Meeting of Lanarkshire NHS Board: 29 March 2017

Lanarkshire NHS Board
Kirklands
Fallside Road
Bothwell
G71 8BB
Telephone: 01698 855500
www.nhslanarkshire.org.uk

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 7 February 2017.

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)
- HEAT Targets for *Clostridium difficile* Infections (CDIs)
- Key Performance Indicators for Meticillin Resistant *Staphylococcus Aureus* (MRSA) Screening
- 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 an 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)
- Antimicrobial Management Team (AMT)
- 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 NHS Board is asked to note this report and highlight any areas where further clarification or assurance is required.

The NHS 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 18 January 2017 (approved by LICC on 7 February 2017)

HAIRT KEY HEADLINES:
QUARTER 4 – OCTOBER TO DECEMBER 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.

- NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

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.

- NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

Surgical Site Infection (SSI) Surveillance

- Caesarean section SSI data Quarter 4 (2016) has demonstrated an increase in the SSI rate from 1.73% (n=7) in Quarter 3 (2016) to 2.75% (n=10) and an increase from 1.14% (n=4) in the same time period compared Quarter 4 (2015).

- Hip arthroplasty SSI data Quarter 4 (2016) has demonstrated an increase in the SSI rate from 0.0% (n=0) in Quarter 3 (2016) to 1.98% (n=2) and an increase from 1.94% (n=2) in the same time period compared Quarter 4 (2015).

- Knee arthroplasty SSI data for Quarter 4 (2016) has demonstrated a decrease in the SSI rate from 1.85% (n=2) in Quarter 3 (2016) to 0.99% (n=1) and an increase from 0.0% (n=0) in the same time period compared Quarter 4 (2015).

- Repair of neck of femur SSI data Quarter 4 (2016) has demonstrated no difference in the SSI rate from 0% (n=0) in Quarter 3 (2016) to 0% (n=0) and no difference from 0.0% (n=0) in the same time period compared Quarter 4 (2015).

Table 1 - SSI Performance Quarter 4 (2016)

Procedure	Number of Procedures	Number of Infections	NHSL SSI Rate (%)
Caesarean Section	364	10	2.75
Hip Arthroplasty	101	2	1.98
Knee Arthroplasty	101	1	0.99
Neck of Femur Repair	75	0	0.00

- NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

HAIRT REPORT:
QUARTER 4 – OCTOBER TO DECEMBER 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 (CAI)

- 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

NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

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 during October to December 2016 is 68% which is **a further decrease of 9%** since the last activity quarter. At the LICC meeting in February 2017, there were discussions around potential issues surrounding the lower compliance level in this quarter which is being taken forward with the Chiefs of Nursing Services. The IPCT will assist sites to improve compliance particularly within the acute medical 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

NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

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.

Mandatory Surveillance:

- Caesarean section SSI data Quarter 4 (2016) has demonstrated an increase in the SSI rate from 1.73% (n=7) in Quarter 3 (2016) to 2.75% (n=10) and an increase from 1.14% (n=4) in the same time period compared Quarter 4 (2015). A review was undertaken by the IPC surveillance nurses to identify any common links in relation to patients who have developed a surgical site infection (SSI). There are risk factors associated with an SSI when a patient is obese or there are longer than normal operation times. There was however no microbiological links identified between the cases.

- Hip arthroplasty SSI data Quarter 4 (2016) has demonstrated an increase in the SSI rate from 0.0% (n=0) in Quarter 3 (2016) to 1.98% (n=2) and an increase from 1.94% (n=2) in the same time period compared Quarter 4 (2015). The 2 hip arthroplasty patients who developed an SSI were operated on different months and no microbiological links were identified.

Voluntary Surveillance:

- Knee arthroplasty SSI data for Quarter 4 (2016) has demonstrated a decrease in the SSI rate from 1.85% (n=2) in Quarter 3 (2016) to 0.99% (n=1) and an increase from 0.0% (n=0) in the same time period compared Quarter 4 (2015).

- Repair of neck of femur SSI data Quarter 4 (2016) has demonstrated no difference in the SSI rate from 0% (n=0) in Quarter 3 (2016) to 0% (n=0) and no difference from 0.0% (n=0) in the same time period compared Quarter 4 (2015).

3.2 SSI Performance

NHS Board Members are to note that the national validated surveillance report from Health Protection Scotland (HPS) is not available to the Head of Infection Prevention and Control until 28 March 2017. A verbal report on the quarter 4 position will be provided at the NHS Board on 29 March 2017. An updated full report will be circulated to NHS Board members post meeting.

