Joint Prevention and Management of Clostridioides difficile Infection Policy V1.0

Document reference code: IC/007/24

This is a joint policy between Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust.

Purpose: This policy provides details on how to reduce the risk of transmission of Clostridioides difficile Clostridioides difficile within healthcare settings, and information on the appropriate treatment of patients with Clostridioides difficile infection. This document takes into consideration the prevalence of Clostridioides difficile both locally and nationally, as well as national guidance.
Target audience: All staff working at the Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust.
Document author and role: Graham Kaye, Senior Infection Prevention and Control (IPAC) Specialist Practitioner.
Document author contact details: 01872 254969.
Document definition: Policy.
Supporting committee and chairperson: Infection Prevention and Control Committee, Louise Dickinson.
Executive director responsible for the policy: Chief Nursing Officer.
Freedom of information: Can be released under the Freedom of Information Act 2000
CFT Document section: Safety and risk, infection control

Audience:

☒ Cornwall Partnership NHS Foundation Trust

☒ Royal Cornwall Hospitals NHS Trust

Key words: GDH, Clostridioides difficile, C.diff, CDI, diarrhoea.

Approval process

Approved at: Infection Prevention and Control Committee.
Date approved: 28 August 2024.
Executive approval: Louise Dickinson.
Date approved by: 28 August 2024.
RCHT General manager confirming approval processes: Joanne Taylor.
RCHT Governance lead confirming approval process: Joanne Taylor.
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RCHT Document Library folder and sub-folder: Clinical / Infection Prevention and Control.

Version control

Version	Date	Author and/ or reviewer	Section	Changes (key points)
V1.0	01/08/2024	Rashima Hamdan Senior IPAC Specialist Practitioner. Graham Kaye Senior IPAC Specialist Practitioner. Rebecca Winney IPAC Specialist Practitioner.	All	Full review and combine RCHT and CFT. Clostridium changed to Clostridioides. Summary now includes both trusts in flow chart. 5.2 PCR testing included. GP samples removed. When to send samples updated. 5.3.4. PPE guidance now reflects transmission based precautions in the national IPAC manual for England. 5.4.14 Checking mattress integrity removed as this should be in the cleaning policy and routine. 5.5.1 Incident reporting updated in line with new reporting procedure. 6. Updated legislation and Guidance. Appendices 3 and 4, third line treatment options added. Appendix 5 added to reflect FMT as a treatment option. Appendices 7 and 8 removed as no longer applicable.

This document replaces:

RCHT - Prevention and Management of Clostridium Difficile Infection Policy V7.0.

CFT - Prevention and Management of Clostridium Difficile Infection Policy IC/007/21.

Summary

All in-patients will have a **daily** Bristol stool chart maintained accurately.

If the Bristol stool chart indicates the patient has type **5, 6 or 7** stools **send a stool sample** and **complete a diarrhoea risk assessment** (DRA).

If the DRA indicates a potentially infective cause is suspected:

- Inform the Infection Prevention and Control (IPAC) team.
- Isolate the patient.
- If the room is not ensuite assign the patient a commode.
- Amber/medium risk clean the bed space as per cleaning policy.
- Staff to adhere to Trust Personal Protective Equipment (PPE) guidelines, including use of gloves and apron, for all contact with the patient and their environment.
- Soap and water to be used for hand hygiene.

Clostridiodes difficile confirmed.

Additional actions:

- Provide the patient with verbal and written information.
- Consider patient transfer to an isolation ward (RCHT).
- Commence and maintain C.diff passport.
- Medical staff to complete medication review; stop PPI/laxatives/aperients if prescribed and if safe to do so, otherwise document rationale for continuation in medical notes.
- Medical team to prescribe Clostridioides Difficile treatment as appropriate per micro guide.

Clinical and ward team to assess condition daily and escalate as appropriate where required.

Fluid balance chart must be maintained, and nutritional assessment undertaken.

Medical team liaise with Consultant Microbiologist if no symptom improvement within 72 hour of commencing treatment.

Patient to receive a weekly multidisciplinary clinical team review to ensure that the Clostridioides difficile infection is being treated optimally and that the patient is receiving all necessary supportive care.

