Prince Edward Island
CANADA
Health and Wellness

Prince Edward Island Guidelines for *Clostridioides difficile* infection (CDI) in Long-Term Care and Community Care Facilities

August 2026

Department of Health and Wellness
Chief Public Health Office

Preface

Clostridioides difficile infection (CDI) remains an important infection prevention and control concern in long-term care (LTC) and community care (CC) facilities. This guideline provides updated provincial guidance to support the prevention and control of CDI in these facilities.

This document replaces the *Provincial Infection Prevention and Control Clostridium difficile Guideline* (September 2010) and reflects current evidence and infection prevention and control practice.

Table of Contents

Executive Summary 5
1.0 Purpose and Scope 5
1.1 Guiding Principles 5
2.0 Background and Transmission 6
3.0 Case Recognition, Definitions, Testing, Reporting, and Surveillance 7
3.1 Suspected CDI 7
3.2 Confirmed CDI 7
3.3 Resolved CDI 8
3.4 Recurrent CDI 8
3.5 New CDI Episode or Reinfection 8
3.6 Colonization 8
3.7 Stool Testing 8
3.8 Surveillance Classification 9
3.9 Reporting, Notification, and Case Review 9
4.0 IPAC Management of Suspected or Confirmed CDI 10
4.1 Routine Practices, Contact Precautions, and PCRA 10
4.2 Hand Hygiene and PPE 10
4.3 Equipment, Toileting, and Fecal Waste 10
4.4 Environmental Cleaning and Disinfection 11
4.5 Linen, Waste, Dishes, and Cutlery 11
4.6 Discontinuation of Contact Precautions 11
5.0 Resident Placement, Movement, and Participation 12
5.1 Resident Placement 12
5.2 Shared Rooms and Cohorting 12
5.3 Movement, Shared Spaces, Dining, and Activities 13
5.4 Transfers, External Appointments, and Movement Between Settings 13
6.0 Outbreak Management 14
6.1 Outbreak Definition and Assessment Triggers 14

6.2 Immediate Response 14
6.3 Ongoing Management 15
6.4 Outbreak Leadership and Coordination 15
6.5 Outbreak Closure and Review 15
7.0 Communication 16
7.1 Internal Communication 16
7.2 Resident, Family, Visitor, and Essential Caregiver Communication 16
7.3 Transfer and Appointment Communication 16
7.4 Outbreak Communication 17
8.0 Roles, Education, Monitoring, and Quality Improvement 17
8.1 Roles and Responsibilities 17
8.2 Education and Competency Support 18
8.3 Monitoring, Audit, and Quality Improvement 19
References 20
Appendix A: Hand Hygiene 21
Appendix B: Point-of-Care Risk Assessment (PCRA) for CDI 22
Appendix C: Contact Precautions for Suspected or Confirmed CDI in LTC/CC 23
Appendix D: Risk Assessment for Placement and Activity Participation for CDI 24
Appendix E: Specimen Collection 25
Appendix F1: Technical Reference / Management of Residents with CDI 26
Appendix F2: Quick Reference / Management of Residents with CDI 27
Appendix G1: Technical Reference / CDI Outbreak Management 28
Appendix G2: Quick Reference / CDI Outbreak Management 29
Appendix H: CDI Outbreak Signage 30
Appendix I: CDI Transfer Communication 31
Appendix J: CDI Outbreak Line List 32
Appendix K: CDI Information for Residents, Families, and Visitors 33

Executive Summary

This guideline provides provincial direction for the prevention, recognition, management, surveillance, and control of suspected or confirmed *Clostridioides difficile* infection (CDI) in LTC and CC facilities.

The guideline addresses:

- Case recognition, testing, reporting, and surveillance;
- Routine Practices and Contact Precautions;
- Hand hygiene and personal protective equipment (PPE);
- Environmental cleaning and disinfection;
- Resident placement, movement, and participation;
- Communication during transfers and appointments;
- Antimicrobial stewardship; and
- Outbreak identification, management, and closure.

Surveillance definitions are provided to support case classification, trend monitoring, quality improvement, and outbreak assessment.

1.0 Purpose and Scope

The purpose of this guideline is to support consistent provincial practice for the prevention, recognition, assessment, management, surveillance, and control of suspected or confirmed CDI in LTC and CC facilities.

This guideline applies to LTC facilities, stand-alone CC facilities, and co-located or integrated LTC/CC facilities.

It is intended for congregate residential care settings where residents may share staff, equipment, common living spaces, transportation services, and environmental services processes.

This guideline should be used in conjunction with applicable legislation, Chief Public Health Office (CPHO) requirements, laboratory guidance, organizational infection prevention and control policies, and other relevant provincial or organizational requirements.

1.1 Guiding Principles

Implementation of this guideline should be guided by the following principles:

Risk-Based and Proportionate Approach

Infection prevention and control (IPAC) measures should be based on the assessed risk of transmission and implemented in a manner that reflects the resident population, care needs, physical environment, staffing model, and available resources within the facility.

Resident-Centred Care

Measures used to prevent and control CDI should support resident dignity, autonomy, mobility, social participation, and quality of life whenever possible.

Routine Practices as the Foundation of Care

Routine Practices are the foundation of infection prevention and control and should be consistently applied for all resident interactions. Contact Precautions should be implemented when indicated by the risk assessment and recommendations within this guideline.

Individualized Decision-Making

Decisions regarding resident placement, movement, cohorting, and participation in communal activities should be based on an individual risk assessment rather than CDI status alone.

Surveillance and Continuous Improvement

Surveillance activities should support timely case identification, monitoring of trends, evaluation of prevention and control measures, and early recognition of potential outbreaks.

2.0 Background and Transmission

Clostridioides difficile (C. difficile) is a spore-forming bacterium that can cause gastrointestinal illness ranging from mild diarrhea to severe colitis, toxic megacolon, sepsis, and death.

Residents may be at increased risk of CDI due to age, underlying illness, antimicrobial exposure, previous CDI, recent hospitalization or other health care exposure, immunosuppressive therapy, gastrointestinal disease or surgery, enteral feeding, gastric acid-suppressing medications such as proton pump inhibitors or H2 blockers, or exposure to contaminated environments, equipment, or shared toileting areas.

CDI spreads primarily by the fecal-oral route. Transmission can occur when hands, surfaces, equipment, bathrooms, commodes, or shared spaces become contaminated with fecal matter containing *C. difficile* spores. Spores can persist in the environment and are resistant to many commonly used disinfectants.

Transmission risk may increase when diarrhea is frequent or uncontrolled, continence is poor, residents require assistance with toileting or hygiene, bathrooms or equipment are shared, environmental contamination occurs, or infection prevention and control practices are not consistently followed.

Effective prevention and control depends on early recognition and consistent application of the measures outlined in this guideline.

