Meeting of NHS Board
27 March 2019

Lanarkshire NHS Board
Kirklands
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SUBJECT: Healthcare Associated Infection (HCAI) Reporting Template

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 position against the Healthcare Association Infection (HAI) Standards 2015 with particular reference to NHSL Board performance against the Annual Operating Plan (AOP) Targets.

2. ROUTE TO THE BOARD

This paper has been:

Prepared	☒	Reviewed	☐	Endorsed	☒

By the Head of Infection Prevention and Control (IPC) and approved by the Lanarkshire Infection Control Committee (LICC).

3. SUMMARY OF KEY ISSUES

The key performance headlines and improvement activity are noted on pages 5-8. Please note that the data contained within the report is only validated locally as it has not been validated nationally by Health Protection Scotland (HPS). The verified data is released from HPS week beginning 1 April 2019. Following the NHS Board meeting, the IPCT will provide NHS Board Members with any updates as appropriate following HPS verified data.

4. STRATEGIC CONTEXT

This paper links to the following:

Corporate Objectives	☒	Annual Operating Plan	☒	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 using the Scottish Government Reporting Template (in Appendix 1).

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

- AOP target for *Staphylococcus aureus* bacteraemias (SABs)
- AOP target for *Clostridium difficile* Infections (CDIs)
- Key Performance Indicators (KPI) for Methicillin Resistant *Staphylococcus Aureus* (MRSA) Screening, Carbapenamase Producing Enterobacteriaceae (CPE) Screening Programmes and Hand Hygiene Compliance.

7. FINANCIAL IMPLICATIONS

The organisation incurs financial implications in the management of an HCAI depending on the length of stay of a patient, the associated treatment required and throughput of patients from a bed management perspective. HPS make reference to a study[1] carried out in 2013 that estimated the inpatient costs of an HCAI 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 HCAI in all healthcare settings is of paramount importance.

8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

- NHSL is working to achieve the AOP for SABs and CDIs.
- There has been no change to the SAB and CDI AOP Targets 2017/2018 and therefore the organisation will continue to work to achieve the current targets in place.

9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

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

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment (EDIA) 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 EDIA.

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)

[1] http://www.hps.scot.nhs.uk/haiic/sshaip/haiprevalencestudy.aspx

- Antimicrobial Management Team (AMT)
- Healthcare Quality Assurance Improvement Committee (HQAIC)
- Lanarkshire Infection Control Committee (LICC) and Sub-groups

12. ACTIONS FOR THE BOARD

The NHS Board is 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 Nursing, Midwifery and Allied Health Professionals (NMAHPs) (Telephone number: 01698 858089)
- Emer Shepherd, Head of Infection Prevention and Control (Telephone number: 01698 366309)

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

4 March 2019

NHS LANARKSHIRE PERFORMANCE – OCTOBER TO DECEMBER 2018

Health Protection Scotland (HPS) Validated Data

Please note national validated data is provided 3 months in arrears from HPS which results in delays in the reporting timescales due to the alignment of reporting schedules.

Staphylococcus aureus Bacteraemia (SABs)

AOP Target:

- No more than 24 SAB cases or less per 100,000 AOBDs by 31 March 2019.
- AOP target trajectory equates to no more than 104 cases per annum/26 cases per quarter.

NHSL Performance (Oct-Dec 18):

- 39 SAB cases compared to 34 cases last quarter.
- A total of 108 cases (Apr-Dec 18) against the annual target of no more than 104 cases.
- The annual AOP target has been exceeded at this point in this activity year with 104 cases and therefore has not been met.

***Clostridium difficile* infection (CDI)**

AOP Target:

- No more than 32 CDI cases or less per 100,000 AOCBs in the aged 15 and over age group by 31 March 2019.
- AOP target trajectory equates to no more than 159 cases per annum/39 cases per quarter.

NHSL Performance (Oct-Dec 18):

- 33 CDI cases compared to 28 cases last quarter.
- A total of 95 cases (Apr-Dec 18) against the annual target of no more than 159 cases.
- The CDI AOP has been met this quarter and NHSL is within trajectory levels to meet the year end AOP target

MRSA & CPE Screening

Key Performance Indicator (KPI): To achieve 90% or above for both screening programmes.

NHSL Performance (Oct-Dec18):

- 84% compliance for MRSA acute inpatient admission screening (an increase of 4% from the previous quarter).
- 78% compliance for CPE acute inpatient admission screening (an increase of 8% from the previous quarter).
- For this reporting period, both KPIs have **not** been met.

Hand Hygiene

Key Performance Indicator (KPI): To achieve 95% or above for taking the appropriate opportunity to decontaminate hands against the 5 Hand Hygiene Key Moments.

NHSL Performance (Oct-Dec18):

- 88% achieved. This is a 3% increase from the last quarter.
- For this reporting period the KPI has **not** been met.

Outbreak Incidence

NHSL Performance (Oct-Dec18):

- 5 ward closures (3 UHW; 1 UHH; 1 North H&SCP)
- 13 restrictions (6 UHW; 3 UHH; 4 UHM)
- 13 Diarrhoea & Vomiting; 2 Vomiting; 1 Diarrhoea
- 59 patients; 18 staff affected

Escherichia coli Bacteraemia (ECB)

NHSL Performance (Oct-Dec18):

- 152 cases.
- This is a reduction of 10 ECB cases from last quarter.

Surgical Site Infection

NHSL Performance (Oct-Dec18):

- 10 C-Section SSIs from 387 procedures (infection rate of 2.58%). This is a reduction of 9 SSIs from last quarter (infection rate of 5% previous quarter).
- 2 Hip Arthroplasty SSIs from 131 procedures (infection rate of 1.53%). This is an increase of 2 from last quarter which reported 0 SSIs.
- 7 Colorectal SSIs from 63 procedures (infection rate of 11.11%). This is a reduction of 1 SSI from last quarter (infection rate of 7.41% previous quarter).
- 6 Vascular SSIs from 67 procedures (infection rate of 8.96%). This is an increase of 3 SSIs from last quarter (infection rate of 4.41% previous quarter).

