Leicestershire Partnership NHS Trust

The Management of Patients with Diarrhoea and/or Vomiting Suspected or Confirmed as Infectious

This policy describes the management and procedures for patients who have diarrhoea and/or vomiting that is suspected or confirmed as infectious.
For the management of patients where an increased incident or outbreak of infection is considered, please see the operational ward management policy for the management of patients with an increased incident or outbreak.

Key Words:	Diarrhoea, Vomiting, Norovirus, Clostridium difficile	
Version:	8	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	17 May 2022	
Name of Author:	Claire king, Infection Prevention and Control nurse	
Name of responsible committee:	Infection Prevention and Control Group	
Please state if there is a reason for not publishing on website:	N/A	
Date issued for publication:	May 2022	
Review date:	October 2023	
Expiry date:	1 May 2024	
Target audience:	ALL LPT Staff	
Type of Policy:	Clinical ✓	Non-Clinical
Which Relevant CQC Fundamental Standards?		

Contents

Version Control and Summary of Changes

	Date	Comment
1	December 2006	First copy
2	December 2009	Review. Amended in line with DH guidance
3	February 2011	Added roles and responsibilities, Staff titles updated to reflect management of change
3.1		Harmonised in line with LCRCHS, LPT and LCCHS (Historical organisations)
4	August 2014	Reviewed by the IPC team in line with latest guidance. Incorporated; 'Guidance on undertaking faecal specimens; IPC precautions for patients in their own homes; role specific training for CQC outcomes 4/5/8 Checklist for immediate management of a patient with diarrhoea and/or vomiting. Flowchart for the management of patient with Cdifficile, diarrhoea and/or vomiting in community hospitals. Clinical management of C.difficile in the community including undertaking daily patient assessments, UHL microbiology contacts, Inter-Healthcare Transfer form
5	August 2015	Change of title policy to reflect content, Reviewed policy to ensure correct in in line with latest guidance.
6	March 2019	Review date Changes made to the document include separation of the management of a patient with potential viral causes for the symptoms and CDT management. Source isolation poster reworked Flowchart for the management of patients with symptoms reworked
7	September 2021	Addition to review NSAIDS, ACEI, ARBs, diuretics. Addition of markers of disease severity. Treatment pathway amended – same first line treatment recommended despite mild, moderate or severe disease; use of metronidazole until CDT results back. Addition of advice to reconsider diagnosis and adherence to treatment if loose stools continue at day 10. Updated definition of recurrence to within 12 weeks of previous episode and relapse to 12 weeks after previous episode. Updated treatment of recurrence to include all severities. Addition to use vancomycin if previously used fidaxomicin for a recurrent episode. Addition to send a stool sample for a recurrent episode if 28 days to 12 weeks. Addition of prebiotics and probiotics not recommended. Amended appendix 1 community hospitals to include advanced nurse practitioners Removal of advice to use alcohol sanitizers after hand washing Updated telephone numbers for CCG IPC advice and local authority contact
8	February 2022	Reviewed and updated in line with current nice guidance