3.0 Case Recognition, Definitions, Testing, Reporting, and Surveillance

This section provides definitions and guidance to support consistent recognition, testing, reporting, surveillance, case review, and outbreak assessment of CDI. These definitions are intended for operational and surveillance purposes and do not replace clinical judgment, diagnosis, or treatment decisions.

When CDI is suspected, clinical assessment and appropriate infection prevention and control measures should begin promptly and should not be delayed while awaiting laboratory confirmation.

3.1 Suspected CDI

CDI should be suspected when a resident develops diarrhea that is new, unexplained, or unusual for that resident.

For operational purposes, suspected CDI means the resident has:

- three or more unexplained loose or liquid stools in a 24-hour period;
- stool that is new or unusual compared with the resident's usual bowel pattern; and
- no clear alternative explanation, such as laxative use, bowel medications, enteral feeding changes, or a known gastrointestinal condition.

Other compatible symptoms may include abdominal pain, fever, ileus, or signs of severe illness. Some residents may present atypically or deteriorate quickly.

When CDI is suspected, initiate appropriate IPAC measures, notify the appropriate provider or designate, and collect a stool specimen if testing is clinically indicated.

3.2 Confirmed CDI

Confirmed CDI means the resident has compatible clinical illness and CDI is confirmed by laboratory testing or another accepted diagnostic method.

Confirmed CDI may include:

- compatible symptoms with a positive laboratory test for toxigenic *C. difficile* or *C. difficile* toxin, in accordance with current laboratory methods;
- pseudomembranes identified by sigmoidoscopy, colonoscopy, or following colectomy;
- histological or pathological diagnosis of CDI; or
- toxic megacolon where CDI is considered the cause.

A positive laboratory result alone does not confirm CDI in an asymptomatic resident. Compatible symptoms or accepted clinical criteria are required.

3.3 Resolved CDI

A CDI episode is considered resolved when diarrhea has resolved for at least 48 hours and the resident's bowel pattern has returned to their usual baseline.

Repeat testing or testing for cure should not be used to determine whether CDI has resolved. Resolution is based on clinical improvement.

3.4 Recurrent CDI

Recurrent CDI means a new episode of compatible symptoms occurs within eight weeks of the diagnostic date of a previous CDI episode, provided the previous episode had resolved.

Recurrent CDI should be distinguished from ongoing illness. If diarrhea never resolved or the resident did not return to baseline, the resident should be reassessed clinically rather than automatically classified as having recurrent CDI.

3.5 New CDI Episode or Reinfection

A new CDI episode, or reinfection, means compatible CDI illness occurs more than eight weeks after the diagnostic date of a previous CDI episode.

Recurrent and new episodes should be recorded consistently to support surveillance, case review, trend monitoring, and outbreak assessment.

3.6 Colonization

Some residents may carry *C. difficile* without symptoms. This is colonization, not CDI.

Asymptomatic residents should not be tested for CDI unless specifically directed by the laboratory, IPAC professionals, or the treating clinician under exceptional circumstances.

Testing, surveillance classification, and management should be based on compatible symptoms and clinical assessment, not laboratory positivity alone.

3.7 Stool Testing

A stool specimen should be collected as soon as possible when CDI is suspected and testing is clinically indicated.

Only unformed stool should be submitted for CDI testing, in accordance with current laboratory requirements. See Appendix E for specimen collection instructions.

Residents should not be tested solely because of previous CDI, exposure to another resident with CDI, room location, or screening considerations in the absence of compatible symptoms.

Repeat testing during the same diarrheal episode and testing for cure are not recommended unless specifically directed by the treating clinician in consultation with the laboratory or IPAC professionals.

3.8 Surveillance Classification

For surveillance and reporting purposes, CDI cases should be classified using accepted Canadian surveillance definitions, adapted as appropriate for LTC and CC facilities. Classification should consider the timing of symptom onset, admission or readmission date, recent hospitalization, recent residence in or transfer from another health care facility, and other relevant health care exposures.

Classification	Surveillance criteria
Health care-associated	Symptoms develop 72 hours or more after admission to the facility; or symptoms develop within 72 hours of admission and the resident had hospitalization, residence in or transfer from another health care facility, or other relevant health care exposure within the previous 4 weeks.
Community-associated	Symptoms are present before admission or develop within 72 hours of admission, and there has been no hospitalization, residence in or transfer from another health care facility, or other relevant health care exposure within the previous 12 weeks.
Indeterminate	Available information does not clearly support classification as health care-associated or community-associated, including where symptom onset occurs more than 4 weeks but less than 12 weeks after discharge from or transfer from a health care facility, or after another relevant health care exposure.

Facilities should apply surveillance classifications consistently for reporting, outbreak assessment, trend monitoring, and quality improvement. Where classification is uncertain, facilities should consult IPAC professionals, the CPHO, or the Provincial Laboratory, as appropriate.

3.9 Reporting, Notification, and Case Review

Facility operators and staff must notify the CPHO or designate of laboratory-confirmed CDI cases in accordance with current provincial reporting requirements.

The Provincial Laboratory must notify the CPHO or designate of positive CDI laboratory results in accordance with current provincial reporting requirements.

Facilities must have internal processes for timely communication of suspected or confirmed CDI to the most responsible provider, IPAC professionals or site designate, site leadership, environmental services, and others as required by organizational policy.

Facilities should maintain a CDI line list when more than one case occurs, transmission is suspected, or an outbreak assessment is initiated. Case review should consider assessment, testing, recent and current antimicrobial therapy, where clinically appropriate, IPAC measures, environmental cleaning and disinfection, communication, and possible epidemiological linkages.

4.0 IPAC Management of Suspected or Confirmed CDI

4.1 Routine Practices, Contact Precautions, and PCRA

Routine Practices must be used for all resident care.

When CDI is suspected or confirmed, Contact Precautions must be initiated promptly in addition to Routine Practices. Precautions should not be delayed while awaiting laboratory confirmation.

A point-of-care risk assessment must be completed before each resident interaction to determine exposure risk, required PPE, safe workflow, placement needs, and environmental risks. See Appendix B.

Facilities must ensure staff have the supplies, equipment, education, and operational supports needed to implement CDI-related IPAC measures.

4.2 Hand Hygiene and PPE

Hand hygiene must be performed according to Routine Practices, Contact Precautions, and the point-of-care risk assessment. See Appendix A.

Hand hygiene is required before and after resident contact, after contact with the resident's environment, after contact with fecal matter or contaminated items, after glove or PPE removal, when entering or leaving the resident room or care space, and whenever hands may be contaminated.

For suspected or confirmed CDI, hand washing with soap and water is preferred after contact with the resident, the resident's environment, fecal matter, or contaminated items, when a dedicated hand hygiene sink is readily available.