Performance against the Annual Operating Plan (AOP)

Staphylococcus auerus bacteraemias (SABs)

- During October to December 2018, there were 39 SAB cases exceeding the trajectory level of 26 per quarter.
- While the target has not been achieved, comparison of performance against April – December 2018 and April – December 2017 demonstrates an overall reduction of 9% from 119 to 108 SAB cases (Chart 1).
- The Infection Prevention and Control Team (IPCT) are focusing on the number of SAB cases assessed as Healthcare associated infections (HCAIs) which are reviewed as part of the IPCT improvement programmes. Of the 39 SAB cases reviewed in quarter 3; 23 cases were HCAIs. (Chart 2).

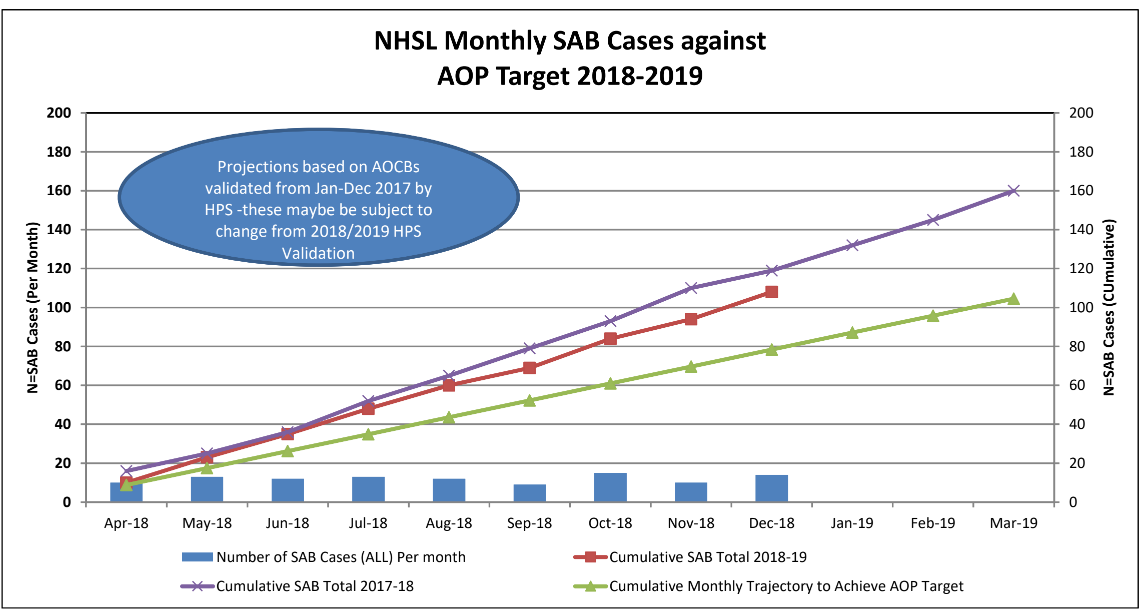


Chart 1 – AOP SAB Peformance (October to December 2018)

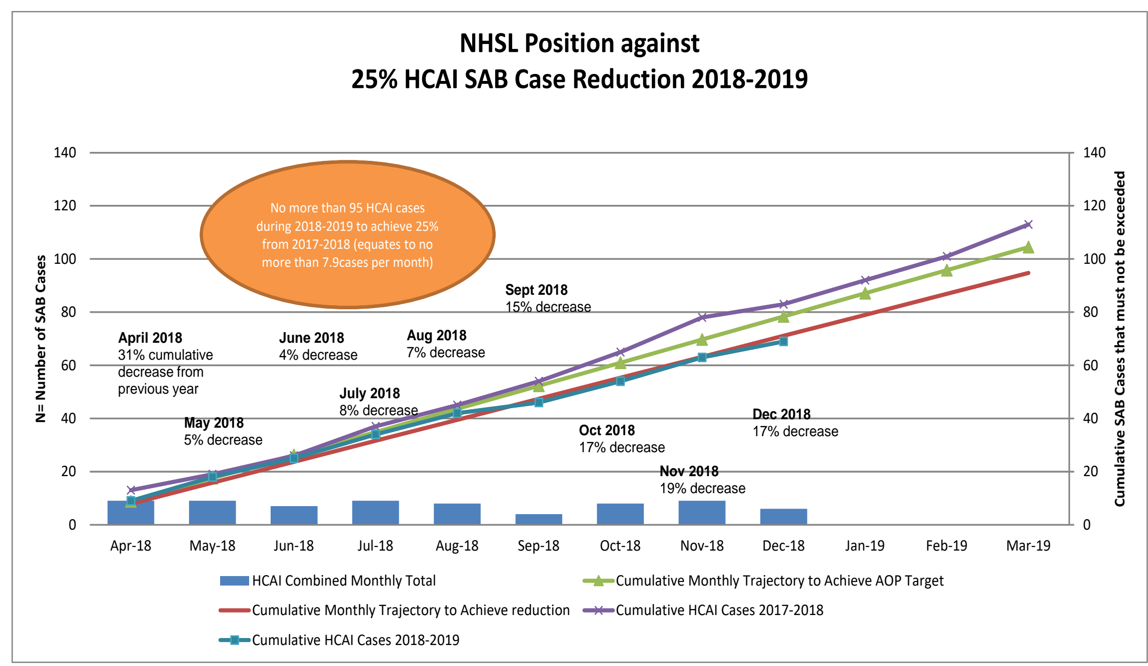


Chart 2 – AOP SAB HCAI Peformance (October to December 2018)

Performance against the Annual Operating Plan (AOP)

Clostridium difficile infections (CDIs)

- During October to December 2018, there were 33 CDI cases which is within the trajectory level of 39 per quarter.
- Whilst the performance remains within trajectory to meet the target at the end of year, there has been an increase in the number of CDI cases reported from April – December 2018 compared to April – December 2017 (Chart 3).
- Of the 33 CDI cases reviewed from October – December 2018, 16 were HCAIs; 16 were community associated infections (CAIs); and 1 was unknown.
- Chart 4 provides the cumulative totals for HCAIs and unknown cases only, which are reviewed as part of the IPCT improvement programmes.