Isolation precautions to continue until the patient has had 72 hours without diarrhoea and normal bowel habits have returned.

A Red/High risk clean must be undertaken once the patient has vacated the bed space (including mandatory Hydrogen Peroxide Vapour (HPV)).

Contents

Data Protection Act 2018 (UK General Data Protection Regulation Legislation)

The Trusts have a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out; it must be opted in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679, contact the Information Governance team.

- Cornwall Partnership NHS Foundation Trust: Email cpn-tr.infogov@nhs.net
- Royal Cornwall Hospitals NHS Trust: Email rch-tr.infogov@nhs.net

1. Introduction

1.1 The toxin produced by Clostridioides difficile was first identified as the cause of antibiotic associated colitis and diarrhoea in 1977.

1.2 The bacterium produces two potent toxins (toxin A and B) that cause mucosal damage and inflammation of the large bowel. Although in most cases it causes a relatively mild illness, occasionally, particularly elderly patients may develop a severe form of the disease called ‘pseudomembranous colitis’. This condition is characterised by significant damage to the large bowel and may lead to gross dilation with possible rupture or perforation of the bowel leading to sepsis and/or even death.

1.3 Clostridioides difficile infection (CDI) is often acquired in hospital, and almost all patients who develop CDI are taking or have recently been given antibiotic therapy. Nearly all antibiotics have been causally associated with Clostridioides difficile; however, some such as Cephalosporin’s, Piperacillin with Tazobactam, Co-Amoxiclav, Ciprofloxacin, Levofloxacin, Clindamycin and Meropenem are more strongly associated. Whereas Gentamicin, Vancomycin and Trimethoprim are much less often associated.

1.4 It has been firmly established that person to person transmission can occur in the hospital setting, and major outbreaks have resulted. Staff hands are the most frequent mode of transmission; however, studies have also demonstrated that Clostridioides difficile (as a spore forming organism) can survive for long periods of time in the environment, and on contaminated equipment.

1.5 The sensible use of antibiotics is the key to the prevention of Clostridioides difficile infection. Unnecessary use of antibiotics must be avoided. Where possible, short courses of narrow-spectrum antibiotics, of only three to five days, are preferred to longer courses. All antibiotic prescriptions should be kept under review. Trust antimicrobial prescribing guidance must be followed. Antimicrobial prescribing audits will be conducted regularly.

1.6 There is increasing evidence that acid-suppressing medications, in particular proton pump inhibitors (PPI's) may be a risk factor for Clostridioides difficile. Given that acid suppression drugs, especially PPIs, may be overprescribed and frequently not reviewed to determine if long-standing prescriptions are still justifiable, consideration should be given to stopping/ reviewing the need for PPIs in patients with or at high risk of Clostridioides difficile.

1.7 This version supersedes any previous versions of this document.

2. Scope

This policy applies to all staff working for or on behalf of the Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust, including volunteer, temporary, locum, bank, agency and contracted staff in their work caring for patients.

3. Definitions and glossary

- CDI - Clostridioides difficile infection.
- GDH - Glutamate dehydrogenase.
- CDAB - Clostridioides difficile toxins A and B.
- IPAC - Infection Prevention and Control.
- DIPC - Director of Infection Prevention and Control.
- CDRNE - Clostridioides difficile Ribotyping Network for England.
- PCR - Polymerase chain reaction.
- PPE – Personal protective equipment.
- HPV - Hydrogen Peroxide Vapour.

Definitions are also contained within the text.

4. Ownership and responsibilities

4.1. Role of Care Group Management Team, Head of Nursing, Area Manager and Matrons

Care Group Management Team, Head of Nursing, Area Manager and Matrons must ensure that resources are available for health care workers to undertake effective standard and isolation precautions.

4.2. Role of Ward Leaders and Departmental Managers

Ward Leaders and Departmental Managers are responsible for ensuring that staff are aware of this guidance and that it is implemented.

4.3. Role of Medical Staff

Medical staff are responsible for managing Clostridioides difficile as a diagnosis in its own right.

