The Newcastle upon Tyne Hospitals NHS Foundation Trust

Management of Clostridium Difficile Infection (CDI)

Effective Date: December 2011 Review Date: December 2012

1. Aim/Scope

To formulate new Trust guidelines for prevention and management of *Clostridium difficile* infection (CDI) in line with updated DH guidance, December 2008, which takes into account a national framework for clinical governance supported by other good practice advice, such as Saving Lives (DH, 2002d) and recommendations aligned with the Health and Social Care Act (2008) and Code of Practice on the Prevention and Control of Infections and related guidance (DoH 2010), in order to fulfil the Codes' requirements for addressing CDI. The principles of this policy applies to all members of NuTH staff, however staff working in community settings e.g. patients homes will be required to undertake a risk assessment appropriate to that situation/environment.

1.1 *C. difficile*, a gram positive spore-forming anaerobic bacilli, is part of normal flora of human bowels (3% in healthy adults, 16-35% in hospitalised patients). It is the leading identified cause of nosocomial diarrhoea associated with antibiotic therapy, symptoms which range from mild/severe diarrhoea, pseudomembranous colitis to toxic megacolon and fatal colonic perforation.[1, 2]

1.2 The pathogenesis of CDI is multifactorial, involving altered bowel flora due to antibiotic use, production of toxins (Toxins A and B) by overgrown *C. difficile* in susceptible host.

Groups at Risk

• Older patients • Severity of underlying disease • Non surgical gastrointestinal procedures • Presence of naso-gastric tube • Anti-ulcer medications	• Stay on Intensive Care Unit • Duration of hospital stay • Duration of antibiotic course • Administration of multiple antibiotics or multiple courses

1.3 National incidence of CDI has increased in the past decade. The proportion of hospital patients with severe, refractory or recurrent disease as well as cases in the community setting has gone up in recent years.

2. Clinical definitions and laboratory diagnosis

2.1 ***C. difficile* infection:** one episode of diarrhoea, defined either as stool loose enough to take the shape of a container used to sample it or as Bristol Stool

chart types 5-7 (Appendix 1), that is not attributable to any other cause, including medicines, and that occurs at the same time as a positive toxin assay and/or endoscopic evidence of pseudomembranous colitis (PMC).

2.1.1 ***C. difficile* testing in the laboratory:** Stool specimens should be sent for toxin testing following two or more episodes of diarrhoea in accordance with Appendix 5.

2.1.2 Community staff caring for patients in the community setting should carry out an assessment prior to submitting a stool specimen and *if C. difficile* is suspected liaise further with the patients GP.

2.1.3 The HPA *C. difficile* Ribotyping Network for England (CDRNE) should be used to undertake PCR (polymerase chain reaction) ribotyping of all isolates from those patients with severe symptoms or from designated Period of Increased Incidence (PII) and outbreaks. Isolates from sporadic cases will only be further investigated at the request of the Medical Microbiologist.

2.2 **PII** of CDI: two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period on a ward.

2.3 **An outbreak of *C. difficile* infection:** two or more cases caused by the same strain related in time and place over a defined period that is based on the date of onset of the first case.

2.4 In suspected cases of ‘silent’ CDI, such as ileus, toxic megacolon or pseudomembranous colitis without diarrhoea, other diagnostic procedures, such as colonoscopy, white cell count (WCC), serum creatinine and abdominal CT scanning, may be required.

2.5 Do not retest for *C. difficile* toxin (CDT) positive cases if patients are still symptomatic within a period of 28 days unless symptoms resolve and then recur and there is a need to confirm recurrent CDI. Discuss with appropriate medical staff.

2.6 More than one test per patient may be required if the first test is negative if there is a strong clinical suspicion of CDI. Retest a further 2 samples at 24 hours intervals if symptoms persist. If patient remains symptomatic, seek advice from microbiologist. Further tests might be necessary in light of clinical evidence.

2.7 Generally it is not advisable to test children under the age of 2 years in whom toxigenic strains of *C. difficile* and toxins A and B may be present in the absence of symptoms.

2.8 *C. difficile* toxin testing service is available 7 days/week in the Microbiology Department, Freeman Hospital. Appropriate patient ID, clinical details and medication information (antibiotics, proton pump inhibitors (PPI), laxatives or aperients), is essential on the request form.

2.9 Positive and equivocal *C. difficile* results are acted upon by Infection Prevention and Control Team (IPCT), who liaise with the appropriate clinical teams looking after the patient. If the original sample is equivocal and symptoms persist, another stool sample will be necessary.

2.9.1 Positive and equivocal C *difficile* results from patients in the community are sent directly from the laboratory to the patients GP. It is the responsibility of the GP to prescribe the appropriate antibiotics seeking microbiology advice if appropriate.

2.9.2 If following antibiotics the patient's symptoms persist, the GP should seek advice from a microbiologist.

2.9.3 A Rapid Review will be conducted on all patients who are confirmed *C. difficile* positive >72 hours after admission or following contact with Trust acute services in the preceding 28 days. This is to be completed by Matron (or Sister/Charge Nurse) and Doctor involved in the patients care supported by IPCN.

