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	STANDARD OPERATING PROCEDURE						
The most up-to-date version of this policy can be viewed at the following web page:							
ww	w.nhsggc.scot/hospitals-services/services-a-to-z/infection-preven	www.nhsggc.scot/hospitals-services/services-a-to-z/infection-prevention-and-control					

#### SOP Objective

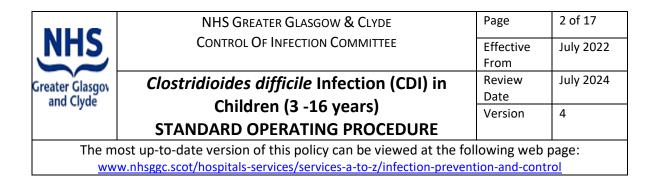
To provide Healthcare Workers (HCW) with details of the care required to prevent crossinfection in children with *Clostridioides difficile* Infection (CDI).

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts and volunteer staff.

## **KEY CHANGES FROM THE PREVIOUS VERSION OF THIS POLICY**

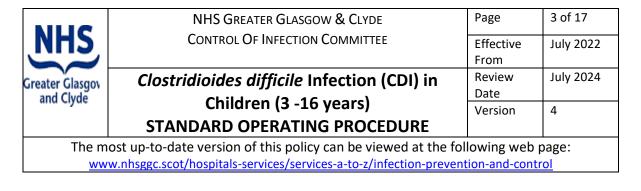
Document Control Summary			
Approved by and date	Board Infection Control Committee 18 <sup>th</sup> August 2022		
Date of Publication	22 <sup>nd</sup> August 2022		
Developed by	Infection Control Policy Sub-Group		
Related Documents	National Infection Prevention and Control Manual		
	NHSGGC SOP CDI (Adults)		
	NHSGGC Hand Hygiene Guidance		
	NHSGGC Outbreak Incident Management Plan		
	NHSGGC SOP Cleaning of Near Patient Equipment		
	NHSGGC SOP Terminal Clean of Ward/Isolation Rooms		
	NHSGGC SOP Twice daily Clean of Isolation Rooms		
	Antimicrobial Prescribing Policies		
Distribution/ Availability	NHSGGC Infection Prevention and Control web page:		
	www.nhsggc.scot/hospitals-services/services-a-to-z/infection-		
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Lead Manager	Director Infection Prevention and Control		
Responsible Director	Executive Director of Nursing		

## **Document Control Summary**

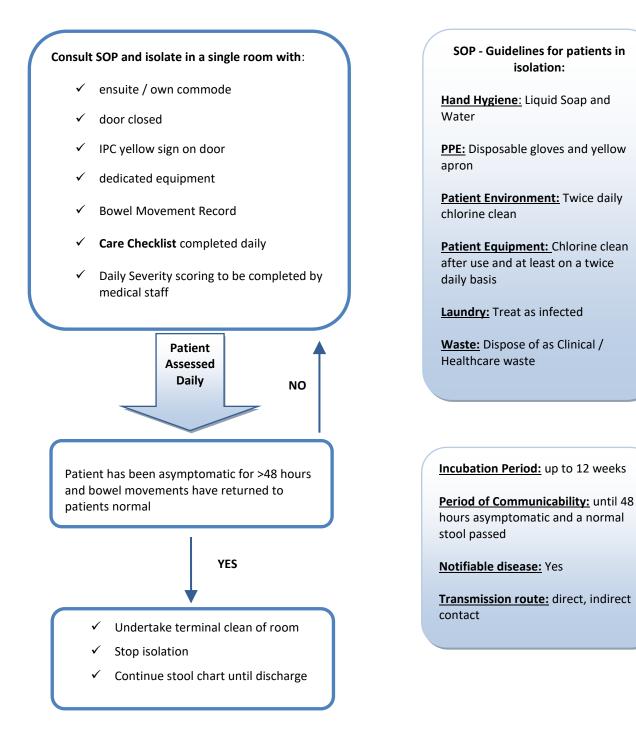


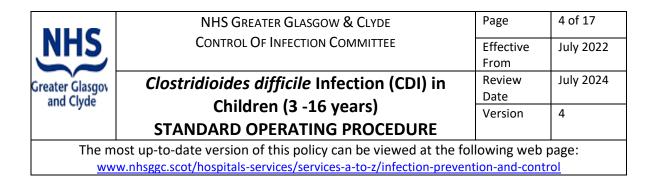
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#### **CDI Paediatric Aide Memoire**





## 1. Responsibilities

## Healthcare Workers (HCWs) must:

• Follow this SOP.