4.4. Role of the Infection Prevention and Control Committee

The Infection Prevention and Control Committee are responsible for approving this policy and monitoring the compliance and implementation of this policy.

4.5. Role of Individual Staff

Every individual has a clinical and ethical responsibility to carry out effective infection prevention and control procedures, and to act in a way which minimises risk to the patient.

5. Standards and practice

5.1 **Principles of management**

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

Letter	Information
S	Suspect that a case may be infective where there is no clear alternative for cause of diarrhoea.
I	Isolate the patient and consult with the IPAC team whilst 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 patients environment.
T	Test the stool by sending a specimen immediately.

5.2 Diagnosis

Based on national guidelines the diagnosis of Clostridioides difficile is performed employing a two-test strategy. All stool samples are initially screened by GDH (Glutamate dehydrogenase) assay. GDH concentration in stools increase during C.diff overgrowth in the gut. Therefore, detection of GDH indicates C.diff colonisation, but not necessarily toxin production. GDH positive specimens are tested for confirmation of toxin production. A positive toxin production confirms the diagnosis of C.diff infection. If a sample is positive for GDH but negative for C.diff toxin, PCR (polymerase chain reaction) may be used to identify the presence of toxigenic C.diff in symptomatic patients.

All stool types 5-7 should be sent to the laboratory regardless of DRA outcome.

C.diff PCR will be performed on those stool samples requiring C.diff testing if the patient is also SARS-CoV-2 positive.

C.diff PCR testing may be performed on those patients who are GDH positive with a second negative toxin test within 48hrs of the previous negative. Supplementary PCR tests must be requested via a medical microbiologist.

- Specimens must be obtained and sent promptly. Stool samples submitted from all hospital inpatients (excluding neonates) will be tested routinely for C.diff toxin. CFT samples should be sent via blood bikes if out of hours.
- Other departments specifically requiring a C.diff toxin test (e.g. outpatients) must request that test on the form when sending the sample.
- Samples taken early in C.diff infection may be toxin negative.
- Samples should be repeated after 48 hours in patients presenting a clear clinical picture of C.diff infection with ongoing symptoms and a negative initial sample.
- A microbiology request form must be completed appropriately, and the specimen container closed securely to avoid leakage.

5.3 Management of a patient with diarrhoea/ suspected Clostridioides difficile infection.

5.3.1 Isolation

- The patient must be isolated a single room, with en-suite facilities where possible and dedicated items of equipment. Where en-suite facilities are unavailable, a dedicated commode should be allocated. Source isolation procedures as per the Isolation Policy must be followed.
- If there are several cases on a ward and there are not enough single rooms to isolate all cases, considerations should be given to cohorting cases in a designated bay with a toilet specifically allocated to the bay.
- Symptoms must be assessed using the Diarrhoea risk Assessment form on nerve centre/ Rio (forms to print CHA 4551) and documented using a Bristol Stool Chart (Order code for Unit 4 for RCHT and Integra for CFT CHA2853).
- The vacated bed space must be cleaned prior to admitting the next patient as per the trust cleaning policy.

5.3.2 Hand Hygiene

Staff hands are the most important mode of transmission from patient to patient. Soap and water must be used for hand hygiene rather than alcohol gel as soap and water is far more effective. Hand sanitisers containing Hypochlorous acid do not require removal from the patients bed side as this has been proven to be effective against C.diff spores. Patients must also be encouraged to wash their hands. If the patient is bed bound, patient wet wipes should be offered for hand hygiene as an alternative to soap and water.

5.3.3 Maintaining Standards of Care

Infection control measures should not compromise the patient's care and should not affect the patient's freedom to be mobilised or attend other departments for health care related visits.

5.3.4 Protective Clothing

Gloves and aprons must be worn for direct patient contact with symptomatic patients or when cleaning the isolation room/ bay. Hands must be washed with soap and water following the removal of protective clothing. Follow the guidance outlined in the national infection prevention control manual for England (NHS England » National infection prevention and control), transmission based precautions.

5.3.5 Family Visitors

Protective clothing is unnecessary unless involved in personal care. Visitors should be advised to wash their hands immediately prior to leaving the isolation room. Visitors should be advised to avoid eating and drinking within the room. If visitors disclose the fact that they are taking antibiotics, they should be advised of the increased risk of infection.

