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NHS

Community Infection Prevention and Control Policy for General Practice

(also suitable for adoption by other healthcare providers, e.g. Podiatry)

C. difficile

(Clostridioides difficile)

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This Policy has been adopted by:

Organisation: ..... …

Signature: ..... Name: .....

Job title: .....

Adoption date: .....

Review date: .....

Any variation to this Policy should be risk assessed, evidence-based, authorised through local governance channels and documented below. The Community Infection Prevention and Control (IPC) Team, Harrogate and District NHS Foundation Trust, cannot endorse or be held responsible for any variations.

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1. Introduction

Clostridioides difficile (*C. difficile)* is a bacterium which produces spores. *C. difficile* spores are a dormant form of the bacteria that are highly resistant to heat and many disinfectants. The spores can survive in the environment for months and even years and are the main route of transmission following contact and ingestion. *C. difficile* spores are widespread in the environment in the UK, commonly found in soil, water, on produce, and on various surfaces both inside and outside of healthcare settings.

C. difficile is present harmlessly in the gut (bowel) of up to 3% of adults and 66% of babies. However, when the balance of gut bacteria is disturbed, for example, when taking antibiotics, *C. difficile* can multiply rapidly. Some strains of *C. difficile* produce toxins which attack the intestines and causes mild to severe diarrhoea or colitis.

The two major toxins produced are toxins A and B and that are linked to its pathogenicity (ability to cause disease). The presence or absence of these toxins is detected in the Laboratory as part of the *C. difficile* testing process.

In the majority of patients, the illness is mild and a full recovery is usual. Elderly people, often with underlying illnesses may, however, become seriously ill.

C. difficile has been associated with outbreaks in health and social care settings. It is, therefore, imperative that good infection prevention and control measures are instigated so that onward transmission does not occur.

Ensure a diagnosis of *C. difficile* infection is recorded (particularly when a person transfers from one care setting to another). This is so that it can be taken into account before any future antibiotics are prescribed.

2. *C. difficile* conditions

There are two types of *C. difficile* conditions:

C. difficile colonisation:

- When a stool sample is tested in a Laboratory and detects the *C. difficile* bacteria, but there are no toxins being produced, the person is said to be colonised
- *C.* difficile colonisation can be a long-term condition. Staff should be aware that these patients are at high risk of progressing from colonisation to infection
- Specific antibiotic therapy for *C. difficile* may be indicated if the patient is symptomatic and this can be discussed with your local duty Microbiologist

***C. difficile* infection (CDI):**

- *C. difficile* infection means that the bacteria are present and producing toxins, causing symptoms which can be mild to severe, including life-threatening pseudomembranous colitis, toxic megacolon and even perforation of the bowel
- Seek prompt specialist advice from a Microbiologist or infectious diseases specialist before starting treatment

3. Risk factors for *C. difficile*

The risk factors associated with acquiring *C. difficile* are:

- **Age** - incidence is much higher in those aged over 65 years
- **Underlying disease** - those with chronic renal disease, underlying gastrointestinal conditions and oncology patients
- **Antibiotic therapy** - patients who are receiving or who have recently received antibiotic treatment (within 3 months), especially broad-spectrum antibiotics such as cephalosporins, e.g. cefuroxime, quinolones, such as, ciprofloxacin, co-amoxiclav or clindamycin. *C. difficile* has been associated with oral, intramuscular and intravenous routes of administration of antibiotics
- **Recent hospital stay** - patients who are frequently in hospital or who have had a lengthy stay in hospital
- **Bowel surgery** - those who have had bowel surgery
- **Other medication** - patients receiving anti-ulcer medications, including antacids and proton pump inhibitors (PPIs), e.g. omeprazole, which are used for treating reflux (heartburn and indigestion)
- **Nasogastric tubes** - patients undergoing treatments requiring nasogastric tubes
- **Previous history of colonisation or infection with *C. difficile*** - patients are at greater risk of developing *C. difficile* infection (CDI)

4. Signs and symptoms

If a patient has diarrhoea (types 5-7 on the Bristol stool form scale, available to download at www.infectionpreventioncontrol.co.uk/resources/bristol-stool-form-scale-poster/), that is not attributable to underlying causes, e.g. inflammatory colitis, overflow, or therapy, such as, aperients, enteral feeding, then it is necessary to determine if this is due to *C. difficile* infection.

