Meeting of Lanarkshire NHS Board: 25 January 2017

Lanarkshire NHS Board
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SUBJECT: HAIRT

1. PURPOSE

This paper is coming to the NHS Lanarkshire (NHSL) Board:

For approval	☐	For endorsement	☐	To note	☒

The purpose of this paper is to update NHSL Board Members on the current status of Healthcare Associated Infections (HCAI) and Infection Prevention and Control (IPC) measures, with particular reference to performance against the Health Efficiency Access Treatment (HEAT) targets and cleanliness monitoring.

2. ROUTE TO THE BOARD

This paper has been:

Prepared	☒	Reviewed	☐	Endorsed	☒

By the Head of Infection Prevention and Control and endorsed at the Lanarkshire Infection Control Committee at its meeting on 15 December 2016.

3. SUMMARY OF KEY ISSUES

The key headlines are noted on pages 4 – 5.

4. STRATEGIC CONTEXT

This paper links to the following:

Corporate Objectives	☒	LDP	☒	Government Policy	☐
Government Directive	☒	Statutory Requirement	☒	AHF/Local Policy	☐
Urgent Operational Issue	☐	Other	☐		

There is a national mandatory requirement for a report relating to IPC to be presented to the NHS Board on a bi-monthly basis utilising the HCAI Reporting Template (HCAIRT). There will be an exception report available only where exceptional issues are identified outwith the mandatory reporting period.

5. CONTRIBUTION TO QUALITY

This paper aligns to the following elements of safety and quality improvement:

Three Quality Ambitions:

Safe	☒	Effective	☒	Person Centred	☒

Six Quality Outcomes:

Everyone has the best start in life and is able to live longer healthier lives; (Effective)	☐
People are able to live well at home or in the community; (Person Centred)	☒
Everyone has a positive experience of healthcare; (Person Centred)	☒
Staff feel supported and engaged; (Effective)	☒
Healthcare is safe for every person, every time; (Safe)	☒
Best use is made of available resources. (Effective)	☒

6. MEASURES FOR IMPROVEMENT

- HEAT Targets for *Staphylococcus aureus* bacteraemias (SABs)
- Key Performance Indicators for Meticillin Resistant *Staphylococcus Aureus* (MRSA) Screening
- HEAT Targets for *Clostridium difficile* Infections (CDIs)
- Standard Infection Control Precautions (SICPs) and Hand Hygiene Compliance
- Facilities Monitoring Tool (FMT) Performance Scores for Domestic and Estates
- National Scottish Antimicrobial Prescribing Group (SAPG) CDI HEAT Target

7. FINANCIAL IMPLICATIONS

The organisation incurs financial implications in the management of an HAI depending on the length of stay of a patient, the associated treatment required and throughput of patients from a bed management perspective. Health Protection Scotland make reference to a study carried out in 2013 that estimated the inpatient costs of an HAI in NHS acute care hospital to be £137 million excluding the costs of those infections occurring outside hospital and highlights that the prevention of an HAI in all healthcare settings is of paramount importance.

8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

- NHSL is not on course to meet the Local Delivery Plan (LDP) for SABs by 31 March 2017.
- NHSL is not on course to meet the LDP for CDIs by 31 March 2017.

9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

Vision and leadership	☐	Effective partnerships	☐	Governance and accountability	☒
Use of resources	☒	Performance management	☐	Equality	
Sustainability	☐				

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment has been completed
Yes ☐ *Please say where a copy can be obtained* No ☒ *Please say why not*

There has been no requirement to date to complete an Equality and Diversity Impact Assessment.

11. CONSULTATION AND ENGAGEMENT

Consultation and contributions have been devised from the following departments/personnel across acute and partnership services:

- Infection Prevention and Control Team (IPCT)
- Property and Support Services Division (PSSD)
- Healthcare Quality Assurance Improvement Committee (HQAIC)
- Lanarkshire Infection Control Committee (LICC) and Sub-groups

12. ACTIONS FOR THE BOARD

The Board are asked to:

Approval	☐	Endorsement	☐	Identify further actions	☐
Note	☒	Accept the risk identified	☐		

The Board is asked to note this report and highlight any areas where further clarification or assurance is required.

The Board is also asked to confirm whether the report provides sufficient assurance about the organisational performance on HCAI, and the arrangements in place for managing and monitoring HCAI.

13. FURTHER INFORMATION

For further more detailed information or clarification of any issues in this paper please contact:

- Irene Barkby, Executive Director of NMAHPs (Telephone number: 01698 858089)
- Emer Shepherd, Head of Infection Prevention and Control (Telephone number: 01698 361100)

Prepared by Emer Shepherd, Head of Infection Prevention and Control
Presented by Irene Barkby, Executive Director of NMAHPs

Prepared 16 November 2016 for approval at the Lanarkshire Infection Control Committee on 15 December 2016.