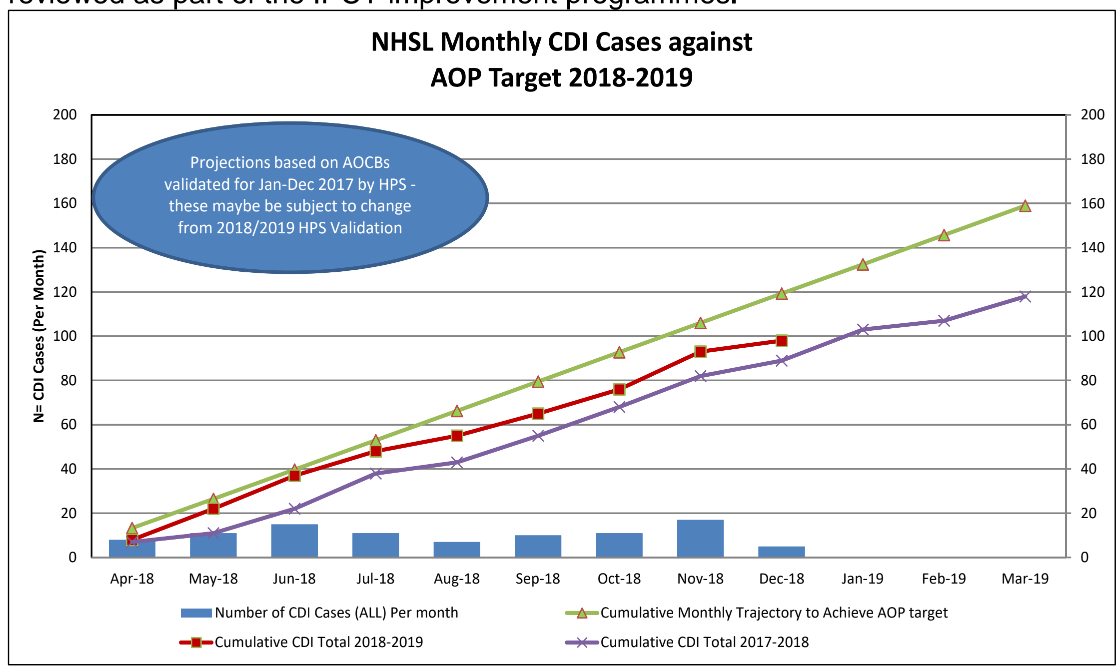


Chart 3 – AOP CDI Performance (October to December 2018)

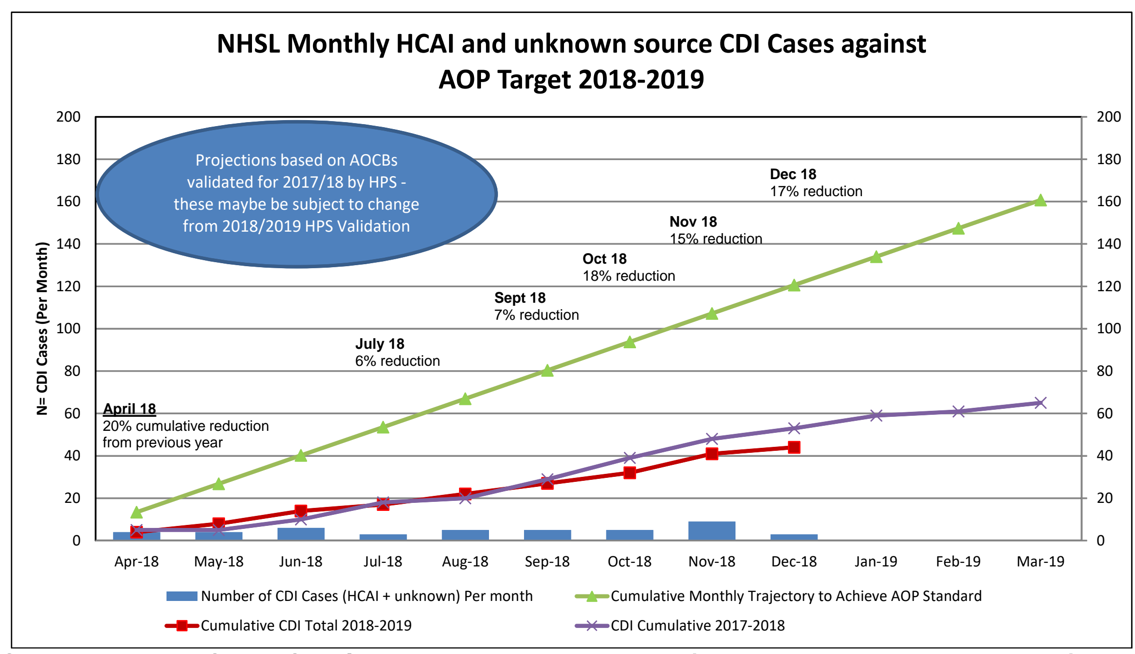


Chart 4 – AOP CDI HCAI / Unknown Performance (October to December 2018)

Performance against Key Performance Indicators

Methicillin resistant staphylococcus auerus (MRSA) National Inpatient Admission Screening

- There is a national requirement for NHS Boards to ensure that all acute inpatient admissions have a clinical risk assessment (CRA) completed.
- NHSL are required to review a minimum of 80 patient records to ascertain whether a CRA has been completed on admission or as part of the pre-operative assessment route.
- The national target is to achieve 90% or above. During October to December 2018, the NHSL reached 84% compliance. This is an increase of 4% from the last quarter (Chart 5).