5.4 Action required once Clostridioides difficile confirmed

5.4.1 Isolation Precautions

Transfer to the isolation ward must be considered and should be arranged via the Site Co-Ordinator. Previously described isolation precautions in single room or cohort must be maintained. Hand hygiene and protective clothing measures as above.

5.4.2 Hand Hygiene

Staff hands are the most important mode of transmission from patient to patient. Soap and water must be used for hand hygiene rather than alcohol rub - soap and water is far more effective. Hand sanitisers containing Hypochlorous acid can still be employed. Patients must also be encouraged to wash their hands. If the patient is bed bound, patient wet wipes should be offered for hand hygiene as an alternative to soap and water.

5.4.3 Protective Clothing

Gloves and aprons must be worn for direct patient contact with symptomatic patients or when cleaning the isolation room/ bay. Hands must be washed with soap and water following removal of protective clothing.

5.4.4 Patient Information

The affected patient should be provided with an explanation of Clostridioides difficile infection and an information leaflet. Provision of the C.diff passport should be considered with advice from IPAC.

5.4.5 **Staff**

Staff very rarely suffer from symptoms related to Clostridioides difficile. However, should staff be receiving antibiotics then they may be at some risk of infection, and therefore should avoid contact with known cases of Clostridioides difficile infection.

5.4.6 **Family visitors**

Protective clothing is unnecessary unless involved in personal care. Visitors should be advised to decontaminate their hands immediately prior to leaving the isolation room. Visitors should be advised to avoid eating and drinking within the room. If visitors disclose the fact that they are taking antibiotics, they should be advised of the increased risk of infection.

5.4.7 **Cleaning**

A chlorine-based disinfectant must be used for daily routine cleaning of the environment where patients with Clostridioides difficile are being nursed. This may be single rooms or a cohort bay.

5.4.8 **Treatment**

- Clostridioides difficile infection must be treated as a diagnosis in its own right.
- Stop antibiotics if possible. This may suffice to prevent diarrhoea developing further. If symptoms are judged enough to warrant treatment, refer to the Antibiotic Policy.
- Refer to treatment algorithm (Appendices 2,3 and 4).
- Treatment days should be counted from the end of any course of other antibiotics if they cannot be stopped immediately.
- Do **not** give anti-motility agents such as Loperamide (due to the risk of toxic megacolon).

- For advice contact the duty Medical Microbiologist.
- The patient will be followed up in the weekly C.diff ward rounds.
- If patient develops bloody diarrhoea or signs of an acute abdomen the possibility of pseudomembranous colitis must be considered, and an urgent surgical opinion should be sought, in addition to further discussions with a Microbiologist.
- If the patient still has diarrhoea after treatment refer to appendices 3 and 4 and discuss with as microbiologist.

5.4.9 **Monitoring of condition**

The severity of CDI must be assessed each day by the clinical team as follows:

- Mild CDI is not associated with a raised WCC; it is typically associated with less than 3 stools of type 5–7 on the Bristol Stool Chart per day.
- Moderate CDI is associated with a raised WCC that is <15 x109/L; it is typically associated with 3–5 stools per day.
- Severe CDI is associated with a WCC >15 x 109/L, or an acute rising serum creatinine (i.e. >50% increase above baseline), or a temperature of >38.5°C, or evidence of severe colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity.
- Life-threatening CDI includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.
- NB: Neutropenic patients will have a low WBC/ no WBC. Advice must be sought from a Microbiologist and/or the patient's Consultant.

An accurate stool chart and fluid balance chart must be maintained and a nutritional assessment undertaken.

5.4.10 **Clearance**

- It is not necessary to send specimens to confirm a patient is negative for Clostridioides difficile toxin unless asked to by a member of the IPAC team or Microbiologist.
- Follow up stool samples are of no value since they often remain positive even in patients who have recovered symptomatically.
- Once a patient has had 72 hours without diarrhoea and a return to normal bowel habits, they can be considered non-infectious. Source isolation precautions can then be stopped.