Definitions that apply to this policy

Adenovirus	Types 40 and 41 cause gastroenteritis especially in children under the age of two. The virus is transmitted by the faecal-oral route with an incubation period of 3-10 days, and lasts approximately one week. Diarrhoea is more prominent than vomiting or fever, and respiratory symptoms are often present. Long term immunity is acquired in childhood.
Asymptomatic	Having no symptoms of illness or disease
Bristol Stool Chart (BSC)	The Bristol stool chart is a diagnostic medical tool used to classify the form of human faeces into seven categories.
Clostridium *difficile* Infection (CDI)	Clostridium difficile infection (CDI) id due to toxin-producing bacteria that causes a more severe form of antibiotic associated diarrhoea. The disease ranges from mild diarrhoea to severe colon inflammation that can be fatal.
Diarrhoea	Diarrhoea is the increased frequency of passing a loose stool that is either a stool loose enough to take the shape of a container used to sample it or noted on the Bristol Stool Chart (BSC) types 5-7 (appendix 3).
Increased incidence	Where cases of the same infection linked in time or place are greater in number than is considered 'normal' or acceptable for that area.
Infection	The invasion and multiplication of microorganisms such as bacteria, viruses and parasites that are not normally present within the body.
Infectious	A disease or disease causing organism able to be passed from one person, animal or plant to another.
Isolate (isolation)	When a patient is cared for in a separate area or room from others, due to them having an infection that may be detrimental to another patient/person's health.
Norovirus	Norovirus has a small infective dose with an incubation period of 12-48 hours. Peak viral shedding occurs between two to five days. The virus is transmitted by the faecal-oral route or from contaminated surroundings. Symptoms typically exist for one or two days and are usually mild in nature. However for elderly or individuals with pre-existing health conditions they may be more serious in nature, and continue for four to seven days.
Organism	An individual animal, plant or single-celled life form
Outbreak	A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.
Personal Protective Equipment	Specialised clothing or equipment worn by employees for protection against health and safety hazards e.g. single use gloves, aprons, surgical gowns, masks and eye protection.
Rotavirus	This is the most common cause of severe diarrhoea among infants and young children. Immunity develops with each infection, so subsequent infections are less severe; adults are rarely affected. Rotavirus gastroenteritis is characterised by vomiting and watery diarrhoea, ad low-grade fever. The incubation period is around two days. Symptoms often start with vomiting followed by four to eight days of profuse diarrhoea. Rotavirus vaccine is now routinely offered to infants.
Vomiting	The act of ejecting the contents of the stomach through the mouth as a result of involuntary spasms of the stomach or oesophagus
Viral infection	Caused by the presence of a virus in the body.

For further information contact: Infection Prevention and Control Team (0116 2951668)

1.0 Purpose of the policy

The purpose of this policy is to inform all healthcare staff within Leicestershire Partnership Trust (LPT) of the management and actions required in the management of patient/s who experience diarrhoea and/or vomiting which is of a suspected or confirmed infectious nature. Prompt recognition of viral diarrhoea and vomiting will reduce the risk of transmission of infection by reducing the movement of the patient and contacts and therefore preventing cross infection or contamination within the healthcare environment.

The policy for the management of increased incidents should also be consulted, when the cause is considered to be viral in nature.

2.0 Summary and key points

It is imperative that a patient's normal bowel habit, type and frequency is identified and documented when the patient first comes under the care of LPT. Without this documented assessment it is not possible to determine if a patient is passing a stool that is not part of their normal bowel habit.

- There can be non-infectious reasons for a patient to experience diarrhoea and/or vomiting which needs to be eliminated before an assumption is made that it is of an infectious nature.

- It is reasonable to instigate source isolation precautions for a patient whilst this assessment is being undertaken if there is a considered risk of infection however faecal samples must only be sent if an infectious cause is being considered.

- Infectious diarrhoea and vomiting may be due to a wide range of micro-organisms, but the ones most likely to be encountered in healthcare settings are viruses such as Norovirus, and bacteria such as those that cause food poisoning e.g. salmonella, campylobacter and bacteria that produce a toxin such as *Clostridium difficile*.

- It is important that staff can recognise diarrhoea and vomiting that may be of an infectious nature and instigate procedures to reduce spread and transmission as promptly as possible.

NB: If a suspected or confirmed increased incident or outbreak of infection is being considered please refer to the policy for the ward management of an increased incidence or outbreak of infection policy for further information.

3.0 Management of patients with diarrhoea and/or vomiting of a suspected or confirmed infectious nature

Contact the Infection prevention and Control team using 1 of the 3 following methods

- Create an electronic referral in SystmOne
- Leave a message on the answerphone (0116 2951668)
- Via Staffnet https://staffnet.leicspart.nhs.uk/support-services/infection-prevention-control/contact-us/ipcform/

3.1 Initial individual patient management (Viral and Bacterial)

Any patient who is admitted to hospital/inpatient facility with or develops diarrhoea (stool types 5-7) and/or vomiting and under the care of LPT staff must, as a priority, have the following assessed and documented:

- Normal bowel function – frequency and type. This is what is normal for the patient when they are well, it may not necessarily be the bowel function they present with on admission to hospital.
- Assess cause of diarrhoea and/or vomiting including underlying conditions (including previous history of CDI or underlying bowel disease), antibiotics, laxatives, proton pump inhibitors, nutrition/dietary fibre, history of recent travel, any recent anaesthetic or bowel surgery.
- In assessing diarrhoea it is important to determine the duration, frequency, pattern, type (watery; bloody; fatty), odour and severity of symptoms.
- If the onset of diarrhoea and/or vomiting is sudden and the symptoms are not clearly attributable to an underlying condition or therapy, the patient must be isolated. Do not wait for further episodes of diarrhoea and/or vomiting.
- Accurate fluid balance management must be instigated and documented.