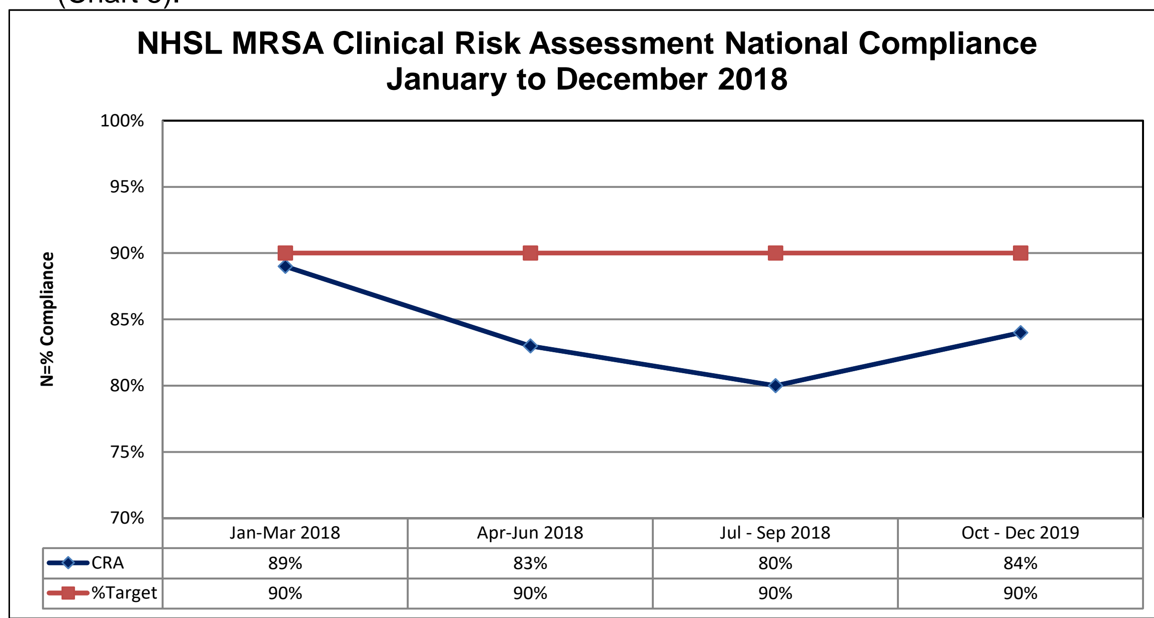


Chart 5 - MRSA Screening (January to December 2018)

Hand Hygiene

- There is a national requirement for NHS Boards to ensure that the completion of hand hygiene audits aim to achieve a compliance level of 95% or above. The organisation reached 88% which is an increase of 4% from last quarter.
- The IPCT have a rolling audit programme that is carried out on a monthly basis in areas across both the acute and health and social care partnership locations.

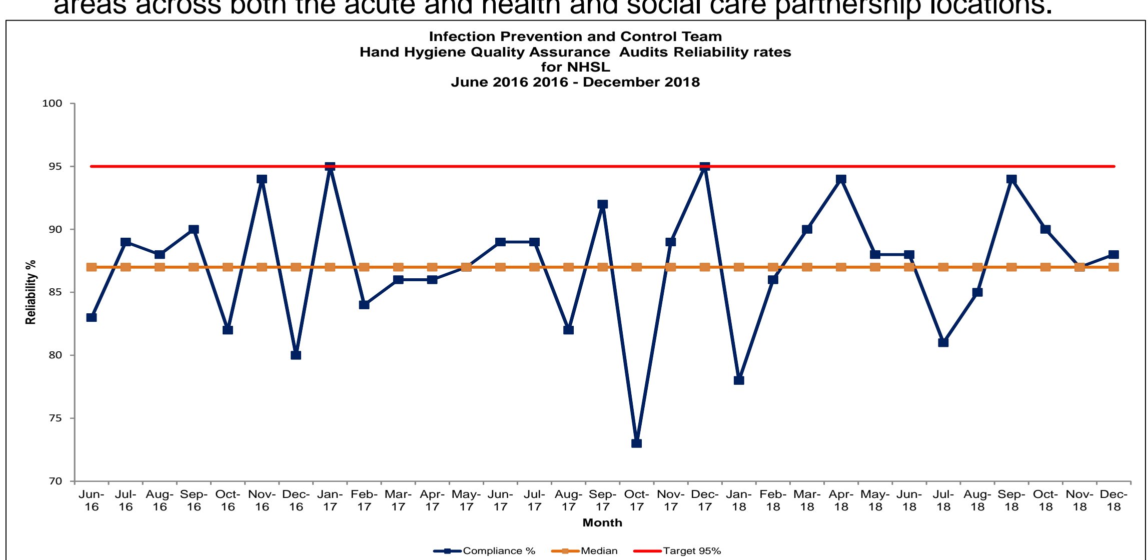


Chart 6 – Hand Hygiene Reliability Rate June 2016 to December 2018

Staphylococcus aureus bacteraemia (SAB)

When Staphylococcus aureus (S. Aureus) breaches the body's defence mechanisms, it can cause a wide range of illness from minor skin infections to serious infections such as bacteraemia or bloodstream infection.

Performance against Annual Operating Plan (AOP) Target:

- All Scottish NHS Boards are required to achieve the SAB AOP Target of 24 cases or less per 100,000 acute occupied bed days (AOBD) by 31 March 2019. For NHSL this equates to no more than 104 SAB cases per annum (26 per quarter). The SAB AOP target has not been met for this reporting period.
- The organisation has exceeded the AOP target in this quarter with a total of 108 SAB cases between April to December 2018.
- There were a total of 39 SAB cases during October to December 2018. Of the number of SABs, 23 were HCAIs and 16 were CAIs.
- Nine of the 23 HCAI SABs were device related.

Quality improvement and interventions in place to reduce SABs:

- Consultation for the NHSL Safety Manual for Infection Prevention and Control is ongoing.
- In anticipation of proposed NHS Scotland Acute Hospitals AMS standards for reduction in Intravenous (IV) antibiotics use, the Scottish Antimicrobial Prescribing Group (SAPG) are developing a Quality Improvement Toolkit to support antibiotic review. The resource will promote systems for reliable IV antibiotic review, effective IV to oral switch and removal of Peripheral Venous Cannulas (PVCs). A reduction in SABs related to PVC site infections are a strong driver for change promoted within the resource.

Risk Management:

- The Safety Manual for Infection Prevention & Control is under design at present. The first chapter of the Manual focuses on best practice for Vascular Access Devices.

Clostridium difficile Infection (CDI)

CDI is an important HCAI, which usually causes diarrhoea and contributes to a significant burden of morbidity and mortality. Prevention of CDI is therefore essential and an important patient safety issue.

Performance against Annual Operating Plan (AOP) Target:

- All Scottish NHS Boards are required to achieve the CDI AOP target of 32 cases or less per 100,000 AOBD in the aged 15 and over age group by 31 March 2019. For NHSL this equates to no more than 159 CDI cases per annum (39 per quarter). The CDI AOP target has been met for this reporting period.
- The CDI AOP target has been met this quarter and it is anticipated that NHSL is within trajectory levels to meet the year end target.
- There were a total of 33 CDI cases during October - December 2018. Of these CDI cases, 16 were HCAIs; 16 were CAIs and there was 1 Unknown.

