Golden Jubilee Foundation

Golden Jubilee National Hospital

Patients at the heart of progress

Prevention and Control of Infection Annual Report 2016/17

Approval record	Date approved
Board Prevention and Control of Infection Committee	8 September 2017
Clinical Governance Risk Management Group	9 January 2018
Clinical Governance Committee	
Chief Executive and Board	

Golden Jubilee National Hospital
Golden Jubilee Foundation

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- Dr Sara Jamdar and Dr John Hood, Prevention and Control of Infection Doctors
- Grace Cox, Department Administrator

1.0 Introduction

Prevention and Control of Infection is everyone's responsibility and, as a multidisciplinary team, every member of staff is expected to maintain the high standards required in health care, ensuring the continuation of high level practice and environmental safety.

The following report details the activities of the Prevention and Control of Infection Team (PCIT) over 2016/17 against the planned Golden Jubilee National Hospital (GJNH) Prevention and Control of Infection Programme (PCIP). Approved by the Prevention and Control of Infection Committee (PCIC), key stakeholders and senior and executive managers, the PCIP is designed to meet the following local and national drivers:

- Scottish Patient Safety Programme (SPSP)
- HEAT (Health, Improvement, Efficiency Access to Services and Treatment Targets for reduction of CDI and SAB)

During 2016/17, the Golden Jubilee National Hospital (GJNH) has:

- maintained our low rates of hospital acquired Clostridium difficile infection (CDI);
- maintained high standards of environmental cleanliness in clinical areas;
- kept Surgical Site Infection (SSI) within control limits in orthopaedics, despite an increase in activity;
- kept surgical site infection low in cardiac surgery; and
- sustained hand hygiene opportunity and technique compliance.

The Board recognises their collective responsibility towards healthcare acquired infection (HAI) risk and continuously supports initiatives to control these. Development, implementation and review of policies, coupled with compliance monitoring surveillance and education, are all components of the Prevention and Control of Infection Team's proactive approach to addressing the HAI agenda at the Golden Jubilee National Hospital.

2.0 Healthcare Associated Infection (HAI)

2.1 *Staphylococcus aureus* bacteraemia (*S. aureus* or SAB)

S. aureus is a Gram positive bacterium which colonises in the nasal cavity of about 30% of the healthy population. Although this colonisation is usually harmless, S. aureus may cause serious infection. These infections are commonly associated with healthcare interventions which allow the bacterium to infect normally sterile body sites.

The mandatory Scottish national Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia surveillance programme was established by the Scottish Executive Health Department (SEHD) in 2001. In July 2006, the surveillance programme was extended to include all *S. aureus* bacteraemias (SABs) in Scotland.

In addition, enhanced *S. aureus* bacteraemia surveillance commenced in 2014. Coordinated by Health Protection Scotland (HPS), this is a mandatory requirement which informs the epidemiology of SAB and increases the opportunity for improvement and sharing of lessons learned across Scotland.

GJNH approach to SAB prevention and reduction

It is accepted within HPS that care must be taken in making comparisons with other Boards because of the specialist patient population within GJNH. Small numbers of cases can quickly change our targeted approach to SAB reduction. All SAB isolates identified within the laboratory are subject to case investigation to determine future learning and quality improvement.

Broad HAI initiatives which influence our SAB rate include:

- Hand Hygiene monitoring;
- MRSA screening at pre-assessment clinics and admission;
- compliance with National Cleaning Service specifications;
- audit of the environment and practices via Prevention and Control of Infection Annual Reviews and monthly Senior Charge Nurse led Standard Infection Control Precautions (SICP) and Clinical Nurse Manager (CNM) Peer Review monitoring; and
- participation in National Enhanced SAB surveillance, gaining further intelligence on the epidemiology of SAB.

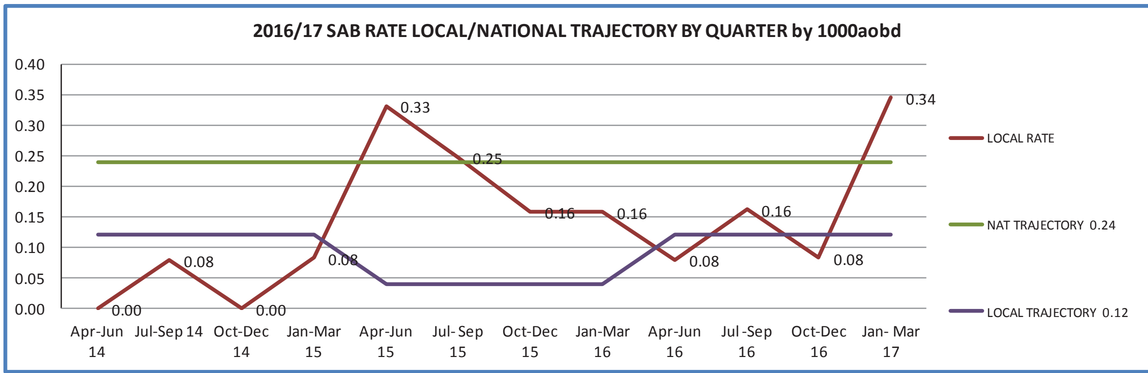
SAB Local Delivery Plan (LDP) Heat Delivery Trajectories