Once establishment of new onset acute diarrhoea has been established, application of the acronym "**SIGHT**" (DH 2009) must be instigated;

S	**S**uspect that a case may be infective where there is no clear alternative cause for diarrhoea
I	**I**solate the patient while determining the cause of the diarrhoea
G	**G**loves and aprons must be used for all contacts with the patient and their environment
H	**H**and washing with soap and water should be carried out before and after each contact with the patient and their environment
T	**T**est the stool for infection by sending a specimen immediately, send for Microbiology and/or virology

NB: Faecal samples should only be taken if considering an infectious cause.

3.2 Patients with suspected/confirmed symptomatic Clostridium difficile

The following documentation must be completed and plans commenced;

a) Review of the patient's current medication by the doctor/ANP/Healthcare practitioner (to include):

STOP:
Antibiotics - consult microbiology if antibiotic therapy is still needed for treatment of underlying infection
Proton Pump Inhibitors (PPIs) - consider alternatives if acid suppression required
Laxatives and prokinetic agents e.g. metoclopramide
Anti-motility agents e.g. loperamide

Where possible STOP:
Immunosuppressant therapy/steroids, Opioids

Review:
Nonsteroidal anti-inflammatory drugs (NSAIDs), Angiotensin-converting-enzyme inhibitors (ACEI), Angiotensin receptor blockers (ARBs), Diuretics – may cause problems in dehydration

b) Accurate fluid balance management must be instigated and documented including:

- Fluid balance chart
- Diarrhoea checklist
- Bristol stool chart
- Electrolyte replacement
- Nutrition assessment and requirements
- Management of CDT guidance

c) Obtaining specimens must include the consideration that the patient may have had a previous positive result for CDT:

- Consider contacting the patients GP or referring hospital for further information as samples may be sent outside of LLR's geographical area dependent on the patient's home address.
- Where there is no previous history of CDT and an infectious cause is being considered a faecal specimen should be collected and sent to the microbiology department requesting microscopy, culture and sensitivity (MC&S) and CDT.
- Faecal samples taken on a weekend or bank holiday should be sent the same day, via taxi if necessary, and in an appropriate container. A delay in sending samples could result in a delay in appropriate treatment.
- A patient previously known to have CDT within the last 28 days does not require a further faecal sample to be tested, and must **not** be sent, but they should be treated as if they are positive for CDT. Treatment advice can be obtained from microbiology.
- If condition has not improved from day 28 to 12 weeks since first episode a repeat sample should be considered.
- Clearance and repeat specimens for *Clostridium difficile* toxin are **not** necessary after initial diagnosis.
- A patient with a positive sample for CDT must be managed using the CDT care pathway and the clinical management of CDI for adult patients/service users in the community.
- The Department of Health defines CDI as either mild, moderate, severe or life threatening. A patient diagnosed with CDT, must have clear documentation in the electronic patient records as to the classification the CDT is considered by the clinician in charge to be.

Mild CDI	Not associated with a raised WCC Typically associated with <3 stools of type 5 – 7 on the BSC per day.
Moderate CDI	Associated with a raised WCC that is <15 x 10^9/L Typically associated with 3 – 5 stools on the BSC per day.
Severe CDI (one or more)	Associated with a WCC >15 x 10^9/L **or** Acute rising serum creatinine (i.e. >50% increase above baseline), or Temperature of >38.5°C **or** Evidence of severe colitis (abdominal or radiological signs). The number of stools may be less reliable indicator of severity.
Life-threatening CDI	Includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.

