Meeting of Lanarkshire NHS Board: 30 October 2019	Lanarkshire NHS Board Kirklands Bothwell G71 8BB Telephone: 01698 855500 www.nhslanarkshire.org.uk	NHS Lanarkshire

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 5-7. Please note that the data contained within the report has been validated nationally by Health Protection Scotland (HPS). The new Standards on Healthcare Associated Infections and Indicators on Antibiotic Use for Scotland were released on 10 October 2019. NHS Lanarkshire is currently developing local AOP standards which will take effect from April 2019.

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

- Annual Operating Plan (AOP) targets - for *Staphylococcus aureus* bacteraemias (SABs) and *Clostridium difficile* Infections (CDIs) the new targets/standards for 2019/2020 have now been received. NHS Lanarkshire is currently developing local AOP standards which will take effect from April 2019.
- Key Performance Indicators (KPI) for Meticillin 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, this 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 using the current definition for SABs and CDIs. The KPIs for Hand Hygiene, MRSA & CPE screening remain the same.

- Hand hygiene: To achieve 95% or above for taking the appropriate opportunity to decontaminate hands against the 5 Moments for Hand Hygiene.
- MRSA Screening: To achieve 90% or above.
- CPE Screening: To achieve 90% or above.

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)
- Antimicrobial Management Team (AMT)
- 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 around the NHSL 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)
- Christina Coulombe Head of Infection Prevention and Control (Telephone number: 01698 366309)

Presented by Irene Barkby, Executive Director of NMAHPs
Prepared by Infection Prevention and Control Team

22 October 2019

NHS LANARKSHIRE PERFORMANCE – APRIL TO JUNE 2019

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 per 100,000 (AOBD) by 31 March 2019.
- AOP target trajectory equates to no more than 104 cases per annum/26 cases per quarter.

NHSL Performance (Apr-Jun19):
- 38 SAB cases compared to 47cases last quarter.
- 27 cases were HCAIs; 11 community associated
- The annual AOP target therefore has **not** been met.

Clostridium difficile infection (CDI)

AOP Target:
- No more than 32 CDI cases per 100,000 (TOBD) 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 (Apr-Jun19):
- 30 CDI cases compared to 24 cases last quarter.
- 16 were HCAIs; 14 were community associated infections (CAIs).
- The CDI AOP has been achieved.

MRSA & CPE Screening

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

NHSL Performance (Apr-Jun19):
- 88% compliance for MRSA acute inpatient admission screening (4% increase from last quarter).
- 69% compliance for CPE acute inpatient admission screening (1% decrease from last quarter).
- For this reporting period, both KPIs have **not** been met.
- This is a national target.

Hand Hygiene

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

NHSL Performance (Apr-Jun19):
- 89% achieved. This is a 3% reduction from the last quarter.
- For this reporting period the KPI has **not** been met.
- This is a local target.

Outbreak Incidence

NHSL Performance (Apr-Jun19):
- Total of 3 outbreaks.
- 1 ward closed (UHM)
- 2 restrictions (UHW)
- 3 Diarrhoea & Vomiting
- 9 patients; 0 staff affected
- This information is for local monitoring.

Surgical Site Infection

NHSL Performance (Apr-Jun19):
- 12 C-Section SSIs from 376 procedures (infection rate of 3.2%). This is an increase of 2 SSIs from last quarter (infection rate of 2.7% previous quarter).
- 1 Hip Arthroplasty SSIs from 107 procedures (infection rate of 0.9%). This is an increase of 1 SSI from last quarter which reported 0 SSIs.
- 9 Large Bowel SSIs from 102 procedures (infection rate of 11.3%). This is an increase of 3 SSIs from last quarter (infection rate of 7.1% previous quarter).
- 0 Vascular SSIs from 70 procedures (infection rate of 0%). This is a decrease of 4 SSIs from last quarter (infection rate of 5% previous quarter).
- All of the data above is monitored both nationally and locally

Escherichia coli Bacteraemia (ECB)

NHSL Performance (Apr-Jun19):
- 144 cases.
- This is an increase of 5 ECB cases from last quarter.
- This information is monitored nationally.

Staphylococcus aureus **bacteraemias (SABs)**

- During April to June 2019, there were 37 SAB cases.
- This is a reduction of 10 SABs from the previous quarter.
- 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 37 SAB cases reviewed in quarter 2; 27 cases were HCAIs; 10 community associated infections (CAIs).