Resident bathroom sinks, utility sinks, hopper sinks, and sinks used for cleaning, disposal, or reprocessing activities should not be used for staff hand hygiene.

PPE must be selected based on the point-of-care risk assessment. Gloves must be worn when contact with the resident, resident environment, fecal matter, contaminated surfaces, or contaminated items is anticipated. Gowns must be worn when providing direct care or when contamination of clothing or forearms is anticipated.

Masks and eye protection are not required for CDI alone but must be used when indicated by Routine Practices, splash or spray risk, another organism, or the resident's clinical presentation.

PPE must be available at the point of care, removed before leaving the resident care area, and followed immediately by hand hygiene.

Residents should be supported to perform hand hygiene after toileting and before eating.

4.3 Equipment, Toileting, and Fecal Waste

Resident care equipment should be dedicated where possible. Shared equipment must be cleaned and disinfected after use and before use with another resident, using products and processes consistent with local policy, manufacturer instructions, and CDI cleaning and disinfection requirements.

A dedicated toilet or commode should be provided where possible, particularly when diarrhea is frequent, continence is poor, or shared bathroom use increases transmission risk.

Facilities must have processes to safely manage fecal waste and reduce environmental contamination from bedpans, commodes, shared bathrooms, and other toileting equipment.

Toileting equipment used for residents with suspected or confirmed CDI must be handled, transported, cleaned, and disinfected according to local procedures using products effective against *C. difficile*.

Practices that may cause splashing or aerosolization of fecal matter, such as spray wands, high-pressure rinsing, and toilet brushes, should not be used.

4.4 Environmental Cleaning and Disinfection

Rooms, bathrooms, shared equipment, and frequently touched surfaces associated with a resident with suspected or confirmed CDI must be cleaned and disinfected using a Health Canada-authorized sporicidal product effective against *C. difficile*.

Products must be used according to manufacturer instructions, including dilution, application, wet contact time, safety precautions, and surface compatibility.

Cleaning must occur before disinfection unless the product is approved for simultaneous cleaning and disinfection and is used according to manufacturer instructions.

Facilities must maintain a written CDI environmental cleaning process that identifies approved products, cleaning and disinfection frequency, staff responsibilities, shared equipment cleaning, discharge or terminal cleaning, and monitoring or audit processes.

High-touch surfaces, bathrooms, toilets, commodes, and surfaces contaminated with stool must be cleaned and disinfected promptly. Cleaning frequency should increase when the resident is symptomatic, transmission is suspected, or an outbreak is declared.

4.5 Linen, Waste, Dishes, and Cutlery

Routine handling processes are generally sufficient for linen, waste, dishes, and cutlery unless otherwise directed by local policy.

Linen and waste should be handled carefully to prevent contamination of staff clothing, surfaces, and the environment. Items should not be shaken.

Dishes and cutlery do not require special handling or disposal solely because of CDI. Disposable dishes and cutlery are not required. Routine dishwashing processes are sufficient when performed according to established standards.

4.6 Discontinuation of Contact Precautions

For residents with suspected CDI, Contact Precautions may be discontinued when CDI has been ruled out and an alternate explanation for symptoms has been identified, or as directed by IPAC professionals following risk assessment.

For residents with confirmed CDI, Contact Precautions should continue until diarrhea has resolved for at least 48 hours and the resident's bowel pattern has returned to their usual baseline.

Discontinuation must be based on clinical improvement and symptom resolution, not repeat testing or testing for cure.

IPAC professionals may recommend a longer duration of precautions based on resident or facility risk factors, including ongoing incontinence, inability to maintain hygiene, shared accommodation, environmental contamination, suspected transmission, or outbreak context.

When Contact Precautions are discontinued, the resident's room or care area must be cleaned and disinfected according to local CDI environmental cleaning procedures.

If a resident develops new compatible symptoms after a previous CDI episode has resolved, the resident must be reassessed promptly and Contact Precautions re-implemented while further assessment occurs.

5.0 Resident Placement, Movement, and Participation

Residents with suspected or confirmed CDI should be managed in a way that reduces transmission risk while supporting dignity, mobility, social participation, and quality of life.

5.1 Resident Placement

A private room with dedicated toileting is preferred where available, particularly when diarrhea is frequent or uncontrolled, continence is poor, or environmental contamination is likely.

Where a private room is not available, placement decisions should be based on risk assessment and consultation with IPAC professionals or the site designate, where required.

Placement decisions should consider the resident's symptoms, continence, hygiene needs, cognitive or functional status, access to toileting, likelihood of environmental contamination, roommate vulnerability, and current transmission risk in the facility.

Where possible, residents with suspected or confirmed CDI should have dedicated toileting and dedicated resident care equipment.

5.2 Shared Rooms and Cohorting

Single-room placement with dedicated toileting should be prioritized where feasible. However, relocation may not always be possible in LTC and CC facilities.

When a resident with suspected or confirmed CDI remains in a shared room, facilities should reduce risk by maintaining Contact Precautions, supporting spatial separation where possible, prioritizing dedicated toileting or cleaning shared bathrooms after use, dedicating or cleaning shared equipment between uses, reinforcing hand hygiene, and reassessing placement if symptoms worsen or transmission risk increases.

Admission of a new resident into a room with a resident who has suspected or confirmed CDI should be avoided where possible. If admission cannot be deferred and no alternative placement is available, the decision should be based on risk assessment and documented according to facility process.

Residents at higher risk of severe outcomes, or those unlikely to safely share accommodation, should be prioritized for single-room placement where feasible.

5.3 Movement, Shared Spaces, Dining, and Activities

Residents with CDI should not be excluded from shared spaces, dining, or activities based on CDI diagnosis alone. Decisions should be based on symptoms, continence, hygiene needs, environmental contamination risk, and current transmission risk.

Participation may continue with modifications when risk can be managed. This may include hand hygiene before and after participation, toileting before activities or meals, clean clothing and contained continence products, dedicated seating where appropriate, avoiding shared equipment unless it can be cleaned and disinfected, and prompt cleaning of contaminated or high-touch surfaces.

Shared space use, communal dining, or group activities should be modified or temporarily restricted when diarrhea is uncontrolled, hygiene cannot be maintained, contamination risk is high, frequent environmental contamination occurs, or ongoing transmission is suspected.

Restrictions should be proportionate, time-limited, reassessed regularly, and discontinued as soon as they are no longer required.

5.4 Transfers, External Appointments, and Movement Between Settings

Facilities should communicate CDI status and required IPAC measures before resident transfer, external appointments, or movement between care settings whenever possible.

Communication should include information needed to support safe care, infection prevention, transport, placement, and continuity of care. See Section 7 and Appendix I.

6.0 Outbreak Management

Facilities must have a documented process for recognizing, assessing, reporting, managing, and closing suspected or confirmed CDI outbreaks in accordance with current provincial, CPHO, and organizational requirements.