Quality improvement and interventions in place to reduce CDIs:

- Prompt recognition of diarrhoeal patients and isolation.
- Antimicrobial stewardship continues to be a priority in the management of CDI patients.

Risk Management:

- There was one case of severe CDI in December 2018. The patient died within 30 days of Clostridium difficile being isolated from the stool sample and CDI was recorded on the death certificate. As per local policy, a multi-disciplinary review was held to discuss the management of the patient's case and ensure learning points are disseminated across the organisation as appropriate.
- There was one learning point agreed which will be taken forward with the clinical, IPC and antimicrobial pharmacy teams. The learning point was that the CDI Guideline states that the patient's antibiotic treatment for CDI should be reviewed after 5 days. This did not take place until day 9 for this patient.

Surgical Site Infection (SSI)

SSI is one of the most common HCAIs and can cause increased morbidity and mortality. It is estimated on average to double the cost of treatment, mainly due to the resultant increase in length of stay. SSI can have a serious consequence for patients affected as they can result in increased pain, suffering and in some cases require additional surgical intervention. The data below illustrates activity between October to December 2018.

Caesarean Section

387 Procedures carried out
10 SSIs following procedure
2.6% Infection Rate

Hip Arthroplasty

131 Procedures carried out
2 SSIs following procedure
1.5% Infection Rate

Vascular

67 Procedures carried out
6 SSIs following procedure
9% Infection Rate

Please note that national mandatory data collection began in April 2017.

Colorectal

63 Procedures carried out
7 SSIs following procedure
11.1% Infection Rate

Please note that national mandatory data collection began in April 2017.

Risk Management:

C-Section

Mandatory SSI surveillance of caesarean section procedures is undertaken for 10 days post operation and voluntary readmission to 30 days. From April 2017, NHSL extended the surveillance period to 30 days post operation resulting in more SSIs being detected from day 11 onwards.

Vascular

Risk factor analysis is undertaken for every patient who develops an SSI based on the presence of three major risk factors at the time of the operation this comprises:

- American Society of Anaesthesiologists ASA ≥ 3
- Wound Class of Contaminated or Dirty
- Length of operation

The presence of any of the aforementioned risk factors is indicative of increased risk of SSI development. Three of the four patients who developed an SSI in November 2018 had two or more risk factors present, in addition three patients had a BMI > 30 and the risk of SSI increases when a patient is obese.

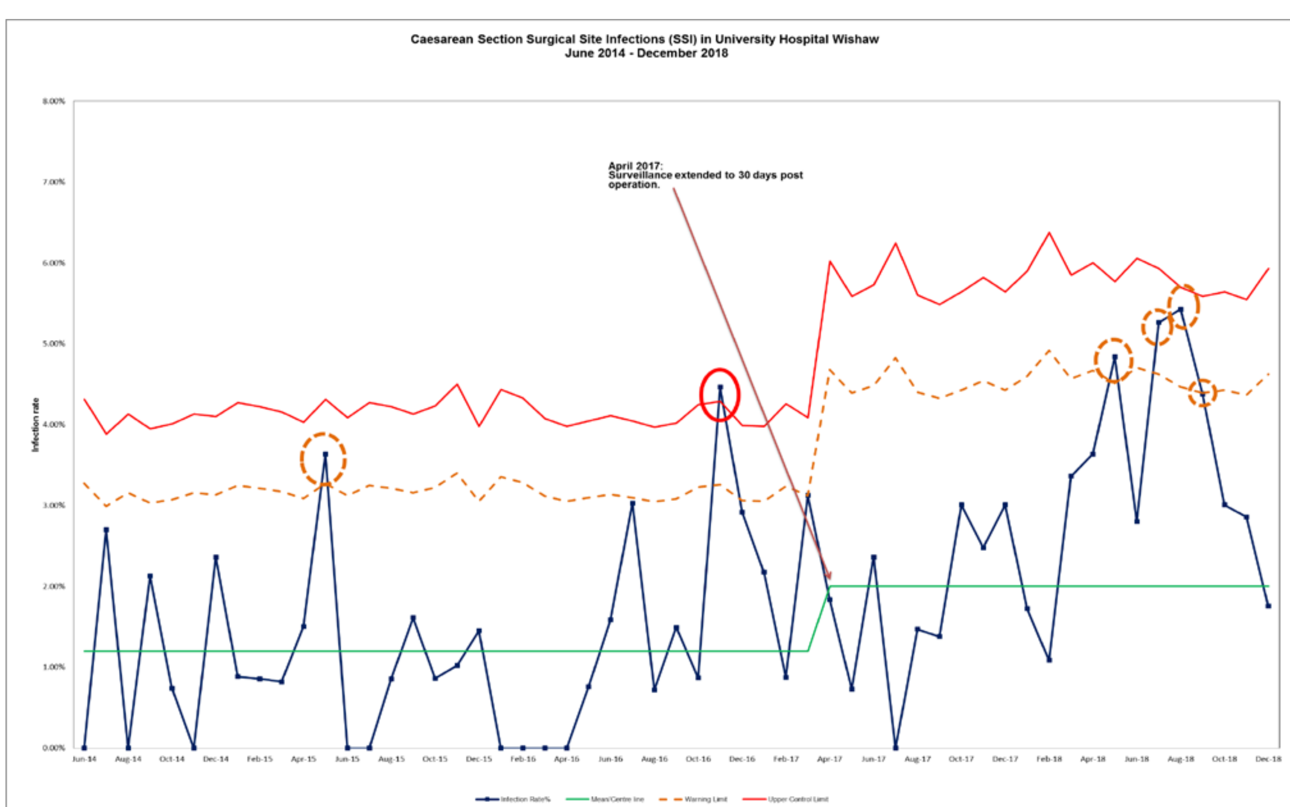


Chart 7 – C-Section Surgical Site Infection (June 2014 to December 2018)

This chart is in statistical control. The chart has been changed to a more sensitive ‘p’ chart which takes account of the denominator, i.e. the number of operations, therefore the warning and upper control limits vary. The Centre Line has been recalculated as the surveillance system changed in April 2017 (monitoring is now to day 30 - not day 10). There are just 21 results at the new Centre Line - 25 results are required to denote the true natural variation.