5.4.11 **Relapse**

If further diarrhoea occurs, relapse must be suspected. The patient must be isolated, and treatment discussed with a Medical Microbiologist. The IPAC team must also be informed.

5.4.12 **Transferring of Patients with Clostridioides difficile**

- Minimising the movement of patients between wards will reduce the exposure of other patients to C.diff when a case of infection has been identified.
- If it is necessary to transfer a patient with C.diff due to clinical need, the receiving area must be informed prior to transfer.
- The IPAC team must be informed of the transfer as soon as possible.
- When a patient has been positive, but symptoms have resolved, the receiving area should be informed. This will ensure that the diagnosis of C.diff is considered if the patient has any further diarrhoea.

5.4.13 **Discharge**

- Medical staff must ensure that the diagnosis of C.diff infection is noted on the information sent to the patient's GP, and the patient should be advised to report to their GP if they experience further diarrhoea.
- Patients must be advised not to take anti-diarrhoeal agents such as Loperamide if they experience further diarrhoea.
- If a patient still has symptoms on discharge, agencies that will provide care for the patient must be informed and the information completed on the transfer form.
- C.diff passport to go with patient on discharge.

5.4.14 **Cleaning of the vacated bed space**

Red/high risk clean of the single room/ bay must be undertaken once the bed space becomes vacant. Hydrogen Peroxide Vapour should be used for single rooms.

5.5 Increased Incidence and Outbreak

A period of increased incidence (PII) is defined as: two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period on a ward.

An outbreak of Clostridioides difficile diarrhoea: two or more cases caused by the same strain related in time and place over a defined period that is based on the date of onset of the first case.

The following actions must be undertaken if a PII is identified on a ward:

- The Care Group Management Team/Head of Nursing, Matron, Ward Leader must be informed by the IPAC team.
- A weekly C.diff ward audit must be undertaken jointly by the Ward Staff and the IPAC team, using the CDI acquisition enhanced measures audit form.

- The audit should continue until the weekly score is >80% in the three sections for three consecutive weeks and there have been no further >48 hours cases of CDI on the ward during that period. The audit results must be fed back to the Matron.
- A weekly antibiotic review in the ward (using local tools); must be carried out by the antibiotic Pharmacist.
- The whole ward must be cleaned with chlorine-based detergent agent until no further symptomatic patients are present on the ward. Each bed space must be cleaned separately with separate cloths.
- The Microbiology Laboratory must use the HPA Clostridioides difficile Ribotyping Network for England (CDRNE) or Centre for Infections to undertake PCR (polymerase chain reaction) Ribotyping of all isolates from patients in the ward.
- An incident meeting must be held as determined by the size and rate of growth of the PII by assessment of the situation by the Director of Infection Prevention and Control (DIPC) and/or the duty Microbiologist with the Clinical Director and Consultants, depending on the number of cases.
- The IPAC team should carry out an automatic review of ward PIIs each week.

5.5.1 **Incident reporting**

All C.diff Hospital Onset Healthcare Associated and Community Onset Healthcare Associated infections are required to be incident reported on the trust incident management system. Reported cases will receive a proportionate response to the incident.

Learning and themes are reported to the IPAC steering group and IPAC committee.

5.5.2 **Death**

- If C.diff causes or contributes to the death of a patient, the clinician in charge of the patient's care must discuss the case with the coroner prior

to the death certificate being issued (this is a local policy agreement with the coroner).

- If a patient with C.diff dies, the death certificate must state whether C.diff was part of the sequence of events leading directly to death or whether it was the underlying cause of death. If either case applies Clostridioides difficile should be mentioned in part 1 of the certificate.
- If C.diff was not part of the sequence of events leading directly to death but contributed in some way to it, this should be mentioned in part 2.
- A patient safety review/incident risk mitigation form must be completed for patients where C.diff is mentioned on part 1 of the death certificate.