Commence a CDI Care Checklist while patient is symptomatic, update daily and complete the risk assessment for any aspect of transmission based precautions (TBP) for CDI that cannot be implemented

<u>Clostridioides Difficile – IPC Care checklist</u>

- Inform their line manager and a member of the Infection Prevention and Control Team if this SOP cannot be followed.
- Provide written and verbal information on CDI for patients and their relatives as appropriate

**Clostridioides Difficile Fact Sheet** 

## Senior Charge Nurse (SCN) must:

- Ensure that the IPC Care checklist is in place while patient is deemed infectious.
- Ensure that written information is provided / available for patients and relatives.
- Ensure a failure to isolate risk assessment is in place if any aspect of TBPs for CDI cannot be implemented

## Managers must:

- Support HCWs and IPCTs in following this SOP.
- Cascade new SOPs to clinical staff after approval by the Board Infection Control Committee (BICC).

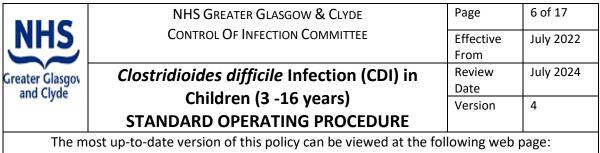
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# Infection Prevention and Control Teams (IPCTs) must:

- Keep this SOP up-to-date.
- Provide education opportunities on this SOP.
- Monitor epidemiology of *Clostridioides difficile* Infection (CDI) within healthcare facility(ies) and advise on infection prevention and control precautions as necessary.
- Advise and support HCWs to undertake a Risk Assessment if unable to follow this SOP.

## **Occupational Health Service (OHS) must:**

• Advise HCW regarding possible infection exposure and return to work issues as necessary

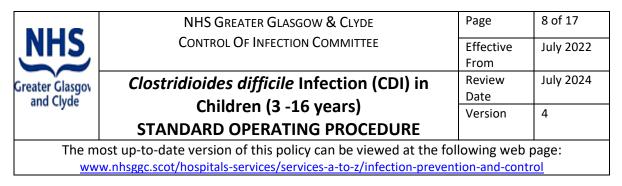


www.nhsggc.scot/hospitals-services/services-a-to-z/infection-prevention-and-control

# 2. General Information on Clostridioides difficile Infection (CDI)

Commission 11 Discont				
Communicable Disease/	Clostridioides difficile is a Gram positive, anaerobic, spore			
Alert Organism	forming, toxin producing gastrointestinal bacillus. 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.			
Case Definition	A child (3-16 years of age) has a diagnosis of CDI if they have			
	a stool specimen positive for CD toxin, diarrhoea (Bowel			
	Movement Record <u>5-7</u> ) and one or more of the following:			
	<ul> <li>Significant co-morbidities i.e. haematology/oncology ;</li> </ul>			
	gastrointestinal			
	<ul> <li>Severe GI disease with bloody diarrhoea and an</li> </ul>			
	unlikely alternative diagnosis			
	Strong clinical suspicion			
	<ul> <li>Antibiotic therapy in the last 4 weeks (especially</li> </ul>			
	ciprofloxacin)			
Case Definition :	Hospital acquired CDI is defined as when a patient has had			
Determination of source	onset of symptoms at least 48 hours following admission to a			
	hospital			
	Healthcare associated CDI is defined as when a patient has			
	had onset of symptoms up to four weeks after discharge			
	from a hospital			
	Indeterminate cases of CDI is defined as a patient who was			
	discharged from a hospital 4–12 weeks before the onset of			
	symptoms.			
	Community associated CDI Is defined as a patient with onset			
	of symptoms while outside a hospital and without discharge			
	from a hospital within the previous 12 weeks – or with onset			