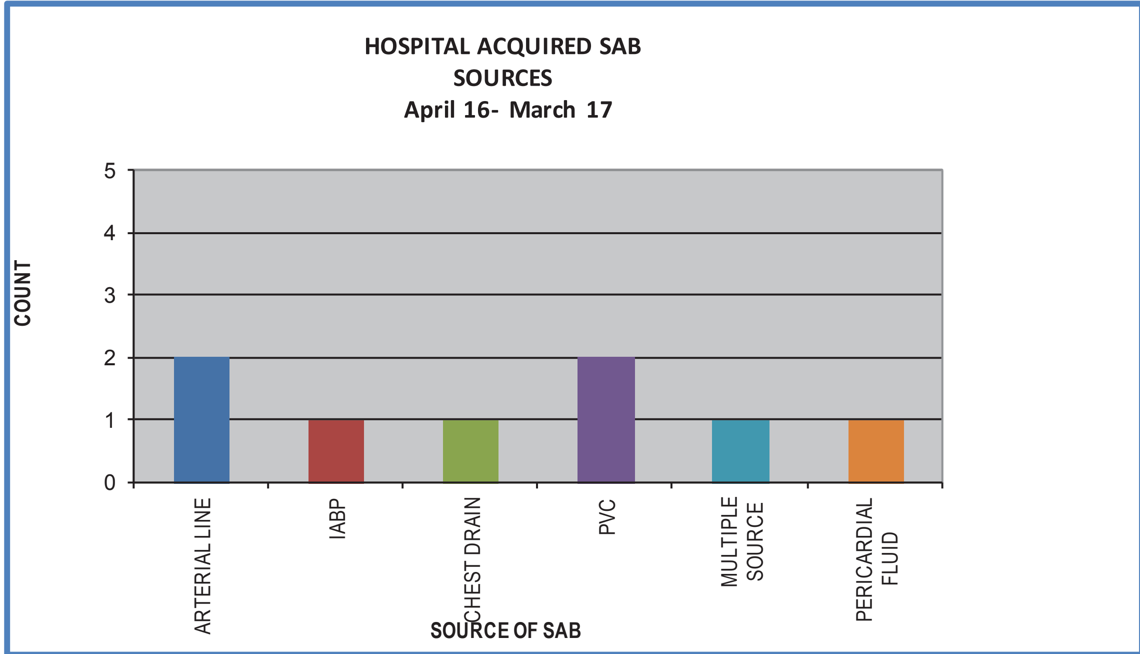
Boards are expected to achieve a rolling target of 0.24 cases per 1,000 acute occupied bed days or lower by year ending March 2017.

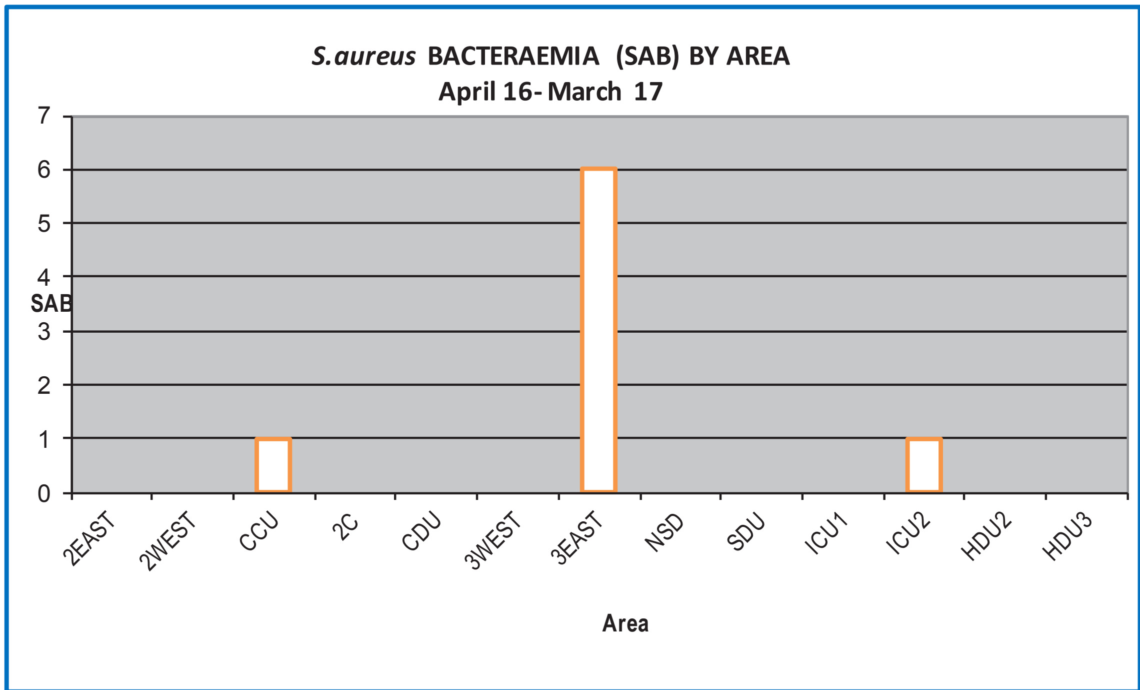
Boards currently with a rate of less than 0.24 are again expected to at least maintain this, as reflected in their trajectories.

Overall April 16- March 2017 rate 0.16 per 1,000 occupied bed days.

The Prevention and Control of Infection Team continue to work closely with the clinical teams and clinical educators to gain insight into the sources of SAB acquisition and associated learning through enhanced surveillance.


2016/17 SAB RATE LOCAL/NATIONAL TRAJECTORY BY QUARTER by 1000aobd
0.40
0.35
0.30
0.25
0.20
0.15
0.10
0.05
0.00
0.33
0.25
0.16
0.16
0.16
0.08
0.08
0.08
0.08
0.00
0.00
0.34
Apr-Jun 14
Jul-Sep 14
Oct-Dec 14
Jan-Mar 15
Apr-Jun 15
Jul-Sep 15
Oct-Dec 15
Jan-Mar 16
Apr-Jun 16
Jul -Sep 16
Oct-Dec 16
Jan- Mar 17
LOCAL RATE
NAT TRAJECTORY 0.24
LOCAL TRAJECTORY 0.12


HOSPITAL ACQUIRED SAB
SOURCES
April 16- March 17
COUNT
5
4
3
2
1
0
ARTERIAL LINE
IABP
CHEST DRAIN
PVC
MULTIPLE SOURCE
PERICARDIAL FLUID
SOURCE OF SAB


S.aureus BACTERAEMIA (SAB) BY AREA
April 16- March 17
7
6
5
4
SAB
3
2
1
0
2EAST
2WEST
CCU
2C
CDU
3WEST
3EAST
NSD
SDU
ICU1
ICU2
HDU2
HDU3
Area

In comparison to 2015/16 data, the sources of SAB have changed and whilst sustained compliance with intra-aortic balloon pump (IABP) bundles has yet to be achieved there is a clear reduction of IABP related SAB.