2.9.4 The community IPCT receive notification of positive C *difficile* samples from GP practices for information only. However following notification of a confirmed *C. difficile* sample on a patient < 72 hours after admission, the IPCN will contact the patients GP and request an antibiotic and/or PPI history. This information, if available, will then be forwarded for inclusion in the Rapid Review.

2.9.5 In acute services, Root Cause Analysis (RCA) will be conducted where there is a period of increased incidence (PII) determined by the Infection Prevention and Control Doctor, an outbreak of *C. difficile* infection, serious clinical disease or when identified on Part 1 or Part 2 of the death certificate.

2.9.6 When C. *difficile* is identified on Part 1 or 2 of a death certificate information may be required from the GP to inform the RCA. The community IPCN will contact the relevant GP and request disclosure of any relevant information. The IPCN will then forward this information for inclusion in the RCA.

3. Management and treatment of CDI

Acute Services

Refer to *C. difficile* management pathway (Appendix 2).

- A patient with diarrhoea should be isolated after one episode of Type 5-7 diarrhoea if infective diarrhoea suspected, in line with the Trust's Standard Precautions, Isolation, Waste Management and Procedures and the Used Laundry Management Policies

- Stool specimens should be sent for *C. difficile* toxin testing if the patient has 2 or more episodes of diarrhoea in 24hrs type 5-7 Bristol Stool Chart (Refer to *C. difficile* testing in the laboratory, Section 2.1 and Appendix 5)

- Only Registered Nurses or Doctors can approve stool sample requests. Clinical details must be provided and include current/recent antibiotics, proton pump inhibitors and patient diagnosis

- Do not send stool samples if the patient is on laxatives, aperients or bowel prep. There may be exceptions to this e.g. liver disease and those in critical care areas. In these instances liaise with Microbiologist or the patients clinician

- IPCT will convey positive or equivocal results to the clinical team

- In-patient areas to commence Diarrhoea (Appendix 3) and/or *C. difficile* care pathway (Appendix 4) and document positive/equivocal result

- An alert will be added to eRecord and the patients notes marked with a blue IPC alert sticker and sheet to identify the patient is *C. difficile* positive

- All staff must use disposable gloves and aprons for all contact with the patient/patient's environment, and wash their hands with antiseptic solution and water as per Hand Hygiene Policy

- Visitors need only wear gloves and an apron if directly involved in patient care and wash hands with antiseptic solution and water before and after each patient contact

- Patients should be encouraged to wash their hands before meals and after visiting the toilet

- Alcohol handrub **must not** be used as an alternative to hand washing as it is not effective against *C. difficile* spores. It can be applied **after** washing to rid hands of remaining non-clostridial organisms

- All antibiotics that are clearly not required should be stopped, as should other drugs, e.g. PPI's, that may cause diarrhoea

- Symptomatic patients should not be transferred/discharged to other areas unless exceptional circumstances and following risk assessment in conjunction with IPCT

- The patient should remain isolated until there has been no diarrhoea (types 1-4 on the Bristol Stool Chart, (Appendix 1) for at least 48 hours

- If isolation in a single room is not possible then nursing in a cohort bay or cohort ward may have to be considered in discussion with IPCT

Community Services

- Patients in community settings who are symptomatic should be individually assessed and when required advice sought from the IPCT regarding their management

- All staff must use disposable gloves and aprons for all contact with the patient/patient's environment, and wash their hands with liquid soap and water as per Hand Hygiene policy

- In a patient home where handwashing facilities are unavailable or inadequate, the member of staff must wash their hands with soap and water at the first available opportunity. A moist hand cleansing wipe can be used, but again hands must be washed with soap and water as soon as possible

- When it is known that relatives and carers are in contact or providing care, to a relative/client with C. *difficile,* e.g. with Community staff involved in patient care, they must be informed of the importance of carrying out effective hand hygiene, and the wearing of disposable gloves and aprons to prevent transmission of *C. difficile* spores

- Alcohol handrub **must not** be used as an alternative to hand washing as it is not effective against *C. difficile* spores. It can be applied **after** washing to rid hands of remaining non-clostridial organisms

- Where community staff are involved in patient care who is known to be symptomatic with *C. difficile,* any disposable waste contaminated with infected faecal material must be disposed of in accordance with Clinical waste in Patients Homes (Appendix 6) and District Nursing Service Process for Collection of Clinical Waste from Patient Home (Appendix 7). This would remain the case until patients become asymptomatic

- If a symptomatic patient is receiving clinical care from a member of community staff and becomes acutely unwell requiring admission to an acute hospital, it is the

responsibility of that member of staff to notify the receiving facility of the patients *C. difficile* status to allow for appropriate management

- A patient is asymptomatic once there has been no diarrhoea for at 48 hours and they have formed stool (types 1-4 on the Bristol Stool Chart, Appendix 1)

3.1 Assess the severity of CDI each day or as clinically indicated as follows:

- **Mild CDI** is not associated with a raised WCC; it is typically associated with <3stools of types 5-7 on the Bristol Stool Chart per day

- **Moderate CDI** is associated with a raised WCC that is $<15 \times 10^9$/L; it is typically associated with 3-5 stools per day

- **Severe CDI** is associated with a WCC $>15 \times 10^9$/L, or an acute rising serum creatinine (i.e. >50% increase above baseline), or a temperature of >38.5°C, or evidence of severe colitis (abdominal or radiological signs). The number of stools may be a less reliable indicator of severity

- **Life-threatening CDI** includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease

3.2 The clinical assessment of the patient and appropriate need for senior medical input in addition to possible need for critical care input should be guided by the actions required on the Patient's Observation Chart and MEWS scoring.