Outbreak response should be proportionate to the number of cases, evidence of transmission, resident risk, affected areas, and facility capacity.

6.1 Outbreak Definition and Assessment Triggers

A CDI outbreak assessment should be initiated when:

- two or more epidemiologically linked suspected or confirmed CDI cases occur within a defined area or time period; or
- there is evidence of ongoing facility-associated transmission.

A possible outbreak should also be considered when cases share common exposures, environmental contamination is frequent or difficult to control, new facility-associated cases occur despite routine control measures, or CDI activity is above the facility's expected baseline.

Outbreak assessment should not be delayed when epidemiological linkage, environmental contamination, or ongoing transmission is suspected.

6.2 Immediate Response

When a CDI outbreak is suspected, the facility should initiate its outbreak management process and notify site leadership, IPAC professionals, and the CPHO, where required.

Initial actions should include:

- initiating or updating the CDI line list;
- increasing surveillance for new gastrointestinal symptoms;
- reinforcing Contact Precautions for symptomatic residents;
- reviewing resident placement, movement, shared spaces, dining, and activities;
- enhancing environmental cleaning and disinfection using a Health Canada-authorized sporicidal product effective against C. difficile;
- reviewing adherence to hand hygiene, PPE, Contact Precautions, and cleaning practices;
- assessing shared exposures, including bathrooms, equipment, staff assignments, dining, activities, and resident movement; and
- reviewing recent antimicrobial exposure, where relevant.

See Appendix J for the CDI outbreak line list.

6.3 Ongoing Management

If an outbreak is confirmed or strongly suspected, outbreak management should continue until transmission is controlled and closure criteria are met.

Ongoing management should include active case finding, symptom surveillance, case review, identification of possible transmission links, resident placement and movement decisions, enhanced cleaning and disinfection, monitoring of IPAC practices, communication with relevant parties, and regular review of outbreak status.

Control measures should be adjusted based on surveillance findings, resident risk, environmental concerns, operational considerations, and direction from IPAC professionals or the CPHO, where applicable.

See Appendices G1 and G2 for CDI outbreak management tools.

6.4 Outbreak Leadership and Coordination

Facilities should identify who is responsible for outbreak leadership and coordination.

Depending on the facility, outbreak coordination may include site leadership, IPAC professionals, clinical leadership, environmental services, the staff illness management lead or designate, pharmacy services, recreation or dietary services, communications personnel, and the CPHO, as appropriate.

The outbreak leadership group should support surveillance, reporting, documentation, review of transmission risks, implementation and monitoring of control measures, communication, outbreak closure, and follow-up actions.

6.5 Outbreak Closure and Review

A CDI outbreak may be declared over in accordance with current provincial and organizational processes once there is evidence that transmission has ceased and no new facility-associated cases have occurred during the required monitoring period.

The decision to declare an outbreak over should occur in consultation with the CPHO, where required.

Following outbreak closure, the facility should complete an outbreak review. The review should consider timeliness of recognition and reporting, surveillance and line list completeness, possible transmission routes, resident placement and movement decisions, adherence to IPAC measures, environmental cleaning and disinfection, staffing or operational impacts, communication, antimicrobial stewardship, and opportunities to improve future outbreak preparedness.

Findings should be used to support quality improvement, education, and updates to local procedures.

7.0 Communication

Facilities must have clear processes for communicating information related to suspected or confirmed CDI. Communication should be timely, accurate, documented where required, and limited to information needed to support safe care, IPAC measures, reporting, resident movement, and continuity of operations.

Privacy and confidentiality must be maintained.

7.1 Internal Communication

Internal communication should support timely assessment, implementation of IPAC measures, environmental cleaning and disinfection, surveillance, case review, outbreak assessment, and coordination of resident placement, movement, transfer, or other operational needs.

Facilities should identify when and how to notify the most responsible provider, IPAC professionals or site designate, site leadership, environmental services, staff illness management process, and the CPHO, where required.

Notifications, escalation decisions, and actions taken should be documented according to organizational policy.

7.2 Resident, Family, Visitor, and Essential Caregiver Communication

Residents, families, visitors, and essential caregivers should receive clear, respectful, plain-language information about CDI and the precautions being used.

Information should include what CDI is, how it spreads, hand hygiene expectations, PPE requirements where indicated, temporary movement or visiting guidance, toileting or cleaning precautions relevant to the resident's care, and when to report symptoms or seek assistance.

Communication should be adapted to the resident's cognitive status, communication needs, language, culture, health literacy, and involvement in care.

See Appendix K for the CDI information sheet for residents, families, and visitors.

7.3 Transfer and Appointment Communication

When a resident with suspected or confirmed CDI is transferred to another facility, hospital, external service, or appointment location, relevant CDI information should be communicated before transfer whenever possible.

Communication should include information needed to support safe care, IPAC measures, transport, placement, and continuity of care. This may include CDI status, symptom onset, current symptoms, stool pattern, continence status, testing status or results, required precautions, relevant care needs, and outbreak status, if applicable.

When a resident attends an appointment without transfer of care, communication should be limited to information needed to support safe care during the appointment.

Transfer and appointment communication should be documented according to organizational policy. See Appendix I for the CDI transfer communication tool.

7.4 Outbreak Communication

When a CDI outbreak is suspected or confirmed, communication should be coordinated with site leadership, IPAC professionals, the CPHO where required, staff, residents, families, visitors, essential caregivers, and receiving services, as applicable.

Outbreak communication should be timely, accurate, consistent, and updated as the situation changes. It should address affected areas, control measures, resident movement, dining, activities, visiting guidance, visitor and essential caregiver expectations, staff illness reporting, transfer or appointment instructions, and direction from the CPHO or other relevant partners, as applicable.

Outbreak communication must respect privacy and confidentiality while providing enough information to support safe care, outbreak control, and continuity of operations.

8.0 Roles, Education, Monitoring, and Quality Improvement

Facilities must define accountabilities, communication pathways, escalation processes, documentation expectations, and education requirements for CDI prevention and management. Responsibilities may vary depending on the facility's structure, staffing model, available services, and whether the facility is stand-alone or co-located.

8.1 Roles and Responsibilities

Facility operators and leadership are responsible for ensuring that CDI prevention and management processes are in place, resourced, and supported. This includes access to policies, procedures, supplies, equipment, approved cleaning products, education, surveillance, reporting, staff illness processes, communication pathways, and outbreak response supports.

IPAC professionals provide guidance on CDI prevention and control, including case review, surveillance interpretation, precautions, resident placement and participation, environmental cleaning and disinfection, outbreak assessment, and quality improvement.

Clinical staff are responsible for recognizing and reporting new or unexplained diarrhea, notifying appropriate providers or designates, supporting specimen collection when ordered, initiating precautions, using hand hygiene and PPE appropriately, and communicating relevant information during resident movement, transfer, appointments, or changes in status.