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		spitals-services/services-a-to-z/infection-prevention	-	
		of symptoms within 48 hours following hospital without stay in a hospital with weeks	-	
Mode of Spread		There is evidence of both direct and in the hands of HCWs and patients; and e contamination via equipment and inst commodes, bedpans and washbowls. spores which can survive for long perio Environmental cleaning is paramount.	environmen ruments, e. C. difficile p	tal g. roduces
Incubation I	Period	Potentially up to 12 weeks.		



# 3. Transmission Based Precautions for CDI

Accommodation (Patient Placement)	The patient should be placed in a single room, preferably with ensuite or own commode. The door to the room should be closed when not in use and a yellow IPCT sign placed on the door. If a side room is unavailable the IPCT will help the clinical team to undertake a risk assessment and advise where to nurse the patient.
	Precautions should continue until the patient has been asymptomatic for 48 hours and bowel movements have returned to normal or, on the advice of a member of the IPCT.
Care Checklist available	Yes. CDI Care Checklist
Clinical/ Healthcare Waste	All non-sharps waste should be designated as Healthcare/Clinical Waste (HCW) and placed in an orange clinical waste bag within the room. Please refer to the <u>NHSGCC Waste Management Policy</u>
Contacts	Specimens should not be sent from patients deemed to be contacts unless they develop loose stools, where there is no other cause for this.
Domestic Services/ Facilities	Domestic staff must follow the <u>NHSGGC SOP for Twice Daily</u> <u>Clean of Isolation Rooms</u> Cleans should be undertaken at least four hours apart

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	v.nhsggc.scot/hospitals-services/services-a-to-z/infection-preven	-			
Equipment	Patient equipment, e.g. commode, BP cu allocated to the patient until no longer co Consider single-use or single patient use should be decontaminated after each use detergent, 1,000 ppm, with 10 minute co <u>Twice Daily Clean of Isolation Rooms SOF</u>	onsidered in equipment. e with chlori ontact time.	fectious. Commodes		
Hand Hygier	Alcohol gel hand rub and chlorhexidine against CDI: Soap and water must be with loose stools.				
	prevent cross infection with CDI. Hands decontaminated before and after each after contact with the environment, aft fluids and before any aseptic tasks. Pat encouraged to carry out thorough hand unable to decontaminate their hands th	Hand hygiene is the single most important measure to prevent cross infection with CDI. Hands must be decontaminated before and after each direct patient contact, after contact with the environment, after exposure to body fluids and before any aseptic tasks. Patients should be encouraged to carry out thorough hand hygiene. If a child is unable to decontaminate their hands then hand hygiene should be carried out by a HCW or patient carer for them.			
		Please refer to <u>NHSGGC Hand Hygiene Guidance</u> Visitors should also be instructed to wash their hands with			
ARHAI Trigger Tool	The ARHAI Trigger Tool must be comple Clinical Staff if there are two or more H same ward in a two week period. IPCNs complete the <u>trigger tool checklist</u> daily longer in place i.e. one or both patients symptomatic or have been discharged.	The ARHAI 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 <u>trigger tool checklist</u> 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:			
	<ul> <li>Request a terminal clean of the trigger</li> <li>Advise on enhanced IPC precaut</li> <li>Undertake SIPC's audit hand hypering</li> </ul>	ions to be i giene audit			