This year, arterial line bundles have been developed by Critical Care and the arterial line policy has been updated in response to arterial line related SAB. Our work plan for the first quarter of 17/18 will focus on PVC maintenance bundle compliance in 3 East.

2.2 *Clostridium difficile* (CDI)

In Scotland, mandatory surveillance of CDI was introduced in 2006 following reports of increasing CDI rates, the increasing severity of the disease around the world, and the rise in voluntary laboratory reports to HPS in the period 1996-2005. Surveillance initially recorded the incidence of CDI in patients aged 65 years and over. In April 2009, the programme was expanded to include patients aged 15-64 years.

GJNH approach to CDI prevention and reduction

Our numbers of CDI cases are low in comparison with other Boards, which is likely to be related to our specialist patient population.

Actions to reduce CDI:

- Ongoing alert organism surveillance and close monitoring of the severity of cases by the PCIT.
- Unit specific reporting and triggers.
- Implementation of HPS Trigger Tool if trigger is breached.
- Implementation of HPS Severe Case Investigation Tool if the case definition is met.
- Typing of isolates when two or more cases occur within 30 days in one unit.

CDI LDP Heat Delivery Trajectories

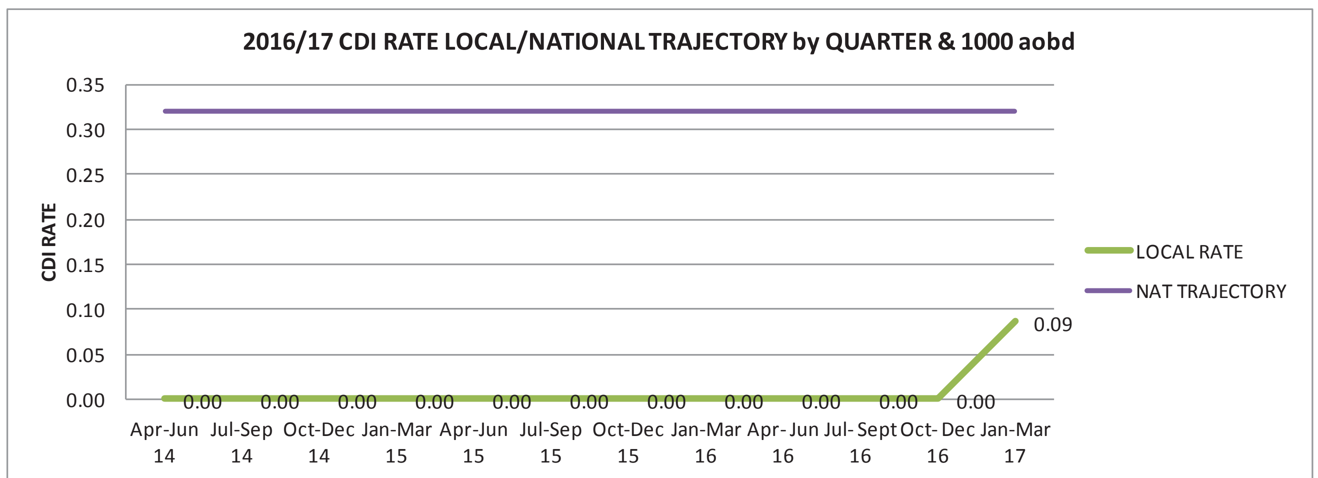
Boards are again expected to achieve a rolling trajectory of 0.32 cases CDI per 1,000 occupied bed days by year ending March 2017. This relates to people aged 15 and over. Boards currently with a rate of less than 0.32 will be expected to at least maintain this, as reflected in their trajectories.

Overall April 2016- March 2017 rate 0.02 per 1000 occupied bed days.

There has only been one case noted since March 2014. No risk factors other than age, justified use of prophylaxis and use of proton pump inhibiters were noted. No cross contamination noted.

C. difficile bacteria are found in the digestive system of about one in every 30 healthy adults. The bacteria often live harmlessly because the other bacteria normally found in the bowel keep it under control. However, some antibiotics and drugs can interfere with the balance of bacteria in the bowel, which can cause the C. difficile bacteria to multiply and produce toxins that make the person ill.

Further HPS CDI Guidance update will be published Summer 2017.



2.3 National Admission Screening Programmes

MRSA

Since 2012 all Boards in Scotland have been expected to perform admission MRSA screening in the form of:

A three question clinical risk assessment (CRA) where, if there is one or more positive answer, a nose and perineal swab are required.
Or
All patients in the five high impact specialties (renal, cardiothoracic, vascular, intensive care and orthopaedics) are screened as a matter of course using nasal and perineal swabs.

The majority of GJNH patients fall into this latter category and our agreed local approach is that all patients staying for a minimum of one night will be screened on admission, and patients requiring longer in patient treatment will be rescreened after 10 days and weekly thereafter.

Since the majority of our patients fall into the latter category of screening we have agreed with HPS and the Scottish Government that participation in the national key performance indicator data submission is not required, however we are keen to continue monitoring compliance in screening and publish this data locally within our HAI reports.

2016 / 17 Data Overview

MRSA SCREENING COMPLIANCE APR 16 - MAR 17

	3 WEST	3 EAST	2C	2D	CCU	NSD	ICU 1	ICU 2	HDU 2	HDU 3	2 EAST	2 WEST
ADMIT SCREEN	99% (n=186)	99% (n= 252)	99% (n=70)	100% (n= 48)	100% (n=61)	99% (n = 71)	97% (n =38)	97% (n = 67)	98% (n = 45)	100% (n = 45)	99% (n = 251)	99% (n = 259)
10 DAY SCREEN	96% (n=28)	85% (n= 40)	NA	NA	NA	87% (n = 23)	0% (n = 1)	91% (n = 23)	75% (n = 4)	50% (n = 4)	75% (n = 16)	58% (n = 25)
7 DAY SCREEN	94% (n=17)	77% (n= 13)	NA	NA	NA	77% (n =22)	NA	89% (n = 18)	100% (n = 2)	67% (n = 6)	64% (n = 14)	82% (n = 11)

Admission screening compliance has sustained reliability. Variation does exists when reviewing compliance with 10 and seven day long term screens, however caution should be taken given the low denominators in some areas e.g. ICU1.

