Clostridioides Difficile Infection Policy (Prevention and Management) (N-010)

Version number:	4.4
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Executive Lead (name and job title):	Hilary Gledhill, Executive Director of Nursing, Allied Health and Social Care Professionals
Name of approving body:	Governance Committee
Date full policy approved:	March 2016
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Next full review date:	December 2025

Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*QPaS – 13 December 2022*
Date EMT as approving body notified for information:	*December 2022*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

Clostridioides difficile (also known as C. difficile) is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. Unfortunately, however it also can be a major cause of healthcare associated infection. People who have been treated with broad spectrum antibiotics, people with serious underlying illnesses and the elderly are at greatest risk with over 80% of reported Clostridioides difficile infections occurring in people aged over 65 years. The symptoms of a Clostridioides difficile Infection (CDI) ranges from mild to severe diarrhoea to, more rarely, severe inflammation of the bowel (known as pseudomembranous colitis).

Although some people can be healthy carriers of Clostridioides difficile in most cases the disease develops after cross-infection from another patient, either through direct patient to patient contact, via healthcare staff, or via a contaminated environment or item of equipment. A patient who has Clostridioides difficile excretes large numbers of the spores in their liquid faeces. The spores can contaminate the general environment around the patient's bed (surfaces, keypads and equipment), the toilet areas, sluices, commodes, bedpan washers, etc. C. difficile spores can survive in the environment for months unless removed by robust cleaning procedures.

2. SCOPE

This policy is aimed at all staff employed by Humber Teaching NHS Foundation Trust and those who provide services within the Trust who undertake direct patient care or who may come into contact with patients affected by a Clostridioides difficile infection or their immediate environment.

3. POLICY STATEMENT

This policy is aimed to provide guidance for the safe management of any patient suspected or confirmed with a C. difficile infection. This includes:

- the prevention of Clostridioides difficile Infection
- the management of any symptomatic patient
- the prevention of cross infection to others

This policy document is supported by the 'Guidance at a Glance – Clostridioides Difficile' (Document link)

4. DUTIES AND RESPONSIBILITIES

The Chief Executive will ensure that:

- Clinical Divisional Leads and clinicians accept ownership for all aspects pertaining to the control of healthcare associated infections. This must include the reduction and appropriate management of Clostridioides difficile within their clinical areas and assurance that specific objectives have been incorporated into their annual plan.

The Director of Infection Prevention and Control (DIPC) will:

- Oversee the control of this policy and its implementation.
- Monitor the impact of this policy and have the authority to challenge inappropriate practice.
- Review each Root Cause Analysis (RCA) conducted for all healthcare associated cases of Clostridioides CDI.
- Initiate an incident control meeting if two or more cases of related healthcare associated CDI occur on a ward within a period of seven days.

The Divisions will:

- Monitor the implementation of the Clostridioides difficile policy and actively ensure that all staff always comply with the content of this policy.
- Ensure that the facilities and equipment required to support effective infection prevention and control practices are in place.
- Ensure that all clinical staff within their division have received appropriate infection prevention and control training.
- Support the matrons/clinicians during the RCA process for any healthcare associated cases of CDI and monitor the action plan.
- Support any remedial action plan implemented following expert consultation as a consequence of any increased incidence of CDI.

The Matrons will:

- Monitor implementation of the policy within their area and ensure action is taken if there are any breaches in practice reported.
- Review all audits conducted by the Infection Prevention and Control Team (IPCT) and take action as necessary.
- Work with the IPCT and other key clinicians to complete an RCA for any Trust apportioned cases of CDI acquired in their area of responsibility.
- Provide a briefing report for any Trust attributed cases of CDI within their area of responsibility.
- Report to the Healthcare Associated Infection Group (HAIG) and clinical network meetings on any infection issues highlighted within their respective areas of responsibility. The number and findings of any healthcare associated infections and subsequent action plans of any root cause analysis completed.
- Ensure a Datix is completed for any Trust attributed cases.