6. Related legislation, national and local guidance

- UK Health Security Agency. (2022) Clostridioides difficile infection Updated guidance on management and treatment. Clostridioides difficile infection: updated guidance on management and treatment (elft.nhs.uk)
- Department of Health and Health Protection Agency. (2008) Clostridium difficile infection: How to deal with the problem. Clostridioides difficile infection: how to deal with the problem - GOV.UK (www.gov.uk)
- Clostridioides difficile infection: antimicrobial prescribing. NICE guideline [NG199]Published: 23 July 2021. Overview | Clostridioides difficile infection: antimicrobial prescribing | Guidance | NICE
- NHS England (2024) National infection prevention and control manual for England National infection prevention and control manual for England

7. Training requirements

There are no training requirements.

8. Implementation

This policy will be implemented via the following routes:

- Information regarding the policy will be included in the IPAC newsletter.
- The policy will be included in the Trust's Document Library.
- The policy will be circulated to all Link Practitioners, Matrons and Heads of Nursing.

9. Document Monitoring arrangements

Information category	Detail of process and methodology for monitoring compliance
Element to be monitored	The management of patients with Clostridioides difficile.
Lead	IPAC team.
Tool	Through practice review and audits recorded on a word or excel template.
Frequency	Weekly during ward visits and documented on ICNet.
Reporting arrangements	Reporting to Ward Leader on the day if isolation not carried out appropriately. Reporting to Microbiologists any concerns regarding treatment. Report by exception to the Infection Prevention and Control Steering Group persistent non-compliance with policy.
Acting on recommendations and lead(s)	Ward Leader to take immediate action where non-compliance with policy identified.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned immediately where necessary. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

10. Updating and review

This policy will be reviewed every 3 years at a minimum.

11. Equality and diversity

This document complies with the Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust equality and diversity statements. The statements can be found in the RCHT Equality Diversity And Inclusion Policy and CFT Equality, Diversity and Inclusion Statement.

The initial equality impact assessment screening form is at appendix 1.

12. Appendix 1: Equality Impact assessment Form

Title of policy or document for assessment: Joint Prevention and Management of Clostridioides difficile Infection Policy V1.0.

Document library section: Clinical / Infection Prevention and Control.

Is this a new or existing document? Existing.

Date of assessment: 19 July 2024.

Person responsible for the assessment: Graham Kaye, Senior IPAC Specialist Practitioner.

What is the main purpose of the document?

This policy provides details on how to reduce the risk of transmission of Clostridioides difficile within healthcare settings, and information on the appropriate treatment of patients with Clostridioides difficile infection. This document takes into consideration the prevalence of Clostridioides difficile both locally and nationally, as well as national guidance.

Who is affected by the document?

☒ Staff ☒ Patients ☒ Visitors ☐ Carers ☐ Other ☐ All

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Concerns

Are there concerns that the procedural document could have a differential impact on the following areas?

If a negative impact has been identified, please complete a full EIA by contacting the Equality, Diversity, and Inclusion Team. For RCHT please contact rcht.inclusion@nhs.net and for CFT please contact cft.inclusion@nhs.net

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Age	☐ Yes ☒ No	
Disability	☐ Yes ☒ No	
Sex	☐ Yes ☒ No	
Gender reassignment	☐ Yes ☒ No	
Pregnancy and maternity	☐ Yes ☒ No	
Race	☐ Yes ☒ No	
Religion and belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Marriage and civil partnership	☐ Yes ☒ No	
Groups at risk of stigma or social exclusion such as offenders or homeless people	☐ Yes ☒ No	
Human rights	☐ Yes ☒ No	

Are there any associated objectives of the document? If yes, what existing evidence (either presumed or otherwise) do you have for this?

There are no associated objectives.

Signature of person completing the equality impact assessment:

Name: Graham Kaye.

Date: 19 July 2024.

13. Appendix 2: Adult in-patient Treatment Algorithm – First Episode of Clostridioides difficile infection (CDI)

Diarrhoea **and** one of the following:

Positive C.difficile toxin test **or** results of C.difficile toxin test pending **and** clinical suspicion of CDI.

↓

If clinically appropriate discontinue non-C.difficile antibiotics to allow normal intestinal flora to be re-established.

Suspected cases must be isolated.

↓

Review GI medications:

- Proton pump inhibitors.
- Antimotility agents e.g. Loperamide – not recommended in acute CDI.
- AKI risk medications (e.g. NSAIDs, ACEi, diuretics).