Treat according to severity[2]

- **Mild and moderate CDI** – oral metronidazole 400-500 mg tds for 10-14 days

- **Severe CDI** – oral vancomycin 125 mg qds for 10-14 days. In severe CDI cases not responding to oral vancomycin 125 mg qds, high-dosage oral vancomycin (up to 500 mg qds, if necessary administered via a nasogastric tube) +/- intravenous (IV) metronidazole 500 mg tds is recommended. The addition of oral rifampicin (300 mg bd) or IV immunoglobulin (400 mg/kg) may also be considered in discussion with Consultant Microbiologist

- **Life-threatening CDI** – oral vancomycin up to 500 mg qds for 10-14 days via nasogastric tube or rectal installation plus IV metronidazole 500 mg tds. Such patients should be closely monitored, with specialist surgical input (colorectal team) and/or critical care referral, and should have their blood lactate monitored. Colectomy should be considered, especially if caecal dilatation is >10 cm. Colectomy is best performed before blood lactate rises >5 mmol/L, when survival is extremely poor

3.2.1 If diarrhoea persists despite 20 days' treatment but the patient is stable and the daily number of type 5-7 stools has decreased, the WCC is normal, and there is no abdominal pain or distension, the persistent diarrhoea may be due to post-infective irritable bowel syndrome. The patient may be treated with an anti-motility agent such as loperamide 2 mg prn (instead of metronidazole or vancomycin). The patient should be closely observed for evidence of a therapeutic response and to ensure there is no evidence of colonic dilatation.

3.2.2 **For first recurrence,** repeat the same antibiotic used to treat the initial episode (unless the first episode was treated with metronidazole and the recurrence is severe CDI, in which case vancomycin should be used).

3.2.3 **For subsequent recurrences,** use vancomycin 125 mg qds. Consider the alternatives listed in the treatment algorithm in Figure 4.

4. Environmental cleaning and disinfection

Acute Services

Refer to Trust Decontamination of the Patient Environment (including Terminal and Deep Cleaning)

- Environmental cleaning of rooms or bed spaces of *C. difficile* patients should be carried out at least daily using combined detergent/chlorine releasing agent (1,000 ppm available chlorine). All commodes, toilets and bathroom areas of CDI patients should be cleaned after each use combined detergent/chlorine releasing agent (1,000 ppm available chlorine).

- Terminal cleaning of the mattress, bed space, bay or ward area after the discharge, transfer or death of a patient with CDI should be thorough. All areas should be cleaned using combined detergent/chlorine releasing agent (1,000 ppm available chlorine), and the curtains should be changed.

- The ward environment should be clutter free and Trust Policy Decontamination of Healthcare Equipment following Patient Use Prior to Service and/or Repair and the Cleaning and Disinfection Procedure should be adhered to.

Community Services

- Community staff to offer advice to patients/carers/relatives on environmental cleanliness in the home setting. Further advice to be sought from the IPCN's when required. **NB**: Cleaning agents containing chlorine must not be used on patient's furniture or carpets. Any faecal soiling on these items must be cleaned using hot soapy water and disposable cloth.

5. Prevention of CDI through antibiotic prescribing

Refer to Trust's Guide to Antimicrobial Therapy.

- Use narrow-spectrum agents for empirical treatment where appropriate
- Avoid use of clindamycin and second- and third-generation cephalosporins especially in the elderly
- Minimise use of fluoroquinolones, carbapenems and prolonged courses of aminopenicillins
- Restricted broad-spectrum antibiotics should be used when indicated by the patient's clinical condition, and should be reviewed on results of microbiological testing or according to the local sensitivities of causative organisms
- Refer to Trust's Antibiotic Stop/Review Date and Indication Policy. When in doubt seek advice from site Microbiologists
- Education in prudent antibiotic use is undertaken by medical and nursing staff at induction and annual mandatory training using the Trust E Learning tool
- IPC information is available via the Trust Intranet and Internet, additionally; every clinical area has a dedicated IPC information board for visitors and patients. Patient information leaflets are produced via the Patient & Public Involvement Committee and are available across the organisation
- Ensure regular audit of antibiotic use with appropriate feed back

6. C. difficile Surveillance

- All NHS Trusts in England are required to participate in the Department of Health's mandatory CDI reporting system and to report all cases of CDT-positive diarrhoea in patients over 2 years of age
- All samples (hospital and wider community) should be tested for all patients aged 65 years and above and for those aged less than 65 years if this is clinically indicated
- Continuous local surveillance of CDI cases with hospitals or Trusts recording and reporting each month all cases (in all age groups) to directorates, wards and units with analysis of trends and exceptional events. Monthly reports of CDI are included in the Infection Prevention and Control Committee (IPCC) and Trust Board meetings

- Trusts should adhere to the standard definition of a PII and outbreak. The following actions are to be undertaken if a PII is identified on a ward;

    - IPCT to urgently inform the Clinical Director, Matron, Ward Manager and Directorate Manager

