**SBAR for Suspected *Clostridioides difficile* Infection (CDI)**

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| **Resident Name** | | | | **DOB** | | | **Unit/Wing, Room** | | **Completed by:** | | |
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| **S** | ***Situation:***  I am reaching out to you regarding the resident above having a suspected CDI | | | | | | | | | | |
| **B** | ***Background:***  PMH (especially existing gastrointestinal diseases, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Antibiotics within the last 90 days?  Irritable bowel disease?  Laxative within the last 72hrs?  Receiving proton-pump inhibitor?  History of CDI?  Advance directives? | | | | □ YES □ NO If yes, Drug name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ YES □ NO If yes, new or worsening? □ YES □ NO  □ YES □ NO  □ YES □ NO  □ YES □ NO If yes, date of last episode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ YES □ NO If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **A** | ***Assessment:***  Vital Signs: BP: \_\_\_\_\_\_/\_\_\_\_\_\_ mmHg HR: \_\_\_\_\_\_ beats/min RR: \_\_\_\_\_\_ breaths/min Temp: \_\_\_\_\_°F/\_\_\_\_\_°C   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Criteria to initiate antibiotics are met if **BOTH** of the following scenarios are selected: | | | | | | □ At least **1** of the following:  □ Diarrhea (≥3 watery stools above baseline within 24hr  period)  □ Presence of toxic megacolon on abdominal radiograph | | **AND** | □ **One** of the following:  □ Positive *C. difficile* test result (Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )  □ Pseudomembranous colitis present on endoscopic or  histopathological examination | | | **Common Test Results:**  GDH (-) / Toxin (-)  GDH (+) / Toxin (+)  GDH (+) / Toxin (-) / PCR (-)  GDH (+) / Toxin (-) / PCR (+)  GDH (-) / Toxin (+) / PCR (-)  GDH (-) / Toxin (+) / PCR (+) | **Interpretation**  No *C. difficile* present; no toxin present  *C. difficile* present; toxin present  *C. difficile* present, no toxin present, no toxin gene present  *C. difficile* present, no toxin present, toxin gene present  No *C. difficile* present, toxin present, no toxin gene present  No *C. difficile* present, toxin present, toxin gene present | | | **Likelihood of Infection:**  Unlikely CDI  Likely CDI  Likely colonization, rule out alternatives  Possible colonization, rule out alternatives  Likely testing error, repeat test if able  Possible testing error, repeat test if able | | **Due to the rapid degradation of *C. difficile* toxin, false negative toxin test results may increase in samples that are improperly handled/stored between time of sample collection and time of sample analysis.** | | | | | | | | | | | | | | | |
| **R** | ***Recommendation(s):***  The above resident:  □ **Does meet criteria to initiate antimicrobial therapy for a CDI at this time:** See Physician/Prescriber Response section below.  □ **Does NOT meet criteria to initiate antimicrobial therapy for a CDI at this time:** Resident may require more frequent monitoring  and/or physician/prescriber assessment. | | | | | | | | | | |
| Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Faxed or □ Called to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family/POA Notified (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Physician/Prescriber Response** | | | | | | | | | | | |
| □ I have reviewed the resident SBAR above | | | | | | | | | | | |
| **Please obtain the following (check all that apply):** | | | | | | | | | | | |
| □ BMP | | □ BUN/SCr | □ CBC with differential | | | □ Stool Culture | | | |  | |
| □ Continue monitoring vital signs and temps; every \_\_\_\_\_\_\_\_\_\_ hours for \_\_\_\_\_\_\_\_\_\_ days  □ Encourage continued fluid intake; \_\_\_\_\_\_\_\_\_\_ oz of fluid every \_\_\_\_\_\_\_\_\_\_ hours until symptoms resolve  □ Monitor/record fluid intake and output | | | | | | | | | | | |
| **Please initiate the following selected antibiotic regimen:** | | | | | | | | | | | |
| ***Clostridioides difficile Infection (Initial)***  □ Vancomycin 125mg PO QID x 10 days  □ Fidaxomicin 200mg PO BID x 10 days  ***Clostridioides difficile Infection (Recurrence)***  □ Fidaxomicin 200mg PO BID x 10 days  □ Vancomycin 125mg PO QID x 10 days, then BID x 7 days, then Daily x 7 days, then every other day x 14 days  **Additional Considerations:**  □ Discontinue any active laxative and/or stool softener while undergoing CDI treatment  □ Discontinue chronic proton-pump inhibitor therapy, or switch to a histamine-2 receptor antagonist (famotidine)  □ Avoid using antimotility medications to treat diarrhea if treating for CDI, as using antimotility medications can increase the risk of toxic megacolon  □ Avoid using any oral sequestrants (e.g., cholestyramine) while treating CDI, as this can bind the antibiotic, making it ineffective to treat CDI | | | | | | | | | | | |
| □ Notify me if symptoms worsen or do not resolve within \_\_\_\_\_\_\_\_\_\_ hours after initiating antibiotics  □ Resident to be considered for hospital admission due to severity of disease and/or the need for IV antibiotics  □ Resident to be considered for gastroenterology consultant due to multiple recurrences of CDI  □ Notify me once culture identification and susceptibilities have resulted. Will adjust antibiotics as needed. | | | | | | | | | | | |
| Order(s) provided via: □ Fax □ Phone □ In-person □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
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| **Physician/Prescriber Signature:** | | | | | | | | | | | **Date/Time:** |
|  | | | | | | | | | | | |
| **Please return fax to: (\_\_\_\_)\_\_\_\_--\_\_\_\_\_\_** | | | | | | | | | | | |
| *Document to be filed under Physician/Prescriber Order or Progress Note* | | | | | | | | | | | |