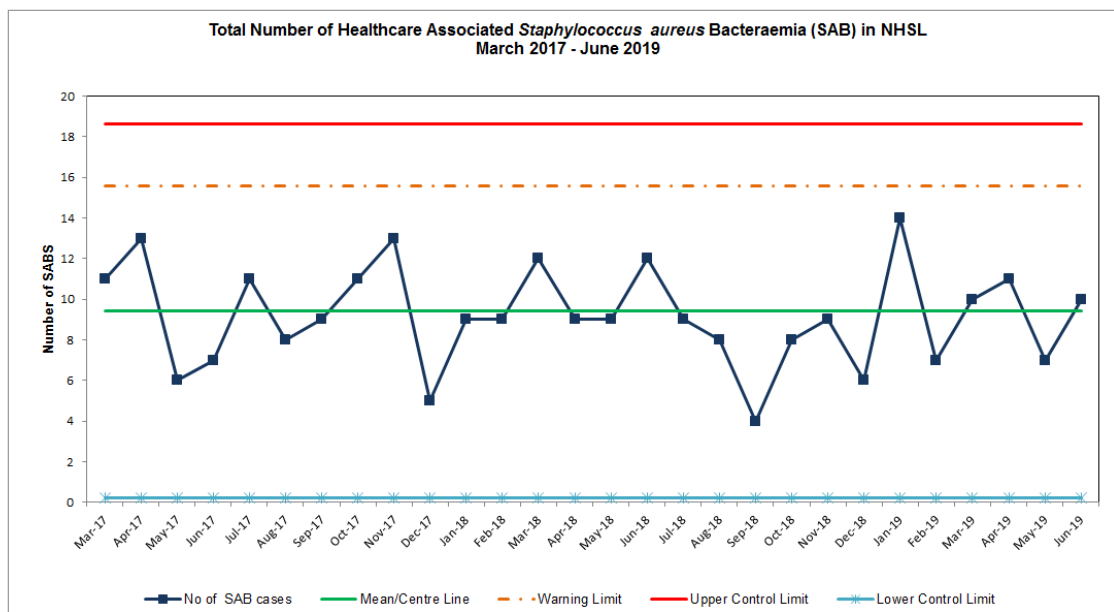


Chart 1 – HCAI SAB cases (April to June 2019)

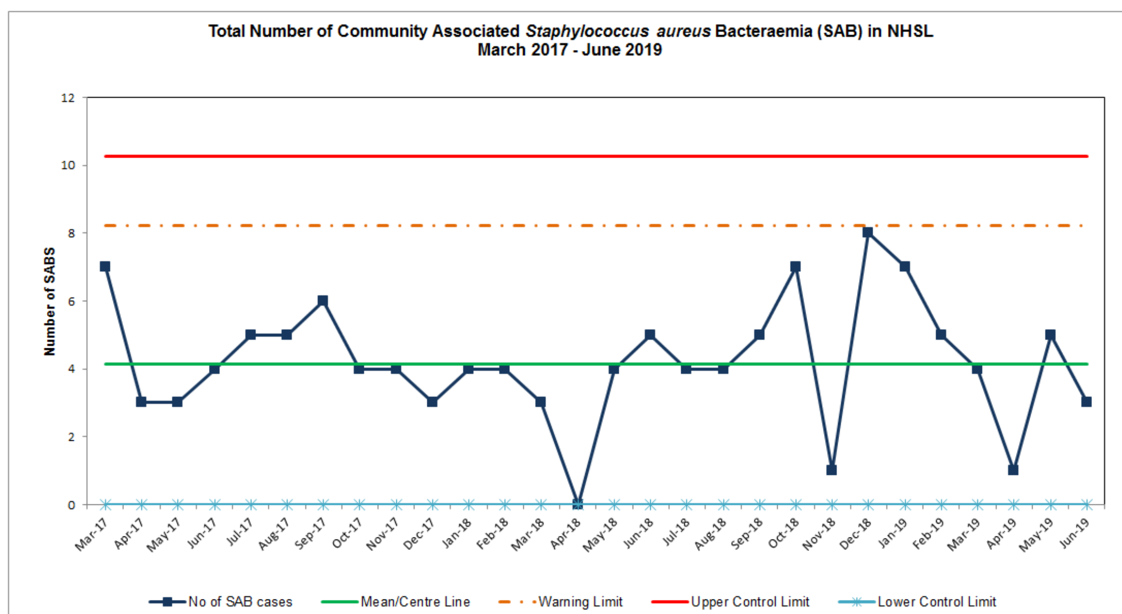


Chart 2 – CAI SAB cases (April to June 2019)

Clostridium difficile infections (CDIs)

- During April to June 2019, there were 30 CDI cases.
- Of the 30 CDI cases assessed in this activity quarter 2, 15 were HCAIs; 15 were community associated infections (CAIs).

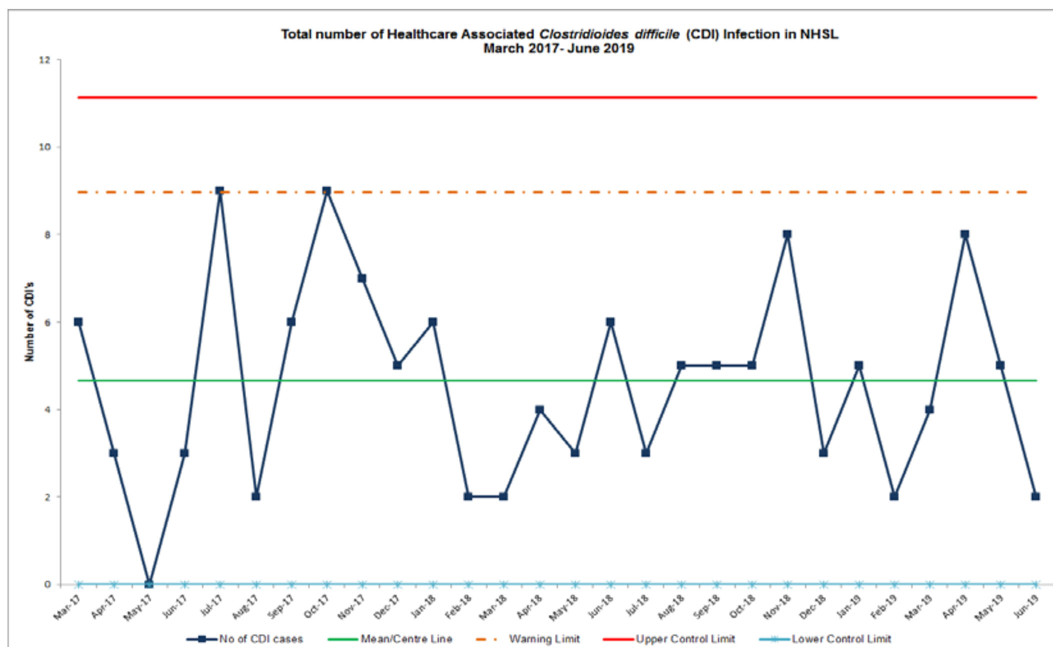


Chart 3 – HCAI CDI cases (April to June 2019)