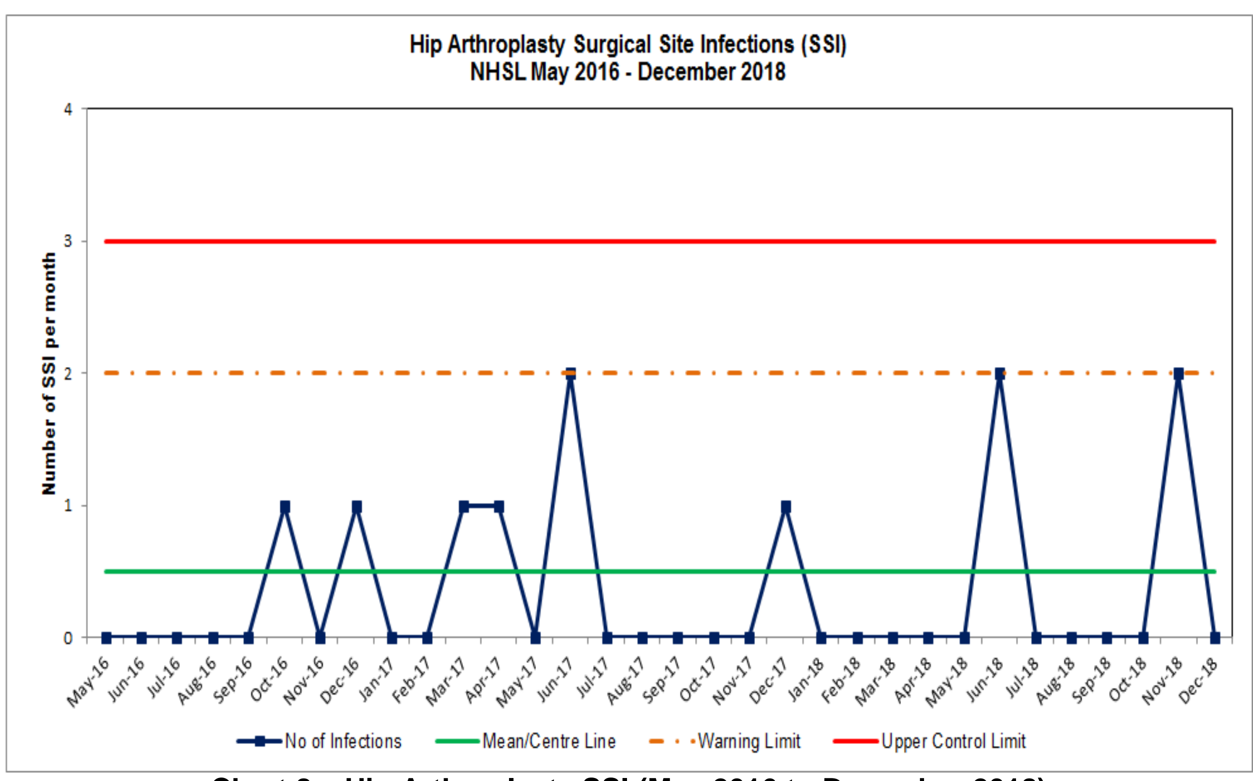


Chart 8 – Hip Arthroplasty SSI (May 2016 to December 2018)

This chart is stable and in statistical control.

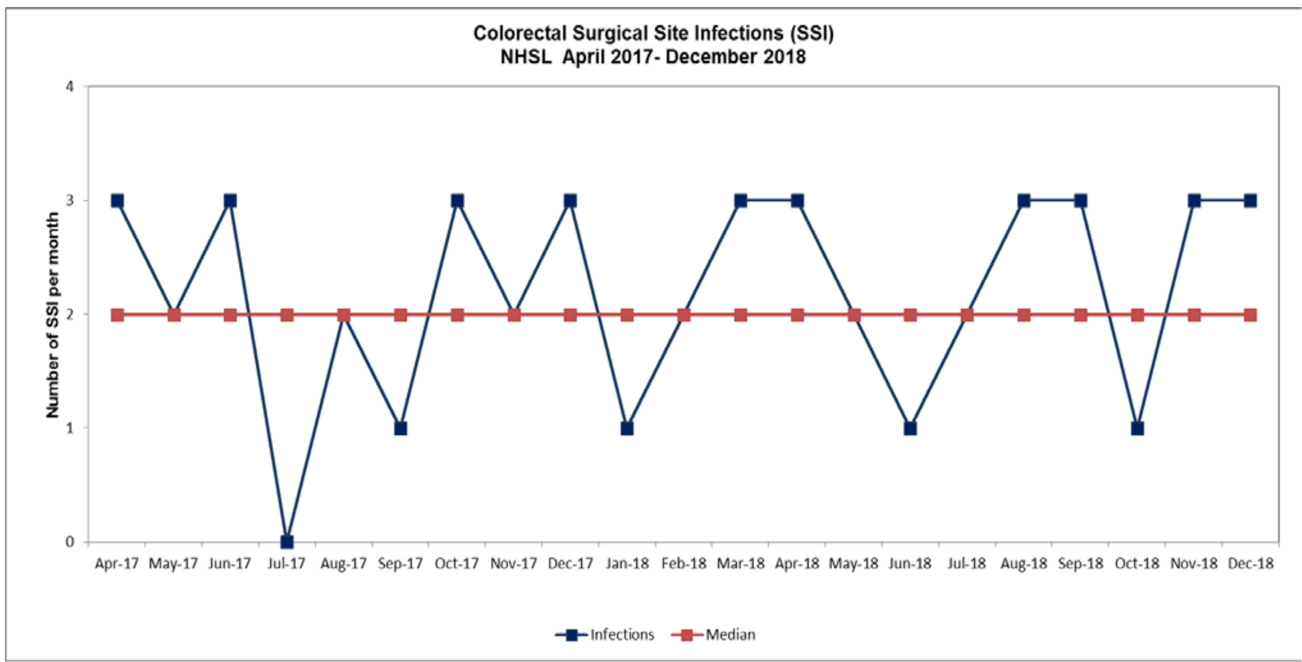


Chart 9 – Colorectal SSI (April 2017 to December 2018)

This is the twenty-first month of collating mandatory national data. Currently there are still too few data points to assess against the statistical control methodology (25 points required). There were 6 SSIs October-December 2018 compared to 8 last quarter.