Department of Health

- If a negative sample for CDT is obtained and the patient is still having diarrhoea and/or vomiting of an unknown cause it is important that other causes are considered and investigated.

d) Patient Care and management regarding source isolation precautions

- If a patient is having diarrhoea source isolation precautions must be commenced, they should be moved into a single room wherever possible if not already nursed in one.
- The patient must have an allocated toilet for their sole use; if this is not possible then a risk assessment must be carried out, identifying what processes have been put in place to minimise the risk of cross contamination to other patients.
- A risk assessment must be carried out and clearly documented in the patients care plan where a single room is required but not available.
- Source isolation precautions must be adhered to where a patient is nursed in a bay, with an allocated toilet.
- A commode must not be used at the bedside (as other patients will be eating, drinking and sleeping in this area).
- The infection prevention and control team must be informed of patients requiring source isolation precautions as soon as practicable. The source isolation form (see Appendix 1) must also be completed and displayed outside the patient's single room or bed space.
- Where possible the single room or bay should have a door and this should be kept shut.
- If it is not possible for the door to be kept shut a written risk assessment must be completed and documented in the electronic patient record. This should identify the possible risk of cross infection.
- The patient's charts and electronic record must not be taken into the single room.
- A patient must continue with source isolation precautions until they have been asymptomatic for at least 48 hours and have passed a formed stool or a normal stool for them or following discussion with the infection prevention and control team.

3.3 Patient/s with suspected/confirmed Viral diarrhoea and/or vomiting

a) The following documentation must be completed and plans commenced; Review of the patient's current medication by the doctor/ANP/Healthcare practitioner (to include):

- Current antibiotic treatments
- Laxatives

b) Accurate fluid balance management must be instigated and documented including:

- Fluid balance chart
- Diarrhoea checklist
- Bristol stool chart
- Electrolyte replacement
- Nutrition assessment and requirements

c) Diagnosis of norovirus infection is often made on clinical grounds from their characteristic features. However the infection can be confirmed following testing of a stool sample.

- Obtaining specimens must include a sample specifically for virology as this is not routinely tested.
- Vomit must not be sent to microbiology. If sent it will be discarded and not tested.
- Stool samples must be taken from every patient who has diarrhoea and thought to be infected; If the sample is contaminated with urine it can still be sent.
- Faeces scraped off the sheet or incontinence pad can also be used if unable to obtain a sample from a bedpan/toilet.
- The sample should contain the runniest part of the sample.
- Faecal samples taken on a weekend or bank holiday should be sent the same day, via taxi if necessary, and in an appropriate container. A delay in sending samples until the next working day could result in a delay in appropriate treatment.

d) Patient Care and management regarding source isolation precautions

- Never wait for positive results before implementing infection prevention and control precautions and outbreak control measures. Viral gastroenteritis is most infectious in the early stages.
- If a patient is having diarrhoea they should remain in their bed space and source isolation precautions commenced immediately (irrespective of whether they are in a single room or a bay).
- If the patient is nursed in a bay, source isolation precautions must be undertaken individually with all patients in that bay.
- A toilet must be allocated for the sole use of the patients within the area where source isolation precautions are being undertaken and cleaned between use with Chlor-Clean
- A commode must not be used at the bedside (as other patients will be eating, drinking and sleeping in this area).
- The infection prevention and control team must be informed of patients requiring source

isolation precautions as soon as practicable. The source isolation form (see Appendix 1) must also be completed and displayed outside the patient's single room or bed space.

- Where possible the single room or bay should have a door and this should be kept shut.
- If it is not possible for the door to be kept shut a written risk assessment must be completed and documented in the electronic patient record. This must identify the possible risk of cross infection.
- The patient's charts and electronic patient record must not be taken into the side room.
- A patient must continue with source isolation precautions until they have been asymptomatic for at least 48 hours and have passed a formed stool or a normal stool for them or following discussion with the infection prevention and control team.
- Only the affected bays need to be closed to admissions and the policy for increased incidents referred to.

3.4 Movement of patients

- Symptomatic patients with diarrhoea and/or vomiting must not be transferred to other wards within LPT, except for purposes of isolation or on clinical need.
- For all transfers the Essential Steps Inter-healthcare Transfer Form must be completed and accompany the patient. This decision must be made in consultation with the infection prevention and control team or the on call manager and be based on a clinical assessment of the risk to other patients.
- Visits to other departments must be kept to a minimum. When this is necessary, either for investigation or treatment, prior arrangements must be made with the manager of that department, so that the trust source isolation policy and the trust policy for cleaning and decontamination can be implemented.
- Symptomatic patients should be seen immediately or at the end of the working session. They should only be sent for when the department is ready to see them; they should not be left in the waiting room/ area with other patients.
- If visits to other hospitals are considered necessary the receiving area should be informed of the patient's status in advance.
- Where possible patients should be treated at the end of a session and their waiting time in the department kept to a minimum.
- The patient must be transported via the ambulance service that must also be made aware of the patients' status in advice.
- The patient must not travel with other patients in the same vehicle.
- A full terminal clean must be carried out for every bed area and equipment

An increase in patient throughput and admission to the acute hospitals during the winter period may also put pressure on the availability of beds. In order to support the admission of patients into beds with the most clinical need, during periods of high levels of Norovirus/viral diarrhoea and/or vomiting patients may be discharged after 24 hours of being asymptomatic, but are clinically fit to be transferred.
This 24 hour default position currently is not in line with national policy and must be done with consultation from the IPC team and in conjunction with the service lead/manager and lead nurse for LPT.