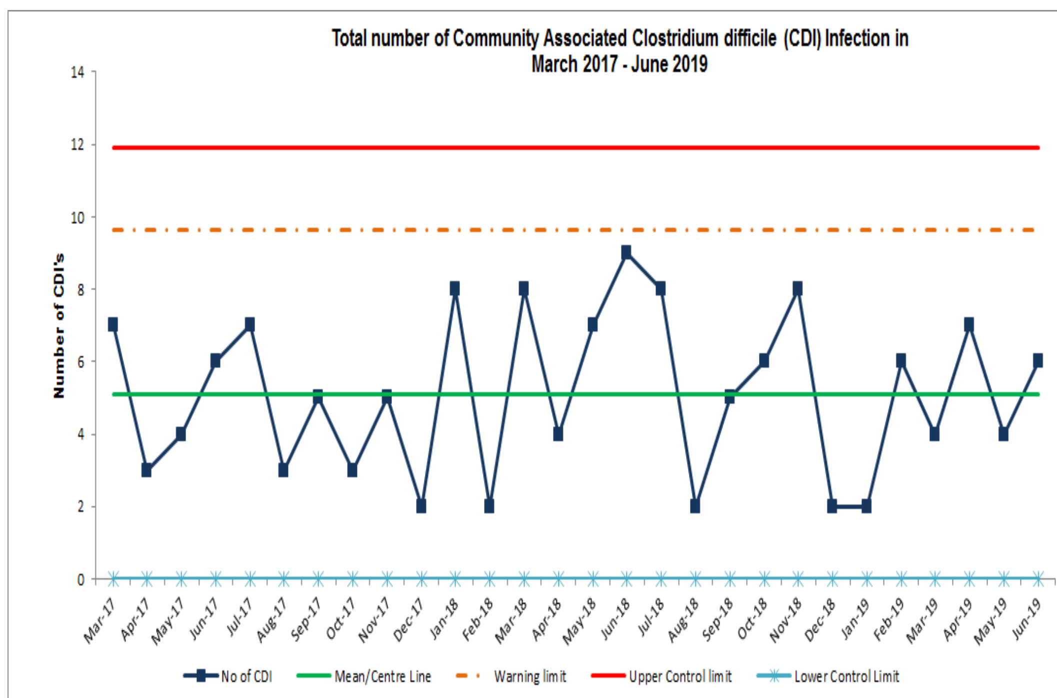
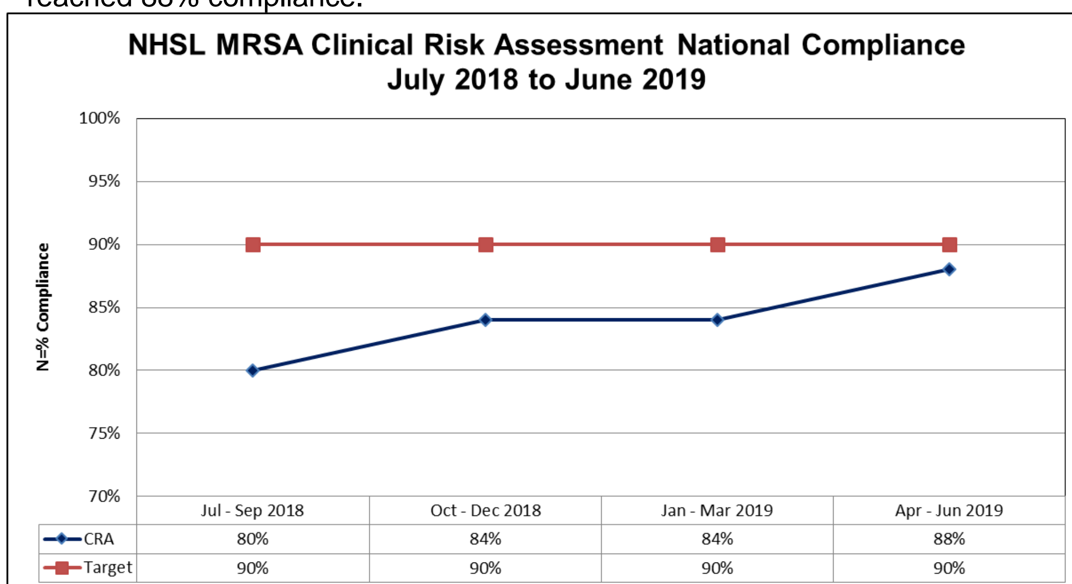


Chart 4 – CAI CDI cases (April to June 2019)

Meticillin resistant *staphylococcus aureus* (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 April to June 2019, NHSL reached 88% compliance.