In comparison to 2015/17 data there is an overall improvement in NSD/ICU 2 and HDU 2. To improve compliance throughout 2016/17, the team arranged a focus group to identify barriers to screening and made refinements on Wardview to clearly identify to staff when screens are due.

Carbapenamase-producing Enterobacteriaceae (CPE)

CMO/SGHD(2013)14 raised concern around the emergence of organisms resistant to carbapenems as extensive spread has occurred within a number of European countries, with some moving to an endemic situation. The number of carbapenemase-producing Enterobacteriaceae (CPEs) detected within the UK has also risen.

The key principles in combating this threat are:

- early detection (through clinical alertness, good diagnostic practice and surveillance);
- containment (through infection control measures together with patient and contact screening as required); and
- prudent prescribing of antibiotics.

The focus for 2016/17 was to further embed screening and education, whilst working collaboratively with HPS CPE Short Life Working Group to further refine national policy. To measure CPE screening uptake, HPS have developed a pilot screening KPI protocol, this will be was tested from April to June 2017. The results of this pilot will inform development and roll out of the system later in 2017/18.

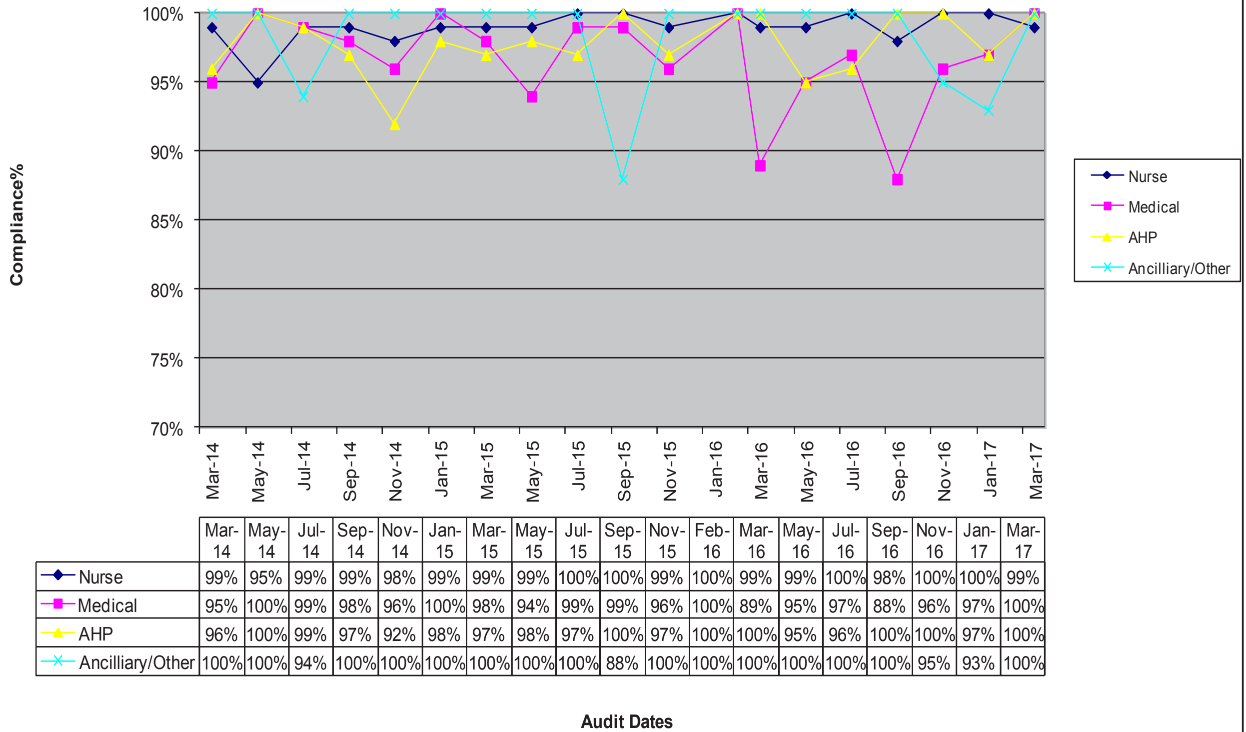
2.4 Hand Hygiene (HH)

Hand hygiene is one of the 10 elements of Standard Infection Control Precautions (SICPs) and remains the most effective means of reducing and preventing the incidence of avoidable illness, in particular healthcare associated infection.

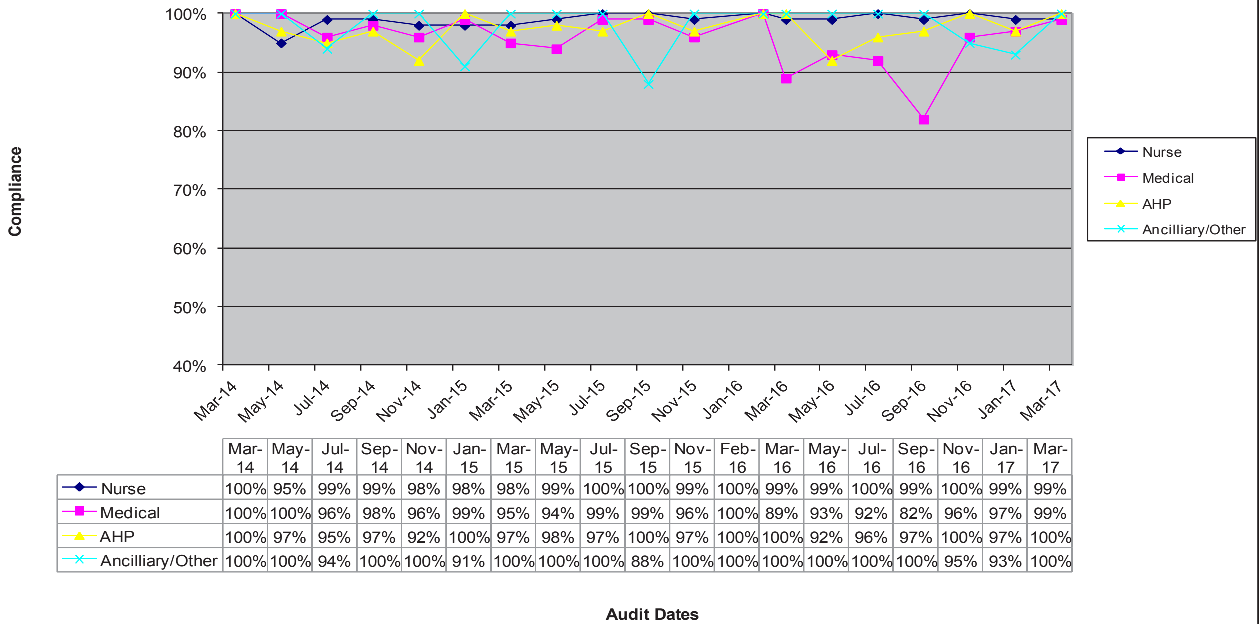
Since 1 October 2013, individual NHS Boards have been given the responsibility for monitoring and reporting HH compliance data and are expected to reintegrate this information into local improvement programmes. Additionally, Boards are required to ensure that they have suitable quality assurance processes in place.