    - Following discussion with Site IPC Doctor an incident meeting should be held as determined by the size and rate of growth of the PII by assessment of the situation by the DIPC and/or the duty microbiologist with the Clinical Director and consultants, depending on the number of cases

    - The Ward Manager to conduct a weekly *C. difficile* ward audit. The audit should continue until the weekly score is >90% in three consecutive weeks and there have been no further cases of CDI >48 hours on the ward during the PII. The audit results to be fedback to the Matron/IPCT for dissemination to relevant directorate staff. The IPCT to monitor the ward on a weekly basis for the duration of the PII

    - Carry out a weekly antibiotic review in the ward (using local tools); this is the responsibility of the antimicrobial pharmacist

    - In conjunction with IPCT, review the requirement to deep clean the whole ward with combined detergent/chlorine releasing agent. Emphasise that each bed space needs to be cleaned separately with separate cloths

- Trusts should report all outbreaks as Serious Untoward Incidents (SUIs) to the Strategic Health Authority (SHA) and the Health Protection Agency (HPA) and subject them to a root cause analysis (RCA). This includes all ward closures that are due to diarrhoea shown to be associated with *C. difficile*

- Local surveillance should include the number of patients with severe infection, the number requiring surgery and the number dying where CDI caused or contributed to the death. A regular review should be conducted of deaths within 30 days of diagnosis of CDI to ensure that a common standard of assessment of causation or contribution to death is being applied. All cases will be reviewed at the Trust's Serious Infection Meeting following RCA

7. Coping with increased prevalence

In line with DH guidelines *C. difficile*: how to deal with the problem[2], following points will be brought into practice.

- Regular meetings (minimum weekly), with the IPCT, Clinical Director/Lead Consultant, Matron, Ward Sister/Charge Nurse and Directorate Manager
- Increase the activity of the IPCT
- Review and maximise isolation procedures

- Institute intensive local surveillance
- Optimise ward cleaning and disinfection
- Communicate diagnostic microbiology results as rapidly as possible
- Enhance communications with all parties and staff
- Reduce the movement of patients and staff to an operationally effective minimum
- Movement of patients with diarrhoea both within and between wards will lead to the spread of CDI
- Isolation wards and cohort bays should have minimal contact with uninfected ward areas
- Great care should be given to identify and preventing the movement of beds, commodes, trolleys and other equipment between areas
- Compliance with guidelines should be audited by the IPCT

8. Death certification

Acute Services

If a patient with CDI dies, the death certificate should state whether CDI was part of the sequence of events leading directly to death or whether it was the underlying cause of death. If either case applies CDI should be mentioned in Part 1 of the certificate. The Trust will notify the commissioners at North of Tyne Primary Care Trust as a SUI every death of a patient where *C. difficile* is entered on either Part 1 or Part 2 of the Medical Certificate of Cause of Death (MCCD).

- If CDI is not part of the sequence of events leading directly to death but contributed in some way to it, this should be mentioned in Part 2 of the certificate

- If a doctor is in doubt about the circumstances of death when writing the certificate, they should consult with the Microbiologist or Director of Infection Prevention and Control (DIPC)

9. Monitoring of policy

- *C. difficile* figures are reported monthly to IPCC by the Director of Nursing and Patient Services/Head of Nursing, these are also reported to Trust Board, Health Protection Agency and Directorates on a monthly basis

- In-patient *C. difficile* deaths are reported monthly to Trust Board via the Infection Prevention and Control Scorecard. If *C. difficile* is detailed on the death certificate, this is reported as a serious untoward incident (SUI), by Clinical Governance and Risk Department

- Following a SUI, PII, or an outbreak the Directorate conduct a RCA and produce a directorate owned action plan following the investigation. Progress will be monitored at a Serious Infection Review meeting

- Compliance with isolation practice and environmental cleanliness is monitored on a monthly basis via the Clinical Assurance Tool (CAT). A monthly scorecard is submitted to Trust Board, IPCC and Directorate Managers

- All Rapid Reviews and RCA's are reviewed and a quarterly report is submitted to IPCC

- Monitoring in the community is via the Essential Steps to safe clean care audit programme; quarterly report is submitted to IPCC

10. Appendices

1. Bristol Stool Chart
2. *C. difficile* clinical management pathway
3. Diarrhoea Care Pathway
4. *C. difficile Care* Pathway specimen record (Link)
5. When to send a stool sample for *C. difficile*
6. Clinical Waste in Patients Homes – Model Flow Chart (September 2011)
7. District Nursing Service Process for Collection of Clinical Waste from Patient Home
8. Request for Collection of Clinical Waste from a Patient's Home

Trust policies:
Standard Precautions
Isolation Policy
Guidelines for Skin Care
Transport of Clinical Specimens
Hand Hygiene Policy
Cleaning and Disinfection Procedure
Decontamination of Healthcare Equipment following Patient Use and Prior to Service and/or Repair
Decontamination of the Patient Environment (including Terminal and Deep Cleaning)
Waste Management Policy and Procedures
Used Laundry Management Policy