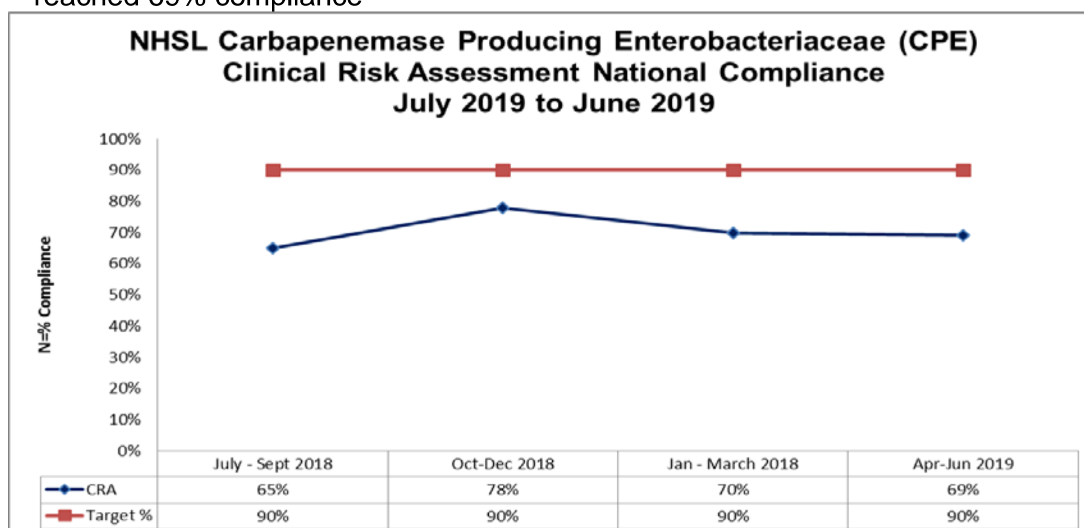


	Jul - Sep 2018	Oct - Dec 2018	Jan - Mar 2019	Apr - Jun 2019
CRA	80%	84%	84%	88%
Target	90%	90%	90%	90%

Chart 5 - MRSA Screening (July 2018 to June 2019)

Carbapenemase Producing *Enterobacteriaceae* (CPE) National Inpatient Admission Screening

- There is a national requirement for NHS Boards to ensure that all acute inpatient admissions have a CRA completed.
- NHSL are required to review a minimum of 80 patient records to ascertain whether a CRA has been completed on admission.
- The national target is to achieve 90% or above. During April to June 2019, NHSL reached 69% compliance



	July - Sept 2018	Oct-Dec 2018	Jan - March 2018	Apr-Jun 2019
CRA	65%	78%	70%	69%
Target %	90%	90%	90%	90%

Chart 6 – CPE Screening (July 2018 to June 2019)

Hand Hygiene

- There is a national recommendation 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 89% which is a decrease of 3% 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.

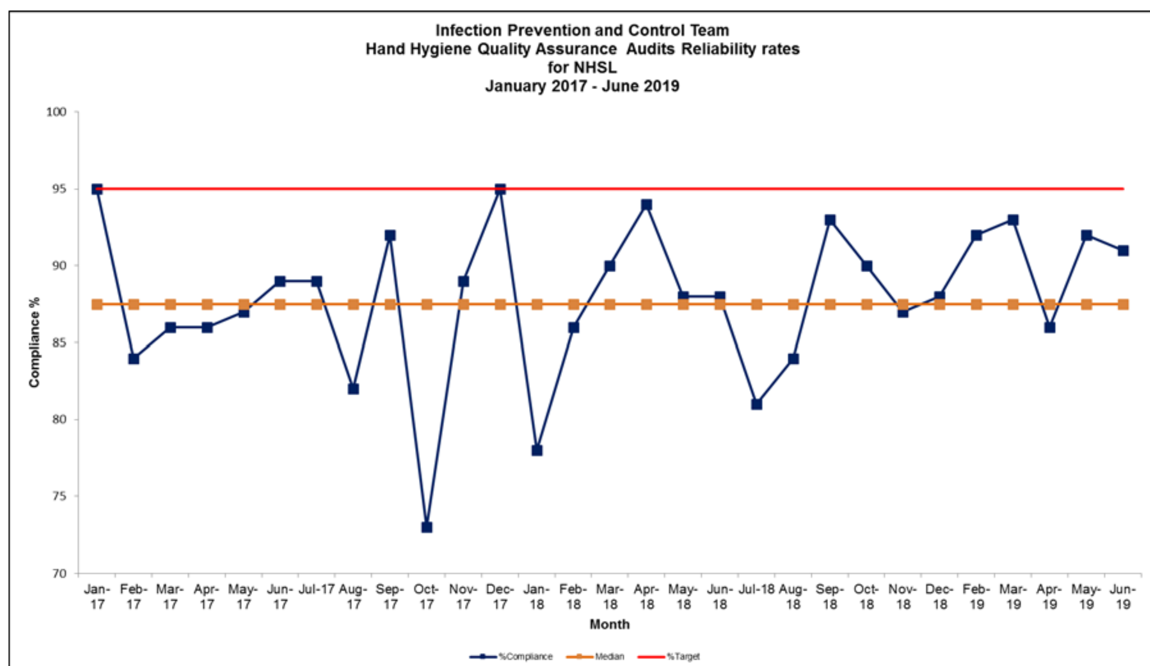
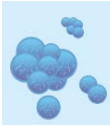


Chart 7 – Hand Hygiene Reliability Rate January 2017 to June 2019



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.

NHSL Performance:

- 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.
- There were a total of 38 SAB cases during April to June 2019. Of the number of SABs, 27 were HCAIs and 11 were CAIs.

Quality improvement and interventions in place to reduce SABs:

- Work continues to progress on the NHSL Safety Manual for Infection Prevention and Control following a consultation process during this activity period.
- Renal patients have been identified as at a higher risk of developing a vascular access device related infection because of the continuous requirement to have dialysis. University Hospital Monklands (UHM) Renal Department carry out a clinical review of all SAB cases and complete an SBAR for discussion with the Senior Nurse. The findings of the reviews are also shared with staff through the safety brief and at the SAB Improvement meetings which are attended by the IPCT.
- SAB rates and sources discussed at Hygiene and Clinical Governance meetings with clinical staff.
- Training on preventative measures to reduce the number of SABs is being carried out at the Care Assurance and Accreditation System (CAAS) study days.