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<u>ww</u>	w.nnsggc.scot/no	ospitals-services/services-a-to-z/infection-preven	ntion-and-con	<u>trol</u>	
		Findings will be reported to the SCN ar	nd ward staf	f who	
		should liaise with IPC and pharmacy co	lleagues on	any	
		actions required as a result.			
		Following this, should another case of HAI CDI emerge, the IPCT will complete a PAG to determine the requirement for an IMT and ward closure.			
Linen		Treat used linen as soiled/ infected, i.e soluble bag then a clear plastic bag, tie laundry bag. (Brown bag used in Ment Please refer to <u>National Guidance on t</u> of linen.	d and then al Health ar	into a eas)	
Moving between wards, hospitals and departments (including theatres)		Except in clinical emergencies, transfer they are symptom-free for 48-hours ar normal stool is not advisable.			
		However, acute receiving units have a high patient turnover and transfer of patients is necessary for effective patient flow and to ensure that patients receive the appropriate care within their specialty. Therefore, Receiving areas <b>MUST</b> be informed of the patient's condition <b>before</b> the patient is transferred and the requirement for a single room.			
		Please follow <u>NHSGGC SOP Terminal C</u> <u>Rooms</u>	lean of War	<u>d/Isolation</u>	

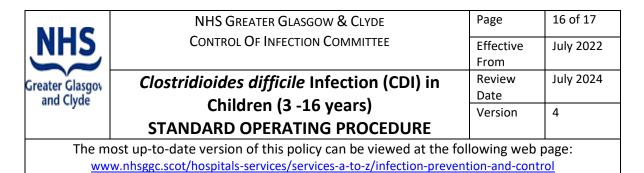
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The mo	-	version of this policy can be viewed at the fo	llowing web	page:	
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Notice for De	oor	The yellow IPC isolation sign must be pl	aced on the	e door to	
		the patient's room.			
Patient Clotl	hina	In Mental Health Services (MHS), on ad			
	iiriy	Whilst patients are very symptomatic to wear hospital gowns.	ney should	De auviseu	
		If relatives or carers wish to take person	nal clothing	home,	
		staff must place clothing into a domest		-	
		then into a patient clothing bag and sta Washing Clothes at Home Patient Infor			
		issued.			
		<b>NB:</b> It should be recorded in the nursing notes that both the			
Dationt Info		advice and information leaflet has been			
Patient Infor	mation	Inform the patient and / or if relevant, the patient's relative/ carer of their condition and the necessary precautions if			
		required. Answer any questions and concerns they may have. A			
		CDI Fact sheet for patients and their relatives is available to			
		download from the IPCT website.			
		<b>NB:</b> It should be recorded in the nursing notes or Care Checklist that the fact sheet has been issued. IPCTs are			
		available to speak to patients or relatives/ carers if required.			
		CDI Fact Sheet			
Personal Pro Equipment (		To prevent spread through direct contact and yellow apron) must be worn for all d	• •	-	
Lquipinent (	FFLJ	patient or the patient's environment/equ			
		If there is a risk of splashing of blood/boo	•		
		protection i.e. mask/visor should also be considered. Hand			
		hygiene must be performed using liquid s donning and after doffing PPE. Alcohol ba	•		
		effective against CDI.			
Precautions	required	Precautions should continue until the p			
until		asymptomatic for 48 hours and bowel movements have returned to the patient's normal or, on advice of a member			
		of the IPCT.	auvice of a	member	
		If symptoms recur, reinstate precaution	ns immediat	ely, send	