The Golden Jubilee monitors HH and ensures a zero tolerance approach to non-compliance. Since March 2014, the Prevention and Control of Infection Nurses (PCINs) have implemented targeted quality assurance for hand hygiene. Monthly departmental data is reviewed by PCINs as part of Standard Infection Control Procedures (SICPs) with compliance and non compliance discussed with SCN / Department Manager.

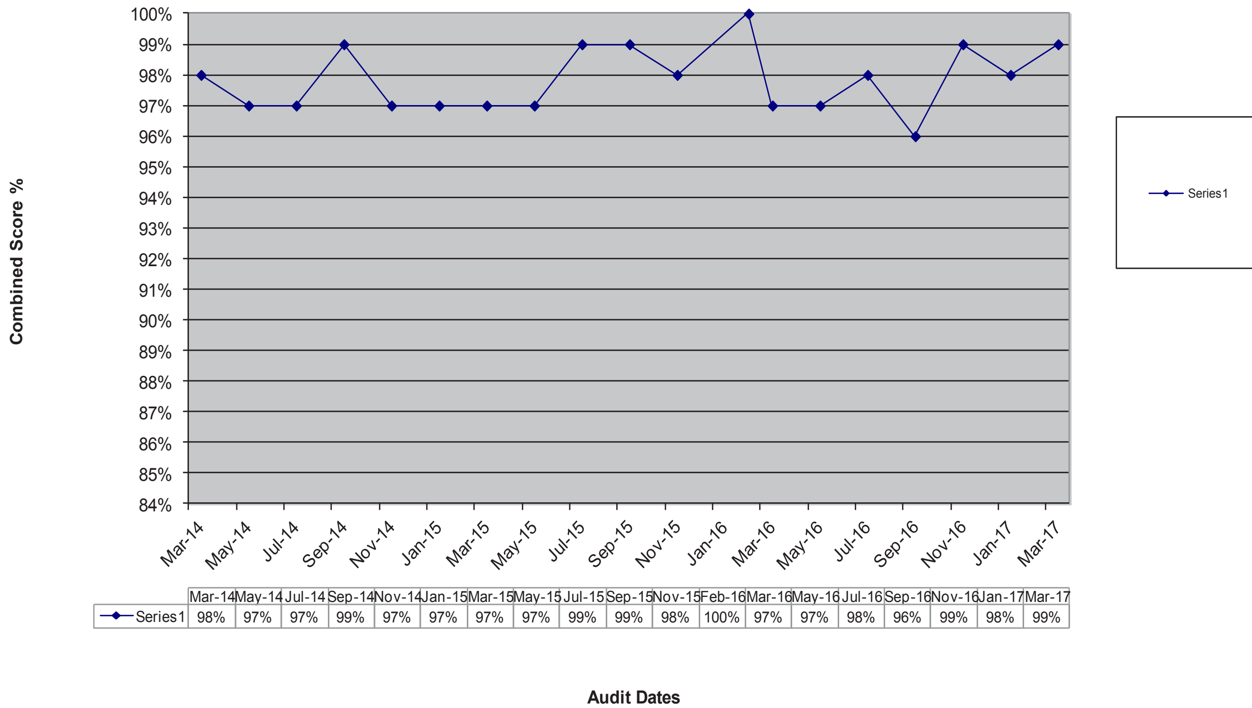
The data below demonstrates compliance with hand hygiene by staff group throughout 2016/17. With the exception of September data, all staff groups are above the national 90% target. No trends were noted in the type of missed opportunities (Five Key Moments).