Risk Management:

- There was one SAB death review meeting during this activity quarter. The patient died within 30 days of *Staphylococcus aureus* being isolated from the blood sample and a SAB was recorded on the patients' 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 and action plans are actioned and shared at the Hygiene meeting.
- The one case review identified the following 2 learning Points for action by the clinical team:

  1. One dose of medication was omitted from the drug chart and it was unclear if the medication was given. Action taken by the SCN was to discuss the importance of recording accurately in the drug charts with the staff at the daily safety brief.
  2. Some staff at the review were not clear on the SAB surveillance definitions.   Action taken by the IPCT to quote the definitions when completing a Datix for the case and recording this in the review tool.

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.

NHSL Performance:

- All Scottish NHS Boards are required to achieve the CDI AOP target of 32 cases or less per 100,000 TOBD 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).
- There were a total of 30 CDI cases during April to June 2019. Of these CDI cases, 16 were HCAIs; 14 were CAIs.

Quality improvement and interventions in place to reduce CDIs:

- Antimicrobial stewardship continues to be a priority in the management of CDI patients. IPCT and antimicrobial team work closely during severe CDI multidisciplinary case reviews.
- Information circulated to wards to advise of prompt and clear identification of patients with loose stools and appropriate action to be taken and not to wait until positive result.

Risk Management:

- There were two cases of severe CDI during the activity quarter.
  As per local policy, a multi-disciplinary review was held to discuss the management of each patient's case and ensure learning points and action plans are completed and shared at the hygiene meeting.

One of the reviews found good practice with no learning points and the second review had 4 Learning points for action by the clinical team and the IPCT:

1. Delay in sending a stool sample to the laboratory. Action taken by clinical staff included education and discussion at the ward daily safety brief and UHM daily huddle.
2. Delay in stool sample reaching the laboratory. Action taken by staff included discussing the prompt delivery of samples to the laboratory by means of the electronic tube system discussed at the daily safety brief.
3. Completion of the stool and fluid balance charts was sub optimal. Action taken by the Senior Charge Nurse was to discuss with the staff at the safety brief and to audit compliance on an on-going basis.
4. The CDI severity sticker was not completed by the medical staff due to lack of clarity of use. Action taken was by the IPCT to clarify the dating and signing of the sticker when applied to the patient's notes. This process was discussed at the IPCT team meeting to ensure standardisation.

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 from April to June 2019. Please note that due to 30 day post operative surveillance for SSI for this period will be validated in October 2019. This data is locally validated at the time of reporting.

Quarterly exception reports are issued to boards by HPS where the incidence of SSI is higher than expected based on the national data; NHSL has not received an exception report for this time period.

Caesarean Section

376 Procedures carried out
12 SSIs following procedure
3.2% Infection Rate

Hip Arthroplasty

107 Procedures carried out
1 SSIs following procedure
0.9% Infection Rate

Vascular

70 Procedures carried out
0 SSIs following procedure
0% Infection Rate

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

Large Bowel

102 Procedures carried out
9 SSIs following procedure
11.3% Infection Rate

There is an increase in the infection rate from the previous quarter, however there were 32 additional procedures carried out for this reporting period.

All 9 of the patients who developed an SSI for this reporting period had additional risk factors.

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 surveillance is carried out at readmission to 30 days. From April 2017, NHSL extended the surveillance period to 30 days post operation to standardise the surveillance period locally in line with all other Scottish Health Boards.