HAIRT KEY HEADLINES:
QUARTER 3 – JULY TO SEPTEMBER 2016

Staphylococcus Aureus **Bacteraemias (SABs)**

- All Scottish NHS Boards are required to achieve the SAB HEAT target of 24 cases or less per 100,000 acute occupied bed days (AOBD) by 31 March 2017.
- The most recent validated surveillance report from Health Protection Scotland (HPS) for Quarter 3 (2016) confirms a total of 41 cases.
- This equates to a SAB rate of 36.7 per 100,000 AOBD which is a rate reduction from 41.8 in Quarter 2 (2016).
- The rate for NHS Scotland for the corresponding period is 33.2 per 100,000 AOBD (Table 1).
- NHSL is not on course to meet the HEAT target for SABs by 31 March 2017. The targeted work continues in clinical areas that have been identified by the IPCT as areas for improvement. A Short Life Working Group (SLWG) has been convened at Monklands Hospital to lead improvement work following renal related SAB increases in the renal dialysis units.

Clostridium *Difficile* Infections (CDIs)

- All Scottish NHS Boards are required to achieve the CDI HEAT target of 32 cases or less per 100,000 AOBD in the aged 15 and over age group by 31 March 2017.
- The most recent validated surveillance report from HPS for Quarter 3 (2016) confirms a total number of 42 CDI cases for NHSL.
- This equates to a CDI rate of 34.2 per 100,000 AOBD which is a rate increase from 26.3 in Quarter 2 (2016).
- The rate for NHS Scotland for the corresponding period is 31.4 per 100,000 AOBD (Table 1).
- NHSL is not on course to meet the HEAT target for CDI by 31 March 2017.

Table 1 – Validated HPS / Information Services Division (ISD) Data Quarter 3 (2016)

HEAT Targets	NHSL Rate Quarter 3 (2016)	National Rate Quarter 3 (2016)	HEAT Target
SAB rate per 100,000 AOBD	36.7	33.2	24 cases per 100,000 AOBD
CDI rate per 100,000 AOBD	34.2	31.4	32 cases per 100,000 AOBD

Surgical Site Infection (SSI) Surveillance

Mandatory Surveillance:

- Caesarean section SSI data Quarter 3 (2016) has demonstrated an increase in the SSI rate from 0.76% (n=3) in Quarter 2 (2016) to 1.73% (n=7) and an increase from 0.85% (n=3) in the same time period compared Quarter 3 (2015).

- Hip arthroplasty SSI data Quarter 3 (2016) has demonstrated a decrease in the SSI rate from 0.76% (n=1) in Quarter 2 (2016) to 0% (n=0) and no difference from 0% (n=0) in the same time period compared Quarter 3 (2015).

Voluntary Surveillance:

- Knee arthroplasty SSI data for Quarter 3 (2016) has demonstrated an increase in the SSI rate from 1.34% (n=2) in Quarter 2 (2016) to 1.85% (n=2) and an increase from 0% (n=0) in the same time period compared Quarter 3 (2015).

- Repair of neck of femur SSI data Quarter 3 (2016) has demonstrated no difference in the SSI rate from 0% (n=0) in Quarter 2 (2016) to 0% (n=0) and a decrease from 1.09% (n=1) in the same time period compared Quarter 3 (2015).

Table 2 - SSI Performance Quarter 3 (2016)

Procedure	Number of Procedures	Number of Infections	NHSL SSI Rate (%)	National SSI Rate (%)
Caesarean Section	405	7	1.7%	1.6%
Hip Arthroplasty	91	0	0.0%	0.6%
Knee Arthroplasty	108	2	1.8%	0.0%
Neck of Femur Repair	78	0	0.0%	0.7%

HAIRT REPORT:
QUARTER 3 – JULY TO SEPTEMBER 2016

SECTION 1

1.1 *Staphylococcus aureus* Bacteraemias (SABs) Surveillance

Staphylococcus aureus is an organism that is responsible for a large number of HCAI, although it can also cause infections in people who have not had any recent contact with the healthcare system.

The most common form is Meticillin Sensitive *Staphylococcus aureus* (MSSA), but the more well known is MRSA, which is a specific type of the organism that is resistant to certain antibiotics and is therefore more difficult to treat.

1.2 SAB – Rapid Review Process

Each SAB in NHS Lanarkshire undergoes a joint rapid review by the IPCT and the clinical team responsible for the patient. Enhanced surveillance data from the patients' healthcare record is collated and the SAB is categorised, using the following national definitions set by HPS.

Healthcare associated infection (HCAI)
Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

- Was hospitalised overnight in the 30 days prior to the positive blood culture being taken.
- Resides in a nursing, long term care facility or residential home.
- Intravenous/Intra-muscular/Intra-articular or subcutaneous medication in the 30 days prior to the positive blood culture being taken, but excluding IV illicit drug use.
- Venepuncture in the 30 days prior to the positive blood culture being taken.
- Underwent any medical procedure which broke mucous or skin barrier i.e. biopsies or dental extraction in the 30 days prior to the positive blood culture being taken.
- Underwent any care for chronic medical condition or manipulation of a medical device by a healthcare worker in the community in the 30 days prior to the positive blood culture being taken i.e. podiatry or dressing of chronic ulcers, catheter change or insertion.