11. References

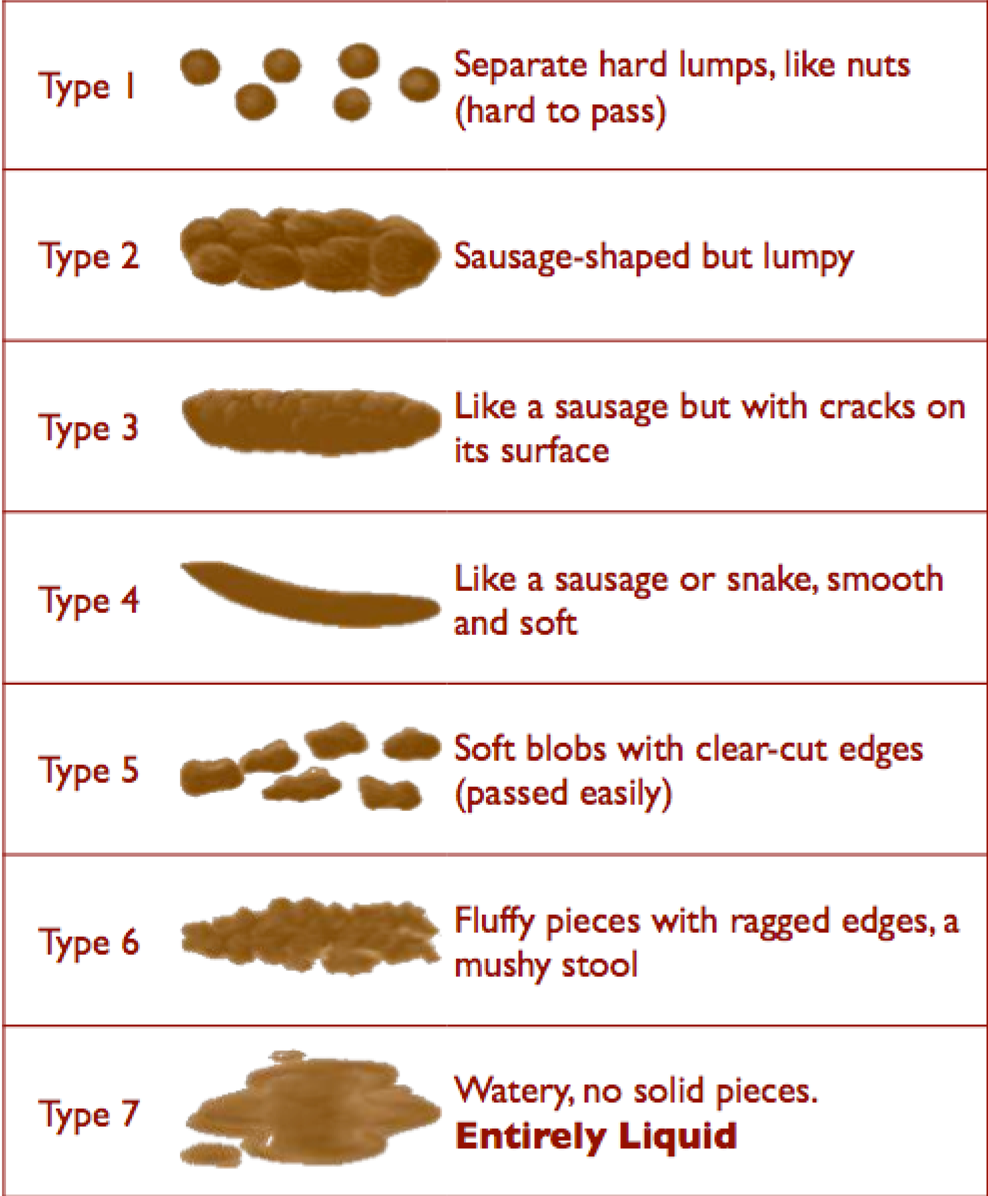
Treatment of C difficile-associated disease: old therapies and new strategies. Aslam S, Hamil RJ, Lancet Infect Dis 2005; vol 5, 509-557

Clostridium difficile infection: How to deal with the problem, DH, December 2008

A good practice guide to control Clostridium difficile: HPA regional microbiology network, Jan 2007