Symptoms include:

- Explosive, foul-smelling watery diarrhoea, which may contain blood and/or mucus
- Abdominal pain and fever due to the toxins causing cell damage
- Dehydration which can be severe due to fluid loss

The symptoms are caused by inflammation (swelling and irritation) of the lining of the bowel and can last from a few days to several weeks. Most people develop symptoms whilst taking antibiotics, however, symptoms can appear up to 10 weeks after finishing a course of antibiotics.

In the majority of patients, the illness is mild and a full recovery is usual. Older patients often with underlying illnesses and CDI may, however, become seriously ill. Occasionally, patients with CDI may develop a severe form of the infection called pseudomembranous colitis which can cause significant damage to the large bowel resulting in perforation, peritonitis and death.

5. Hydration

Fluid loss due to diarrhoea can lead to dehydration. Patients with *C. difficile* should be encouraged to drink plenty of fluids unless medically advised to restrict fluids.

6. Diagnosis

It is difficult to diagnose *C. difficile* just by symptoms alone. Therefore, a diarrhoea sample should be sent to the microbiology laboratory and tested for the presence of *C. difficile.*

7. Routes of transmission

C. difficile produces microscopic spores which are invisible to the naked eye and are passed in diarrhoea.

The main routes of transmission of *C. difficile* spores are:

- Contaminated hands of staff and patients
- Contact with contaminated surfaces or equipment, e.g. toilet flush handles/buttons, toilet assistance rails

8. Prevention of *C. difficile*

The main methods of preventing and reducing transmission of *C. difficile* are:

- Good antimicrobial stewardship following your local ‘Antibiotic Prescribing Policy’
  - Antibiotics should not be prescribed unless necessary
  - Where possible, broad spectrum agents should be substituted by those with a narrower spectrum of activity
  - Courses of antibiotics should be as short as the clinical condition allows

  - Use of antibiotics associated with CDI should be avoided where possible
- Good hand hygiene with liquid soap, warm running water and drying with paper towels. Alcohol handrub should not be used as it is **not** effective at killing *C. difficile* spores
- Appropriate use of personal protective equipment (PPE), e.g. disposable gloves and apron
- Reducing the number of spores in the environment by thorough cleaning and then disinfecting with a sporicidal product

The following mnemonic protocol (SIGHT) should be applied when managing suspected potentially infectious diarrhoea.

Table 1: SIGHT mnemonic (adapted from *Clostridium difficile infection: How to deal with the problem*)

S	**Suspect that a case may be infective where there is no clear alternative cause for diarrhoea**
I	**Isolation. Advise isolating the patient if they are a resident in a care home**
G	**Gloves and aprons must be worn for all contact with the patient and their environment**
H	**Hand washing with liquid soap and warm running water should be carried out before and after each contact with the patient and the patient's environment**
T	**Test the stool for toxin by sending a specimen immediately**

9. Management and treatment

- Review existing antibiotic treatment and stop it unless essential. If an antibiotic is still essential, consider changing to one with a lower risk of causing *C. difficile* infection.
- Anti-motility agents, e.g. Imodium, Lomotil, which are given to stop diarrhoea, should not be prescribed in acute infection.
- Consideration should be given to stopping/reviewing the need for PPIs in patients with or at high risk of *C. difficile* infection (CDI).
- Advice on treatment can be sought from your local Consultant Microbiologist or your local antimicrobial prescribing guidelines.
- Antibiotic treatment for patients who are symptomatic with CDI should be prescribed in line with your local 'Antibiotic Prescribing Policy'.
- In mild cases of CDI, and those where the diarrhoea is settling, antibiotic treatment may not be indicated.

- In cases of *C. difficile* colonisation, antibiotic treatment is not usually indicated.
- The severity of illness should be assessed using the following table.