Hospital acquired infection (HAI)

- Positive blood culture obtained from a patient who has been hospitalised for longer than 48 hours.

Community acquired infection (CA)

- Positive blood culture obtained from a patient within 48 hours of admission to hospital that does not fulfil any of the criteria for healthcare associated bloodstream infection.

Not known

- The SAB is not an HAI, and unable to determine if community or HCAI.

1.3 SAB Performance

For Quarter 3 (2016), validated data from HPS shows NHSL reported 41 SAB cases per 100,000 AOBDs which equates to a rate of 36.7 (Table 3).

Charts 1 and 2 provide an overview of local performance trends by quarterly rates (Chart 1) since September 2013 as verified by HPS and by the number of SAB cases (Chart 2) since August 2014.

Table 3 – Validated HPS / ISD Data Quarter 4 (2015) to Quarter 3 (2016) SAB Performance

	Quarter 4 Oct-Dec 2015	Quarter 1 Jan-Mar 2016	Quarter 2 Apr-Jun 2016	Quarter 3 Jul – Sept 2016
NHS Lanarkshire	36.8	36.5	41.8	36.7
NHS Scotland	32.6	32.6	31.1	33.2

Chart 1 – Quarterly rates for NHSL SABs per 100,000 Acute Occupied Bed Days September 2013 – September 2016

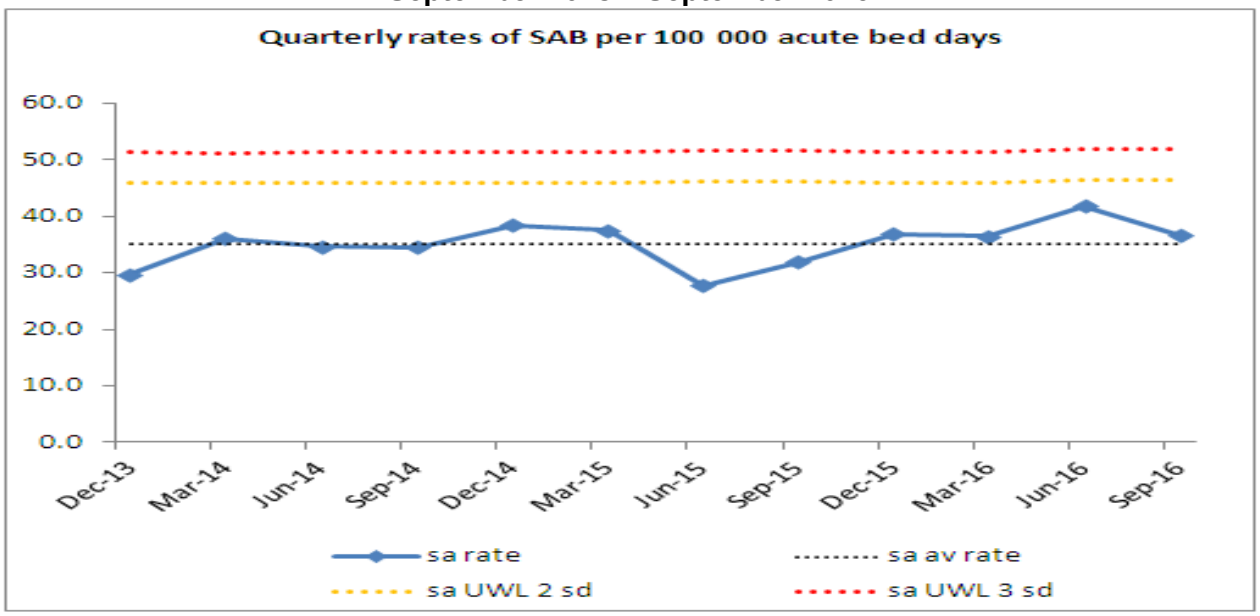
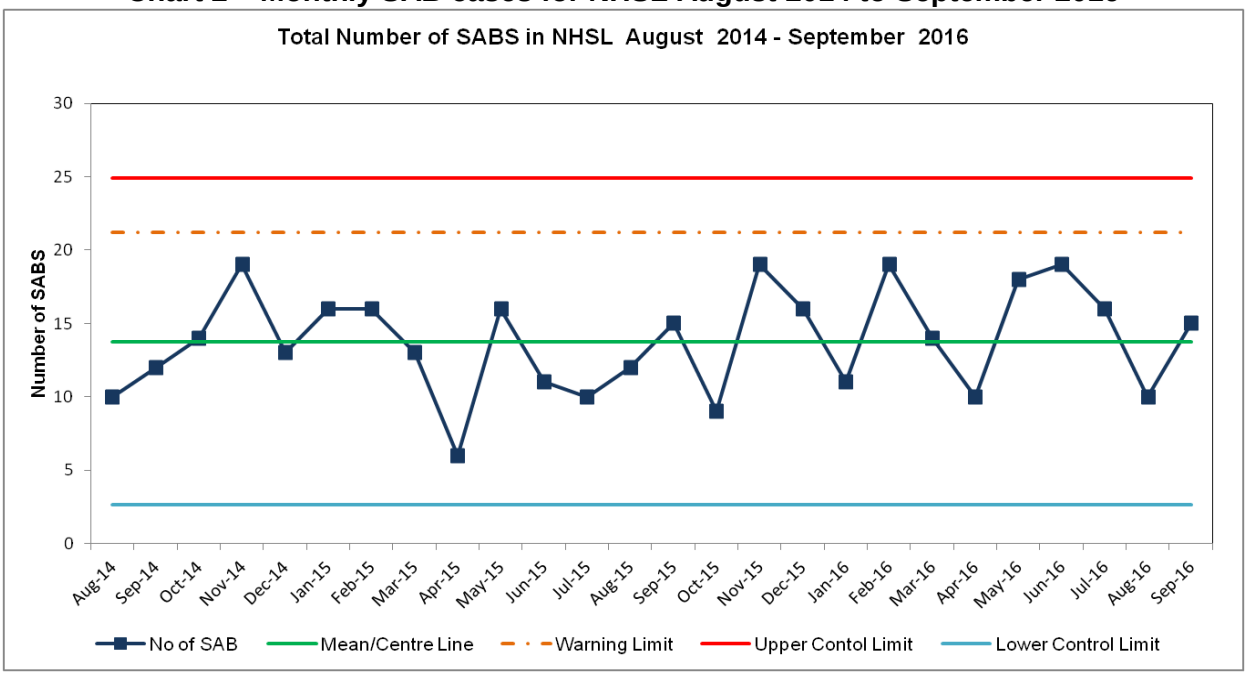