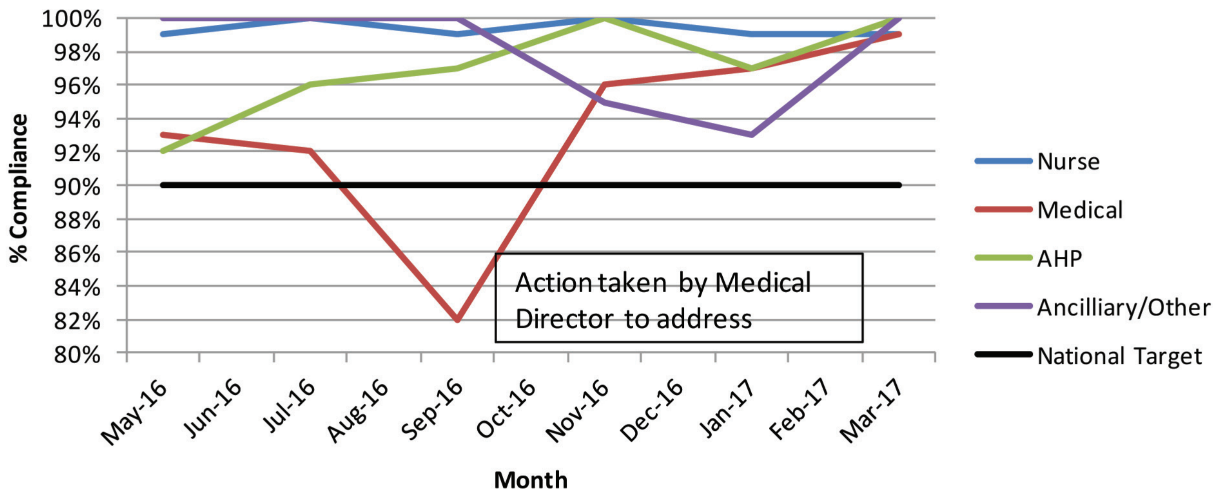
	Mar-14	May-14	Jul-14	Sep-14	Nov-14	Jan-15	Mar-15	May-15	Jul-15	Sep-15	Nov-15	Feb-16	Mar-16	May-16	Jul-16	Sep-16	Nov-16	Jan-17	Mar-17
Nurse	99%	95%	99%	99%	98%	99%	99%	99%	100%	100%	99%	100%	99%	99%	100%	98%	100%	100%	99%
Medical	95%	100%	99%	98%	96%	100%	98%	94%	99%	99%	96%	100%	89%	95%	97%	88%	96%	97%	100%
AHP	96%	100%	99%	97%	92%	98%	97%	98%	97%	100%	97%	100%	100%	95%	96%	100%	100%	97%	100%
Ancilliary/Other	100%	100%	94%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	95%	93%	100%



	Mar-14	May-14	Jul-14	Sep-14	Nov-14	Jan-15	Mar-15	May-15	Jul-15	Sep-15	Nov-15	Feb-16	Mar-16	May-16	Jul-16	Sep-16	Nov-16	Jan-17	Mar-17
Nurse	100%	95%	99%	99%	98%	98%	98%	99%	100%	100%	99%	100%	99%	99%	100%	99%	100%	99%	99%
Medical	100%	100%	96%	98%	96%	99%	95%	94%	99%	99%	96%	100%	89%	93%	92%	82%	96%	97%	99%
AHP	100%	97%	95%	97%	92%	100%	97%	98%	97%	100%	97%	100%	100%	92%	96%	97%	100%	97%	100%
Ancilliary/Other	100%	100%	94%	100%	100%	91%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	95%	93%	100%


HH Combined (Opportunity and Technique)Score
Combined Score %
Audit Dates
Series1

	Mar-14	May-14	Jul-14	Sep-14	Nov-14	Jan-15	Mar-15	May-15	Jul-15	Sep-15	Nov-15	Feb-16	Mar-16	May-16	Jul-16	Sep-16	Nov-16	Jan-17	Mar-17
Series1	98%	97%	97%	99%	97%	97%	97%	97%	99%	99%	98%	100%	97%	97%	98%	96%	99%	98%	99%


Hand Hygiene Compliance by Staff Group 16/17
% Compliance
Month
Nurse
Medical
AHP
Ancilliary/Other
National Target
Action taken by Medical Director to address

2.5 Scottish Surveillance of HAI Programme (SSHAIP)

The Scottish Surveillance of HAI Programme within HPS coordinates the Surgical Site Infection (SSI) surveillance programme. This is mandatory in NHSScotland and all NHS boards are currently required to undertake surveillance for caesarean section and hip arthroplasty procedures as stated in the Health Department Letter (HDL) 2006 (38) [18] and Chief Executive's Letter (CEL) (11) 2009.

In 2011, amendments to the national surveillance requirements of HDL 2006 (38) were implemented, enabling SSI light surveillance methodology to be applied to mandatory and non mandatory procedures from 1 July 2011. This means that the appropriate data has to be completed for all confirmed SSIs, for all patients undergoing procedures. This has since been our local approach to orthopaedic surgery surveillance. Post discharge surveillance requirements, via re-admission data to 30 days post-op, were unaffected by the amendments.