Table 2: Severity of *C. difficile* infection

Severity of *C. difficile* infection	
1	Mild disease: typically <3 stools per day type 5-7 (on Bristol stool form scale) and a normal white cell count (WCC)
2	Moderate disease: typically 3-5 stools per day type 5-7 and raised WCC (but <15x10^9/L)
3	Severe disease: WCC >15x10^9/L, or a temperature of >38.5ºC or acutely rising serum creatinine (e.g. >50% increase above baseline) or evidence of severe colitis (abdominal symptoms or radiological signs). The number of stools may be less reliable as an indicator of severity
4	Life threatening disease: includes hypotension, partial or complete ileus or toxic megacolon

Recurrence of diarrhoea following treatment

A further episode of *C. difficile* infection could either be a relapse, which is more likely to be with the same *C. difficile* strain, or a recurrence, which is more likely to be with a different *C. difficile* strain. As it is difficult to distinguish between them in clinical practice, accepted definitions that relapse occurs within 12 weeks of previous symptom resolution and recurrence occurs more than 12 weeks after previous symptom resolution.

Recurrence of *C. difficile* occurs in up to 25% of cases after the first episode. This increases to 40-60% after a second and third episode respectively.

If a patient has a further episode, a second course of treatment is usually indicated. It is recommended that prescribing advice be sought from your local Consultant Microbiologist.

10. Infection prevention and control measures

Always use ‘Standard infection control precautions’ (SICPs) and, where required, ‘Transmission based precautions’ (TBPs), refer to the ‘SICPs and TBPs Policy for General Practice’.

Hand hygiene

- Staff should be ‘Bare below the elbows’ whilst on duty.
- Alcohol handrubs do not kill spores, therefore, should **not** be used.
- Hands should be washed with liquid soap and warm running water and dried with paper towels after contact with each patient (and their environment if a home visit is undertaken, including immediately prior to leaving).

Refer to the ‘Hand hygiene Policy for General Practice’.

PPE

- All staff should wear disposable gloves and aprons for all contact with the patient.
- Gloves and apron should be changed between tasks, removed in the room, disposed of as infectious waste and hands washed with liquid soap and warm running water after removing PPE.
- Gloves and apron should be worn if a home visit is undertaken to a symptomatic patient. Gloves should be removed first and hands washed, then apron removed and disposed of in the patient's household waste and hands washed thoroughly.

Refer to the 'PPE Policy for General Practice'.

Cleaning and disinfection

C. difficile spores can survive in the environment for months or possibly years if not adequately cleaned. If a patient who is confirmed to have *C. difficile* and has either had diarrhoea in the last 48 hours, or whilst in the Practice, the immediate environment, e.g. couch, work surfaces, toilet, should be decontaminated.

Cleaning with detergent wipes or general purpose neutral detergent and warm water alone is **insufficient** to destroy *C. difficile* spores. Following cleaning, surfaces must be disinfected with a sporicidal product, e.g. 1,000 parts per million (ppm) chlorine-based disinfectant solution or equivalent product, as per manufacturer's instructions. Alternatively, a combined '2 in 1' detergent and chlorine-based disinfectant product can be used. A fresh solution must be made up to the correct concentration every 24 hours and the solution bottle must be labelled with the date and time of mixing.

Any care equipment required for patient management/care must be cleaned and disinfected using a sporicidal product after use on the patient.

- Cleaning care equipment should be undertaken as per the 'National colour coding scheme for cleaning materials and equipment in General Practice'.

Note:

- Chlorine-based disinfectant solutions may damage soft furnishings, carpets and some equipment. A risk assessment of using such solutions on surfaces should be made and where deemed unsuitable to use, general purpose neutral detergent and warm water, a steam cleaner or carpet cleaning machine, should be used
- Antibacterial surface sprays, including Milton and Flash with bleach, are **not** effective against *C. difficile* spores

- Best practice is to use disposable mops heads when cleaning and disinfecting a contaminated area.
- Mop buckets should be washed after each use with general purpose neutral detergent and warm water and dried with paper towels, then wiped with a sporicidal disinfectant, and stored upside down to air dry in the housekeeping/cleaners equipment store room.
- Any concerns regarding the standard of environmental cleanliness must be reported to the person in charge immediately.

Refer to the 'Safe management of care equipment Policy for General Practice' and the 'Safe management of the care environment Policy for General Practice'.