Chart 2 – Monthly SAB cases for NHSL August 2014 to September 2016



1.4 MRSA Screening – Clinical Risk Assessment (CRA)

National Key Performance Indicators (KPIs) stipulate that all NHS Boards across Scotland are required to achieve 90% compliance with CRA for MRSA.

Eighty healthcare records are randomly reviewed per quarter in acute clinical areas where a CRA is required. Results from this audit are reported to Hygiene Groups and to the LICC on a quarterly basis and uploaded to the HPS National Portal.

CRA compliance for NHSL for Quarter 3 (2016) is 77% which is **a decrease of 11%** since Quarter 2 (2016). The IPCT continue to focus on improvement work within acute wards to improve performance over Quarter 3 particularly in the receiving wards.

SECTION 2

2.1 *Clostridium Difficile* Infection (CDI) Surveillance

Clostridium difficile is an organism that is responsible for a large number of HCAI although it can also cause infections in people who have not had any recent contact with the healthcare system.

2.2 CDI – Rapid Review Process

A severe case of CDI is defined as any patient with CDI with:

- One or more severity markers, i.e. temperature >38.5°C, WBC > 15 cells x 10^9/L creatinine > 1.5 x baseline, suspicion of PMC, toxic megacolon, ileus, or CT evidence of severe disease.
- Has died within 30 days following a diagnosis of CDI where it is recorded as either the primary or a contributory factor on the death certificate.
- Has persisting CDI where the patient has remained symptomatic and toxin positive despite 2 courses of appropriate therapy.

Each CDI in NHSL undergoes a rapid review by the IPCT and the clinical team responsible for the patient. All CDI cases deemed as severe undergo a multidisciplinary case review within 48 hours using an adapted local version of the national review tool from HPS.

2.3 CDI Performance

For the last available reporting Quarter 3 (2016), the validated data from HPS confirms NHSL reported 42 CDI cases per 100,000 AOBDs which equates to a rate of 34.2.

Charts 3 and 4 provide an overview of local performance trends by rate (Chart 3) since September 2013 as verified by HPS and by the number of SAB cases (Chart 4) since August 2014.

Table 4 - Validated HPS / ISD Data Quarter 4 (2015) to Quarter 3 (2016) CDI Performance

	Quarter 4 Oct-Dec 2015	Quarter 1 Jan-Mar 2016	Quarter 2 Apr-Jun 2016	Quarter 3 Jul-Sept 2016
NHS Lanarkshire	45.9	30.7	26.3	34.2
NHS Scotland	38.0	26.8	27.1	31.4

Chart 3 – Quarterly rates for NHSL CDIs per 100,000 Acute Occupied Bed Days September 2013 – September 2016