The Ward Manager/Charge Nurse/Team Leader will:

- Ensure this policy is fully implemented by all members of the health care team within their sphere of responsibility. Any concerns that cannot be resolved at ward/departmental level should be highlighted to the Matron/line manager and a member of the IPCT.
- Be responsible for ensuring that patients are cared for in adherence with this policy and for escalating any situations where safe placement or practice cannot be achieved.
- Ensure any suspected or actual incidence of CDI is reported to the IPCT within one working day.
- Ensure any patient who is diagnosed as having CDI is given advice and an ongoing plan of care is initiated.
- Participate in the Root Cause Analysis process for any health care associated case of CDI within their area.

The Infection Prevention and Control Team will:

- Ensure that this policy remains consistent with current national evidence and guidance.
- Provide expert advice in accordance with this policy.
- Support staff in the implementation of this policy and assist with any associated risk assessment where complex factors are involved.
- Plan and deliver a programme of infection prevention and control education which includes information on Clostridioides difficile for all clinical staff within the Trust.
- Assist in the monitoring of this policy.
- Lead in the completion of the RCA process for any Trust apportioned CDI.
- Take a proactive role in any cases of increased incidence of CDI or incident control meetings resulting from an outbreak of CDI.

All staff must:

- Be aware of the contents of this policy.
- Adhere to all aspects of the policy.

- Report any breaches of this policy to their line manager.
- Alert their manager if they feel that they require further advice/education or training.

5. PROCEDURES

Clostridioides difficile associated disease is often a complication of broad-spectrum antibiotic therapy, occurring when a reduction in normal intestinal bacteria/flora allows Clostridioides difficile to flourish and produce toxins (A & B). People over the age of 65, those who have recently undergone surgery and people with serious underlying disease are particularly susceptible. Clostridioides difficile is not only a risk to the individual patient with infection but can be the cause of outbreaks in hospitals.

5.1. Clinical Features

- Clostridioides difficile can range from asymptomatic carriage to severe illness; it may be self-limiting in some cases. Stools may be watery and/or bloody with a distinctive foul smell and green or yellowish-brown appearance.
- Patients may experience abdominal pain, fluid and electrolyte disturbance, and a low-grade pyrexia.
- Occasionally Clostridioides difficile infection can cause severe inflammation of the gut, ulceration, and perforation (pseudomembranous colitis) which may be life threatening.

5.2. Methods of Spread

The bacterium can produce spores that can survive for long periods within the patient and the immediate environment. These spores are resistant to drying, heat and many disinfectants.

Clostridioides difficile may be acquired by:

- Direct patient to patient contact by the faecal-oral route.
- Direct spread via health care staff.
- Indirect spread via environmental contamination.

5.3. Recognising Suspected Infectious Diarrhoea

Often the first signs or symptoms of CDI will be explosive watery and offensive diarrhoea, which may also be associated with fever, bloody stools and abdominal cramps.

There may also be other significant factors such as the patient:

- taking antibiotics within the last 3 months
- previously been diagnosed with CDI
- previously been on a ward where there is already a known case of CDI
- been taking proton pump inhibitor (PPI) medication concurrently with antibiotics

If a patient is suspected of having CDI (or any other infectious diarrhoea) the **SIGHT** Protocol should immediately be adopted as shown below:

S	**Suspect that a case may be infective when there is no clear alternative cause for diarrhoea.** **Diarrhoea** is defined as one episode (or more) of diarrhoea, not attributed to any other cause where the stool is loose enough to take the shape of the container, or is No 5 to 7 on the Bristol Stool Chart (**please refer to Appendix 3**)

I	**Isolate the patient within two hours and consult with the infection prevention and control team while determining the cause of the diarrhoea**
G	**Gloves and aprons to be used for all contact with the patient and their environment**
H	**Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment**
T	**Test the stool for *Clostridioides difficile* by sending a specimen immediately**

5.4. Interpretation of Results and Actions to be taken

Clostridioides difficile can be present in low numbers in healthy adults. The presence of the organism in the stool is therefore not diagnostic. The diagnosis of CDI is based upon the presence of the Clostridioides difficile toxin. A faecal sample which has been sent to the laboratory will be subject to a series of tests which can be interpreted and used to inform the types of precautions and treatments necessary to manage the patient appropriately. Different laboratories may use different testing methodology however the Infection Prevention and Control Team or Microbiologist will assist clinicians to clarify results and understand what specific action is necessary for the individual patient.