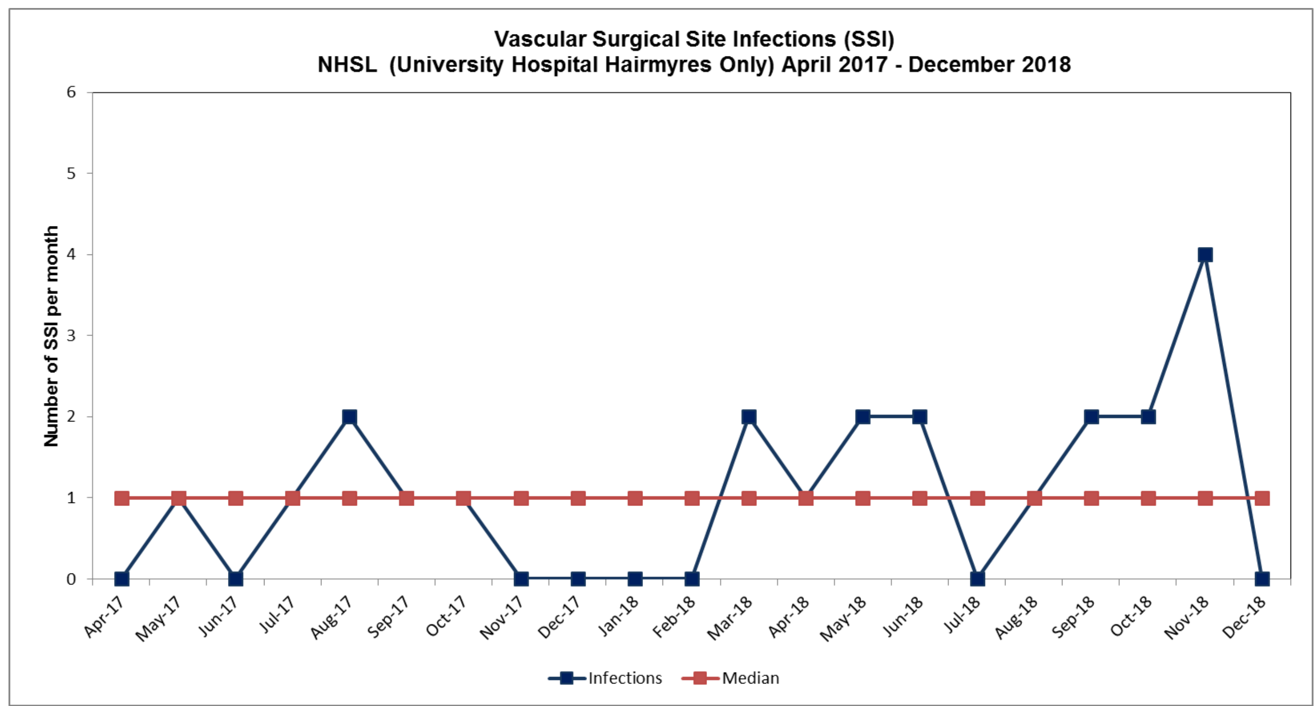
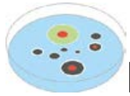


Chart 10 – Vascular SSI (April 2017 to December 2018)

This is the twenty-first month of collating national mandatory data. Currently there are still too few data points to assess against the statistical control methodology (25 points required). There were 6 SSIs October-December 2018 compared to 3 last quarter.



MRSA Acute Inpatient Admission Screening

A clinical risk assessment (CRA) is required to be completed for all acute inpatient admissions. This method of screening allows high risk patients to be pre-emptively isolated whilst the results of the test are awaited, this reduces the number of patients who require to be laboratory tested for MRSA.

Key Performance Indicator:

- Overall compliance was 84% against a national requirement of 90% or above.
- The organisation did not meet the AOP target for the activity quarter. There was however an increase from the previous quarter of 4%.
- See Chart 5 (page 7) for the performance chart.

Carbapenemase-producing enterobacteriaceae (CPE) Inpatient Admission Screening

Enterobacteriaceae are a family of gram negative bacteria (sometime called coliforms) which are part of the normal bacterial gut and are a type of antibiotic resistant bacteria. These organisms are some of the most common causes of many infections such as UTIs, intra-abdominal infections and bloodstream infections. A CRA is required to be completed for all acute inpatient admissions.

Key Performance Indicator:

- NHSL did not meet the compliance of 90% or above.
- The organisation have reached 78% compliance level during this activity quarter. This is an increase of 13% from the previous quarter.
- This is the third quarter of collating data against this KPI. Table 1 demonstrates the improvements made each quarter.

Performance against Target of 90%	Apr – Jun 18 (n=%)	Jul – Sept 18 (n=%)	Oct – Dec 18 (n=%)
University Hospital Hairmyres	10	43	70
University Hospital Monklands	73	72	89
University Hospital Wishaw	30	79	74
Overall Compliance	**38**	**65**	**78**

Table 1- CPE Inpatient Admission Screening Compliance (April to December 2018)

Hand Hygiene

Hand Hygiene is a term used to describe the decontamination of hands by various methods including routine hand washing and/or hand disinfection which includes the use of alcohol gels and rubs.

Hand Hygiene is recognised as being the single most important indicator of safety and quality of care in healthcare settings.

Key Performance Indicator:

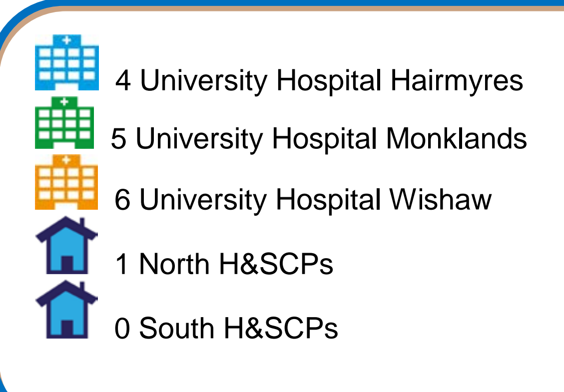
- Overall compliance was 88% against a national requirement of 95% or above.
- For this quarter, NHSL has not met the KPI.