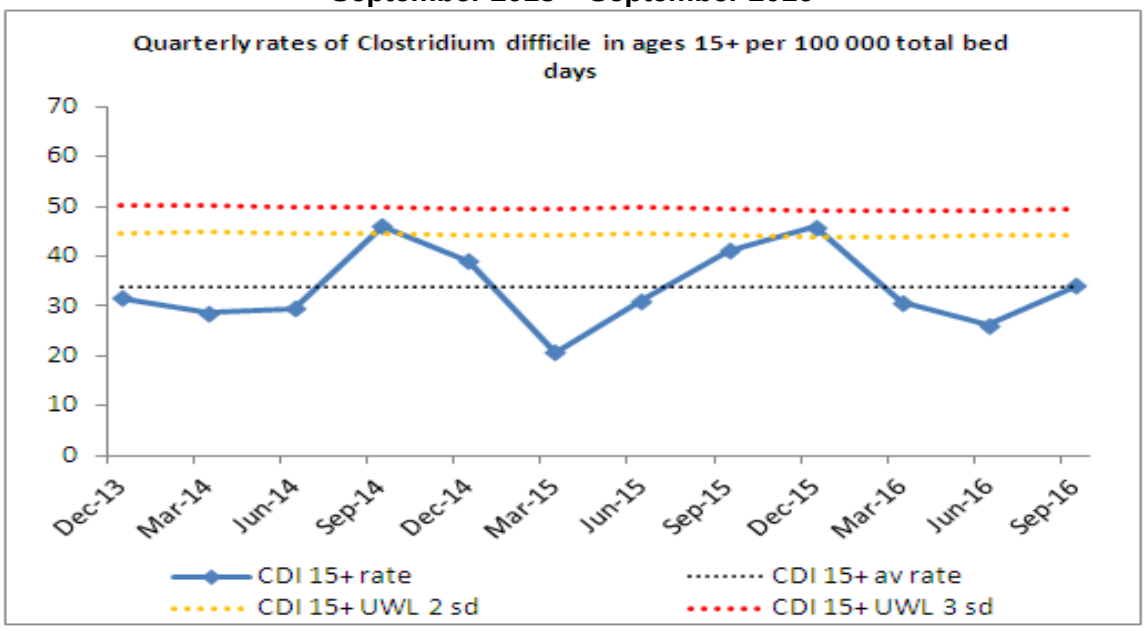
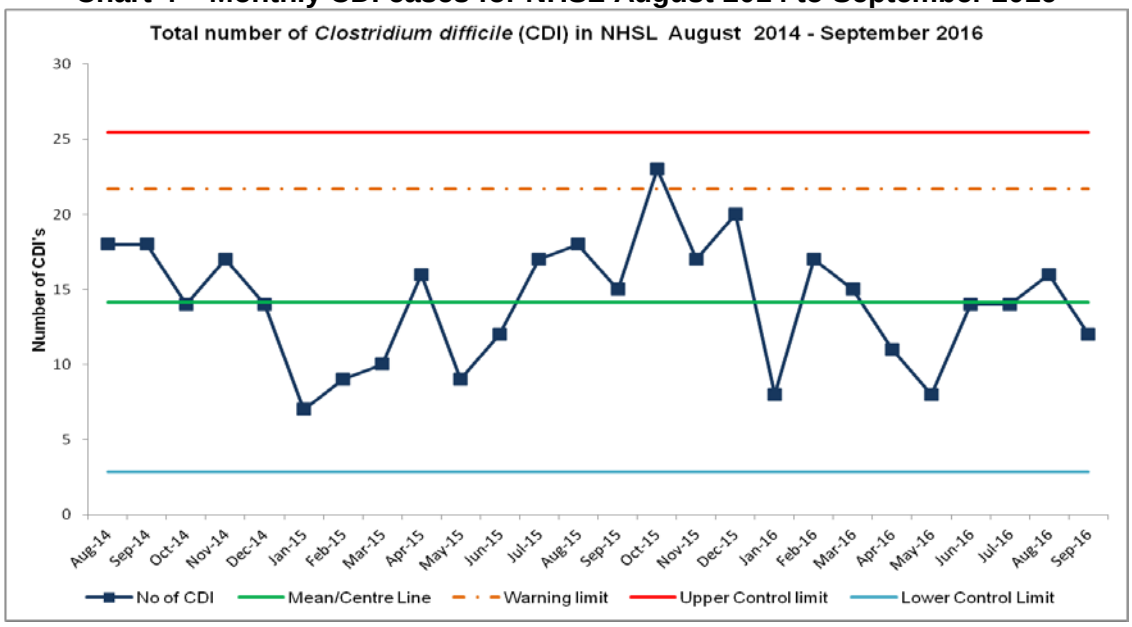


Chart 4 – Monthly CDI cases for NHSL August 2014 to September 2016



SECTION 3

3.1 Surgical Site Infection (SSI) Surveillance

NHSL participates in the SSI surveillance programme for hip arthroplasty and caesarean section procedures as per the mandatory requirements of Health Department Letter (HDL) (2006)38 and Chief Executive Letter (CEL) 11(2009). NHSL also complete additional SSI surveillance of knee arthroplasty and neck of femur repair. It is anticipated that NHS Boards will be mandated in 2017 to commence SSI surveillance of colorectal and vascular surgery.

3.2 SSI Performance

In Quarter 3 (2016), HPS validated data shows NHSL SSI rates is below the national rates for all except hip arthroplasty procedures for which NHSL is below (Table 5).