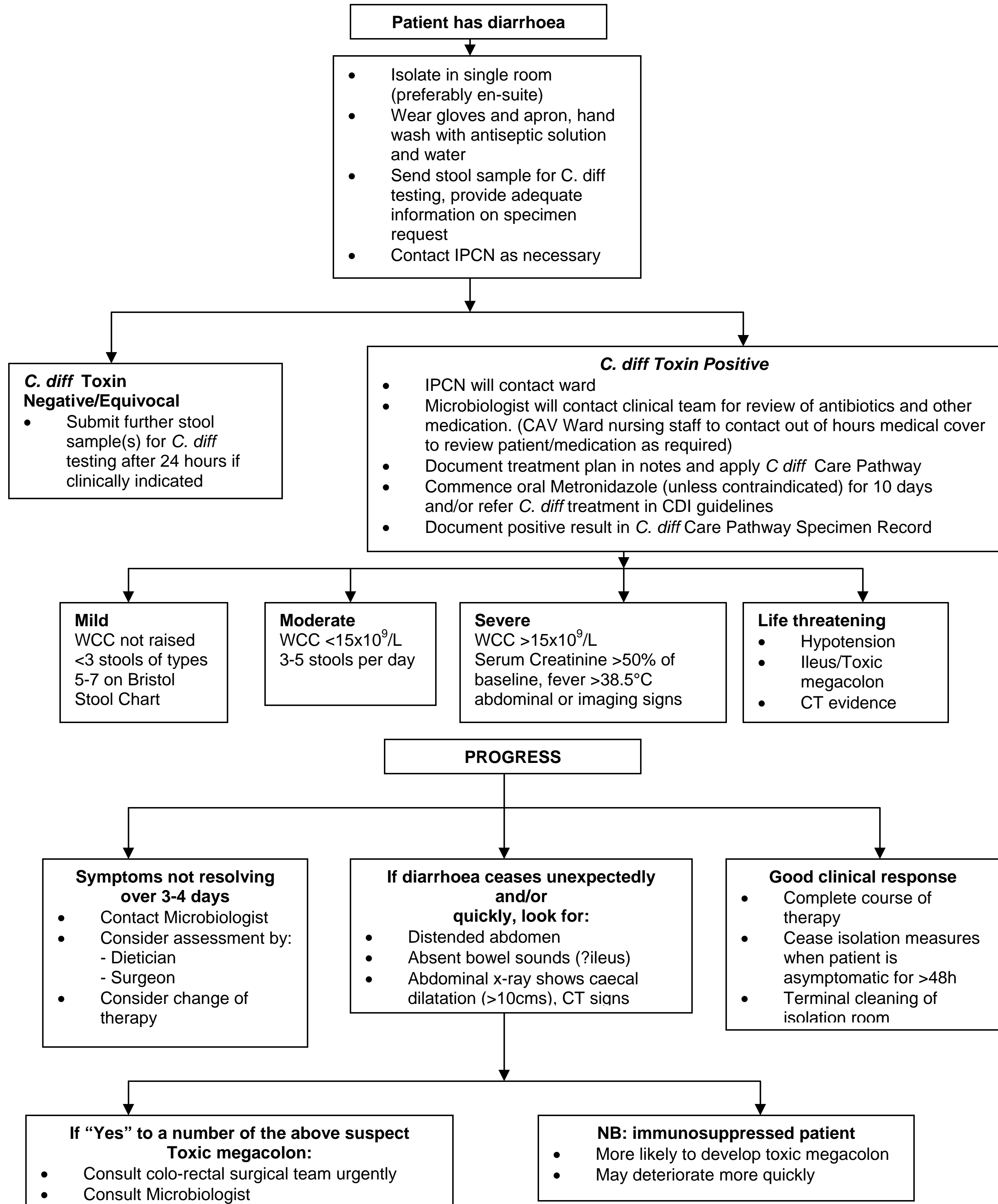
Essential steps to safe clean care. DH 2006

Appendix 1



Appendix 2

Clostridium difficile Clinical Management Pathway



Affix patient identification label in box below or complete details

Surname	Patient i.d.No.
Forename	D.O.B. DDMMYYYY
Address	NHS No.
	Sex. Male / Female
Postcode	

