OHA

Ontario

Public Reporting of *Clostridium difficile* (*C.difficile*)

Frequently Asked Questions

A: Managing *C. difficile* Cases in Hospitals

1. How do you manage the linens in *C. difficile* cases?

While there are no special considerations for the management of linens for *C. difficile* cases, care should be taken in how linens are treated. For instance, linens should not be dragged across the floor unbagged.

2. Do you consider visitor restriction to be a part of outbreak control measures for CDAD?

Visitor restrictions are not usually required in outbreaks of CDAD. Hospitals may wish to consider ensuring that their current visitor policies are being enforced as part of outbreak control measures for CDAD. Policies could include the number of visitors at a time, and ensuring that all visitors follow the necessary infection control precautions while in the hospital.

3. The new Provincial Infectious Disease Advisory Committee (PIDAC) surveillance document states on page 96 that GI illness (diarrhea) including *C. difficile*, salmonella, etc. is defined as two loose bowel movements in 24 hours. However, the best practice document for the management of *C. difficile* states that it is defined as three loose bowel movements in 24 hours. How does PIDAC explain the discrepancy in the definition of diarrhea?

There are issues about counting loose bowel movements in general. There will need to be consensus in the documents moving forward. Two or three loose bowel movements make no difference in terms of the actions you will take. You are to investigate at the onset of diarrhea unexpected for that individual.

4. In terms of a patient with known inflammatory bowel issues, should we continue to monitor for *C. difficile*?

In this case, worse than normal diarrhea would need to be investigated. The statement regarding this on page 10 in the 'PIDAC Best Practices Document for the Management of *Clostridium difficile* in all health care settings' was more a reference that ongoing diarrhea does not need to be continuously monitored. Unexpected change in bowel frequency or consistency (change in diarrhea) should always be investigated.

5. Can you put patients with *C. difficile* together, ie. a patient with toxin A and a patient with toxin B or various stage *C. difficile* patients?

As outlined on page 11 in the 'PIDAC Best Practices Document for the Management of *Clostridium difficile* in all health care settings,' your first choice would be to have patients in a single room with their own toilet. However, if you have several confirmed cases, you can cohort known symptomatic cases. Cases should not be cohorted until there is laboratory confirmation that they are *C. difficile* toxin positive. It does not matter if they are toxin A or toxin B.

B: Treating *C. difficile* Cases in Hospitals

6. What are your feeling about the use of probiotics and also separately proton pump inhibitors in the acquisition of CDAD?

Probiotics still have not been shown to play a significant role and the proton pump inhibitor issue still remains quite controversial.

C: Public Reporting Process and Requirements

7. When looking at baseline rates - an increase in baseline may be hospital wide and one may not see large numbers of cases on specific units. Only retrospectively may it become apparent that you have a hospital wide outbreak.

Once facilities begin to collect their data on a daily basis, hospital incidence and clusters may become evident quickly. It is recommended that facilities review their *C. difficile* infection cases regularly and calculate their rates monthly. If there were a high suspicion that rates are climbing above baseline then it would be prudent to carry out a preliminary calculation of rates and not wait for month end.

8. Is it likely or possible that infection rates for *C. difficile* will vary from hospital to hospital depending on the type of patients served by the hospital?

Rates may vary. For example, if there are large regional cancer centers attached to facility, there might be elevated rates of *C. difficile*. You must know your baseline rates, as well as how your hospital compares to similar hospitals. You will then be able to identify when rates are rising. It is useful to stratify unique settings by size and risk. It is important to know your own baseline before you go beyond your four walls.

9. With respect to data collection of *C. difficile* patients, is data to be collected on acute patients or both acute and chronic patients?

Data (numerator and denominator) must be collected on all patients (e.g., acute, chronic, and other relevant denominator indicators such as institutional source), with the exception of patients under 1 year of age.

10. Please confirm if patient days are census days OR discharge days based on separations.

Patient days should be based on census days.

11. Does denominator data collection (patient days for the month) include mental health and rehab patient days?

Yes. Children under one year should be excluded from the numerator and denominator data. All other patients (e.g., acute, chronic, rehab, mental health) should be included.

12. What is your definition of infant days?

Infants are defined as being less than one year of age.

13. For free standing paediatric centres, infant patient days can't be totally excluded so the rates will be diluted. Will this be considered when rates are reported?

Only patients less than one year of age should be excluded from the numerator and denominator.

14. Since there is an established link between antibiotics and CDAD, why not exclude patients not on antibiotics when calculating patient days?

There is sometimes a time delay between antibiotics being discontinued and onset of symptoms. Although antibiotics may be the most common risk factor, they are not the only risk factor. Other risk factors include chemotherapy, bowel surgery, etc. Patients who are not on antibiotics are still at risk and need to be counted.