Table 5 – Number of surgical procedures and SSI for Quarter 3 (2016)

Procedure	Number of Procedures	Number of Infections	NHSL SSI Rate (%)	National SSI Rate (%)
Caesarean Section	405	7	1.7%	1.6%
Hip Arthroplasty	91	0	0.0%	0.6%
Knee Arthroplasty	108	2	1.8%	0.0%
Neck of Femur Repair	78	0	0.0%	0.7%

SECTION 4

4.1 Hand Hygiene

NHSL hand hygiene is audited monthly by clinical staff and results collated. In addition quality assurance audits are undertaken by the IPCT.

The IPCT commenced a hand hygiene monitoring programme from April 2016 which includes the completion of validatory audits using the World Health Organisation (WHO) 5 Moments Observation Tool and report findings to Hygiene Teams and LICC (Table 6).

Table 6 – NHSL Hand Hygiene Monitoring Compliance (n= %) October 2015 to September 2016

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
AHP	83	96	97	98	95	90	94	95	92	96	76	98
Ancillary	94	97	91	89	91	85	92	69	96	93	88	66
Medical	95	94	95	95	96	93	93	85	87	82	86	92
Nurse	97	97	97	97	97	97	97	97	96	97	96	98

The results of the compliance levels for Allied Health Professional (AHPs), Ancillary and Medical staff have been flagged with the relevant head of service to feed this back to their respective staff groups.

4.2 Cleaning and the Healthcare Environment

All areas within NHSL scored green in the most recent report in the Health Facilities Scotland (HFS) National Cleaning Specification (Table 7). The national validated data for for Quarter 3 (2016) was not available at the time of reporting and will be available for the next report to the NHS Board members covering October to December 2016.

Table 7 – HFS National Cleaning Specification for Quarter 2 July to September 2016

Key: *D – Domestic* *E – Estates*		Quarter 4 Jan-Mar 16		Quarter 1 Apr-Jun 16		Quarter 2 Jul-Sept 16	
		D (n=%)	E (n=%)	D (n=%)	E (n=%)	D (n=%)	E (n=%)
Acute	Hairmyres	93.4	97.5	93.9	97.7	93.9	97.3
	Monklands	94.7	95.8	95.2	94.8	95.0	95.0
	Wishaw	97.1	97.8	97.1	97.8	96.7	97.8
HSCP	Airdrie/Coatbridge	98.7	97.1	96.6	96.8	96.2	96.0
	Cleland/Monklands	96.4	98.3	95.7	98.3	96.7	97.6
	Hamilton/East Kilbride	96.4	96.7	94.9	94.7	93.2	96.4

4.3 Executive Director / Senior Management Inspection (SMI) Programme

As per recommendations from the Vale of Leven Inquiry (2014) and the Healthcare Improvement Scotland (HIS) Standards for HCAI (2015), NHS Boards are required to implement a programme of ward visits by Senior Managers and Infection Prevention and Control on a regular basis.

In NHSL, a quarterly SMI programme is in place complemented by a bi-monthly Head of Infection Prevention and Control Inspection programme.

In August 2016, a SMI with the Chief Executive was conducted at Monklands Hospital. A number of wards were visited and the Out-patients Department.

4.4 Outbreaks of Infection

Norovirus activity was reported in 6 wards (Tables 8 and 9) during Quarter 3 (2016):

Table 8 – Norovirus activity detail July – September 2016

Month/Year	Hospital	Ward	Ward/Room Closure	Number of days closed in total	Number of Patients Affected	Number of Staff Affected
July	Wishaw	9	Room	2	3	0
August	Udston	Clyde	Room/Ward	3	5	3
August	Udston	Brandon	Room/Ward	9	3	11
August	Udston	Clyde	Ward	4	2	0
August	Monklands	22	Room	3	1	0
September	Hairmyres	5	Room	3	5	0

Table 9 – NHSL Norovirus Activity October 2015 to September 2016 (Ward or Room Closures)

Month	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Ward	0	1	1	0	0	1	5	0	0	0	3	0
Room	0	0	0	3	0	2	1	2	1	1	1	1

SECTION 5

5.0 Acute Antimicrobial Prescribing

All national antimicrobial prescribing indicators to support the CDI HEAT target for acute hospitals have now been revised by the Scottish Antimicrobial Prescribing Group (SAPG) and aligned with the second Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP 2; 2014-18) priority areas as well as Healthcare Improvement Scotland's recently launched HAI Standards in February 2015. The AMT is currently testing data collection processes to ensure all required aspects of the new measures are being delivered in practice at ward level. For any patient receiving antibiotic therapy:

- All doses are administered
- Indication is documented
- Duration or review date is documented
- Antibiotic choice is compliant with local policy

The four new measures above are being assessed in pilot wards by AMT staff using the Safer Patient Safety Programme (SPSP) Plan, Do, Study, Act (PDSA) cycle of change improvement methodology before robust roll out to one medical and one surgical "downstream" ward across all three acute sites in NHSL begins on a weekly basis. All NHS Boards in Scotland are re-aligning antimicrobial surveillance in this manner.

