**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/](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](image)

**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

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
<th>Details</th>
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| 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 >48 hours 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

Positive *C. difficile* toxin test on diarrhoeal stool?

Yes

Was the patient ≥ 2 years of age on the date of admission/attendance?

Yes

Was the patient symptomatic during attendance at your facility? symptom onset/specimen collection (Emergency, Outpatient or Inpatient)

No

Is the specimen date at least 8 weeks after the last known reported positive test for that patient?

Yes

Was the symptom onset (specimen collection) date > 48 hrs after admission?

No

This episode fits the Hospital Identified CDI case definition and should be included in surveillance data.

Yes

This episode fits the Cat A (HAI-HCF) CDI case definition and should be included in surveillance data.

No

Do not include in surveillance data

Record this episode on the CDI surveillance reporting form

For more information

**Infection Control Service**
**Communicable Disease Control Branch**
**Telephone:** 1300 232 272

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