

*Clostridioides difficile* is a Gram positive, anaerobic, spore forming, toxin producing gastrointestinal bacillus. However, recent studies have shown that *C. difficile* is an emerging pathogen in the paediatric setting, causing a range of illness; from mild diarrhoea to life changing conditions such as pseudo-membranous colitis, toxic megacolon, intestinal perforation and septic shock. It is imperative that clinical judgement is exercised in order that aetiologies are appropriately investigated.

A child (3-16 years of age) has a diagnosis of CDI if they have a stool specimen positive for CD toxin, diarrhoea (Bristol stool chart 5--7) and one or more of the following:

- Significant co-morbidities i.e. haematology/oncology ; gastrointestinal
- Severe GI disease with bloody diarrhoea and an unlikely alternative diagnosis
- Strong clinical suspicion
- Antibiotic therapy in the last 4 weeks (especially ciprofloxacin)

***Daily assessment of severity by clinical team***

If the patient is confirmed as CDI, and while the patient is symptomatic of loose stools, medical staff are required to undertake a daily severity assessment using the assessment tool below. Daily severity assessments should continue until patient has been asymptomatic for more than 48 hours. Severity assessment in paediatric population (3-16 years) Criteria	Yes	No	Score if Yes
Diarrhoea >5 times per day			1
Abdominal pain and discomfort			1
Rising white cell count			1
Raised C-reactive protein			1
Pyrexia >38°C			1
Evidence of pseudo membranous colitis			2
Intensive care unit requirement			2
Total score			

≥ 5 = severe disease

If a patient is assessed as severe the IPCT will:

- refer to the CDI treatment algorithm (paeds)
- Communicate severe cases to the Senior Management Team/ Microbiology and Clinical Team
- IPCT will generate a datix

## **A Clinical Review is required if the patient**

- Has severe or life threatening CDI
- 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 complications of CDI (toxic megacolon, perforation or refractory colitis)
- Died within 30 days following a diagnosis of CDI where it is recorded as either the primary or a major contributory factor on the death certificate
- Had persisting CDI where the patient has remained symptomatic and toxin positive despite two courses of appropriate therapy

## ***Deaths due to CDI (Underlying or Contributing)***

If death certificate records are not available, the lead IPCN will contact the General Manager (GM) for the service, and advise them that the records are not available. The Lead Infection Prevention and Control Doctor (LIPCD), Infection Prevention and Control Manager (IPCM), Associate Nurse Director, Infection Prevention and Control (ANDIPC), Clinical Services Manager (CSM) and Lead Nurse for the area must be informed of all patients who died in hospital who are or who have been positive for CDI during their current admission, and the cause of death if available. If a Datix has not been completed for a severe case one should be completed at this point.

Medical staff completing a death certificate in which CDI is noted (part 1 or 2) should discuss this with the consultant in charge of the patient's clinical care and refer case to the Procurator Fiscals Office. If CDI is placed on part 1, medical staff should inform the CSM and GM for the area.

Medical staff should familiarise themselves with NHSGGC Guidance on the Completion of Medical Certificates of Cause of Death.

The Health Protection Scotland (HPS) Trigger Tool must be completed by the IPCT and Clinical Staff if there are two or more HAI CDI cases in the same ward in a two week period. IPCNs and ward staff will complete the trigger daily until the trigger is no longer in place i.e. one or both patients are no longer symptomatic or have been discharged. The following actions will be taken by the IPCT when a trigger is met:

- Request a terminal clean of the ward at the start of the trigger
- Advise on enhanced IPC precautions to be in place.
- Undertake IPC audit (if not done in last 3 months ) hand hygiene audit
- Ask the antimicrobial pharmacist to review prescribing