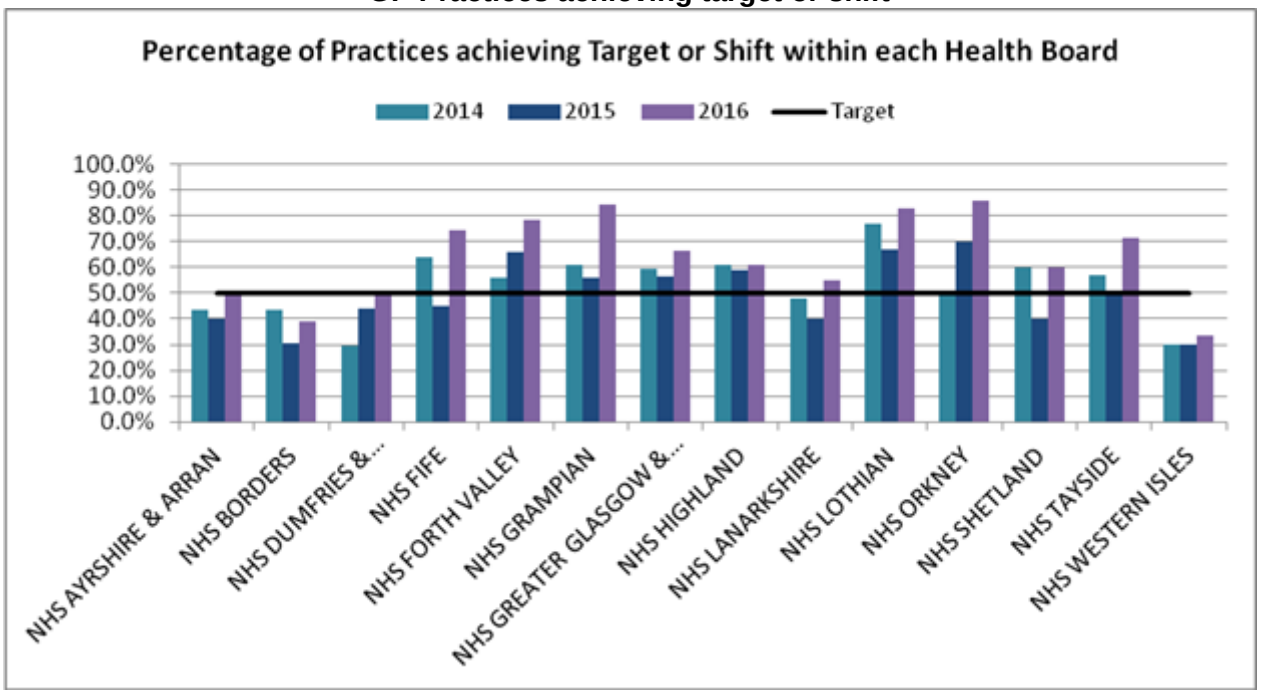
Preliminary data for NHSL confirms high compliance with administration of all doses, local policy recommendations and documentation of antibiotic indication. It also highlights clear areas for improvement, in particular oral antibiotic course length documentation. The AMT continues to progress this work on all three acute sites with close feedback and communication with front line clinical teams.

5.1 Antimicrobial Prescribing Primary Care

The national level three antibiotic indicator data for primary care is based on volume of antibiotic items prescribed (volume of antibiotic items/1000pts/day) against a nationally agreed set target and is assessed annually using PRISMS data from Quarter 4 (January-March) period each year. NHSL remains the highest outlier in comparison to all other NHS Boards however consistent reduction continues to be observed in each quarterly PRISMS data set. For example, latest NHSL PRISMS data for Quarter 2 (July-Sept) 2016/2017 shows a prescribing volume of 1.97 items per 1000 patients per day, approximately 15.8% lower than Q2 for 2012/13 and the equal lowest value ever achieved for a Q2 period since 2011/12.

In addition, NHSL was one of 11 health boards in 2016 to achieve the national level three antibiotic indicator for primary care for 2015/2016 with 55.1% of NHSL GP practices either achieving target or sufficient shift status. NHSL AMT continues to work with key stakeholders to support and facilitate local quality improvement initiatives which aim to reduce inappropriate antibiotic prescribing and build on this positive downward shift in prescribing volume in primary care.

Chart 5 - National level three antibiotic indicator for primary care NHS Board position GP Practices achieving target or shift



SECTION 6

6.1 NHS Lanarkshire Board Report

This report includes all CDI episodes including GP samples with no other exclusions and SAB episodes with no exclusions.