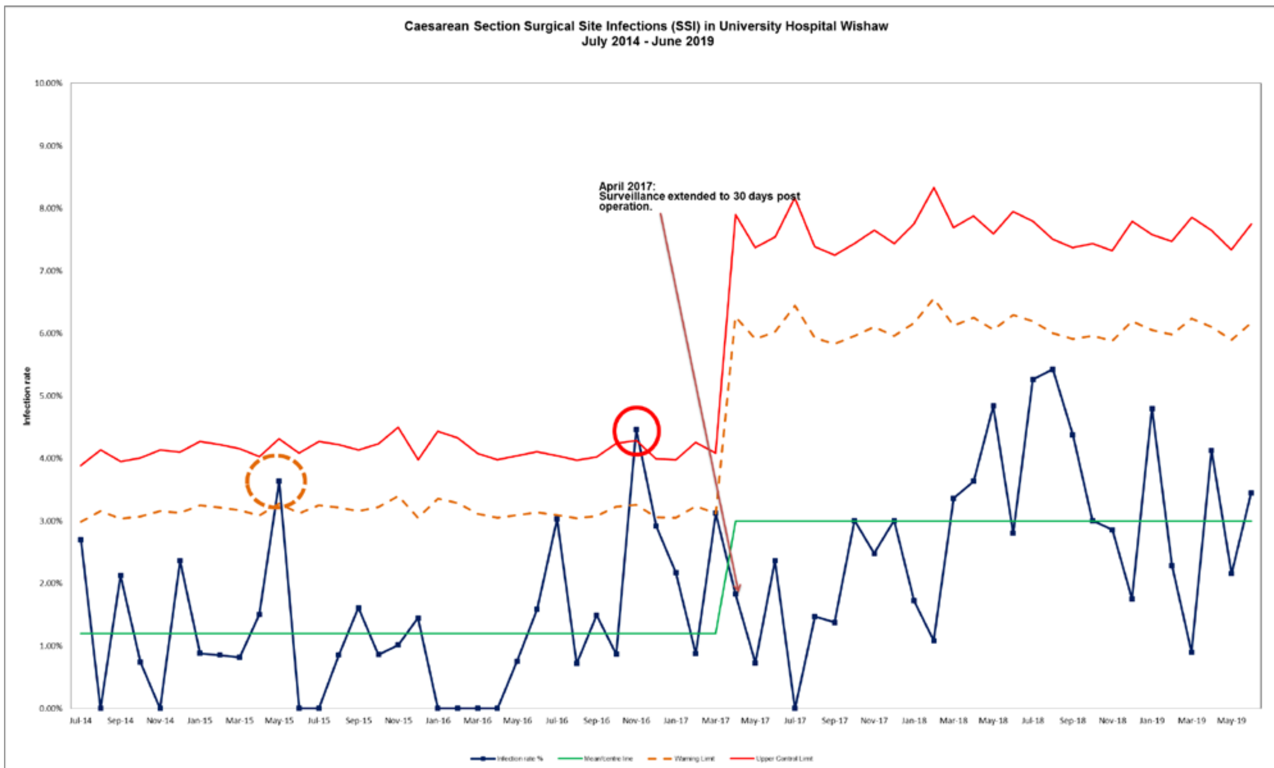


Chart 8 – C-Section Surgical Site Infection (July 2014 to June 2019)

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 Control Limit has been recalculated as the surveillance system changed in April 2017 (monitoring is now to day 30 - not day 10). The chart is currently in control.

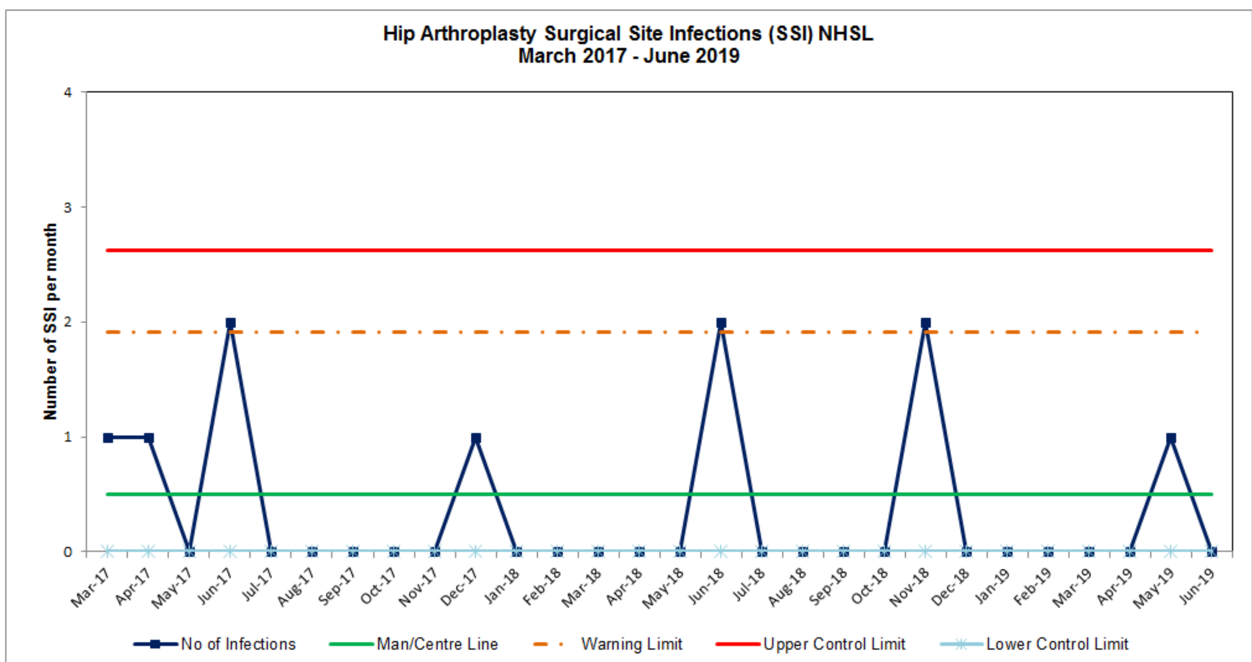


Chart 9 – Hip Arthroplasty SSI (March 2017 to June 2019)

This chart is stable and in statistical control.