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		further specimens and inform a me			
					-1.
Daily and we	eekly check	IPCNs will check daily (Monday -Frida			
by IPCT		patients with CDI until TBPs are no lo	nger requ	uired a	nd
		thereafter weekly for 4 weeks.			
Daily assess	•	If the patient is confirmed as CDI, and			
severity by c	ciinical team	symptomatic of loose stools, medic		•	
		undertake a daily severity assessme	-		
		tool below. Daily severity assessme			
		patient has been asymptomatic for			
		Medical staff should consider the ne	eeu to ta	Ke DIO	ous to
		complete the severity score.			
		Severity assessment in paediatric po	opulatior	า (3-16	years)
		Criteria	Yes I	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
		Raised C-reactive protein Pyrexia >38 C			1 1
		Raised C-reactive proteinPyrexia >38 °CEvidence of pseudo membranous colitis			1 1 2
		Raised C-reactive proteinPyrexia >38 CEvidence of pseudo membranous colitisIntensive care unit requirement			1 1
		Raised C-reactive proteinPyrexia >38 °CEvidence of pseudo membranous colitisIntensive care unit requirementTotal score			1 1 2
		Raised C-reactive proteinPyrexia >38 CEvidence of pseudo membranous colitisIntensive care unit requirement			1 1 2
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease			1 1 2
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the			1 2 2
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a	lgorithm	(paed	1 2 2
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases	lgorithm to the Se	(paed nior	1 1 2 2 s)
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases the         Management Team/ Microb	lgorithm to the Se	(paed nior	1 1 2 2 s)
		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases	lgorithm to the Se	(paed nior	1 1 2 2 s)
Clinical royid		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases f         Management Team/ Microb         • IPCT will generate a datix	lgorithm to the Se biology ar	(paed nior	1 1 2 2 s)
Clinical revie		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases to Management Team/ Microb         • IPCT will generate a datix	lgorithm to the Se biology ar tient:	(paed nior	1 1 2 2
assessment	(CRA) and	Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases f         Management Team/ Microb         • IPCT will generate a datix         A Clinical Review is required if the pa         • Has severe or life threatening	lgorithm to the Se biology ar tient: g CDI	(paed nior nd Clin	1 1 2 2 s) ical Teams
assessment Reporting of		Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases to         Management Team/ Microb         • IPCT will generate a datix         A Clinical Review is required if the pa         • Has severe or life threatening         • Was admitted to ITU for treat	lgorithm to the Se biology ar tient: g CDI	(paed nior nd Clin	1 1 2 2 s) ical Teams
assessment	(CRA) and	Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases f         Management Team/ Microb         • IPCT will generate a datix         A Clinical Review is required if the pa         • Has severe or life threatening         • Was admitted to ITU for treat	Igorithm to the Se biology ar tient: g CDI tment of	(paed nior nd Clin CDI or	1 1 2 2 s) ical Teams
assessment Reporting of	(CRA) and	Raised C-reactive protein         Pyrexia >38 ℃         Evidence of pseudo membranous colitis         Intensive care unit requirement         Total score         ≥ 5 = severe disease         If a patient is assessed as severe the         • refer to the CDI treatment a         • Communicate severe cases to         Management Team/ Microb         • IPCT will generate a datix         A Clinical Review is required if the pa         • Has severe or life threatening         • Was admitted to ITU for treat	lgorithm to the Se piology ar tient: g CDI tment of pseudom	(paed nior nd Clin CDI or	1 1 2 2 s) ical Teams

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<ul> <li>megacolon, perforation or refra</li> <li>Died within 30 days following a is recorded as either the primary factor on the death certificate</li> <li>Had persisting CDI where the pa symptomatic and toxin positive appropriate therapy</li> </ul>			liagnosis of ( or a major c ient has rem	contributory nained
Deaths due t (Underlying Contributing	or	If death occurs then please see the Adult process to be followed. CDI (adult) SOP	: CDI Guideli	ne for the

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Treatment		Mild disease (score 1.2)					
meatment		Mild disease (score 1-2) Mild disease may not require treatment. Consider oral					
		metronidazole for 10-14 days if symptoms persist					
		Moderate disease (score 3-4)					
		Oral metronidazole for 10-14 days.					
		Consider escalation to oral Vancomycin if non resolution of symptoms					
		Severe disease ≥5					
		Oral Vancomycin and iv metronidazole.		-			
		intervention/ colectomy if evidence of	caecal dilata	ation on			
		imaging					
		https://clinicalguidelines.nhsggc.org.uk/paediatrics/infectiou					
		s-disease-paediatric/clostridium-difficile-infection-cdi-in-					
<u>En o cimo no n</u>		children-diagnosis-and-management/					
Specimens r	requirea	Send faecal specimens from any patient who has loose stools that score 5-7 on Bowel Movement Record (Appendix 1) and					
		if no other cause of diarrhoea is known					
		stools persist, another two samples should be sent at 24-					
		hour intervals. Relevant clinical information must be supplied with the specimen.					
		There is no requirement to send clearance specimens from patients who become asymptomatic.					
		Specimens should not be sent whilst patient is on treatment.					
		Only when a relapse of CDI is suspected should you repeat					
		the toxin testing and exclude other potential causes of					
		diarrhoea, and only after 14 days of treatment. Relapse can					
		also occur up to 14 days after therapy has stopped.					
Stool Charts	5	It is the responsibility of staff looking after the patient within					
		the area to record signs and symptoms o					
		appropriate, e.g. Bowel Movement Recor					
		date, time, size and nature of the stool sl					
		while symptomatic and continued until discharge in order to reduce the risk of cross infection.					