↓

Oral Vancomycin 125mg QDS for 10 days.

If poor response to vancomycin or not tolerated consider:

Fidaxomicin 200mg 12-hourly for 10 days.

Note: should not normally be considered treatment failure until day 7 of treatment.

↓

Daily Assessment - include review of severity markers, fluid/electrolytes.

↓

Symptoms not improving or worsening.

Should not normally be deemed a treatment failure until day 7 of treatment.

However if evidence of severe CDI continues or worsens: Surgery/GI/Microbiology consultation.

↓

Consider (under Microbiology advice only): Oral Vancomycin up to 500mg QDS for 10 days **with** or **without**: Metronidazole IV 500mg TDS for 10 days.

↓

If no improvement further discussion with Surgery/GI/Microbiology.

14. Appendix 3: Adult inpatient Treatment Algorithm – Relapse of Clostridioides difficile infection (CDI)

Relapse defined as CDI infection WITHIN 12 weeks of symptom resolution of previous case.

Relapse (**within** 12 weeks of symptomatic resolution).
Diarrhoea **and** one of the following:
Positive C.difficile toxin test **or** results of *C*.difficile toxin test pending **and** clinical suspicion of CDI.

↓

If clinically appropriate **discontinue non-C.difficile antibiotics** to allow normal intestinal flora to be re-established.
Suspected cases must be isolated.

↓

Review GI medications:

- Proton pump inhibitors.
- Antimotility agents e.g. Loperamide – not recommended in acute CDI.
- AKI risk medications (e.g. NSAIDs, ACEi, diuretics).

↓

Fidaxomicin 200mg 12-hourly for 10 days.

↓

Daily Assessment - include review of severity markers, fluid/electrolytes.

↓

Symptoms not improving or worsening
Should not normally be deemed a treatment failure until day 7 of treatment.
However if evidence of severe CDI continues or worsens: **Surgery/GI/Microbiology consultation.**

>1 relapse consider third line treatment FMT, tapered vancomycin or other antibiotics (e.g. Tigecycline) in discussion with infection team.

15. Appendix 4: Adult inpatient Treatment Algorithm – Recurrence of Clostridioides difficile infection (CDI)

Recurrence defined as a further episode of CDI more than 12 weeks after symptom resolution.

Recurrence (**more than** 12 weeks of symptomatic resolution).
Diarrhoea **and** one of the following:
Positive C.difficile toxin test **or** results of C.difficile toxin test pending **and** clinical suspicion of CDI.

↓

If clinically appropriate **discontinue non-C.difficile antibiotics** to allow normal intestinal flora to be re-established.
Suspected cases must be isolated.

↓

Review GI medications:

- Proton pump inhibitors.
- Antimotility agents e.g. Loperamide – not recommended in acute CDI.
- AKI risk medications (e.g. NSAIDs, ACEi, diuretics).

↓

Oral Vancomycin 125mg 6-hourly for 10 days **or**
Fidaxomicin 200mg 12-hourly for 10 days.