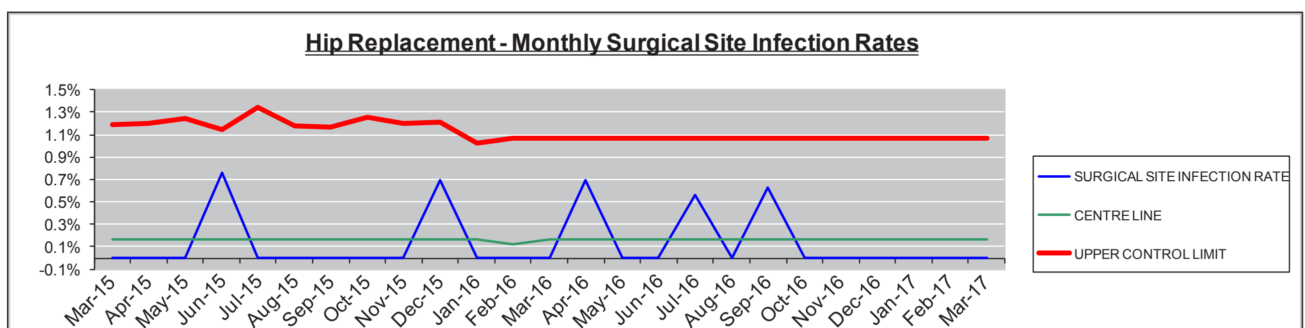
Orthopaedic Surgery Light Surveillance

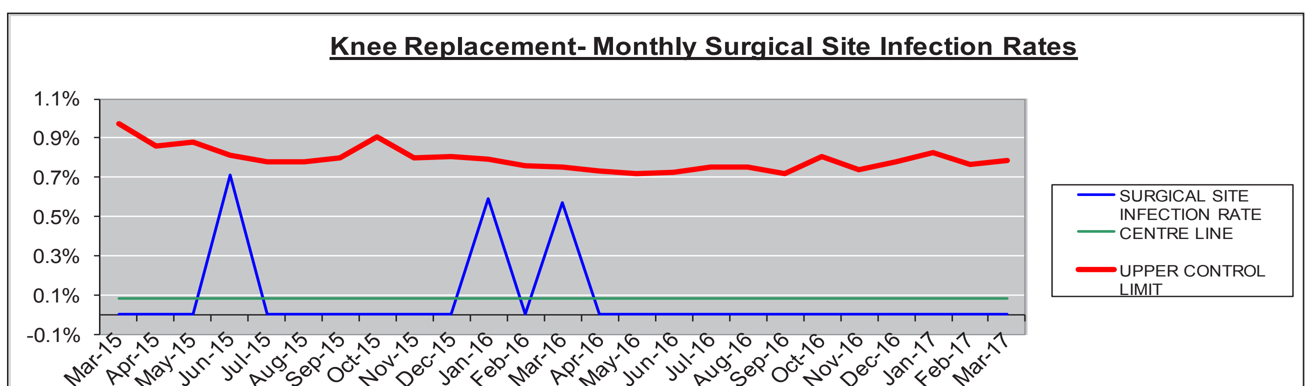
During 2016/17 there were 1,772 hip replacement procedures with an SSI rate of 0.11% (n=2) and 1,843 Knee replacement procedures, with an SSI rate of 0.0% (n=0).

Orthopaedic surveillance is performed from surgery until 30 days post discharge. Numbers of post-operative infections for both hip and knee implant surgery have remained within our control limits and surveillance is ongoing.

The team quality assures orthopaedic surveillance via the following processes:

- reviewing all long stay patients (patients who have been in the hospital for 10 days or more) to determine the reason for extended stay;
- review all readmissions (patients readmitted within 30 days of a prior stay) and all patient deaths;
- receive and review alerts from the laboratory system detailing positive wound swab/ wound fluid results; and
- review of ward safety briefs three times a week to check for any readmitted patients or any patients with known or suspected wound infections.



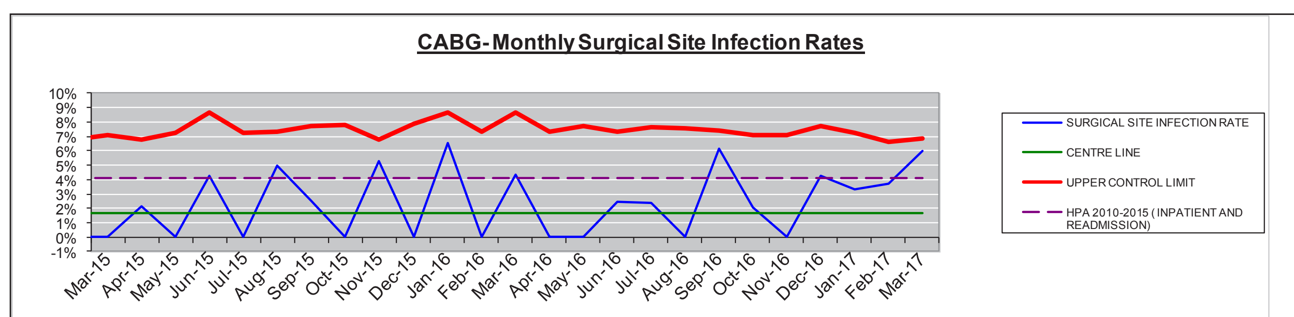


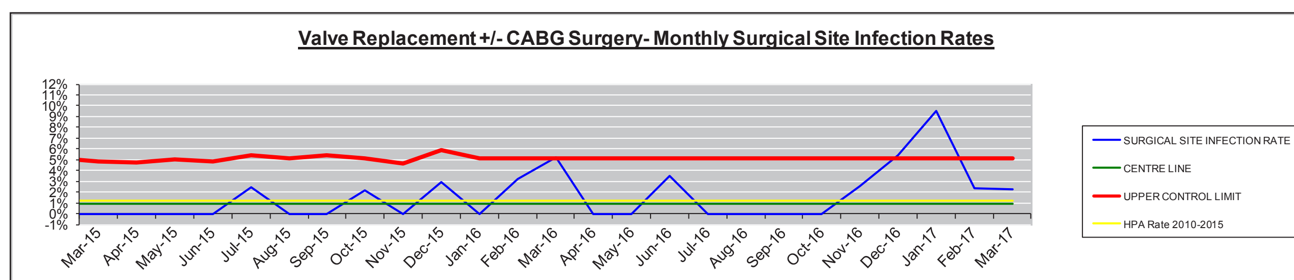
Coronary Artery Bypass Graft (CABG) and Valve Surgery Full Surveillance

Cardiac surveillance is performed from surgery until 30 days post discharge. No other Board in NHSScotland collects this data, therefore benchmarking continues to use data from our NHS England counterparts via the Health Protection Agency (HPA).

There were 562 CABG procedures during 2016/17, with an SSI rate of 2.67 % (n=15), and 540 Valve replacements +/- CABG procedures with an SSI rate of 2.04% (n=11).

A review of all cardiac SSI was undertaken in response to a slight increase identified in December 2016 to March 2017 by the surveillance process. No commonalties were identified and the PCIT continue to perform enhanced surveillance.





Point Prevalence Survey

The Board participated in the National Prevalence Survey data collection in September 2016 and hosted HPS as part of the gold standard validation process.

Local data does not suggest any trends in HAI and national data is still under review to inform future local workplan objectives.

3.0 Prevention and Control of Infection Policies

All Prevention and Control of Infection policies have been reviewed as per the policy review calendar 2015-2017 and in accordance with Healthcare Improvement Scotland (HIS) HAI Standards guidance of policy review two yearly.

The National Infection Prevention and Control Manual (NIPCM) Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) Policy were updated three times in 2016/17. Updates were shared extensively within the Board.

Boards are required to provide assurance that the National Infection Prevention and Control Manual has been implemented via compliance monitoring. A number of processes are in place and were further refined in 2015/16 to monitor compliance within the Board, these include:

- Monthly Senior Charge Nurse SICPs reporting in all clinical areas.
- Prevention and Control of Infection Nurse Checklists.
- Monthly Clinical Nurse Manager Peer Reviews.

This process has also been subject to review by the Audit and Risk Committee via external auditors providing further assurance of robust compliance NIPCM monitoring.

New Policies

New and emerging pathogens and changes in service delivery require a continual review of the application of prevention and control of infection practices and (as a result) the following new policies have been developed and implemented:

- Housekeeping Service Provision.
- Use of Positive and Neutral Pressure Rooms in NSD.