Interpretation	Action
Clostridioides difficile negative	• Further lab testing may be required in order to screen for other causes. • Isolation precautions to continue until full screening completed and symptoms ceased for a minimum of 48 hours is achieved.
Clostridioides difficile carriage, e.g. GDH positive result/toxin negative	• Not active infection, but potential for transmission to others and for future active infection. • Isolation precautions to continue until symptoms ceased for a minimum of 48 hours is achieved. • Implement Clostridioides difficile care plan.
Clostridioides difficile positive, e.g. GDH positive result toxin positive	• Active infection requiring treatment and isolation precautions until symptoms ceased for a minimum of 48 hours and a formed stool is achieved. • Implement Clostridioides difficile care plan

5.5. Treatment and Antibiotic Prescribing

It is important for clinicians to be able to assess and recognise the severity of the infection as this will inform the type of treatment necessary in accordance with the NICE guideline NG199 Clostridioides difficile infection: antimicrobial prescribing

A patient diagnosed with CDI should be assessed daily utilising the guidance in Appendix 2. Specialist advice (e.g. from a consultant microbiologist) should be sought where a patient does not respond to treatment or deteriorates.

All concurrent medication must also be reviewed by medical staff and antibiotic prescribing should be commenced in accordance with the. NICE guideline NG199 Clostridioides difficile infection: antimicrobial prescribing.

Where a patient is receiving end of life care clinicians should assess the impact of the symptoms of the CDI on the patient's comfort, dignity and overall condition when considering treatment options. This assessment should also include consideration of the risk of transmission to others, especially if symptoms are profuse or uncontrolled.

There is no requirement to routinely re-test a patient found to be Clostridioides difficile positive as toxins may continue to be detected for many weeks following treatment and resolution of symptoms.

Re-testing however may be recommended only in the following situations:

- If symptoms had resolved following treatment but have recurred.
- If initial testing was negative, but symptoms persist and there is cause to clinically suspect CDI.
- On the specific advice of the Microbiologist or IPCT.

5.6. Recurrence of Symptoms

If a patient's symptoms return following the discontinuation of treatment, they should be regarded as infectious and appropriate infection control precautions reinstated.

It may also be necessary to recommence antibiotic therapy (see Appendix 2). Advice must be sought from the Consultant Microbiologist.

5.7. Movement of Infected Patients

The routine transfer of patients affected by CDI to other units and departments should occur only after consultation with the IPCT.

If unit transfers or visits to other departments are essential, the receiving area should be informed of the patient's status in advance and **an inter-healthcare transfer form** should be completed; This form can be found utilising the following link: inter-healthcare transfer form. Where possible patients should be treated at the end of a session and their waiting time in the department kept to a minimum.

5.8. Visitors

Hand washing with soap and water should be performed by visitors before entering and on leaving the room/cohort area where a patient is being nursed in isolation due to Clostridioides difficile infection. Visitors are required to wear gloves and aprons when performing or assisting with direct patient care. Visitors are not required to wear protective clothing at other times provided they are not having direct contact with other hospital patients.

5.9. Environmental Cleaning

Clostridioides difficile spores can survive in the environment for months or years and can be found on multiple surfaces in healthcare settings unless removed by robust cleaning. The cleaning of rooms or bed spaces of C. difficile patients should be carried out at least daily using chlorine disinfectant product (at least 1,000 parts per million (PPM) available chlorine), ensuring the required contact time for the disinfection product.

All commodes, toilets and bathroom areas of CDI patients should also be cleaned after each use with chlorine disinfectant product (at least 1,000 ppm available chlorine).

- Clostridioides difficile spores can contaminate the environment and may persist for many months unless removed by thorough cleaning.

- Areas/rooms occupied by patients known to be Clostridioides difficile positive are to be cleaned as per the functional risk category for the area but should be cleaned at least once daily using chlorine containing cleaning agents. Particular attention should be paid to the cleaning of high frequency touch points, floors/walls in toilet areas, commodes, as these areas are most likely to be subject to faecal contamination.
- It is vital that all flat surfaces are kept free from clutter to aid cleaning.
- All equipment that has been in contact with an affected patient will require cleaning in accordance with Trust disinfection/sterilisation policy. Some specialist equipment may not tolerate chlorine and staff must refer to manufacturer's guidance in these instances.
- Any contaminated equipment must be thoroughly decontaminated using a chlorine releasing agent.