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<u></u>	v.misggc.scot/nc	spitals-services/services-a-to-z/infection-prever		.101			
Surveillance		Surveillance of CDI is mandatory in Scotland and is reported to HPS by the Diagnostic Laboratory.					
		Local surveillance in NHSGGC is returned to wards with a prevalence of CDI monthly using Statistical Process Control Charts (SPCs). SPCs are not a substitute for local referral by clinical staff and ICTs but should be used to monitor trends and promote quality improvement.					
Terminal Cle Room	aning of	<ul> <li>Follow SOP for Terminal Clean of Isolation Rooms. If isolation is discontinued and the patient remains in hospital, consider moving the patient to a new bed-space. This will allow the patient's bed, bed locker and bed table to be decontaminated thoroughly. These items can be expected, without cleaning, to remain contaminated.</li> <li><i>NB:</i> relapse and re-infection from the environment can be as high as 20% in patients with CDI.</li> <li>See <u>NHSGGC SOP Terminal Clean of Ward/Isolation Rooms</u></li> </ul>					
Visitors		Visitors are not required to wear aprons and gloves unless participating in patient care. If PPE is worn by patients or visitors it should be removed before leaving the room. Visitors should be advised to decontaminate their hands with liquid soap and water on leaving the room/ patient. Visitors should also be advised not to use communal areas or to sit on beds, while patient is infectious.					



## 4. Evidence Base

Pai S et al. Five years experience of clostridium difficile infection in children at a UK tertiary hospital: proposed criteria for diagnosis and management. PLOS 2012; 71-6

Lees E A et al. The role of Clostridium difficile in the paediatric and neonatal gut — a narrative review. Eur J Clin Microbiol Infect Dis (2016) 35:1047-1057

http://www.nipcm.hps.scot.nhs.uk/

https://www.hps.scot.nhs.uk/web-resources-container/guidance-on-prevention-andcontrol-of-clostridium-difficile -infection-cdi-in-health-and-social-care-settings-inscotland/

	NHS GREATER GLASGOW & CLYDE	Page	17 of 17		
NHS	CONTROL OF INFECTION COMMITTEE	Effective	July 2022		
		From			
Greater Glasgov	Clostridioides difficile Infection (CDI) in	Review	July 2024		
and Clyde		Date			
and Ciyde	Children (3 -16 years)	Version	4		
	STANDARD OPERATING PROCEDURE				
The most up-to-date version of this policy can be viewed at the following web page:					
www.nhsggc.scot/hospitals-services/services-a-to-z/infection-prevention-and-control					

Appendix 1 – Bowel Movement Record (adapted from the Bristol Stool Scale)

#### BOWEL MOVEMENT RECORD

Name:						Month:		Year:		
Name.										
Date	Time	Size S-small M-medium L-large S M L	Type 1 Separate hard lumps like nuts (hard to pass)	Type 2 Sausage shaped bar lumpy	Type 3 Like a sausage but with cracks on surface	Type 4 Like a sausage or snake, smooth and soft	Type 5 Soft blobs with clear- cut edges (passed easily)	Type 6 Fluffy pieces with ragged edges, a mushy stool	Type 7 Watery, no solid pieces (entirely liquid)	Staff Initials
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Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997