

Appendix 1 – *Clostridioides difficile*

Quick Reference Guide

Term	Definition										
<i>C. difficile</i> basics	Gram-positive, anaerobic, spore-forming, potentially toxigenic bacterium that is the most common infectious cause of diarrhoea.										
<i>C. difficile</i> infection	<i>Clostridioides difficile</i> infection - A patient who has clinical features suggestive of <i>C. difficile</i> infection (diarrhoea, ileus, toxic megacolon), plus Microbiological evidence of toxin (A and/or B) producing <i>C. difficile</i> or Pseudomembranous colitis demonstrated on colonoscopy.										
Risk groups	Factors associated with people at high risk of <i>C. difficile</i> infection include hospitalisation, extensive antibiotic use, multiple co-morbidities, including primary or secondary immunodeficiency, Hirschsprung disease, solid organ transplantation, inflammatory bowel disease, cystic fibrosis proton inhibitor use, presence of a gastrostomy tube and structural or postoperative intestinal disorders.										
<i>C. difficile</i> transmission	Person-to-person spread through the faecal-oral route. Direct and indirect contact where hands, devices, fomites, or the environment may become contaminated also serve as a reservoir for <i>C. difficile</i> spores.										
<i>C. difficile</i> treatment	<i>C. difficile</i> infection is usually treated as per therapeutic guidelines, such as oral metronidazole or oral vancomycin. Alternative treatments are also available for recurrent infection and for children.										
<i>C. difficile</i> testing	Collection of stool specimen which meets the criteria of diarrhoea and takes the shape of the container. Refrigerate if left out for >2.										
<i>C. difficile</i> IPC	PREPARE - Have OMP and convene outbreak control team in an outbreak. READINESS SIGHT protocol on immediate suspicion <table border="1"> <tr> <td>S</td><td>Suspect <i>C. difficile</i> infection for any adult patient who develops diarrhoea with no clear cause, particularly in those who have been prescribed antibiotic or immunosuppressive therapy in the last 12 weeks</td></tr> <tr> <td>I</td><td>Isolate the patient/resident. Consult with the infection prevention and control team where available while determining the cause of the diarrhoea</td></tr> <tr> <td>G</td><td>Apply standard and contact precautions Gloves and aprons must be used for all contacts with the patient/resident and their environment</td></tr> <tr> <td>H</td><td>Hand hygiene with alcohol-based hand rub (ABHR) following glove removal, or soap and water if hands are visibly soiled or when there is a breach in glove integrity, should be carried out as per the Hygiene. HCW should be bare below the elbows.</td></tr> <tr> <td>T</td><td>Test the stool for <i>Clostridium difficile</i> toxin, by sending a specimen immediately</td></tr> </table>	S	Suspect <i>C. difficile</i> infection for any adult patient who develops diarrhoea with no clear cause, particularly in those who have been prescribed antibiotic or immunosuppressive therapy in the last 12 weeks	I	Isolate the patient/resident. Consult with the infection prevention and control team where available while determining the cause of the diarrhoea	G	Apply standard and contact precautions Gloves and aprons must be used for all contacts with the patient/resident and their environment	H	Hand hygiene with alcohol-based hand rub (ABHR) following glove removal, or soap and water if hands are visibly soiled or when there is a breach in glove integrity, should be carried out as per the Hygiene . HCW should be bare below the elbows.	T	Test the stool for <i>Clostridium difficile</i> toxin, by sending a specimen immediately
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	RESPONSE • isolation of cases in a single room with an unshared ensuite • cohort with other <i>C. difficile</i> infection patients based on microbiological confirmation of the cause of diarrhoea • continue standard and contact precautions with strict adherence to the 5 moments of hand hygiene until diarrhoea has ceased for 48 hours • dedicated patient equipment or clean and disinfect equipment and environment between each patient use or encounter • enhanced environmental cleaning and disinfection (daily and on discharge from any clinical zone) • undertake thorough discharge cleaning and disinfection • use ARTG-listed combined detergent and disinfectant products (2-in-1 clean), or ARTG-listed chemical disinfectant that makes specific claims for use against <i>C. difficile</i> (as part of a 2-step clean) • single-use bed pans can be utilised where possible • patient dedicated re-useable bed pans should be reprocessed in the ward washer/disinfector between uses by themselves and cannot be washed with items from other patients. • waste should be discarded as per local procedures • provide information to patients ACSQHC Infection prevention and control resources for consumers • visitors do not need to wear gown and gloves but must perform hand hygiene. Where there is prolonged contact or likely contact with faeces, gloves as a minimum are recommended in conjunction with strict adherence to hand hygiene. Visitors should not visit anyone else in the facility immediately after visiting someone with <i>C. difficile</i>. • alerts will be placed in the ieMR and HBCIS. • surveillance of <i>C. difficile</i> infection in facilities should be undertaken as per the Australian Commission on Safety and Quality in Healthcare: Implementation Guide for Surveillance of <i>C. difficile</i> and the Queensland Health Guideline for Surveillance of Healthcare Associated Infection. Investigate and manage any outbreaks.
	RECOVERY • an outbreak should be declared over when there is no further transmission, and there has been a return to the organisation's baseline <i>C. difficile</i> infection rate • debrief and evaluate the effectiveness of measures in the event of an outbreak or case of <i>C. difficile</i> infection