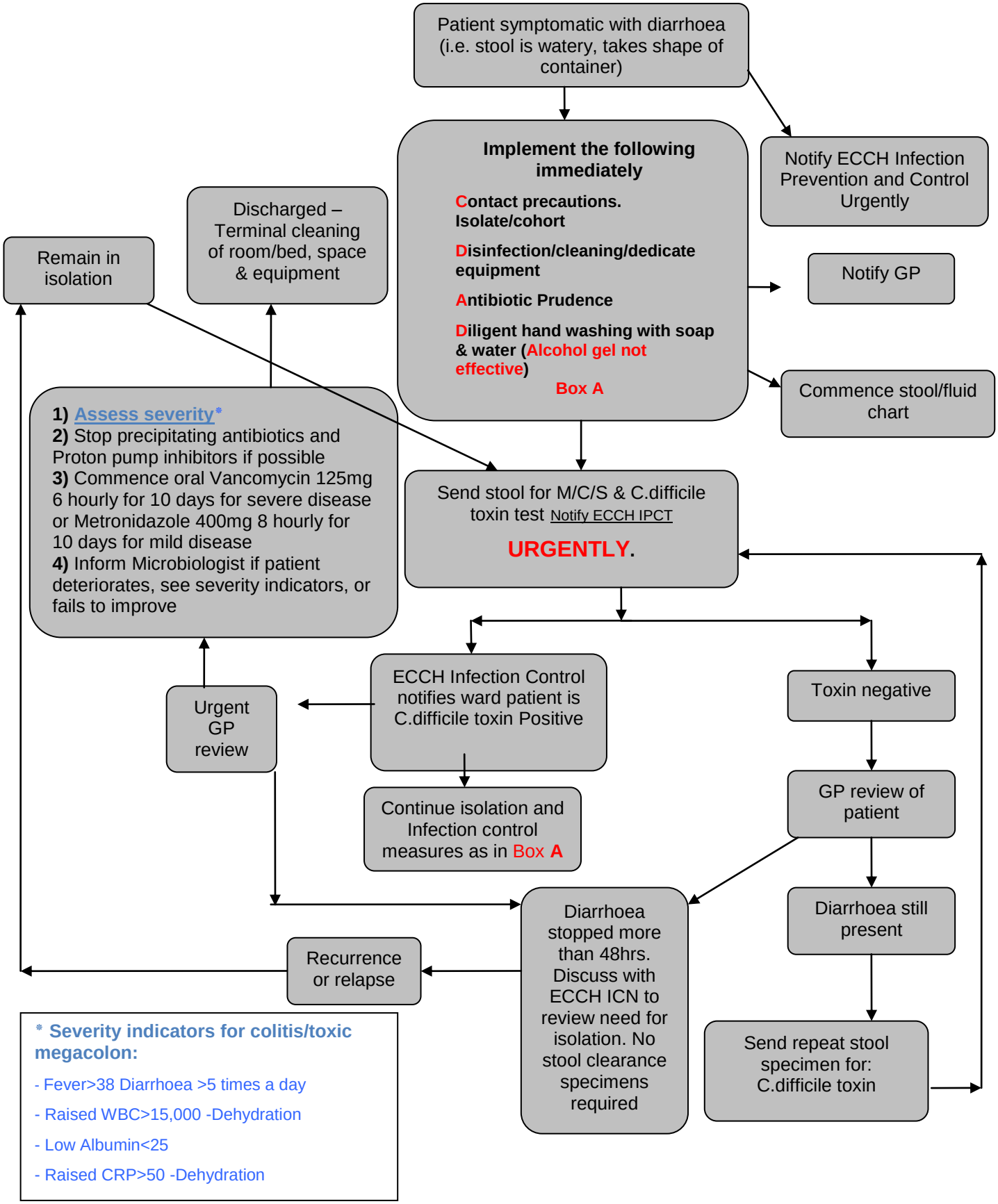
9. Author

Infection Prevention and Control Team

THE BRISTOL STOOL FORM SCALE

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

Flow chart for management of in-patient Clostridium Difficile



Contact details for Consultant Microbiologists at JPUH , 01493 453548/452478

Next review September 2020

GP Patient Clostridium Difficile Management Flow Chart

Notified of positive sample by ECCH infection prevention and control team (IPCT)

[Supply information for root cause analysis]

1. Assess severity*
2. Stop precipitating antibiotics if possible
3. Stop/advise against antimotility drugs and proton pump inhibitors
4. Commence antibiotics for C. difficile**
5. If this diagnosis is a relapse of a previously positive patient please contact the consultant microbiologist for advice via JPUH switchboard on 01493 452452

If patient anxious/concerned give contact number of IPCT 01502 445251

Give patient standard advice with regards to good hygiene and a bland diet stressing the importance of suitable and adequate fluids