Appendix 3

Care Pathway for a Patient with Diarrhoea

Date: ______________________

Ward: ______________________

Site: ______________________

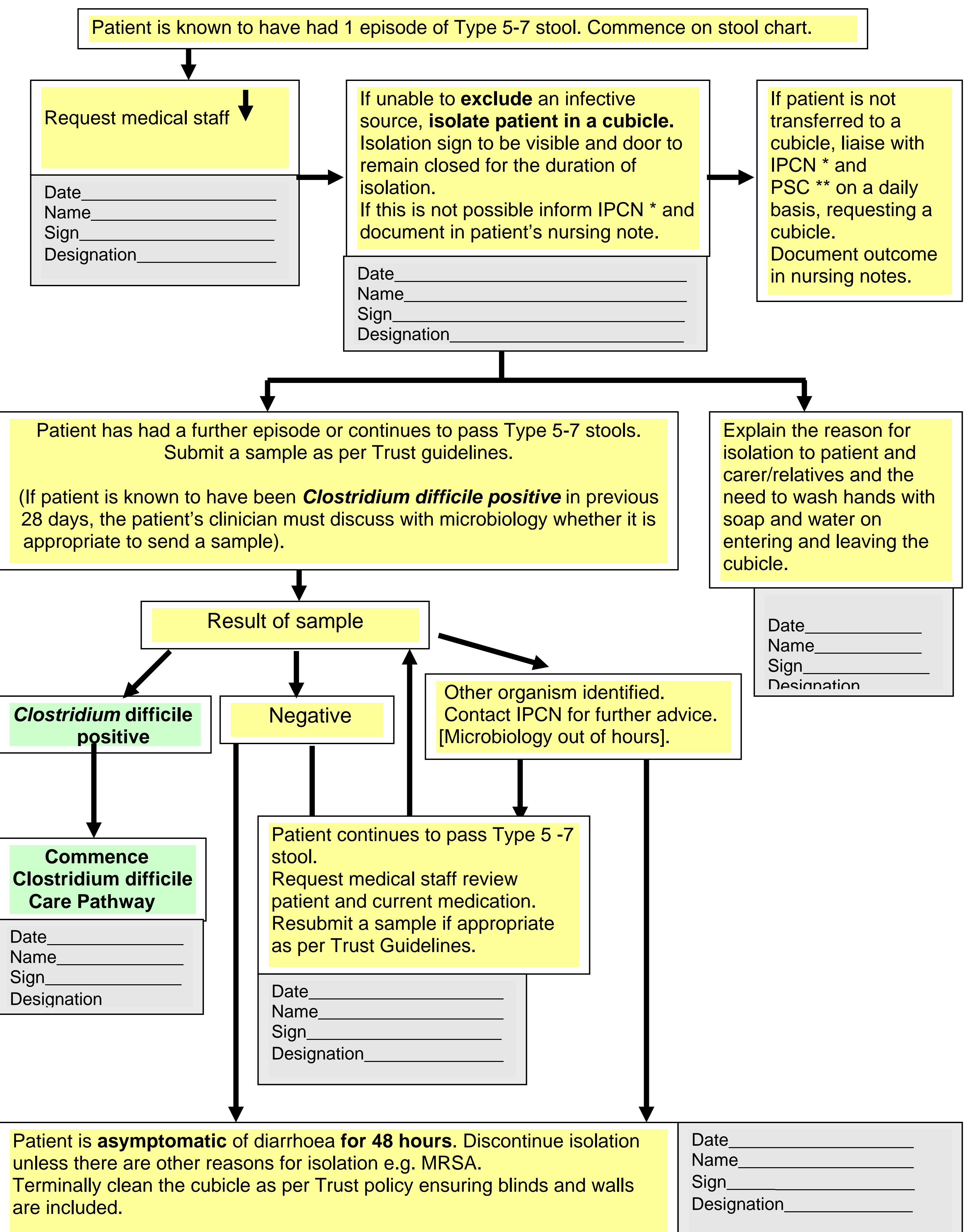
Directorate: ________________

Bristol Stool Chart

Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its 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**

Stool Chart

Date/Time Stool Passed	Type [No 1-7]	Specimen sent Yes/No	Result	Print Name/Signature Designation



Patient is known to have had 1 episode of Type 5-7 stool. Commence on stool chart.
Request medical staff
Date
Name
Sign
Designation
If unable to exclude an infective source, isolate patient in a cubicle.
Isolation sign to be visible and door to remain closed for the duration of isolation.
If this is not possible inform IPCN * and document in patient's nursing note.
Date
Name
Sign
Designation
If patient is not transferred to a cubicle, liaise with IPCN * and PSC ** on a daily basis, requesting a cubicle.
Document outcome in nursing notes.
Patient has had a further episode or continues to pass Type 5-7 stools.
Submit a sample as per Trust guidelines.
(If patient is known to have been Clostridium difficile positive in previous 28 days, the patient's clinician must discuss with microbiology whether it is appropriate to send a sample).
Explain the reason for isolation to patient and carer/relatives and the need to wash hands with soap and water on entering and leaving the cubicle.
Date
Name
Sign
Designation
Result of sample
Clostridium difficile positive
Negative
Other organism identified.
Contact IPCN for further advice.
[Microbiology out of hours].
Commence Clostridium difficile Care Pathway
Date
Name
Sign
Designation
Patient continues to pass Type 5 -7 stool.
Request medical staff review patient and current medication.
Resubmit a sample if appropriate as per Trust Guidelines.
Date
Name
Sign
Designation
Patient is asymptomatic of diarrhoea for 48 hours. Discontinue isolation unless there are other reasons for isolation e.g. MRSA.
Terminally clean the cubicle as per Trust policy ensuring blinds and walls are included.
Date
Name
Sign
Designation

Appendix 4 **C. Diff Care Pathway**

C. diff care pathway *(click link to open pathway)*

Appendix 5

WHEN TO SEND A STOOL SAMPLE FOR CLOSTRIDIUM DIFFICILE

DO NOT SEND STOOL SAMPLE IF:

- **Patient has had only 1 episode of diarrhoea in 24 hrs type 5-7 Bristol Stool Chart**
- **Patient is on laxatives/aperients/bowel prep**
- **The patient has had a positive C. difficile result within the previous 28 days**

DO SEND A STOOL SAMPLE IF:

- **The patient has 2 or more episodes of diarrhoea in 24 hrs type 5-7 Bristol Stool Chart**
- **Original sample was negative but symptoms persist**
- **Original sample was equivocal and symptoms persist**

SUBMISSION OF SAMPLES:

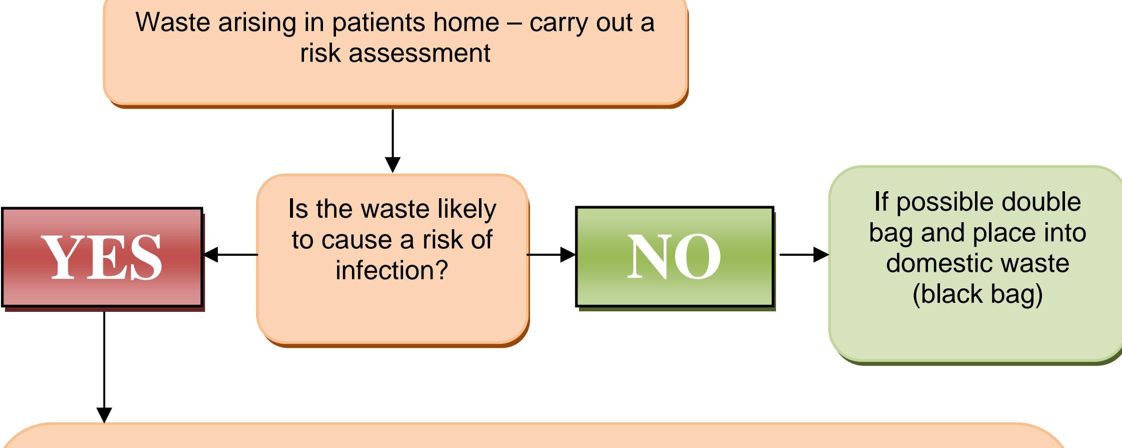
- **Only Registered Nurses/Doctors can approve request**
- **Clinical details MUST be provided and**
    - **include current/recent antibiotics**
    - **include Proton Pump Inhibitors (PPIs)**
    - **patient diagnosis**