3.5 Visiting arrangements

- Patients in source isolation may be visited by family and friends.
- Visitors do not routinely need to wear protective garments
- Advice must be provided by the nursing staff if relatives are involved with direct patient care. They should then wear disposable gloves and aprons, removing them after use and placing them into clinical waste, then wash their hands with soap and water.
- Visitors must be advised not to visit if they are suffering from diarrhoea and vomiting and for 48 hours after their symptoms have ceased.
- In some rare circumstances the ward may be completely closed to visitors.

3.6 Visiting health care staff, volunteers and ad hoc workers

- Non-essential therapy may need to be delayed or suspended for symptomatic patients if they are unwell.
- A risk assessment must be completed to ascertain the risk to other patients if therapy continues.
- Volunteers must report to the nurse in charge for advice and guidelines on what duties they may undertake with regard to symptomatic patients. It is the responsibility of the nurse in charge to ensure the volunteer is aware of any precautions that need to be taken.
- Visitors such as hairdressers, trolley vendors and similar non-essential visitors must not be allowed to restricted areas until the restrictions have been lifted and appropriate cleaning carried out.

3.7 Discharge of patients

- Patients who are symptomatic with diarrhoea and/or vomiting may be considered for discharge to other hospitals, nursing and residential homes.
- This **must** be discussed in advance with the receiving area/carers to ensure that adequate facilities (i.e. ability to provide source isolations precautions) and necessary equipment are available.
- The receiving hospital, nursing or residential home must confirm appropriate arrangements are in place prior to admission. This must be documented in the electronic patient record and discharge documentation.
- In the event that the place of discharge does not have the appropriate facilities to isolate the patient, the transfer then **must be delayed** until the patient has been symptom free for at least 48 hours.
- Symptomatic patients with diarrhoea and/or vomiting can be considered for discharge to their own home if they are deemed to be medically fit and a package of care in place to ensure that the patient is managed safely. This **must** be discussed in advance with the Community Services and family if they are going to be involved in their care or living with them. This must be documented in the electronic patient record and discharge documentation.
- It is the responsibility of the discharging Doctor/Advanced Nurse Practitioner to communicate with the General Practitioners (GP) about symptomatic patients who are being discharged into the care of the community. The GP should also be informed of those patients who have recovered from diarrhoea and/or vomiting but are no longer symptomatic on the discharge letter.

- The infection prevention and control team must be informed of the final decision regarding the discharge of symptomatic patients.

3.8 Transport of symptomatic patients

- A patient who is symptomatic and is to be discharged from a community hospital to another place of care or to their own home, transport arrangements must be planned in advance.
- If planning in advance is not possible due to the patient requiring an emergency transfer then where possible the ambulance crew and receiving hospital must be informed of the patient's symptoms and potential infection risk.
- If the patient is to be transferred by ambulance, the ambulance liaison officer must be advised of the patient's diagnosis and the need for a designated ambulance. The ambulance liaison officer will need to be informed of the source isolation precautions required.
- Patients must not be transferred by taxi or volunteer cars.
- A patient who is discharged and is using personal private transport must be provided with the appropriate equipment (i.e. disposable nitrile gloves, disposable aprons, disposable vomit bowls and continence pads) for the driver, who must be advised of the infection prevention and control precautions necessary in the event of a body fluid spillage.
- The importance of hand decontamination following handling of body fluids and waste must be discussed as well as the importance of hand washing using soap and water at the earliest convenience. Any waste must be double bagged and disposed of as normal household waste.

3.9 Infection prevention and control precautions in a patient's own home

- When visiting patients who are suspected of or have a confirmed vomiting and/or diarrhoeal infection in their own home, a good standard of infection prevention and control precautions must be maintained to prevent carriage of transient organisms between patients.
- All practices identified for caring for a patient in an inpatient area including; hand hygiene, use of personal protective equipment and cleaning of equipment (belonging to LPT) must be adhered to for patients in their own home.