Table 2 – Number of surgical procedures and SSI for Quarter 4 (2016) in NHSL

Procedure	Number of Procedures	Number of Infections	NHSL SSI Rate (%)
Caesarean Section	364	10	2.75
Hip Arthroplasty	101	2	1.98
Knee Arthroplasty	101	1	0.99
Neck of Femur Repair	75	0	0.00

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 3 – NHSL Hand Hygiene Monitoring Compliance (n= %) January to December 2016

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
AHP	98	95	90	94	95	92	96	76	98	97	97	95
Ancillary	89	91	85	92	69	96	93	88	66	76	90	100
Medical	95	96	93	93	85	87	82	86	91	94	87	91
Nurse	97	97	97	97	97	96	97	96	98	97	97	99

The results of the compliance levels 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 4 – HFS National Cleaning Specification for Quarter 3 October to December 2016

Key: *D – Domestic* *E – Estates*		**Quarter 4 Jan-Mar 16**		**Quarter 1 Apr-Jun 16**		**Quarter 2 Jul-Sept 16**		**Quarter 3 Oct-Dec 16**	
		D (n=%)	E (n=%)	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	94.0	98.6
	Monklands	94.7	95.8	95.2	94.8	95.0	95.0	95.2	96.3
	Wishaw	97.1	97.8	97.1	97.8	96.7	97.8	96.5	97.3
H&SCP	Airdrie/ Coatbridge	98.7	97.1	96.6	96.8	96.2	96.0	98.1	97.9
	Cleland/ Motherwell	96.4	98.3	95.7	98.3	96.7	97.6	97.6	99.8
	Hamilton/ East Kilbride	96.4	96.7	94.9	94.7	93.2	96.4	95.1	97.1

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.

An SMI was carried out in Wishaw General Hospital on 21 November 2016 visiting Ward 18 – Surgical. There was an intention to visit the Emergency Department however due to operational pressures at the time of inspection was not appropriate to inspect. There were no major areas of concern raised for escalation as part of the inspection.

4.4 Outbreaks of Infection

Norovirus activity was reported in 15 wards (Tables 8 and 9) during Quarter 4 (2016):

Table 5 – Norovirus activity detail October – December 2016

Month/ Year	Hospital	Ward	Ward/Room Closure	N= Total days closed	N=Total Patients Affected	N= Total Staff Affected
November 2016	Monklands	4	Room	2	2	10
		20	Room	3	3	0
		17	Room	4	4	6
		11	Room	2	1	0
		17	Room	4	1	0
	Wishaw	9	Room	10	10	1
		10	Ward	6	9	11
		3	Ward	6	5	13
	Hairmyres	CCL	Room	1	1	0
	Beckford Lodge	Iona	Ward	5	2	4
December 2016	Hairmyres	13	Ward	9	11	9
		14	Room	7	5	1
		13	Room	3	1	0
	Monklands	12	Room	8	5	3
		22	Room	7	2	2

Table 6 – NHSL Norovirus Activity January 2016 to December 2016 (Ward or Room Closures)

Month	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
Ward	0	0	1	5	0	0	0	3	0	0	3	1
Room	3	0	2	1	2	1	1	1	1	0	12	4

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.