If you have any queries regarding sample submission please discuss with Medical Microbiologist

Appendix 6

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Clinical waste in Patients Homes – Model Flow chart



Hazardous Infectious waste (CAT B)

Examples include:-

- Waste containing a significant quantity of blood (e.g. haemodialysis)
- Dressings from infected blood stained wounds (e.g. HIV, Hepatitis B)
- Wound vacuum drains (excluding topical negative pressure)
- Acute gastro intestinal infections (e.g. Clostridium Difficile)
- Heavily exuding infected wounds (e.g. MRSA)

Dispose of as hazardous infected clinical waste (Orange bag) ready for collection

Additional considerations

- Gain prior consent from patient for storage and collection of hazardous infectious waste.
- Ensure safe storage away from children /animals (waste **cannot** be left on the street awaiting collection).
- Bags should be appropriately labelled (date, service and locality) and secured with plastic tag.
- Medicinal waste should be returned to patients pharmacy
- Sharps waste generated by patient and not healthcare worker must go back to patients GP in appropriate sharps box

The health care worker responsible for generating the waste must seek approval from their Cluster Co-ordinator for collection to be undertaken by the **contracted waste supplier.**

Cluster Co-ordinator to send details to contactor who will arrange collection

NB Staff will need to inform their Cluster Co-ordinator once waste collection service no longer required.

District Nursing Service
Process for Collection of Clinical Waste from Patient Home

Process	Responsibility	Timescale
Identify need for collection of clinical waste according to flow chart Appendix 1	District Nurse	
Forward Request Form to Cluster Co-ordinator for authorisation	District Nurse	
Check Request Form + authorise Forward via email to SRCL (sallan@srcl.com, myates@srcl.com, adevlin@srcl.com) Copy to Angie.Drinkald@newcastle-pct.nhs.uk James.Dixon@nuth.nhs.uk	Cluster Co-ordinator	
Input details onto spreadsheet	Admin Team Lead	
Confirmation received SRCL to 'Reply to All' with confirmation	SRCL	
Email District Nurse to confirm service set up	Admin Team Lead	
Forward Spreadsheet to clinical Nurse Lead monthly for audit Copy to James.Dixon@nuth.nhs.uk	Admin Team Lead	
Inform Central Admin when service to cease	District Nurse	As soon as possible when identified
Email SRCL (sallan@srcl.com, myates@srcl.com, adevlin@srcl.com) to cancel service Using standard email memo Copy to James.Dixon@nuth.nhs.uk Copy to cluster co-ordinator for information	Admin Team Lead	As soon as possible when identified

Appendix 8

SRCL Account Number: 9500683

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Newcastle Hospitals Community Health

Request for Collection of Clinical Waste from a Patient's Home

Patient's Name			
Address			
Post Code			
Telephone Number			
Has the waste been risk assessed and findings recorded on patients care plan?	☐ Yes	☐ No	
Has the patient given consent to the waste being stored within their home until collection	☐ Yes	☐ No	
Type of waste	Infectious Clinical (i.e. dressings, swabs)	Medicinally Contaminated	Infectious Clinical Liquid Waste (i.e. wound drains)
	☐	☐	☐
	Orange Bag	Yellow Bag	Rigid Leak Proof Container with Orange Lid
Amount to be collected and Frequency *i.e. 1 bag once a week*			
Date waste collection to commence			
Name of Requestor		**Date**	
Other Comments *(Please include details of access restrictions etc)*			

Once completed forward this form to your Cluster Co-ordinator for authorisation.

Please Note: You must inform your Cluster Co-ordinator when the collection is no longer required.

For Office Use Only:			
Cluster Co-ordinator Name		**Date Authorised**	

Once authorised, Cluster Co-ordinator to email form onto: myates@srcl.com & sallan@srcl.com to arrange collection (copying in james.dixon@nuth.nhs.uk and Admin).

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Policy for Management of Clostridium difficile infection (CDI)	Policy Author:	Dr M Narayanan
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)	No	
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? *(If "yes", please answer sections 4(b) to 4(d)).*	No	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments: Acute and Community Policies merged, undertaken by Louise Hall, Sue Craggs, Sheila Postlethwaite	**Action Plan due (or Not Applicable):**

Name and Designation of Person responsible for completion of this form: Louise Hall, Matron Infection Prevention and Control Date: 6th December 2011 ....

Names & Designations of those involved in the impact assessment screening process: Louise Hall, Matron Infection Prevention and Control ....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.