Environmental services are responsible for cleaning and disinfection according to the facility's CDI environmental cleaning process, including use of approved sporicidal products, required wet contact times, safety precautions, enhanced cleaning, and terminal cleaning where required.

Facilities must have a staff illness management process for reporting, assessment, work exclusion, and return-to-work guidance when staff have vomiting, diarrhea, or symptoms compatible with communicable gastrointestinal illness.

The most responsible provider or prescriber is responsible for clinical assessment, testing decisions, diagnosis, treatment, review of other causes of diarrhea, and review of antimicrobial therapy where clinically appropriate.

Residents, families, visitors, and essential caregivers are responsible for following facility instructions related to hand hygiene, PPE where required, movement, visiting, activities, toileting, and reporting symptoms or concerns.

Pharmacy services, where available, should support antimicrobial stewardship, case review, outbreak review, and collaboration with prescribers, IPAC, leadership, and quality improvement teams.

8.2 Education and Competency Support

Facilities should provide CDI education during orientation, when practice changes occur, and when surveillance findings, audits, outbreak reviews, or updated guidance identify a need for reinforcement.

Education should address CDI recognition, Routine Practices, Contact Precautions, point-of-care risk assessment, hand hygiene, PPE use, safe toileting and fecal waste management, environmental cleaning and disinfection, specimen collection, resident placement and movement, transfer communication, staff illness reporting, and outbreak response, as applicable.

Facilities should support staff competence through observation, coaching, audit, feedback, and targeted education, where appropriate.

Residents, families, visitors, and essential caregivers should receive clear, respectful, plain-language information about CDI and related precautions. See Appendix K.

8.3 Monitoring, Audit, and Quality Improvement

Facilities should use monitoring, audit, feedback, case review, surveillance findings, outbreak reviews, resident safety information, and staff feedback to strengthen CDI prevention and control practices.

Audit activities may include hand hygiene, PPE use, initiation and discontinuation of Contact Precautions, environmental cleaning and disinfection, management of resident care and toileting equipment, transfer communication, surveillance documentation, line list completion, and outbreak response.

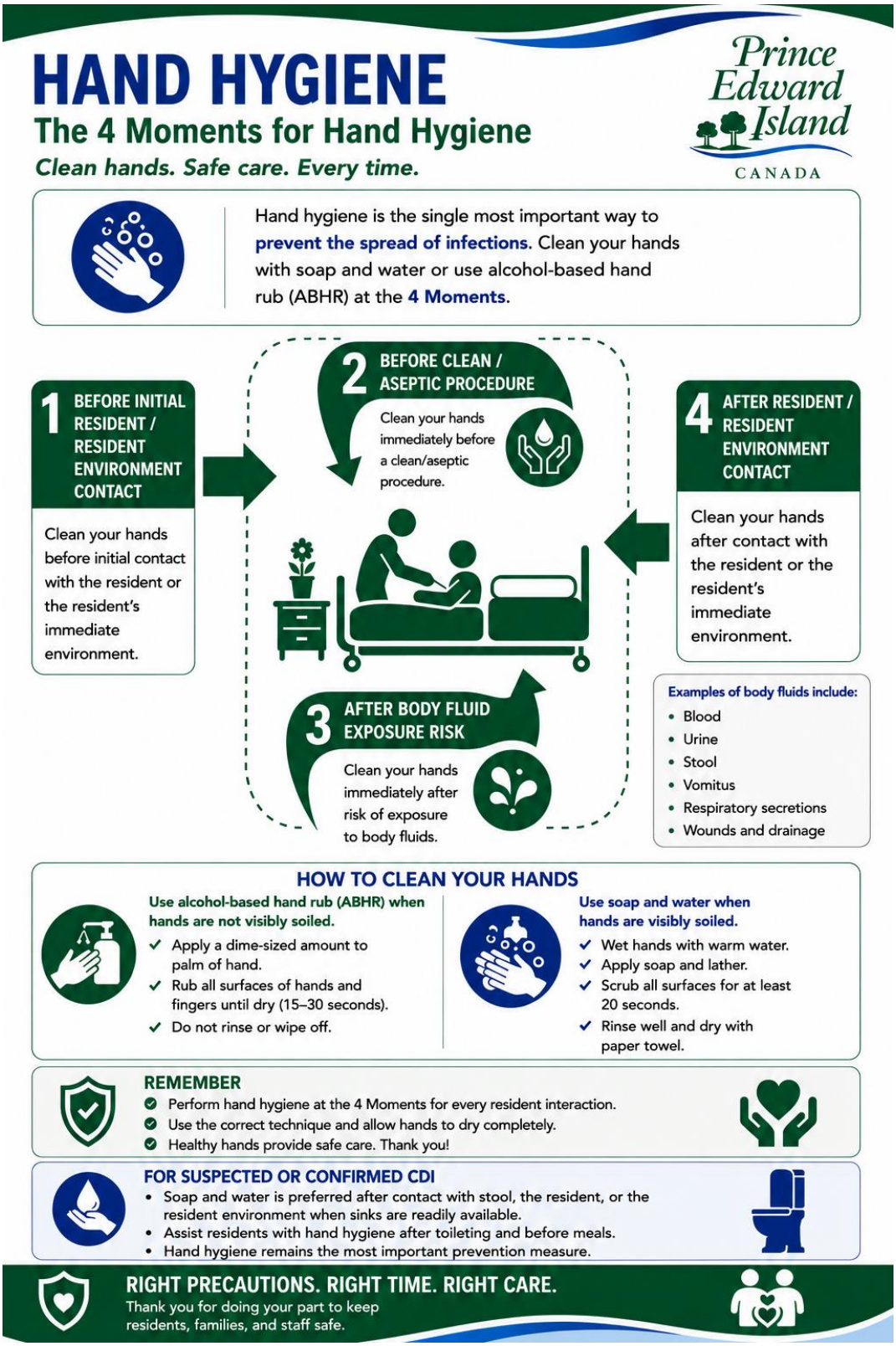
Audit frequency should be based on risk and may increase during outbreaks, suspected transmission, identified practice concerns, or quality improvement initiatives.

Findings should be shared with relevant staff and leadership and used to support corrective action, education, local procedure updates, outbreak preparedness, and ongoing improvement.

