ICT Process for identifying cases of CDI that require Clinical Review (CR)

ICT identifies cases of CDI which are * defined as severe by local clinical team or cited on either part of patient’s death certificate

ICT generates DatixWeb Report *
Report should be sent to the area where the case has been attributed to (HAI) or in the case of non-HAI the area from which the sample has been sent. If the patient is in another ward/area the SCN should be copied into the DatixWeb Report.

Data Team

Include CDI date of report and DatixWeb Report reference number as a table in the Sector/Directorate Monthly Report.

e-mail sent to:
- Sector/Directorate (SCN, Consultant, Chief Nurse, CSM, GM, LN)
- IC SMT
- IC Data Team
- Sector ICD

Sector ICT


e-mail should include:
- Clinical details, DatixWeb ref number and CDI CR Tool. ICT should advise clinical teams to complete CRT fields in the DatixWeb Report.

Continue to monitor all CDI cases until discharged or died.

* Definitions:
A severe case of CDI is defined as any patient with CDI who:
- was admitted to ITU for treatment of CDI or its complications,
- had endoscopic diagnosis of pseudomembranous colitis with or without toxin confirmation,
- had surgery for the complication of CDI (toxin megacolon, perforation or refractory colitis),
- following a diagnosis of CDI where it is recorded as either the primary or contributory factor on the death certificate,
- had persisting CDI where the patient has remained symptomatic and toxin positive despite two courses of appropriate therapy,
- after CDI assessment by clinical staff the episode/case is deemed to be severe.

*NB: When generating a Datix, the ICPT should select:

Category: ‘Infection Control’

Sub-category: ‘Severe Clostridium Difficile Infection’

Do not select ‘other’. 