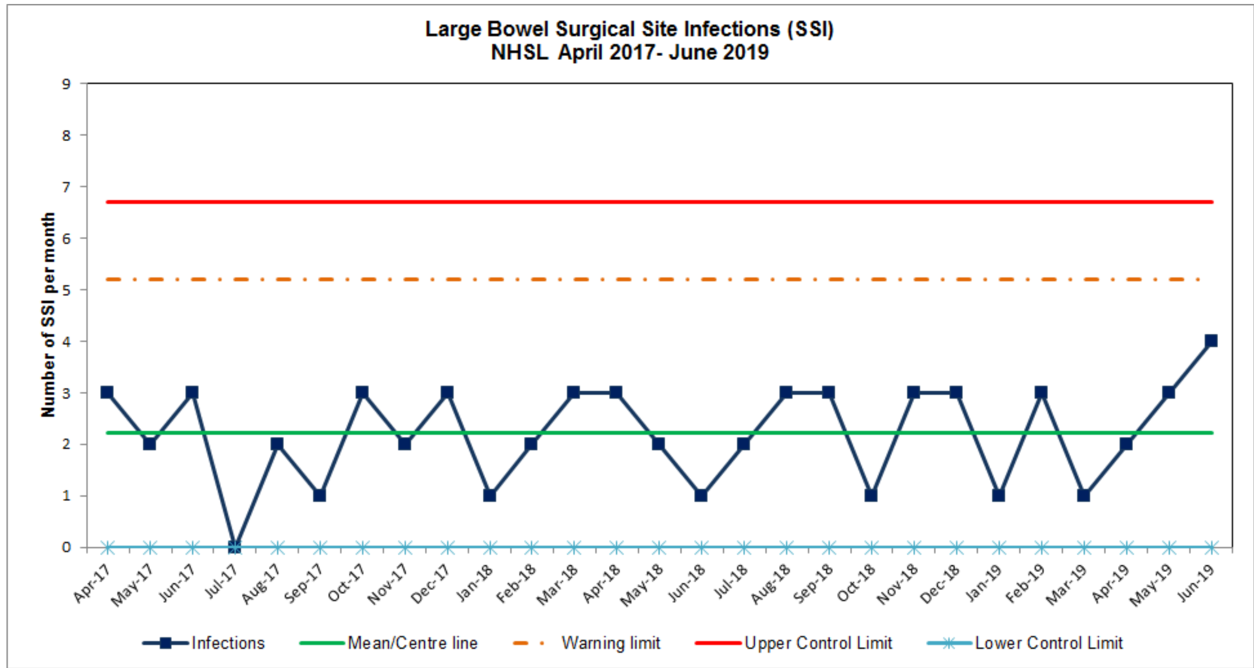


Chart 10 – Large Bowel SSI (April 2017 to June 2019)

This chart is stable and in statistical control.

There is an increase in the infection rate from the previous quarter, however there were 32 additional procedures carried out for this reporting period.

All 9 of the patients who developed an SSI for this reporting period had additional risk factors.

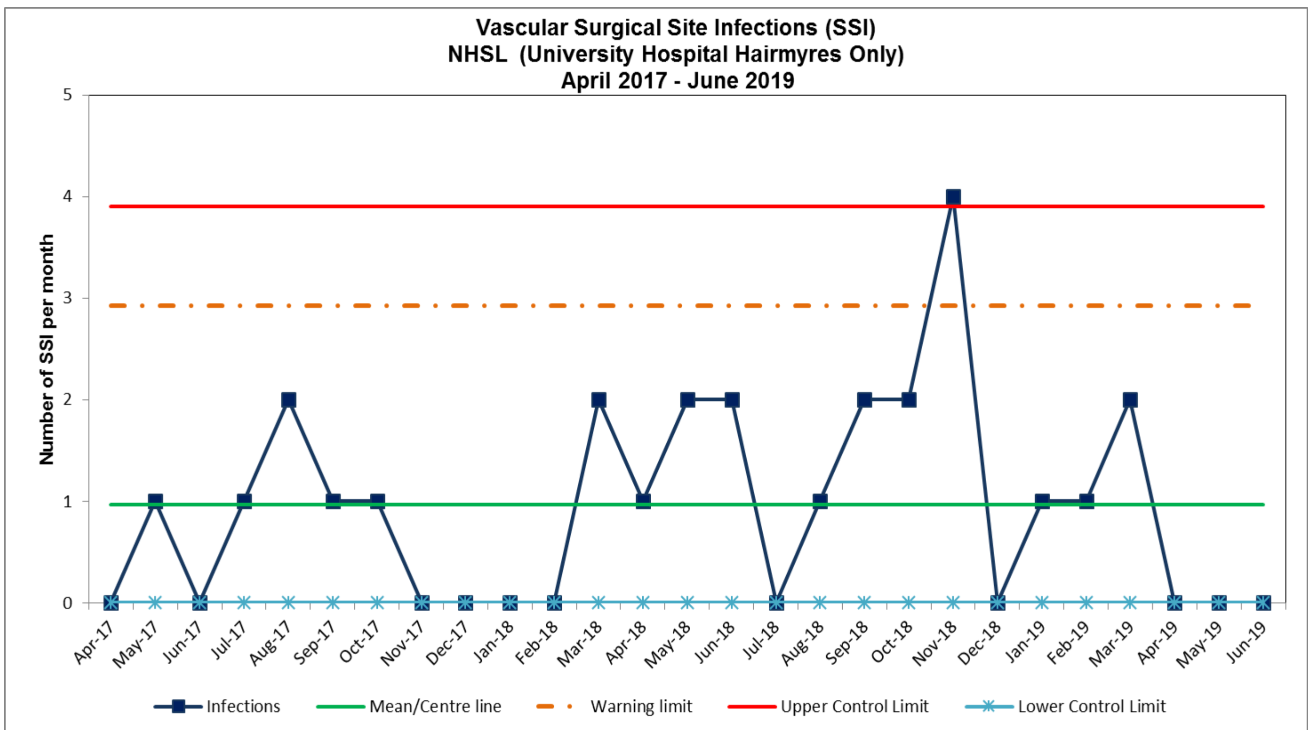


Chart 11 – Vascular SSI (April 2017 to June 2019)

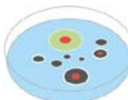
This chart is stable and in control.

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:

- Quarter 1 compliance was 88% against a national requirement of 90% or above.
- The organisation did not meet the AOP target for the activity quarter, however an increase from the previous quarter of 4%.
- See Chart 5 (page 7) for the performance chart. Performance is discussed at the local Hospital Hygiene meetings.
- The MRSA/CPE screening module on Learn pro is promoted with staff at the hygiene meetings.



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:

- Quarter 1 compliance was 69% against a national requirement of 90% or above.
- The organisation did not meet the AOP target for the activity quarter with a decrease of 1% from the previous quarter.
- See Chart 6 (page 7) for the performance chart.
- Performance is discussed at the local Hospital Hygiene meetings.
- The MRSA/CPE screening module on Learn pro is promoted with staff at the hygiene meetings.
- Staff encouraged to complete the New NHS Education for Scotland teaching module promoted at the Hygiene meetings.
- Education sessions on CPE screening and management of patients planned.