↓

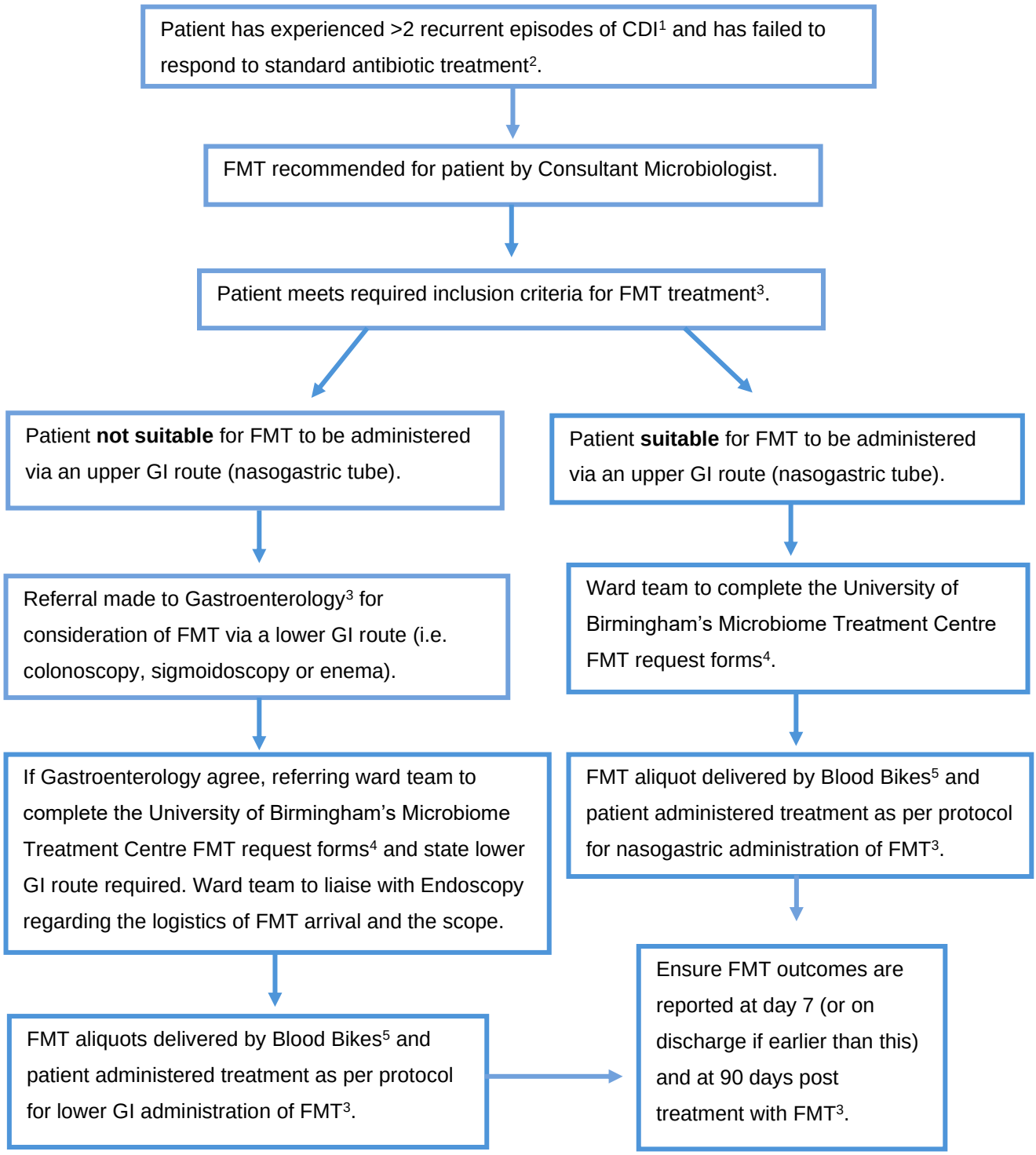
Daily Assessment - include review of severity markers, fluid/electrolytes.

↓

Symptoms not improving or worsening
Should not normally be deemed a treatment failure until day 7 of treatment.
However if evidence of severe CDI continues or worsens: **Surgery/GI/Microbiology consultation.**

>1 recurrence consider third line treatment FMT, tapered vancomycin or other antibiotics (e.g. Tigecycline) in discussion with infection team.

16. Appendix 5. Treatment Algorithm - Faecal Microbiota Transplant (FMT)



References:

[1] Recurrent CDI is defined as a further episode >12 weeks after previous symptom resolution.
[2] Guidelines published by the British Society of Gastroenterology (BSG) and Healthcare Infection Society (HIS) recommend that FMT should be considered earlier than after second CDI recurrence for patients with

severe, fulminant or complicated CDI who are not responding to antibiotic therapy. https://www.journalofhospitalinfection.com/action/showPdf?pii=S0195-6701%2824%2900080-X

[3] Information and forms can be requested by contacting bhs-tr.FMT@nhs.net or 0121 414 4547.

[4] Referrals should be made via Maxims.

[5] In the event that Blood Bikes are unable to deliver the FMT aliquot a courier will need to be arranged by the requesting team.