Clostridium difficile Infection (CDI) Surveillance

CDI case definition

A CDI episode is defined as a laboratory confirmed C. *difficile* infection. Diagnosis is by a PCR-based toxin test on faeces from a symptomatic patient. Record only positive results from **diarrhoeal** stools, i.e. do not report positive results from screening specimens or asymptomatic patients.

Inclusions

- Cases from all patients attending an acute care facility while symptomatic (including inpatients, HITH patients and patients attending Emergency departments, outpatient departments or haemodialysis units etc.).

Exclusions

- Cases where a known previous positive specimen has been reported within the previous 8 weeks (an isolate obtained from a patient more than 8 weeks since the last positive test is regarded as a new episode)
- Patients less than 2 years old at date of attendance/admission.

CDI exposure classification

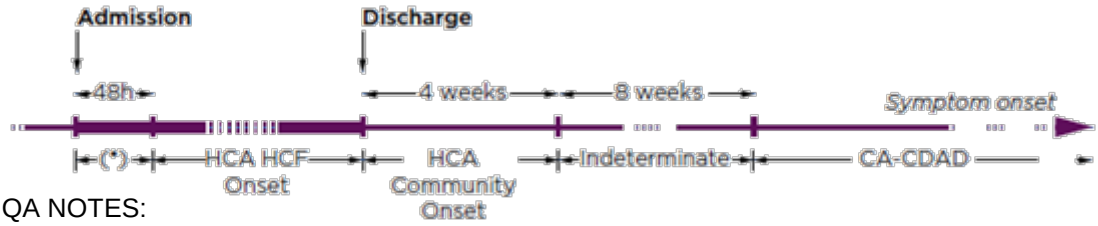
Currently the national data collection for CDI only includes those episodes that are first identified in a specimen collected in an acute care facility. However, the Australian Commission for Safety and Quality in Health Care has developed an Implementation Guide for CDI surveillance that describes sub-categorisation of episodes according to their most likely place of acquisition into 5 separate categories. Available from: http://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/national-hai-surveillance-initiative/ .

At the present time, South Australian contributors are requested to only apply the Category A (HCA-HCF) exposure classification (see Figure 1 below) as a sub-set of Hospital identified.

Category A: Healthcare associated – Healthcare facility onset (HCA-HCF)

Date of CDI symptom onset more than 48 hours after admission to a health care facility and prior to discharge from the facility. If date of symptom onset is not available, the date/time of specimen collection is used as a proxy.

Figure 1



QA NOTES:

- Outpatient and Emergency records – Attendance date should match specimen/symptom onset date*
- Category A records – ensure reported specimen/onset date is > 48hrs after admission.
- Specimen/onset date must be between admission and discharge dates

**Sources for identifying onset date may include (but are not limited to) medical notes, lab request date, specimen request form or the patient.*

Data Element Table

Field Name	Description	Details
UR or Postcode	Unique record identification number	• This is the patient's medical record number (MRN) or postcode for Private hospitals that do not supply MRN • Mandatory field, cannot be null
Gender	Sex of the patient	• Mandatory field, cannot be null
Date of Birth	The patients full year of birth, including day and month	• If date of birth is not known or cannot be provided, provision of a generic estimate is acceptable (the first day of the appropriate month or 01/01/ of the appropriate year • Format date as dd/mm/yyyy • Mandatory field, cannot be null
Date of Admission / Attendance	The date the patient attended the Emergency or Outpatient Dept or date the patient was admitted	• Format date as dd/mm/yyyy • Mandatory field, cannot be null
Attendance Type	Identifies if the type of hospital attendance/admission	• Permissible values: Inpatient, Outpatient or Emergency • Mandatory field, cannot be null
Ward	The ward where patient was located at time specimen was collected.	• This is NOT the acquisition ward , only the ward at the time the specimen was taken • Field should not be Null if *"Attendance Type"* = Inpatient
Specimen/Onset Date[#]	Identifies the date of symptom onset or the date the specimen was taken	• Format date as dd/mm/yyyy • Must be within the reporting month • Mandatory field, cannot be null
LAB Name	Identifies the laboratory organisation that processed the specimen	• Mandatory field, cannot be null
Specimen Number	Positive specimen's unique identification number	• Identifier allocated by the laboratory to the pathology result • Mandatory field, cannot be null
Category	Identifies record as healthcare associated where applicable	• Permissible values: Cat A or N/A • Field should not be null
Comment	Record any relevant additional information	

NOTE:

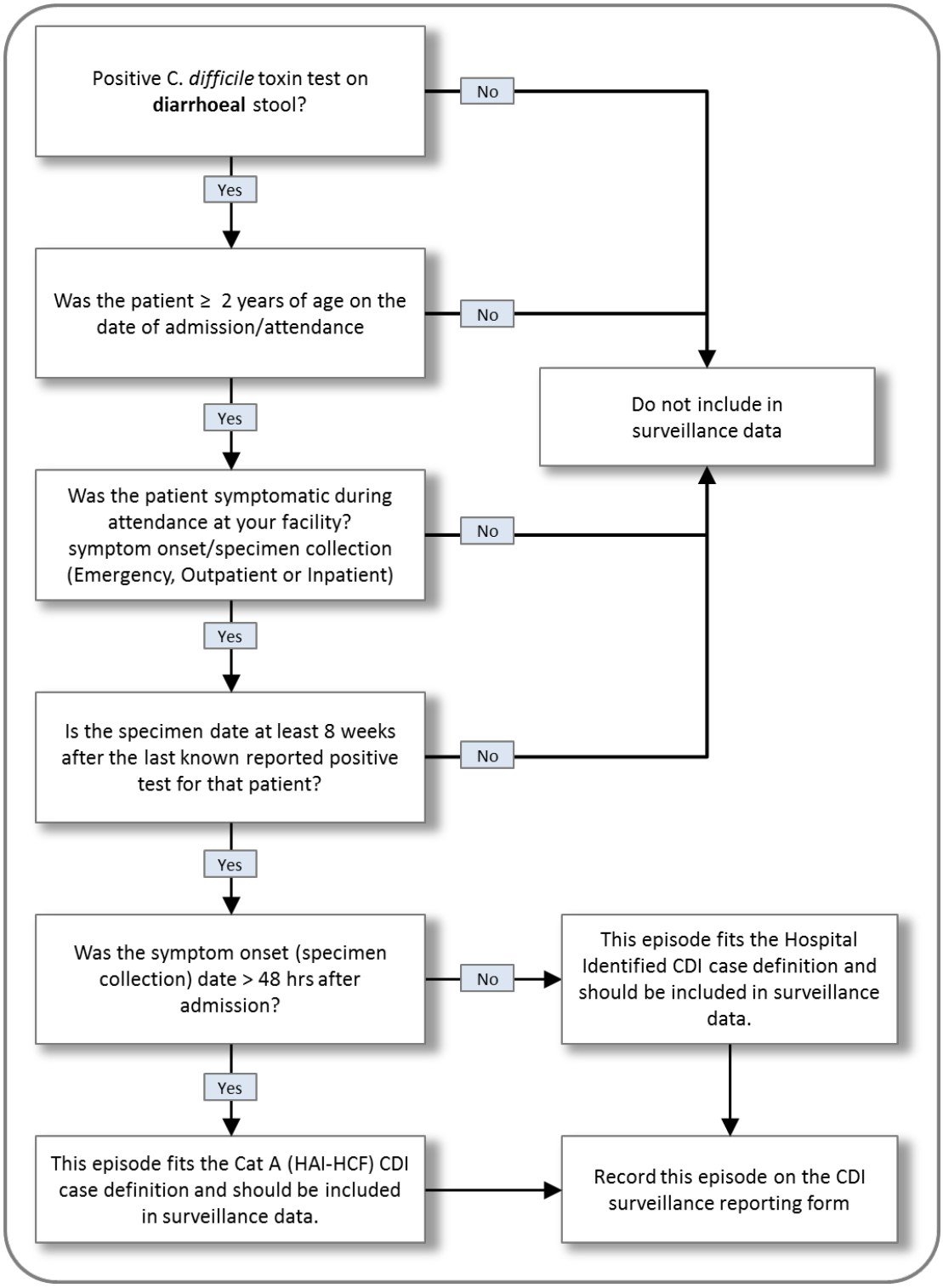
- [#]Identification/investigation of onset date is only required if the specimen collection date is >48hours after admission.
- Given state reporting currently only collects data on hospital identified and Category A (HCA-HCF) episodes as a sub-set, if a patient has a specimen taken during a current visit and it is identified as being associated with a previous admission, do not classify as a "post discharge" in the secondary acquisition, classify as NEW. Post-discharge information can be recorded as a comment in ICIMS.

Careconnect.sa infection control users (ICIMS)

To ensure record is included in the Category A field select:

- Primary Acquisition = HCA
- Secondary Acquisition = New.

Flow Chart



For more information

Infection Control Service
Communicable Disease Control Branch
Telephone: 1300 232 272
www.sahealth.sa.gov.au/infectionprevention

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