Advise patient to contact GP surgery if symptoms persist
If surgery require advice on treatment contact ECCH IPCT or consultant microbiologist via JPUH switchboard 01493 452452

Stool samples for clearance **<u>are not</u>** required

If symptoms return post treatment **within 28 days** of the last sample **<u>do not</u>** send a repeat sample treat on symptoms if unsure of treatment contact ECCH IPCT or consultant microbiologist via JPUH switchboard 01493 452452

*__Severity indicators: for colitis/toxic megacolon__:
- Fever>38 Diarrhoea >5 times a day (not a reliable indicator)
- Abdominal tenderness/pain/distension

<u>If available</u>
- Raised WBC>15,000

__ Antibiotics__

Commence oral Metronidazole 400mgs TDS for mild disease for 10 days
or Commence oral Metronidazole 400mgs TDS for mild disease for 10 days
or Vancomycin 125mg QDS for 10 days for severe disease

IC24 Patient Clostridium difficile Management

Flow Chart

NOTIFIED BY LAB' OF C. DIFFICILE TOXIN POSITIVE SAMPLE

Contact patient

1. ASSESS SEVERITY*
2. STOP PRECIPITATING ANTIBIOTICS IF POSSIBLE
3. STOP/ADVISE AGAINST ANTIMOTILITY DRUGS
4. ADMISSION MAY BE REQUIRED IF PATIENT UNWELL/UNABLE TO COPE AT HOME
5. **COMMENCE ANTIBIOTICS FOR C. DIFFICILE****

Patient information leaflets are available from all pharmacies in Great Yarmouth and Waveney and http://nww.knowledgeanglia.nhs.uk/infection_control/cdiff_diag_treat_ncc_mar15.pdf

Give patient standard advice with regards to good hygiene and a bland diet stressing the importance of suitable and adequate fluids and bleach based cleaning of the home use of separate toilet where possible

ADVISE PATIENT TO CONTACT GP SURGERY IF SYMPTOMS PERSIST AFTER 4 DAYS OF TREATMENT

STOOL SAMPLES FOR CLEARANCE **ARE NOT** REQUIRED

***Severity indicators: for colitis/toxic megacolon**:

- Fever>38 Diarrhoea >5 times a day (not a reliable indicator)
- Abdominal tenderness/pain/distension

If available

** **Antibiotics**

Commence oral Metronidazole 400mgs TDS

for mild disease for 10 days

or

Vancomycin 125mg QDS for 10 days for severe disease

This document is for the use of the out of hours provider in Waveney and Norfolk to manage results of cases that occur out of normal working hours

Teresa Lewis teresalewis@nhs.net

IC24 Patient PCR Positive Toxin Management Flow Chart

NOTIFIED BY LAB' OF C.DIFFICILE **PCR toxin** POSITIVE SAMPLE

Contact patient

1. Could the diarrhoea be explained by another cause other than C.difficile? if NO then follow this advice
2.ASSESS SEVERITY*
3. STOP PRECIPITATING ANTIBIOTICS IF POSSIBLE
4. STOP/ADVISE AGAINST ANTIMOTILITY DRUGS
5. ADMISSION MAY BE REQUIRED IF PATIENT UNWELL/UNABLE TO COPE AT HOME
6. **COMMENCE ANTIBIOTICS FOR C. DIFFICILE IF SYMPTOMS SERVERE WITH PROFUSE DIARRHOEA****
7. IF THIS DIAGNOSIS IS A RELAPSE OF A PREVIOUSLY POSITIVE PATIENT PLEASE CONTACT THE CONSULTANT MICROBIOLOGIST FOR ADVICE via hospital switchboard

Patient information leaflets are available from all pharmacies in Great Yarmouth and Waveney and
http://www.greatyarmouthandwaveneyccg.nhs.uk/page.asp?fldArea=1&fldMenu=15&fldSubM

Give patient standard advice with regards to good hygiene and a bland diet stressing the importance of suitable and adequate fluids and bleach based cleaning of the home use of separate toilet where possible

ADVISE PATIENT TO CONTACT GP SURGERY IF SYMPTOMS PERSIST AFTER 4 DAYS OF TREATMENT IF GIVEN OR IF SYMPTOMS PERSIST WITHOUT TREATMENT

Stool samples for clearance or within 28 days **are not** required

***Severity indicators: for colitis/toxic megacolon**:
- Fever>38
- Diarrhoea >5 times a day (not a reliable indicator)
- Abdominal tenderness/pain/distension

If available
- Raised WBC>15.000

** **Antibiotics**
Commence oral
Metronidazole 400mgs TDS for mild disease for 10 days
or
Vancomycin 125mg QDS for 10 days for severe disease

This document is for the use of the out of hours provider in Waveney and Norfolk to manage results of cases that occur out of normal working hours
Teresa Lewis teresalewis@nhs.net