References

1. Public Health Agency of Canada. *Clostridium difficile Infection: Infection Prevention and Control Guidance for Management in Long-Term Care Facilities.*
2. Public Health Agency of Canada. *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.*
3. Public Health Ontario; Provincial Infectious Diseases Advisory Committee (PIDAC). *Best Practices for Infection Prevention and Control in Long-Term Care.*
4. Public Health Ontario; Provincial Infectious Diseases Advisory Committee (PIDAC). *Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings.*
5. Public Health Ontario; Provincial Infectious Diseases Advisory Committee (PIDAC). *Routine Practices and Additional Precautions in All Health Care Settings.* 3rd ed.
6. Canadian Nosocomial Infection Surveillance Program. *Surveillance Protocol for Clostridioides difficile Infection (CDI).* 2026. Revised October 2025.
7. Vancouver Coastal Health. *Care and Management of Clostridioides difficile Infection (CDI) in Long-Term Care (LTC) and Assisted Living (AL).* Revised June 2025.
8. Prince Edward Island. *Provincial Infection Prevention and Control Clostridium difficile Guideline.* September 2010. Superseded document retained for historical reference.

Appendix A: Hand Hygiene



Appendix B: Point-of-Care Risk Assessment (PCRA) for CDI

Appendix C: Contact Precautions for Suspected or Confirmed CDI in LTC/CC

Appendix D: Risk Assessment for Placement and Activity Participation for CDI

RESIDENT RISK ASSESSMENT
FOR PLACEMENT AND ACTIVITY PARTICIPATION
For *Clostridioides difficile* Infection (CDI)

Prince Edward Island CANADA

Support resident-centred decisions for placement, movement, communal activities, and participation.

RESIDENT INFORMATION

Name: _____

Date of Birth (yyyy-mm-dd): _____

Location/Unit: _____

Date of Assessment (yyyy-mm-dd): _____

Time: _____ CDI Status: ☐ Suspected ☐ Confirmed

ASSESSOR INFORMATION

Assessor Name: _____

Role/Title: _____

Signature: _____

Review Frequency: ☐ Daily ☐ More often if needed ☐ As symptoms improve

Reassess at least daily and with any change in the resident's condition.

Next Review Date (yyyy-mm-dd): _____

RISK-BASED ASSESSMENT FOR CDI TRANSMISSION

RISK FACTOR	LOWER TRANSMISSION RISK (Generally supports participation)	HIGHER TRANSMISSION RISK (May require additional measures)	ASSESSMENT (✓ one)
DIARRHEA	Resolved or controlled (formed or baseline pattern)	Frequent, uncontrolled, or explosive diarrhea	☐ Lower ☐ Higher
CONTINENCE	Stool contained	Incontinence or frequent leakage	☐ Lower ☐ Higher
TOILETING	Uses toilet/commode safely or requires minimal assistance	Frequent accidents or extensive assistance required	☐ Lower ☐ Higher
HAND HYGIENE	Performs hand hygiene independently or accepts assistance	Unable or unwilling to perform hand hygiene or accept assistance	☐ Lower ☐ Higher
COGNITION / BEHAVIOUR	Follows instructions and participates appropriately	Wandering, touching surfaces, unable to follow instructions	☐ Lower ☐ Higher
MOBILITY	Movement can be managed safely	Movement increases contamination risk	☐ Lower ☐ Higher
ENVIRONMENT	Minimal contamination of surfaces or equipment	Frequent contamination of surfaces or equipment	☐ Lower ☐ Higher
OUTBREAK STATUS	No evidence of transmission in facility	Suspected or confirmed outbreak or transmission in facility	☐ Lower ☐ Higher

No single risk factor automatically requires activity restriction, cohorting, or private room placement. Consider all factors together.

IF OVERALL RISK IS LOWER
Continue Routine Practices and Reassess Regularly
Residents may participate in:

Communal dining | Recreation programs | Social activities | Therapy programs | Facility movement

Participation may be considered when:
- Diarrhea is controlled
- Stool is contained
- Hand hygiene is performed
- Clothing and continence products are clean
- Environmental contamination is unlikely

IF OVERALL RISK IS HIGHER
Consider Additional Risk Reduction Measures
- Enhanced supervision
- Assisted hand hygiene
- Toileting before activities
- Dedicated seating
- Enhanced environmental cleaning
- Temporary activity modifications
- Placement review

Restrictions should be individualized, documented, reassessed regularly, and discontinued as soon as they are no longer required.

BEFORE PARTICIPATION IN COMMUNAL ACTIVITIES: Assess whether:

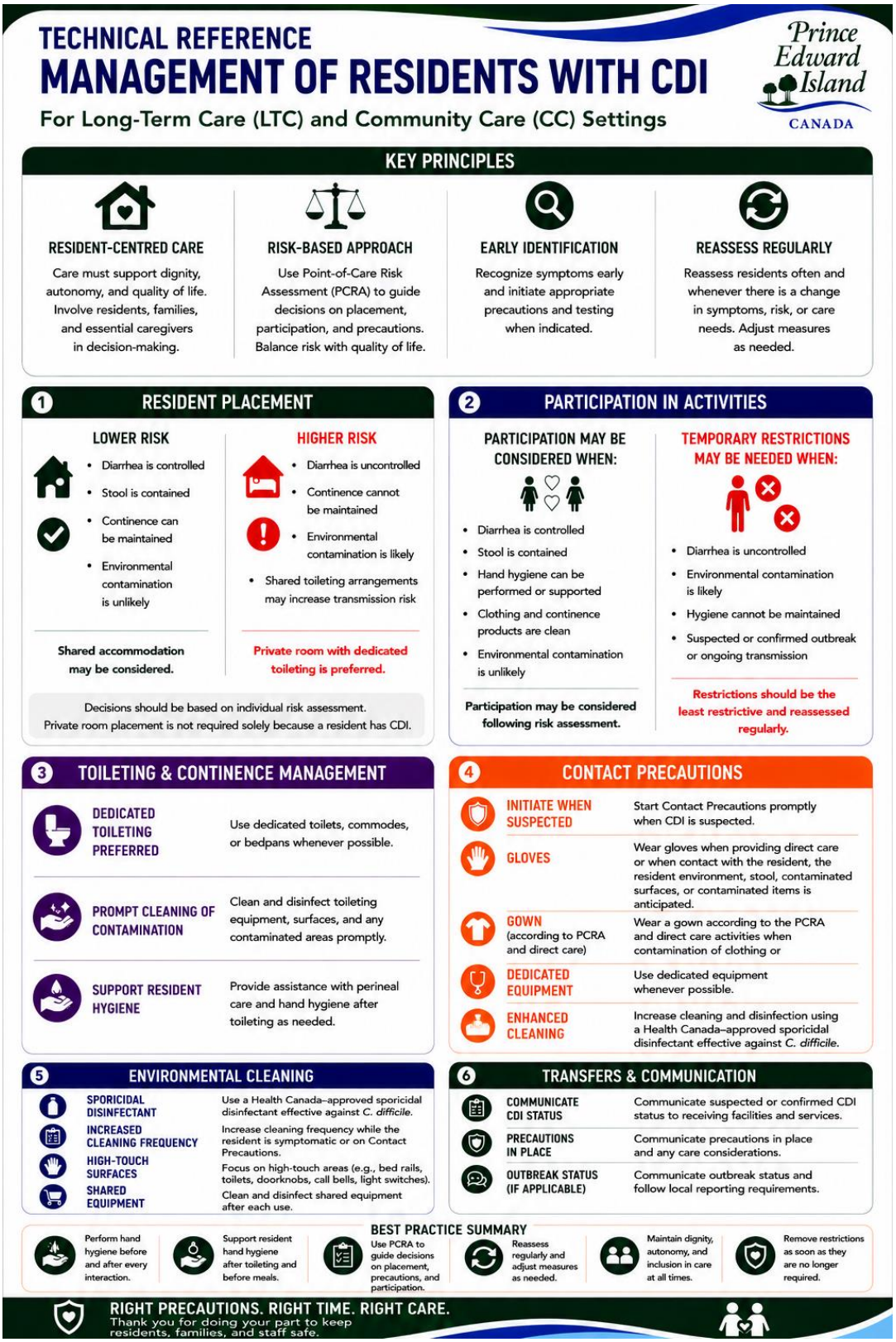
Diarrhea is controlled? | Stool is contained? | Hand hygiene has been performed? | Clothing and continence products are clean? | Environmental contamination is unlikely? | Participation can occur safely?