5.10. Cleaning Process following Patient Discharge

Following discharge or transfer of a patient from an isolation room it is to be terminally cleaned i.e. Trust approved disinfectant product used in accordance with manufacturers dilution instructions and all the bedside furniture and window curtains are cleaned / changed prior to the next patient using the room.

- Prior to the cleaning being undertaken the patient must have vacated the area. The area must be cleared of all personal effects, equipment, linen and any healthcare waste prior to the clean.
- Staff must wear appropriate personal protective equipment in accordance with the Trust Standard Precautions Policy.
- All equipment requires a visual inspection for any signs of ingress or damage which renders cleaning ineffective. If there are concerns about the integrity of the equipment, replacement /repair should be discussed with the nurse in charge.
- A Trust approved disinfectant product must be used to clean the area and equipment.
- Equipment must be decontaminated and thoroughly dried prior to storage.
- Staff should ensure that all surfaces are thoroughly dry.
- At the end of the clean the nurse in charge is to ensure that the checklist is completed with a member of the cleaning team, prior to the room being re-opened.

5.11. Discharge Planning

- Affected patients may be discharged home as soon as considered clinically fit.
- There should be no restrictions on institutions, such as residential homes, receiving patients who have had CDI and are now clinically asymptomatic. Good communication with other institutions is imperative before the patient is transferred; this should be supported by written information on an inter-healthcare transfer form and discharge letter.
- Patients should not however be discharged to a nursing or residential homes whilst they are symptomatic.

5.12. Root Cause Analysis

A Root Cause Analysis must be undertaken for each case of Trust apportioned CDI.

It is usual to reflect on the previous three months when conducting a CDI RCA. During this time some patients may have accessed clinical services from a variety of sources, requiring a multi-organisational approach.

- Where a patient is deemed to have acquired the infection within a Trust inpatient unit (determined by the timescale of admission/onset of symptoms/sample testing) the RCA process will be led jointly by the matron for the clinical area and the IPCT. All action plans will be monitored by the Division Clinical Network.
- Where a patient is deemed to have acquired the infection within another care setting (e.g. other Trust) or community setting (e.g. own home/residential setting) and there have been clinical interventions from Trust services (e.g. Community Nursing/Therapies/inpatient episodes) the IPCT will review any care delivered.

5.13. Control of a Period of Increased Incidence/Clostridioides difficile Outbreak

If two or more cases of healthcare associated CDI (more than 48 hours after the patient's admission, i.e. new cases, not relapses), occur on a ward within seven days:

- The IPCT, Infection Control doctor, matron and DIPC must be informed.
- The IPCT and/or the Infection Control doctor will assess the situation to determine whether an incident meeting should be held. It is possible that the ward may require closure to admissions and have restricted movement/discharges during this period.
- The audit tool for monitoring isolation precaution principles in clinical practice will be initiated by the infection prevention and control team to be completed daily by the clinical team until the optimum compliance score has been achieved, only then will completion reduce to weekly.
- An antibiotic review should be undertaken by the pharmacist.
- An enhanced cleaning program will be commenced.

5.14. Patient Death Certification

- If a patient with Clostridioides difficile dies, the death certificate must state whether Clostridioides difficile infection 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 must be mentioned in Part 1 of the certificate.
- If Clostridioides difficile infection was not part of the sequence of events leading directly to death but contributed in some way to it, this must be mentioned in Part 2 of the death certificate.
- The RCA process is to include a review of the patient condition at 30 days. If a patient dies within a 30 day period of diagnosis with Clostridioides difficile the Director of Infection Prevention and Control should be informed and a mortality review undertaken to determine whether a Serious Incident should be declared.

5.15. Surveillance

Surveillance of Clostridioides difficile infection is included in the mandatory healthcare associated infection surveillance system programme. This is coordinated by the UK Health Security Agency (UKHSA). The UKHSA has a requirement that all acute NHS hospitals maintain surveillance and reporting of patients over two years of age who are diagnosed with Clostridioides difficile.

The IPCT will perform surveillance of new cases of CDI routinely as part of the alert organism surveillance.

Monthly IPC performance data is included within the quality dashboard identifying Trust apportioned cases and performance against the agreed commissioning thresholds.

Quarterly performance dashboards for the inpatient areas include C.diff cases.