Carers and/or relatives caring for someone with suspected vomiting and/or diarrhoea should be encouraged/advised:

- That (if prescribed) the patient must complete a course of antibiotics even if they feel better
- Encouraging the patient to drink fluids
- To practice good hand hygiene (following removal of gloves and aprons) for example; after using the toilet / changing nappies, after handling rubbish and before and after preparing food and drinks
- To keep all surfaces clean. (With a bleach-based household detergent if the surface will withstand it).
- The importance of washing all bedding, towels and clothing on the hottest cycle the fabric(s) will allow
- Foul linen should not come into contact with ordinary household laundry

Carers and/or relatives caring for someone with positive stool sample/clinical symptoms for *Clostridium difficile* infection must be advised (in addition to the above) on:

- Arrangements need to be in place (e.g. patient/family member, carer, district nurse) to carry out **DAILY** assessment to identify and report worsening symptoms and to alert the patient's General Practitioner on:
    - Temperature – is it raised?
    - Is the abdomen bloated?
    - Is there abdominal pain?
    - Increased frequency and change of stool type (use Bristol Stool Chart and record frequency and type)
    - Hydration and nutritional status

If this advice is given to relatives it is imperative the staff giving the advice ascertain that the relative is able and happy to take on this responsibility, and this must be documented accordingly.

3.10 Staff sickness due to diarrhoea and/or vomiting

- Occupational health must be informed of symptomatic staff. Advice regarding symptomatic staff will be given by occupational health.
- All staff must remain off work until they have been symptom free for 48 hours.

4.0 Training

There is no training requirement identified within this policy.

5.0 Appendices

Clostridioides difficile infection: antimicrobial prescribing

NICE National Institute for Health and Care Excellence

Assessment

For suspected or confirmed *C. difficile* infection, see Public Health England's guidance on diagnosis and reporting

Assess:

- whether it is a first or further episode
- severity of infection
- individual risk factors for complications or recurrence (such as age, frailty or comorbidities)

Prescribing considerations

Review existing antibiotics and stop unless essential

If still essential, consider changing to one with a lower risk of *C. difficile* infection

Review the need to continue:

- proton pump inhibitors
- other medicines with gastrointestinal activity or adverse effects, such as laxatives
- medicines that may cause problems if people are dehydrated, such as NSAIDs

Do not offer antimotility medicines such as loperamide

Do not offer bezlotoxumab to prevent recurrence of infection because it is not cost effective

Consider a faecal microbiota transplant for a recurrent episode of infection after 2 or more previous episodes

July 2021

Clostridioides difficile

Treating suspected or confirmed *C. difficile* infection in **adults**

Offer an oral antibiotic

In the community, consider seeking prompt specialist advice before starting treatment

If oral medicines cannot be taken, seek specialist advice about other enteral routes for antibiotics (nasogastric tube or rectal catheter)

Treating suspected or confirmed *C. difficile* infection in **children and young people**

Offer an oral antibiotic

Treatment should be started by, or after advice from, a specialist

Base choice on what is recommended for *C. difficile* infection in adults; take into account licensed indications for children and young people, and what products are available

Preventing *C. difficile* infection

See Public Health England's guidance on *C. difficile* infection, and NICE's guidance on healthcare-associated infections and antimicrobial stewardship

Ensure a diagnosis is recorded (particularly when a person transfers from one care setting to another)

Do not offer antibiotics

Do not advise people taking antibiotics to take prebiotics or probiotics to prevent *C. difficile* infection

Advise on:

- drinking enough fluids to avoid dehydration
- preventing the spread of infection
- seeking medical help if symptoms worsen rapidly or significantly at any time

Reassess if symptoms or signs do not improve as expected, or worsen rapidly or significantly at any time; daily review may be needed, for example, in hospitals

If antibiotics have been started for suspected *C. difficile* infection, and subsequent stool sample tests do not confirm infection, consider stopping these antibiotics

H

Refer people in the community to hospital if they are severely unwell, or symptoms or signs worsen rapidly or significantly at any time; refer urgently if the infection is life threatening

In the community, consider referral if the risk of complications or recurrence is high because of individual factors such as age, frailty or comorbidities

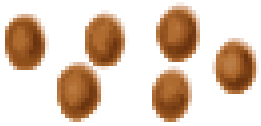
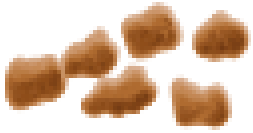
When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

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.