6.1.2 SAB monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	1	3	1	3	0	1	0	0	0	1	1	0
MSSA	8	16	15	8	19	13	10	18	19	15	9	15
TOTAL	9	19	16	11	19	14	10	18	19	16	10	15

6.1.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	9	6	5	1	4	6	7	1	2	7	4	6
Ages 65+	14	11	15	7	16	10	3	7	12	7	12	6
Ages 15+	23	17	20	8	20	16	10	8	14	14	16	12

6.1.3 Hand Hygiene Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
AHP	83	96	97	98	95	90	94	95	92	96	76	98
Ancillary	94	97	91	89	91	85	92	69	96	93	88	66
Medical	95	94	95	95	96	93	93	85	87	82	86	92
Nurse	97	97	97	97	97	97	97	97	96	97	96	98

6.1.4 Cleaning compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	97	97	97	95	96	96	96	96	95	96	93	95

6.1.5 Estates Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	98	98	98	98	98	98	97	97	97	97	97	97

6.2 Hairmyres Hospital Report Card

This report identifies all healthcare associated and unknown CDI episodes for Hairmyres Hospital and all hospital associated SAB episodes

6.2.1 SABs monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	0	0	0	1	0	0	0	0	0	0	0	0
MSSA	2	2	1	0	0	0	0	1	2	1	1	1
TOTAL	2	2	1	1	0	0	0	1	2	1	1	1

6.2.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	1	0	0	0	0	0	1	0	0	0	0	0
Ages 65+	0	0	2	1	3	0	0	3	4	1	2	1
Ages 15+	1	0	2	1	3	0	1	3	4	1	2	1

6.2.3 Hand Hygiene Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
AHP	100	90	100	100	887	100	83	90	71	66	50	100
Ancillary	100	100	83	81	100	76	71	40	100	100	83	66
Medical	94	92	100	90	93	97	96	91	82	88	93	95
Nurse	98	100	98	98	96	100	98	98	96	97	96	96

6.2.4 Cleaning compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	93	93	92	94	93	93	94	94	94	94	94	94

6.2.5 Estates Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	99	99	99	99	99	99	99	97	98	97	97	97

6.3 Monklands District General Hospital Report Card

This report identifies all healthcare associated and unknown CDI episodes for Monklands Hospital and all hospital associated SAB episodes

6.3.1 SABs monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	0	0	0	1	0	1	0	0	0	0	0	0
MSSA	0	4	3	1	4	3	1	3	5	5	1	1
TOTAL	0	4	3	2	4	4	1	3	5	5	1	1

6.3.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	1	1	3	1	1	3	0	0	0	2	1	2
Ages 65+	1	2	2	1	2	2	0	0	3	0	4	1
Ages 15+	2	3	5	2	3	5	0	0	3	2	5	3

6.3.3 Hand Hygiene Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
AHP	90	100	97	100	95	95	100	100	100	85	90	91
Ancillary	96	96	94	100	93	100	100	66	100	100	66	50
Medical	95	98	93	96	96	95	91	89	84	80	84	80
Nurse	97	94	97	97	97	98	96	95	97	96	98	98

6.3.4 Cleaning compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	95	95	95	94	95	95	96	96	94	95	95	95

6.3.5 Estates Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	95	95	95	96	96	96	95	96	94	95	96	95

6.4 Wishaw General Hospital Report Card

This report identifies all healthcare associated and unknown CDI episodes for Wishaw General Hospital and all hospital associated SAB episodes

6.4.1 SABs monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	1	0	0	0	0	0	0	0	0	0	1	0
MSSA	0	3	1	2	2	2	1	3	4	0	3	4
TOTAL	1	3	1	2	2	2	1	3	4	0	4	4

6.4.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	3	0	1	0	0	0	2	1	0	1	0	0
Ages 65+	3	1	6	1	0	2	0	1	0	1	1	1
Ages 15+	6	1	7	1	0	2	2	2	0	2	1	1

6.4.3 Hand Hygiene Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
AHP	50	100	93	96	95	83	91	97	90	100	68	100
Ancillary	100	100	84	80	78	76	86	100	100	89	100	100
Medical	96	90	96	97	97	83	92	76	87	75	74	95
Nurse	96	95	95	96	94	94	96	95	95	96	91	98

6.4.4 Cleaning compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	97	97	97	97	97	97	98	97	96	97	92	96

6.4.5 Estates Monitoring Compliance (n= %)

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Board	98	98	98	98	98	98	98	98	98	98	98	98

6.5 Out of Hospital Report Card

This report identifies all community associated CDI episodes including GP samples and all SAB episodes associated with the community such as nursing homes and community sources such as GP surgeries.

6.5.1 SAB monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	0	3	1	1	0	0	0	0	0	0	0	0
MSSA	6	7	10	5	13	8	8	11	8	6	4	2
TOTAL	6	10	11	6	13	8	8	11	8	6	4	2

6.5.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	2	5	3	0	3	3	4	0	2	4	2	3
Ages 65+	8	8	6	4	10	6	3	3	5	5	6	4
Ages 15+	10	13	9	4	13	9	7	3	7	9	8	7

6.6 Community Hospital Report Card

This report identifies all healthcare associated CDI episodes and all SAB episodes associated to the community hospitals listed below:

- Cleland
- Coathill
- Kello
- Kilsyth
- Kirklands
- Lockhart
- Udston
- Wester Moffat

6.6.1 SAB monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0	0	0	0	0	0	0

6.6.2 CDI monthly case numbers

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65+	0	0	0	0	1	0	0	0	0	0	0	0
Ages 15+	0	0	0	0	1	0	0	0	0	0	0	0