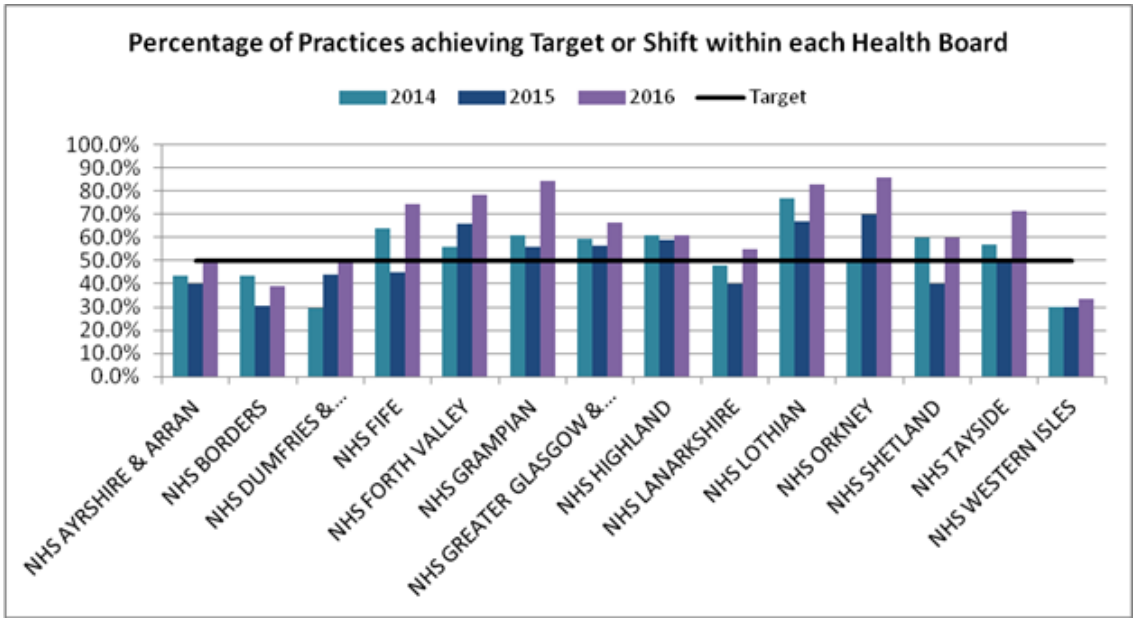
Preliminary data for NHSL confirms high compliance with administration of all doses, local policy recommendations and documentation of antibiotic indication. It also highlights clear areas for improvement, in particular oral antibiotic course length documentation. The AMT continues to progress this work 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 1 - 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

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
MRSA	3	0	1	0	0	0	1	1	0	0	2	0
MSSA	8	19	13	10	18	19	15	9	15	13	11	17
TOTAL	11	19	14	10	18	19	16	10	15	13	13	17

6.1.2 CDI monthly case numbers

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
Age 15-64	1	4	6	7	1	2	7	4	6	4	1	2
Ages 65+	7	16	10	3	7	12	7	12	6	10	12	10
Ages 15+	8	20	16	10	8	14	14	16	12	14	13	12

6.1.3 Hand Hygiene Monitoring Compliance (n= %)

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
AHP	98	95	90	94	95	92	96	76	98	97	97	95
Ancillary	89	91	85	92	69	96	93	88	66	76	90	100
Medical	95	96	93	93	85	87	82	86	92	94	87	91
Nurse	97	97	97	97	97	96	97	96	98	97	97	99

6.1.4 Cleaning compliance (n= %)

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

6.1.5 Estates Monitoring Compliance (n= %)

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

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

6.2.2 CDI monthly case numbers

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

6.2.3 Hand Hygiene Monitoring Compliance (n= %)

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

6.2.4 Cleaning compliance (n= %)

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

6.2.5 Estates Monitoring Compliance (n= %)

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

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

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
MRSA	1	0	1	0	0	0	0	0	0	0	1	0
MSSA	1	4	3	1	3	5	5	1	1	3	4	7
TOTAL	2	4	4	1	3	5	5	1	1	3	5	7

6.3.2 CDI monthly case numbers

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

6.3.3 Hand Hygiene Monitoring Compliance (n= %)

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
AHP	100	95	95	100	100	100	85	90	91	88	80	80
Ancillary	100	93	100	100	66	100	100	66	50	100	60	100
Medical	96	96	95	91	89	84	80	84	75	95	82	84
Nurse	97	97	98	96	95	97	96	98	97	96	96	98

6.3.4 Cleaning compliance (n= %)

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

6.3.5 Estates Monitoring Compliance (n= %)

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
Board	96	96	96	95	96	94	95	96	95	96	97	97

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

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

6.4.2 CDI monthly case numbers

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

6.4.3 Hand Hygiene Monitoring Compliance (n= %)

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
AHP	96	95	83	91	97	90	100	68	100	100	100	95
Ancillary	80	78	76	86	100	100	89	100	100	83	100	100
Medical	97	97	83	92	76	87	75	74	95	88	80	90
Nurse	96	94	94	96	95	95	96	91	98	95	94	99

6.4.4 Cleaning compliance (n= %)

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

6.4.5 Estates Monitoring Compliance (n= %)

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

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

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

6.5.2 CDI monthly case numbers

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16
Age 15-64	0	3	3	4	0	2	4	2	3	1	0	1
Ages 65+	4	10	6	3	3	5	5	6	4	2	7	6
Ages 15+	4	13	9	7	3	7	9	8	7	3	7	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

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

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