Advice for symptomatic patients in their own home

- Keep finger nails short and clean.
- Wash hands thoroughly with liquid soap and warm running water, especially after going to the toilet and before preparing or eating food.
- Use a separate towel to dry hands, this should be washed daily. Make sure this is not used by other members of the household or visitors.
- After an episode of diarrhoea, close the toilet seat lid before flushing, this will reduce spread onto surrounding surfaces.
- Clean hard surfaces in toilets/bathrooms, e.g. taps, toilet flush, door handles, soap dispenser, at least daily using household bleach following the directions on the label (generally 1 part bleach to 10 parts cold water).
- To prevent contamination of hands, the sink and surrounding environment, do not rinse soiled linen and clothing by hand.
- Soiled clothing or linen should be washed as soon as possible, separately from other items, on a pre-wash cycle in the washing machine, followed by a wash cycle on the highest temperature advised on the label.
- If possible, have a shower or bath every day as *C. difficile* can be present on other areas of the body.
- Where possible, stay at home until free from diarrhoea for 48 hours and have passed a formed stool, or bowel habit has returned to normal, to prevent spreading it to other people.
- Do not take medicines to stop diarrhoea as this will stop *C. difficile* being cleared from the body, unless prescribed by a doctor.
- Drink plenty of fluids to prevent dehydration unless medically advised to restrict fluids.
- Visitors, including pregnant women and children, are not at risk if they are healthy.
- Once recovered, there is no risk to other people.
- If given a *C. difficile* card, please show it to healthcare professionals. The card lets healthcare professionals know about the *C. difficile* and if treatment with antibiotics is needed in the next 12 months, they will choose a type of antibiotic to help prevent the symptoms of diarrhoea returning.

11. Referral or transfer to another health or social care provider

- Symptomatic patients should not be transferred within or to another health or social care environment until they have had no diarrhoea for 48 hours and passed a formed stool or their bowel habit has returned to their normal type, unless **essential** investigations or treatment is required.

- If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of the patient's *C. difficile* status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate infection prevention and control (IPC) measures to be taken, e.g. transported without other patients, isolated on admission.
- Staff preparing to transfer a patient to another health and social care provider should complete a patient passport or the Inter-health and social care infection control transfer Form (available to download at www.infectionpreventioncontrol.co.uk/resources/inter-health-and-social-care-infection-control-transfer-form/) . This should accompany the patient. Refer to the 'Patient placement and assessment for infection risk Policy for General Practice'.
- SICPs and TBPs should be followed whenever transferring a patient, whether they have a confirmed infection or not.
- The completed transfer documentation should be supplied to the receiving health or social care provider and a copy filed in the patient's notes.
- Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with the 'Safe management of care equipment Policy for General Practice'.

12. *C. difficile* card

Some areas now issue patients who are confirmed CDI or *C. difficile* colonised with a '*C. difficile* card'. The card is provided so the patient can present it at any consultation with a healthcare professional or admission to hospital. This will alert the healthcare worker/admitting unit to the patients' *C. difficile* diagnosis and help support appropriate antibiotic prescribing, if required.

13. Investigation of *C. difficile* infection cases

Your local Community IPC team may use the Patient Safety Incident response Framework (PSIRF) for incidences of *C. difficile* infection for the purpose of learning and improving patient safety. The General Practice may be requested to supply relevant information for this process.

14. Infection Prevention and Control resources, education and training

The Community IPC Team have produced a wide range of innovative educational and IPC resources designed to assist your General Practice in achieving compliance with the *Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance* and CQC registration requirements.

These resources are either free to download from the website or available at a minimal cost covering administration and printing:

- 27 IPC Policy documents for General Practice
- Preventing Infection Workbook: Guidance for General Practice
- IPC CQC assessment preparation Pack for General Practice
- IPC audit tools, posters, leaflets and factsheets
- IPC Bulletin for General Practice Staff

In addition, we hold educational study events in North Yorkshire.

Further information on these high quality evidence-based resources is available at www.infectionpreventioncontrol.co.uk.

15. References

Department of Health and Social Care (Updated December 2022) *Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance*

Department of Health and Social Care and Public Health England (2013) *Prevention and control of infection in care homes – an information resource*

Department of Health (Updated September 2019) *Clostridium difficile infection: How to deal with the problem*

National Institute for Health and Care Excellence (2021) *Clostridioides difficile infection: antimicrobial prescribing NICE guideline 199*

National Institute for Health and Care Excellence (Updated March 2017) *Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139*

NHS England (Updated 2025) *National infection prevention and control manual (NIPCM) for England*

UK Health Security Agency (Updated September 2022) *Clostridioides difficile*: guidance, data and analysis

UK Health Security Agency (May 2025) *Increase in Clostridioides difficile infections (CDI): current epidemiology, data and investigations – technical report*