Guidelines for completion of CDI-CRT (July 2014)

Section	Description
Ward (current)	The ward the patient is in at time of specimen
Date of admission	Date the patient was admitted to the ward the patient is currently in.
Lead Reviewer	Please document the name and title of the patient's consultant who will undertake lead in review
Review team	Please document the names and titles of all those involved in the review of this patient. It should as minimum include the SCN and the lead nurse
Did the patient have significant co morbidities on admission	Please list any medical treatment and or conditions that may have had a significant impact on the severity or the outcome of this incident for example bowel disease.
Was the patient assessed daily for CDI severity markers? (if not carried out, please give reason)	Please document if severity assessment was undertaken every day while patient was symptomatic of diarrhoea. If severity assessment has not been carried out every day as above, please document the reason why.
If patient is a severe case, was treatment reviewed and adjusted as per CDI treatment algorithm?	Yes / No. If no please document reason why not.
Were consultations requested from surgery, gastroenterology and microbiology if appropriate? (if yes, please give detail.)	List consultations to other specialities listed and outcome.
Following review, was anything identified that could have prevented the patient becoming a severe case?	Please list any treatment pathways that could have been taken / avoided which may have prevented the patient becoming a severe case.
Actions to be taken (including person responsible and timescale)	Please document any actions including changes in practice that have been agreed in light of this review, including who will take forward these actions and the timescales for completion.