Staff Group Compliance:
A breakdown of the staff group compliance levels from IPCT audits completed during October to December 2018 are:

- **Nursing**: 285 nursing staff compliant from 321 observations (89%)
- **Doctors**: 59 medical staff compliant from 70 observations (84%)
- **Ancillary/Other**: 54 ancillary/other staff compliant from 60 observations (90%)
- **Allied Health Professionals (AHPs)**: 40 AHPs compliant from 45 observations (89%)

Please note that the performance above is a cumulative quarterly compliance. The information contained within Appendix 2 provides a breakdown of the quarterly data above by month as a percentage as this is a national mandatory reporting requirement.

Outbreak Management



4 University Hospital Hairmyres

5 University Hospital Monklands

6 University Hospital Wishaw

1 North H&SCPs

0 South H&SCPs

94 beds closures due to restrictions or ward closures

59 patients affected

18 staff affected

5 Wards Closed to new admissions
(Range: closed from 2 days to 8 days)

13 Room Restrictions
(Range: restrictions from 1 day to 6 days)

Reasons for Closures

- 13 Diarrhoea and vomiting
- 2 Vomiting
- 1 Diarrhoea

Interventions to support outbreak management:

- New signage has been developed to alert staff and visitors when wards are closed due to IPC issues.
- As part of the Surveillance, Engagement, Education and Device (SEED) Programme information to support the prompt management of suspected norovirus and influenza cases was circulated to all clinical areas.
- Increased daily IPC huddles are in place as per IPC Winter Plan
- A debrief report was circulated at the LICC in December 2018 in relation to Wards 9 & 10 UHW in line with best practice.

Appendix 1 - National Mandatory Reporting Requirement
It is a national mandatory requirement to include this HAI reporting template in NHS Board reports by the Scottish Government.

NHS Lanarkshire Board Report

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

SAB monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
MRSA	1	0	0	1	0	1	0	0	0	1	0	0
MSSA	12	13	15	9	13	11	13	12	9	14	10	14
TOTAL	13	13	15	10	13	12	13	12	9	15	10	14

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	5	0	5	2	3	7	2	1	3	5	2	1
Ages 65+	9	4	6	6	8	8	9	6	7	6	15	4
Ages 15+	14	4	11	8	11	15	11	7	10	11	17	5

Hand Hygiene Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
AHP	84	100	100	100	100	100	86	100	100	100	84	89
Ancillary	75	100	85	100	79	100	100	100	36	88	88	87
Medical	74	100	90	78	86	80	67	78	63	82	80	88
Nurse	80	76	86	89	91	86	80	84	93	87	86	89

Cleaning compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	96	95	96	96	96	96	97	97	97	96	96	96

Estates Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	99	98	99	99	99	99	99	99	99	99	99	99

University Hospital Hairmyres Report Card

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

SABs monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
MRSA	1	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	4	4	1	1	2	3	2	1	4	1	0
TOTAL	2	4	4	1	1	2	3	2	1	4	1	0

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	0	0	0	0	1	0	0	0	1	1	0	0
Ages 65+	2	0	1	3	1	1	2	0	2	0	0	1
Ages 15+	2	0	1	3	2	1	2	0	3	0	0	1

Hand Hygiene Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
AHP	90	100	100	-	100	-	100	100	100	100	80	100
Ancillary	100	100	86	100	60	100	78	100	88	100	75	78
Medical	100	100	87	100	-	82	100	60	100	100	100	90
Nurse	97	78	88	94	88	80	84	88	93	68	75	90

Cleaning compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	95	95	95	95	96	96	96	96	95	95	95	95

Estates Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	99	99	99	99	99	99	99	99	99	99	99	100

University Hospital Monklands Report Card

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

SABs monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
MRSA	0	0	0	1	0	1	0	0	0	0	0	0
MSSA	3	2	5	3	5	2	4	4	3	2	5	3
TOTAL	3	2	5	4	5	3	4	4	3	2	5	3

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	0	0	0	0	0	1	0	0	0	1	1	0
Ages 65+	1	1	0	0	0	0	0	0	0	1	2	1
Ages 15+	1	1	0	0	0	1	0	0	0	2	3	1

Hand Hygiene Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
AHP	-		-	-	-	100	92	90	100	100	-	60
Ancillary	100		67	-	80	100	100	100	50	-	86	-
Medical	100		100	50	80	100	60	100	60	40	82	67
Nurse	90		78	100	90	96	81	100	94	91	94	81

Cleaning compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	95	94	95	95	96	95	96	96	96	96	96	97

Estates Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	96	96	97	97	96	97	98	98	98	98	97	97

University Hospital Wishaw Report Card

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

SABs monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	4	3	3	5	3	2	1	1	0	0	3	3
TOTAL	4	3	3	5	3	2	1	1	0	1	3	3

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	0	0	1	0	2	1	0	1	1	1	1	0
Ages 65+	3	1	0	1	0	3	3	5	2	2	4	1
Ages 15+	3	1	1	1	2	4	3	6	3	3	5	1

Hand Hygiene Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
AHP	78	100	100	100	100	100	100	-	-	100	100	100
Ancillary	33	-	100	100	100	100	100	-	100	83	100	80
Medical	58	100	89	100	100	50	50	67	100	80	100	100
Nurse	93	91	96	95	96	79	78	88	100	93	87	94

Cleaning compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	96	96	96	96	97	97	97	97	97	97	97	97

Estates Monitoring Compliance (n= %)

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Board	99	99	99	99	99	99	99	99	99	100	100	100

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.

SAB monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	4	4	3	0	4	5	4	4	5	7	1	8
TOTAL	4	4	3	0	4	5	4	4	5	7	1	8

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	3	0	0	2	1	5	2	0	1	2	1	1
Ages 65+	1	1	2	2	6	4	4	1	3	4	7	1
Ages 15+	4	1	2	4	7	9	6	1	4	6	8	2

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
- Udston
- Wester Moffat

SAB monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
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

CDI monthly case numbers

	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65+	0	0	0	0	0	0	0	0	0	0	0	0
Ages 15+	0	0	0	0	0	0	0	0	0	0	0	0