Bristol Stool Chart

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 the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Appendix 3

6.0 References and Associated documents

Ahmed SM, Hall AJ, Robinson AE, et al, Global prevalence of Norovirus in cases of gastroenteritis; a systematic review and meta-analysis. Lance Infectious Diseases 2014; 14, 725 - 730

Daniel J, Cepeda JA, Cameron F, Cloy K, Wishart D, Templeton KE, Epidemiology and costs associated with Norovirus outbreaks in NHS Lothian, Scotland 2007-2009. Journal of Hospital Infection 2011; 79 354-358

Department of Health March 2012. Up-dated Guidance on the Diagnosis and Reporting of Clostridium difficile,

Health and Safety at Work Act 1974

Health and Social Care Act, DH 2008 Updated 2015

Health Protection Agency, Department of Health, 2008 Clostridium difficile infection: How to deal with the problem.

Howell MD, Novack V, Grgurich P, Soullaiard D, Novac L, Pencina M, Talmor D (2010).Iatrogenic gastric acid suppression and the risk of nosocomial Clostridium difficile infection .Arch Intern Med 170:784-90

Leicestershire Partnership Trust 2018, Cleaning and Decontamination. IPC.

Leicestershire Partnership Trust, Hand Hygiene Policy (including Bare Below the Elbows) May 2019. IPC.

Leicestershire Partnership Trust, Management of a Patient requiring source isolation 2018. IPC.

Leicestershire Partnership Trust 2018, Personal Protective Equipment. IPC.

Leicestershire Partnership Trust, Management of Waste 2017. IPC.

National Institute for Health and Care Excellence (NICE) www.nice.org.uk

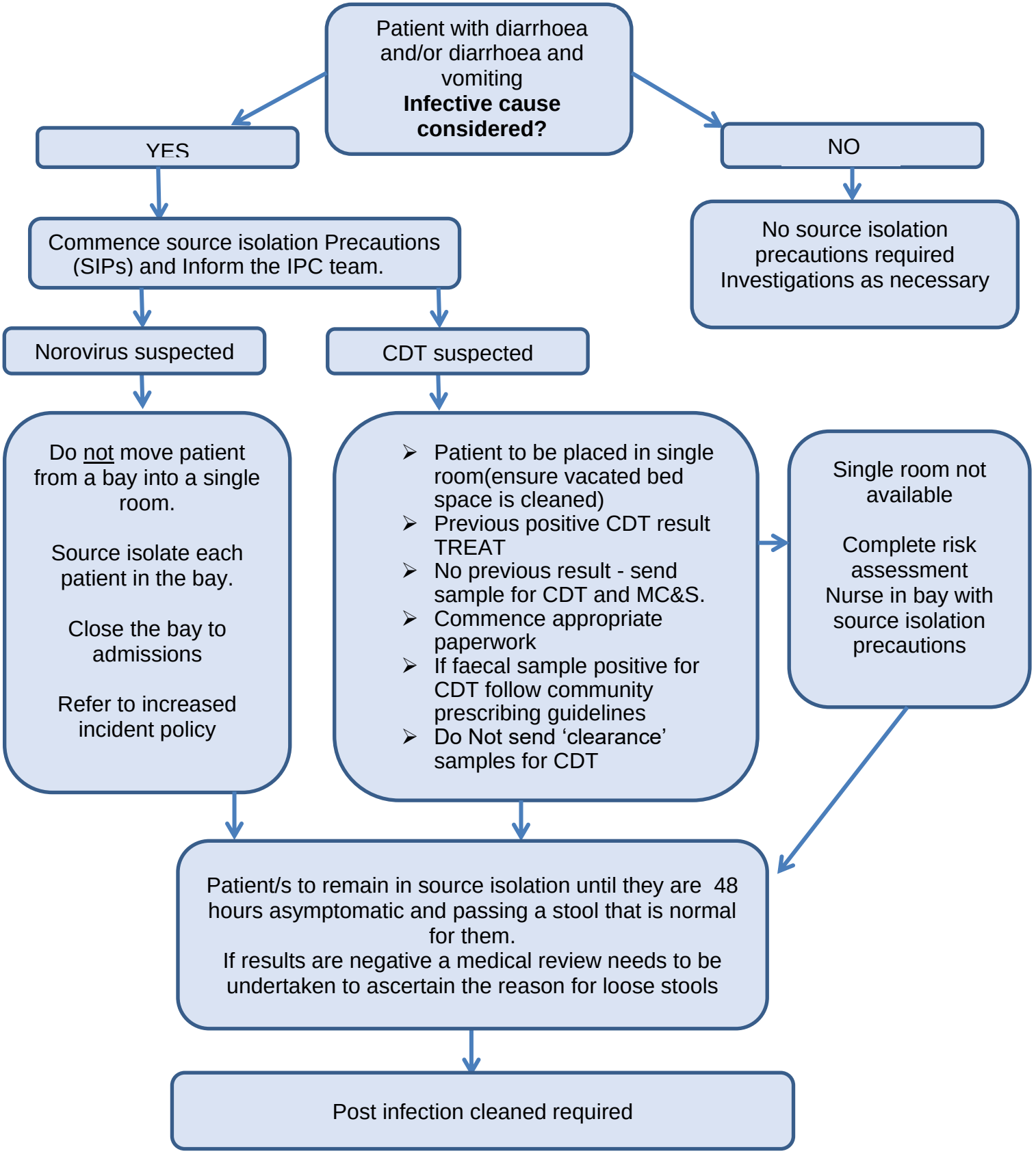
Public Health England. May 2013. Updated guidance on the management and treatment of Clostridium difficile infection.