RESIDENT-CENTRED DECISION MAKING
- CDI status alone should not determine placement, participation, movement, or access to services.
- Residents should remain engaged in activities whenever safely possible.
- Decisions should balance infection prevention, dignity, autonomy, mobility, and quality of life.
- Restrictions should be proportional to the risk of transmission.
- Reassess regularly as symptoms improve.

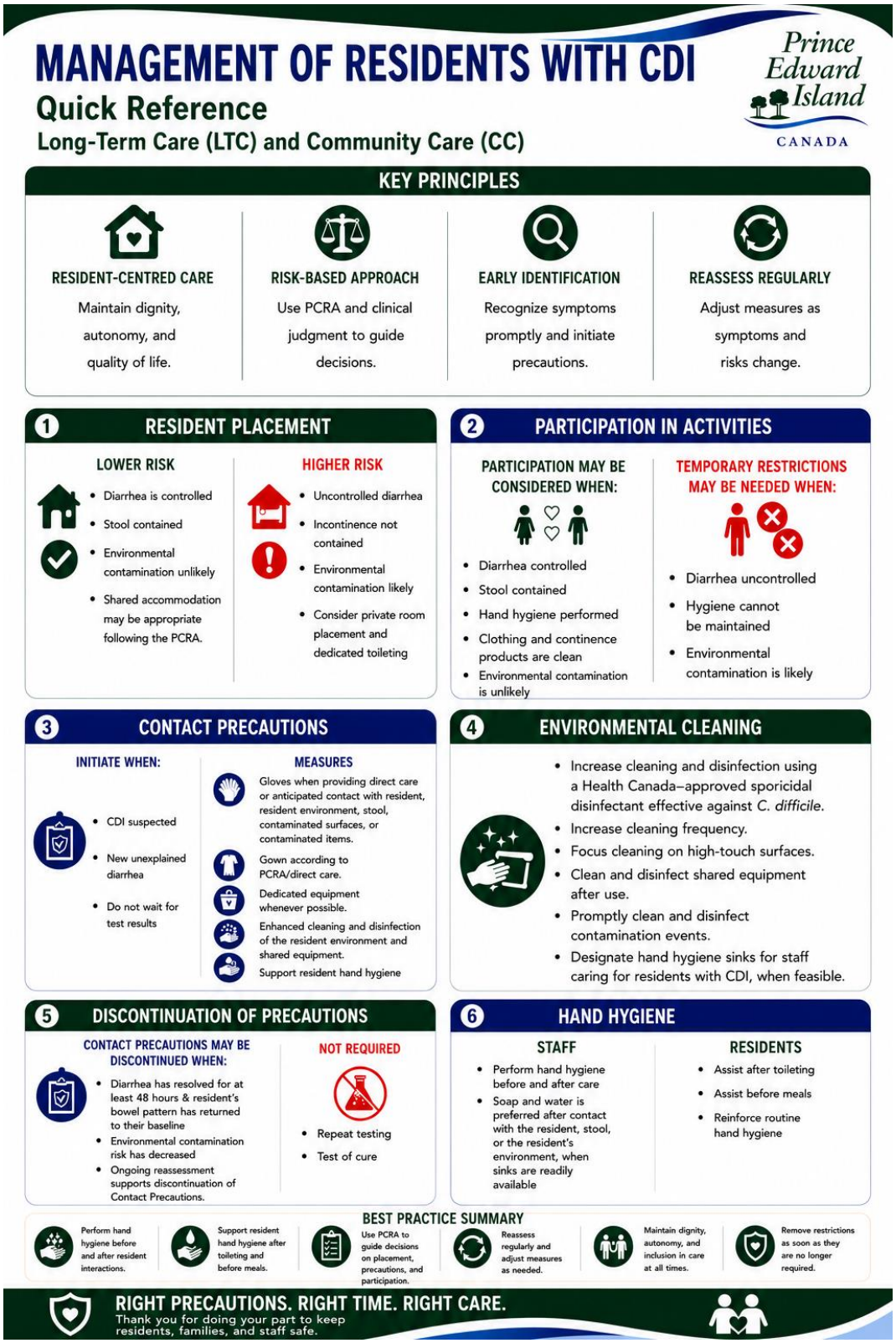
RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.
Thank you for doing your part to keep residents, families, and staff safe.

Appendix E: Specimen Collection

Appendix F1: Technical Reference / Management of Residents with CDI



Appendix F2: Quick Reference / Management of Residents with CDI



Appendix G1: Technical Reference / CDI Outbreak Management

Appendix G2: Quick Reference / CDI Outbreak Management

Appendix H: CDI Outbreak Signage

Appendix I: CDI Transfer Communication

CDI TRANSFER COMMUNICATION

Suspected or Confirmed *Clostridioides difficile* Infection (CDI)

Prince Edward Island
CANADA

Effective transfer communication supports continuity of care and reduces the risk of transmission.

