Recovery from C. difficile infection: discharge

Original independent practice. Findings, treatment dates and documented discharge arrangements are fictional case facts, not universal treatment instructions. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. Assume that today is 3 November 2026. Mr Matejka is returning to residential care today. You are the doctor discharging Mr Norman Matejka from the medical ward. Using the case notes, write a discharge letter to Dr Alida Fiala, Care-Home General Practitioner, Residential Care Medical Service, 44 Clinic Road, SW1A 2AA, United Kingdom, explaining his recovery, completed treatment, current infection-control advice and follow-up for possible recurrence. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details and background			
1. Name: Mr Norman Matejka	☐	☐	☐
2. DOB: 08/09/1944 (82 yrs)	☐	☐	☐
3. Residential care since 2024; returning today, 03/11/26	☐	☐	☐
4. GP already knows mild dementia and knee osteoarthritis	☐	☐	☐
5. Baseline: staff administer medicines and prompt fluids	☐	☐	☐
6. Walks with frame; normally one formed stool daily	☐	☐	☐
7. Remote cataract surgery; no ongoing eye symptoms	☐	☐	☐
8. Daughter blames kitchen staff for infection; allegation unsupported	☐	☐	☐
Admission: 24 October 2026			
9. 24/10/26: admitted with watery stools approximately 6/day, cramps and poor intake	☐	☐	☐
10. Recent antibiotic course for cellulitis completed before admission; leg now healed	☐	☐	☐
11. Stool toxin positive for C. difficile; first documented episode	☐	☐	☐
12. Dehydrated on admission; received IV fluids	☐	☐	☐
13. 24/10 provisional instruction: isolate in room; meals alone; pending IPC review	☐	☐	☐
Treatment and progress			
14. Oral vancomycin 24/10–02/11: 10-day course completed; all doses received	☐	☐	☐
15. IV fluids stopped 26/10; drinking with staff prompts	☐	☐	☐
Treatment and progress			
16. 29/10: last unformed stool	☐	☐	☐
17. 30/10–03/11: one formed stool daily; usual bowel habit restored	☐	☐	☐
18. Appetite improving; no further nausea	☐	☐	☐
19. 03/11: afebrile; abdomen soft, non-tender	☐	☐	☐
20. Renal function returned to documented baseline	☐	☐	☐
Current infection-control advice			
21. 02/11 IPC review: room isolation ended; initial room-only instruction superseded	☐	☐	☐
22. Ongoing care advice: soap-and-water handwashing for patient and staff	☐	☐	☐
23. Care home briefed on toilet/environmental cleaning	☐	☐	☐
24. No loperamide: advice documented for patient and care staff	☐	☐	☐
Discharge plan: 3 November 2026			
25. Discharge today; no further antibiotics prescribed	☐	☐	☐
26. Staff to chart stools/intake, encourage fluids; GP review 06/11	☐	☐	☐
27. Recurrent diarrhoea → same-day GP assessment; stool sample if requested	☐	☐	☐
28. Marked deterioration, collapse or new confusion → emergency assessment	☐	☐	☐
29. Home confirms staff can monitor; daughter informed of discharge	☐	☐	☐

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