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 89% against a national requirement of 95% or above.
- There has been a decrease from 92% compared to the previous quarter. NHSL has not met the KPI.
- Hand hygiene task group being developed. Terms of reference discussed at the LICC.
- Hand hygiene training carried out to coincide with the newly launched hand hygiene products.
- Hand hygiene will be promoted at the planned winter road shows in the acute and H&SCP sites.

Staff Group Compliance:
A breakdown of the staff group compliance levels from IPCT audits completed during April to June 2019 are:

- **Nursing**: 274 nursing staff compliant from 295 observations (93%)
- **Doctors**: 48 medical staff compliant from 60 observations (80%)
- **Ancillary/Other**: 29 ancillary/other staff compliant from 42 observations (69%)
- **Allied Health Professionals (AHPs)**: 54 AHPs compliant from 56 observations (96%)

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

0 University Hospital Hairmyres

1 University Hospital Monklands

2 University Hospital Wishaw

0 North H&SCPs

0 South H&SCPs

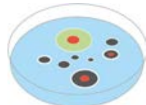
3 bed closures due to restrictions or ward closures

9 patients affected

0 staff affected

1 Ward Closed to new admissions
(Range: closed 6 days)

2 Room Restrictions
(Range: restrictions from 2 days to 3 days)



Reasons for Closures

- 3 Diarrhoea and vomiting

Interventions to support outbreak management:

- 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 Surveillance Prevention Update Daily (SPUD)
- Improved and formalised updates on actual or potential ward closure/room closure Consultant Microbiologists on call at the weekend

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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
MRSA	0	0	0	1	0	0	0	2	1	0	1	0
MSSA	13	12	9	14	10	14	21	10	13	12	11	13
TOTAL	13	12	9	15	10	14	21	12	14	12	12	13

CDI monthly case numbers

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Age 15-64	2	1	3	5	2	1	2	5	5	6	3	2
Ages 65+	9	6	7	6	15	4	5	4	3	8	7	4
Ages 15+	11	7	10	11	17	5	7	9	8	14	10	6

Hand Hygiene Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
AHP	86	100	100	100	84	89	-	86	88	93	100	100
Ancillary	100	100	36	88	88	87	-	91	88	73	92	64
Medical	67	78	63	82	80	88	-	97	89	74	83	87
Nurse	80	84	93	87	86	89	-	89	91	91	90	94

Cleaning compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	97	97	97	96	96	96	96	96	96	96	96	96

Estates Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	99	99	99	99	99	99	99	99	98	98	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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	3	2	1	4	1	0	2	2	2	0	2	1
TOTAL	3	2	1	4	1	0	1	0	2	1	2	1

CDI monthly case numbers

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Age 15-64	0	0	1	1	0	0	1	0	1	0	0	0
Ages 65+	2	0	2	0	0	1	1	0	0	1	1	1
Ages 15+	2	0	3	0	0	1	2	0	1	1	1	1

Hand Hygiene Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
AHP	100	100	100	100	80	100	-	100	-	-	-	-
Ancillary	78	100	88	100	75	78	-	100	0	67	-	67
Medical	100	60	100	100	100	90	-	92	71	60	100	75
Nurse	84	88	93	68	75	90	-	81	100	100	100	97

Cleaning compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	96	96	95	95	95	95	95	95	95	95	96	96

Estates Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	99	99	99	99	99	100	99	99	95	99	100	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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
MRSA	0	0	0	0	0	0	0	0	0	0	1	0
MSSA	4	4	3	2	5	3	7	3	2	5	4	1
TOTAL	4	4	3	2	5	3	7	3	2	5	5	1

CDI monthly case numbers

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Age 15-64	0	0	0	1	1	0	1	1	1	3	0	0
Ages 65+	0	0	0	1	2	1	1	0	0	3	0	0
Ages 15+	0	0	0	2	3	1	2	1	1	5	0	0

Hand Hygiene Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
AHP	92	90	100	100	-	60	-	86	-	100	-	-
Ancillary	100	100	50	-	86	-	-	94	100	80	56	33
Medical	60	100	60	40	82	67	-	100	100	85	67	80
Nurse	81	100	94	91	94	81	-	90	76	89	82	86

Cleaning compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	96	96	96	96	96	97	95	95	95	95	95	95

Estates Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	98	98	98	98	97	97	98	97	97	97	96	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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
MRSA	0	0	0	1	0	0	0	1	0	0	0	0
MSSA	1	1	0	0	3	3	3	1	2	2	0	4
TOTAL	1	1	0	1	3	3	3	2	2	2	0	4

CDI monthly case numbers

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Age 15-64	0	1	1	1	1	0	0	2	1	1	1	0
Ages 65+	3	5	2	2	4	1	1	0	1	1	3	0
Ages 15+	3	6	3	3	5	1	1	0	2	2	4	0

Hand Hygiene Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
AHP	100	-	-	100	100	100	-	50	88	80	100	100
Ancillary	100	-	100	83	100	80	-	80	100	75	100	33
Medical	50	67	100	80	100	100	-	100	100	82	100	80
Nurse	78	88	100	93	87	94	-	100	100	88	100	86

Cleaning compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	97	97	97	97	97	97	96	96	97	96	96	96

Estates Monitoring Compliance (n= %)

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Board	99	99	99	100	100	100	100	100	99	99	99	99

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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	4	4	5	7	1	8	0	0	0	3	1	0
TOTAL	4	4	5	7	1	8	0	0	0	3	1	0

CDI monthly case numbers

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Age 15-64	2	0	1	2	1	1	0	0	0	2	2	2
Ages 65+	4	1	3	4	7	1	0	0	0	4	2	3
Ages 15+	6	1	4	6	8	2	0	0	0	6	4	5

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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
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

	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
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