RESIDENT INFORMATION

Resident Name: _____

Date of Birth: _____

Medical Record Number (MRN): _____

Unit / Location: _____

Transfer Date: _____

Transfer Time: _____

Sending Facility: _____

Receiving Facility: _____

CDI STATUS

☐ Suspected CDI

☐ Confirmed CDI

Current Bowel Status

☐ Active diarrhea

☐ Diarrhea improving

☐ Returned to baseline bowel pattern

Date symptoms began: _____

Date specimen collected: _____

Laboratory result (if available): _____

_____

INFORMATION TO COMMUNICATE	COMMUNICATED
CDI status (suspected or confirmed)	☐
Current bowel status	☐
Contact Precuations in place	☐
PPE requirements (e.g., gloves, gown)	☐
Continence considerations	☐
Mobility considerations	☐
Dedicated equipment in use	☐
Current CDI treatment and start date	☐
Outbreak status (if applicable)	☐
Recent antimicrobial therapy	☐
Additional care considerations / other important information	☐

BEFORE TRANSFER

- ✓ Confirm resident information.
- ✓ Ensure documentation is complete.
- ✓ Ensure receiving facility has been notified.
- ✓ Communicate current precautions and care requirements.
- ✓ Communicate outbreak status if applicable.
- ✓ Ensure transfer documentation accompanies the resident.

RECEIVING FACILITY CONFIRMATION

Receiving Contact: _____

Position: _____

Name of person providing information: _____

Date / Time Communicated: _____

Comments: _____

_____

TRANSFER COMMUNICATION REMINDER

Communicate suspected or confirmed CDI status, current symptoms, precautions in place, outbreak information (if applicable), and any additional care requirements **before transfer and upon arrival at the receiving facility.**

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.

Appendix J: CDI Outbreak Line List

CDI OUTBREAK LINE LIST

For Suspected or Confirmed *Clostridioides difficile* Infection (CDI)

Prince Edward Island
CANADA

A line list helps detect patterns, support outbreak management, and monitor progress during an outbreak.

OUTBREAK INFORMATION

Facility: _____ Date Outbreak Declared: _____

Unit / Home Area: _____ Date Outbreak Closed: _____

Outbreak Number: _____ IPAC Lead / Contact: _____

Outbreak Status (check one):

☐ Under Investigation ☐ Active ☐ Closed

CDI OUTBREAK LINE LIST

Case Number	Resident Identifier (Name / MRN)	Unit / Location (Room / Area)	Symptom Onset Date (yyyy-mm-dd)	Specimen Collection Date (yyyy-mm-dd)	Laboratory Result (+ / - / Pending)	Contact Precautions Initiated (Y / N)	Hospital Transfer (Y / N)	Outcome (Active / Resolved / Deceased)	Notes

SURVEILLANCE SUMMARY

Total Suspected Cases: _____

Total Confirmed Cases: _____

Total Active Cases (today): _____

Total Resolved Cases: _____

Total Hospital Transfers: _____

Total Deaths: _____

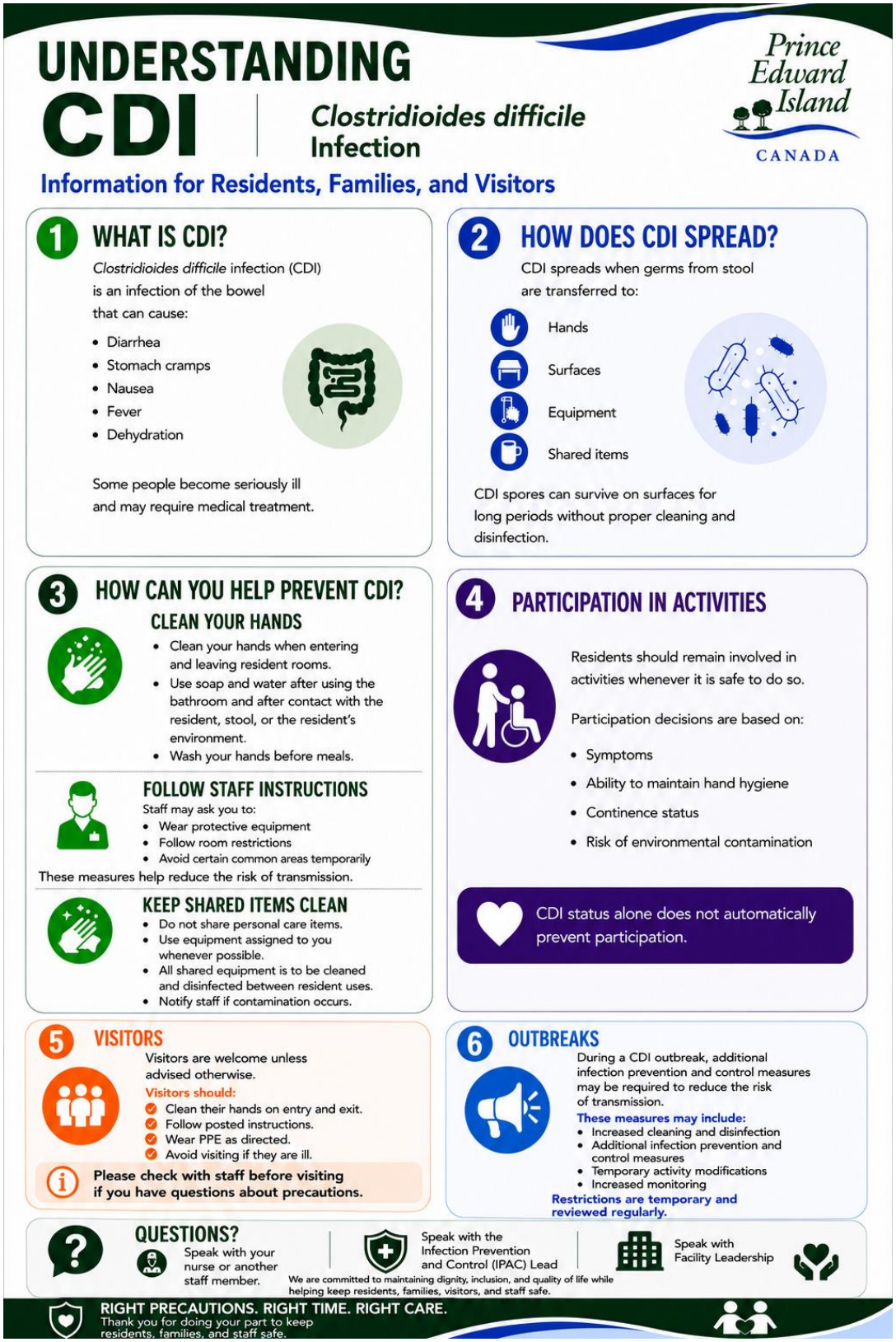
OUTBREAK MANAGEMENT REMINDERS

- Update this line list daily during the active outbreak.
- Use standardized case definitions.
- Verify laboratory results.
- Maintain confidentiality.
- Share line list with IPAC/CPHO as required.
- Support root cause analysis and control measures.
- Review trends and update outbreak status regularly.

HOW TO USE THIS LINE LIST

- Enter all suspected and confirmed CDI cases.
- Record key dates and outcomes.
- Review trends to guide outbreak response.
- Keep current and accurate.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.

Appendix K: CDI Information for Residents, Families, and Visitors