Clinical audit of *Clostridium difficile* management

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Aims

Clostridium difficile is a serious and highly infectious colitis, often occurring as a complication in frail elderly patients in hospital and across the community. In recent decades the incidence and mortality rates from *C difficile* have increased, due to both virulence factors and widespread use of broad-spectrum antibiotics. There is strong evidence that good clinical care of these patients reduces morbidity, mortality and helps to limit cross-infection. In accordance with the National Institute of Health and Care Excellence and Public Health England standards, we carried out an audit to assess the clinical care of these patients on our medical wards.

Methods

An audit pro forma for data collection was developed, based on established standards. Thirty confirmed *C difficile* cases over a 1-year period were identified from our laboratory database and reviewed retrospectively. We developed a management pro forma to prompt good documentation and support high standards of care. A hospital-wide screensaver was designed to raise awareness, and a knowledge quiz disseminated to improve understanding among clinical staff. Eleven cases over the following 9 months were audited, using the same methods.

Results

See Table 1.

Table 1. Summary of results

Standard	First cycle	Second cycle
Stool sample sent in <72 hours	73%	88%
Daily stool chart completed	33%	100%
Severity calculated	30%	82%
Appropriate antibiotics given	10%	100%
High-risk antibiotics reviewed	47%	91%
Antimotility agents stopped	27%	73%
NSAIDs reviewed/stopped	77%	100%
PPI reviewed/stopped	60%	100%
Hydration status reviewed	23%	100%
Electrolyte status monitored	33%	91%
Gastro review	57%	73%
Dietician review	57%	82%

NSAIDs = non-steroidal anti-inflammatory drugs; PPI = proton pump inhibitor.

Conclusion

We identified in our first audit cycle that *C difficile* management did not meet recommended standards. We implemented measures that aimed to improve knowledge, prompt excellent care and aid documentation. Re-audit demonstrated an improvement in adherence to all standards. A reduced number of cases could potentially have been associated with lower levels of cross-infection. This work has been presented at local and regional forums to disseminate knowledge. The clinical pro forma has been accepted as trust documentation and incorporated into local guidelines, accessible via the intranet. We now look to make this a sustainable change, by identifying a team to continue assessing the impact of this work. ■

Conflict of interest statement

None declared.

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