The appropriate Integrated Care Board will be informed of any **hospital onset healthcare associated** Clostridioides difficile toxin positive results as stipulated within any agreed protocols

Definitions applied to cases reported to the healthcare associated infection data capture system are as follows:

- **hospital onset healthcare associated**: cases that are detected in the hospital two or more days after admission
- **community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks

- **community onset indeterminate association**: cases that occur in the community (or within two 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
- **community onset community associated**: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the Trust reporting the case in the previous 12 weeks.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA and has been assessed as having a low impact.

7. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy (P001).

This policy is also to be shared via:

The Infection Prevention and Control Link Practitioner Network
The Modern Matron Network
The Division Clinical Network

This policy will be disseminated by being placed on the Trust Intranet Policies section and the Infection Prevention and Control section. It will also be shared by the global email communication to all staff.

The principles and procedures within this policy are reflected within the mandatory infection prevention and control training sessions.

8. MONITORING AND AUDIT

Criteria	Minimum Requirements	Evidenced by
1	All cases of CDI will be reported to Public Health England (PHE) in accordance with national mandatory surveillance requirements.	Reported data can be viewed on the PHE website.
2	Patients with CDI will be reviewed by the IPCT to review isolation precautions and monitoring of symptoms.	Case investigation/ RCA/Notes review Datix reports
3	Patients with confirmed CDI will be isolated appropriately.	Case investigation/ RCA/Notes review Quarterly audit of patient placement and isolation facilities and infection risk assessment.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Definitions

Clostridioides difficile is a gram positive organism. It is anaerobic which means that it lives in oxygen free conditions.

Diarrhoea is defined as a stool/faeces loose enough to take the shape of the container used to sample or as types 5-7 on the Bristol stool chart.

***Clostridioides difficile* infection** (CDI) is defined as one episode (or more) of diarrhoea, not attributed to any other cause, (including medicines), where the stool is loose enough to take the shape of the container or is No 5 to 7 on the Bristol Stool Chart and that occurs at the same time as a positive toxin assay and/or endoscopic evidence of pseudomembranous colitis.

References

Department of Health (2015) The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance DH: HMSO Document link

https://www.gov.uk/government/consultations/clostridioides-difficile-infection-guidance-on-management-and-treatment

NHS Standard Contract 2022/23 Minimising *Clostridioides difficile* and Gram-negative bloodstream infections