Royal College of Nursing, 2013. The management of diarrhoea in adults. RCN guidance for staff. London

World Health Organisation: Guidelines on hand Hygiene in Health care – The 5 Moments for Hand Hygiene (2009)

NICE, July 2021. NICE Guideline NG199 Clostridioides difficle infection: antimicrobial prescribing.

Flowchart for the management of Patients with diarrhoea and/or vomiting



Leicestershire Partnership NHS
NHS Trust

SOURCE ISOLATION PRECAUTIONS

TO HELP US PREVENT THE SPREAD OF INFECTIONS

Everyone* entering this room must:

Be “Bare Below the Elbows”

Wash their hands

Wear Gloves

Wear an apron

This applies to all staff entering the room whether or not contact with the patient or environment is anticipated

Please keep the door closed

***Visitors do not need to wear an apron and gloves but must wash their hands prior to entering and leaving the room.**

Please speak to the nurse in charge for further advice

Monitoring Assurance

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
Page 12	Staff adhere to good standard of infection prevention and control precautions to prevent carriage of transient organisms between patients.	Page 12- Hand hygiene audits. Page 12- Personal protective equipment Audits	Hand hygiene audit compliance Personal protective equipment Audits.	Infection Prevention and Control Committee Matron teams	Monthly Monthly
Page 10	A full terminal clean must be carried out for every bed area/equipment following patient discharge/transfer	Page 10- Monthly cleaning audits	Cleaning Audits	Facilities zonal leads	Monthly

Contribution List

Key individuals involved in developing the document

Name	Designation
Amanda Hemsley	Lead Infection Prevention and Control Nurse
Laura Brown Claire King Clarissa Swann Andy Knock	Infection Prevention and Control Team

Circulated to the following individuals for consultation

Name	Designation
Anne Scott	Executive Director of Nursing, AHP's and Quality
Emma Wallis	Associate Director of Nursing and Professional Practice
Claire Armitage	Lead nurse for community AMH
Michelle Churchard	Head of nursing AMH\LD services
Alison O'Donell	Interim head of learning and development
Louise Evans	Deputy head of nursing FYPC\LD
Kam Palin	Occupational health nurse
Tejas Khatau	Lead pharmacist FYPC
Jane Martin	Acting deputy head of nursing DMH
Katie Willetts	Senior nurse, Specialist nursing FYPC
Bernadette Keavney	Head of trust health & safety compliance
Samantha Roost	Senior health, safety and security advisor
Helen Walton	Estates and facilities property manager
Clare Pope	LD modern matron Bradgate unit
Sarah Latham	Deputy head of nursing community hospitals
Elizabeth Compton	Senior Matron AMH Bradgate unit
Carmela Senogles	Acting deputy head of nursing FYPC
Bernadette Williams	Facilities manager