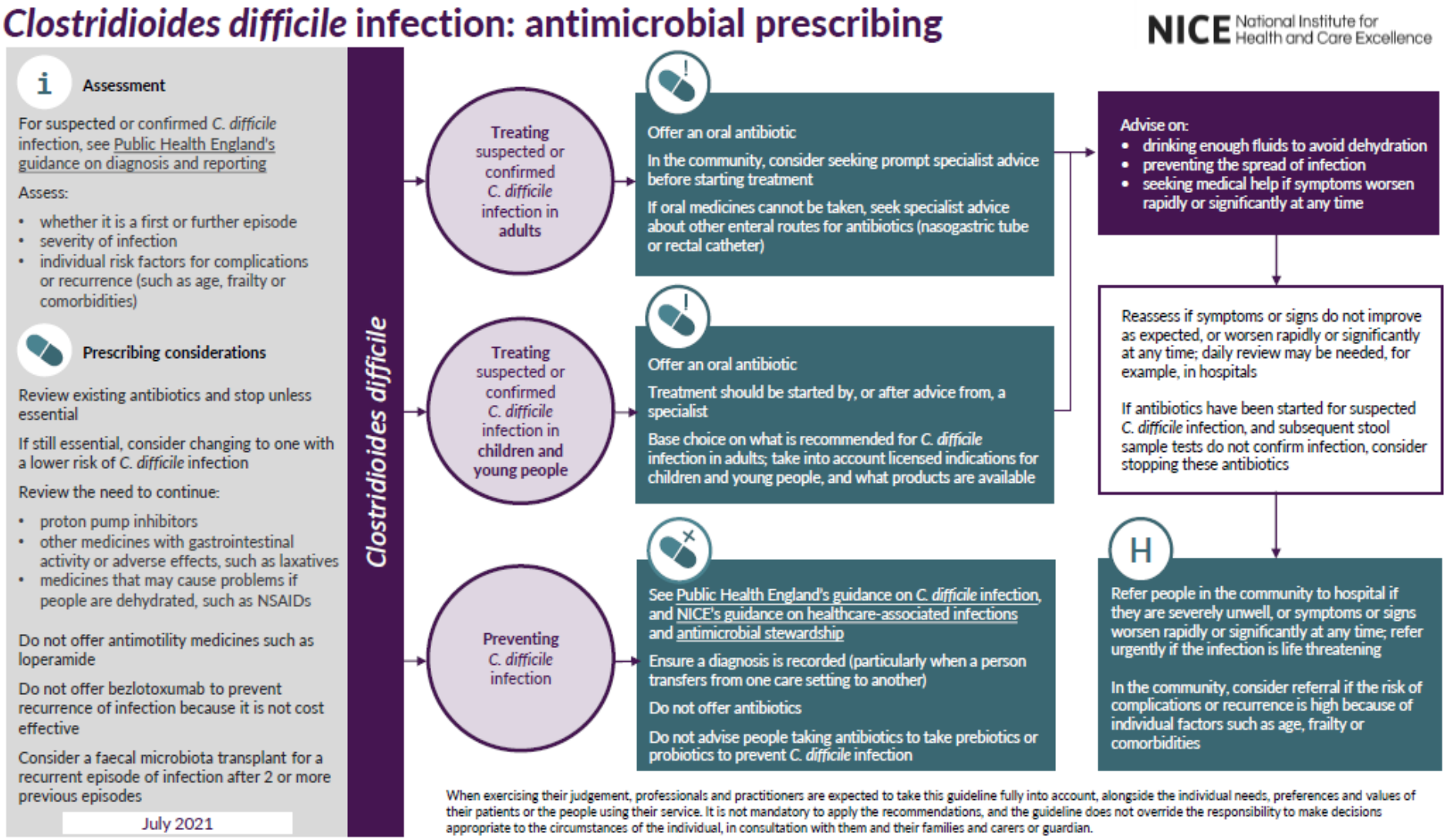
NICE 2021 NICE guideline [NG199] Clostridioides difficile infection: antimicrobial prescribing Overview | Clostridioides difficile infection: antimicrobial prescribing | Guidance | NICE

Public Health England Guidance Collection Clostridioides difficile: guidance, data and analysis

Appendix 1: Bristol Stool Form Definition

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, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

Appendix 2: Clostridioides difficile infection: antimicrobial prescribing



Clostridioides difficile infection: antimicrobial prescribing

NICE National Institute for Health and Care Excellence

Choice of antibiotic for adults aged 18 years and over

Treatment	Antibiotic, dosage and course length
First-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection	Vancomycin: 125 mg orally four times a day for 10 days
Second-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection if vancomycin is ineffective	Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for *C. difficile* infection if first- and second-line antibiotics are ineffective	Seek specialist advice. Specialists may initially offer: Vancomycin: Up to 500 mg orally four times a day for 10 days With our without Metronidazole: 500 mg intravenously three times a day for 10 days
Antibiotic for a further episode of *C. difficile* infection within 12 weeks of symptom resolution (relapse)	Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for a further episode of *C. difficile* infection more than 12 weeks after symptom resolution (recurrence)	Vancomycin: 125 mg orally four times a day for 10 days OR Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for life-threatening *C. difficile* infection	Seek urgent specialist advice, which may include surgery. Antibiotics that specialists may initially offer are: Vancomycin: 500 mg orally four times a day for 10 days With Metronidazole: 500 mg intravenously three times a day for 10 days

See the BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.
See Specialist Pharmacy Service guidance on choosing between oral vancomycin options. If ileus is present, specialists may use vancomycin rectally.
Use clinical judgement to determine whether antibiotic treatment for *C. difficile* infection is ineffective. This is not usually possible to determine until day 7 because diarrhoea may take 1 to 2 weeks to resolve.
There is no agreement on the definition of relapse or recurrence in *C. difficile* infection. For this guideline, 12 weeks was agreed as the cut-off point between relapse and recurrence.

Appendix 3: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name**: Clostridioides difficile Infection Policy (Prevention and Management) (N-010)
2. **EIA Reviewer** (name, job title, base and contact details): **Deborah Davies, Lead Nurse, Infection Prevention & Control**, Trust Headquarters, Mary Seacole Building, Willerby Hill, Beverley Road, Willerby, East Riding of Yorkshire, HU10 6ED
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** Policy

Main Aims of the Document, Process or Service
This policy is aimed to provide guidance for the safe management of any patient suspected or confirmed with a C. difficile infection.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	No adverse impact identified.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	No adverse impact identified.
Sex	Men/Male Women/Female	Low	No adverse impact identified.
Marriage/Civil Partnership		Low	No adverse impact identified.
Pregnancy/ Maternity		Low	No adverse impact identified.
Race	Colour Nationality Ethnic/national origins	Low	For any patient whose first language is not English, as information needs to be provided and understood, staff will follow the trust interpretation policy.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	No adverse impact identified.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Sexual Orientation	Lesbian Gay men Bisexual	Low	No adverse impact identified.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	No adverse impact identified

Summary

Please describe the main points/actions arising from your assessment that supports your decision. None of the equality strands have been identified in the initial impact assessment. The practices/actions recommended in this policy is based upon the potential for cross-infection of a potentially harmful bacteria from one individual to another. Factors for consideration will include microbiological data, extent of symptoms and the potential risk of the spread of infection to others in conjunction with other safety risk factors.	
EIA Reviewer: Deborah Davies	
Date completed: 18 November 2022	Signature: D Davies

Appendix 4: Document Control Sheet:

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	**Policy – Clostridioides difficile Infection Policy (N-010)**		
Document Purpose	The policy is aimed to provide guidance for the safe management of any patient suspected or confirmed with a C. difficile infection. This includes: • The prevention of Clostridioides difficile Infection • The management of any symptomatic patient • The prevention of cross infection to others		
Consultation/ Peer Review:	Date:	Group / Individual	
List in right hand columns consultation groups and dates	November 2022	Healthcare Associated Infection Group	
	December 2022	QPaS	
Approving Committee:	**Governance Committee**	Date of Approval:	March 2016
Ratified at:	Trust Board	Date of Ratification:	April 2016
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	No additional training required	Financial Resource Impact	No additional resources required
Equality Impact Assessment undertaken?	Yes [X]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [X]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [X]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		

Monitoring and Compliance:

Criteria	Minimum Requirements	Evidence by
1	All cases of CDI will be reported to Public Health England (PHE) in accordance with regional mandatory surveillance requirements	Reported data can be viewed on the PHE Website
2	Patients with CDI will be reviewed by the IPCT to review isolation precautions and monitoring of symptoms	Case investigations RCA Notes review Datix reports
3	Patients with confirmed CDI will be isolated appropriately	Case investigation RCA Notes review Quarterly audit of patient placement and isolation facilities and infection risk assessment

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*Review*	*2008*	*New policy*
1.1	*Review*	*Feb 10*	*Adopted from HMH on formation of HFT*
2.0	*Review*	*Dec 10*	*Reviewed*
2.2	*Review*	*Aug 11*	*Changes to reference section*
3.0	*Review*	*April 13*	*Changes to all sections reflecting updated guidance, Trust re-structure, updated documentation and monitoring*
4.0	*Review*	*March 16*	*Changes to reflect Trust restructure and to review updated national guidance on 'The management and treatement of Clostridioides difficile infections' pages*
4.1	*Review*	*April 16*	*Minor changes* *Seciton 5.13 and Section 10 following comments received*
4.2	*Review*	*Jan 18*	*Minor changes* *Amended sections 3,4,5,9 to reflect the current organisational and committee structures.* *Removal of appendix 1 as now embedded in SystemOne and Lorenzo*
4.3	*Review*	*Feb 21*	*Review of policy content* *Minor changes made throughout the document including the replaced name 'Clostridium difficile' with 'Clostridioides difficile' to reflect changes in microbial taxonomy.*
4.4	*Review*	*Dec 22*	*Full review of policy content* *Minor amendments made throughout the document to align with the current Trust structure* *Amends include* • *Nice antibiotic guidance algorhythm included as appendices 2 in alignment with the NICE Clostridioides difficile infection antimicrobial prescribing recommendations.* • *The Trusts Guidance at a Glance document (appendix also amended to reflect these changes.* • *Refence section updated.* *Approved at QPaS December 2022.*