4.0 Prevention and Control of Infection Programme (PCIP) 2015/16

The Prevention and Control of Infection Team achieved 96% of the planned outputs detailed in the PCIP 2016/17. The remaining two objectives have been carried over to the 2017/18 programme.

5.0 Quality Improvement and Programme of Audit

Audits were completed in accordance with the 2016/17 audit plan and action plans to revise issues have been completed where necessary. The audit programme is ongoing.

6.0 Antimicrobial Management Team (AMT)

The Prevention and Control of Infection Team continue to support the work of the Antimicrobial Management Team.

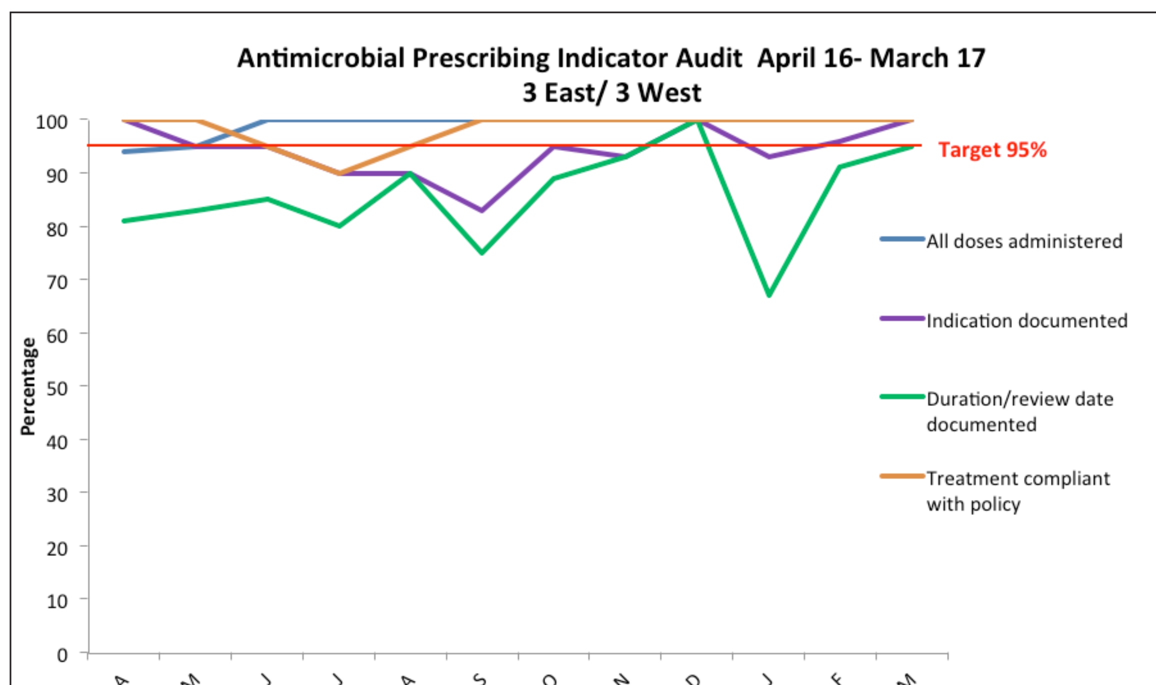
The majority of the AMT work plan was conducted remotely due to the expiration of the Chair position with no immediate replacement. This was resolved with the previous Chair increasing their tenure on an interim basis.

The main work undertaken by the antimicrobial pharmacists has been:

- **Continuation of Scottish Antimicrobial Prescribing Group (SAPG) antimicrobial prescribing indicator data collection**
  This involves data collection within cardiac, orthopaedic, plastic and thoracic surgery every six months, to ensure compliance with surgical prophylaxis guidelines. It also includes weekly auditing of antibiotic prescribing across 3 East and 3 West to ensure compliance with SAPG standards regarding documentation of duration, indication, compliance with empirical guidance and the correct administration of all doses. This information is shared with all relevant staff, including recommendations for improvement. It is also recorded nationally within the SAPG database for reference.

- **National Point Prevalence data collection in September**
- **Promotion of International Antibiotics Awareness Day in November**
  The theme for this year was 'Stop Antimicrobial Resistance', aimed at educating and raising awareness of the importance of preservation of effective antibiotics for serious infections and continuing bacterial resistance to antibiotics. Leaflets, posters and stationery were handed out and a stall managed within the hospital by the antimicrobial team. The team discussed with patients, staff and relatives the importance of not using antibiotics inappropriately e.g. for the common cold, and encouraged them to pledge to become 'Antibiotic Guardians'.
- **Audit of individual areas as required**
  Scottish Adult Congenital Cardiac Service (SACCS) audit to ensure compliance with surgical prophylaxis guidance after an update to guidance which has led to extensive work regarding education and re-audit. Also audit of antibiotic prescribing within NSD leading to work alongside clinical governance to ensure excellent compliance continues.
- **Ongoing twice weekly clinical ward rounds with Consultant Microbiologist**
  This process promotes review with the nurse practitioners or medics of patients who are currently on antibiotic therapy or who are clinically showing signs of infection. It is an opportunity for microbiologists to provide advice on cultures and sensitivities and for pharmacists to advise on doses, drug combinations, and escalation of therapy or de-escalation based on clinical state.
- **Periodic review of guidance to ensure up to date**
  This includes a recent update of empirical antibiotic guidance, due for release Summer 2017

In addition, a stand-alone Antimicrobial Stewardship module for nurses has been developed in collaboration with our Antimicrobial Pharmacist and Clinical Educators. Transfer to Learn Pro for implementation has been delayed due to a vacant post in-house and being unable to access external skill set. This is being actively progressed in our 17/18 work programme.



7.0 HAI education

The PCIT delivers an annual programme to all members of staff and includes induction, core training and mandatory annual updates. In response to the Vale of Leven findings, NHS Education Scotland (NES) undertook a training needs analysis for infection control teams. This was in order to understand the specific patient safety and quality improvement learning needs of PCI staff required for the delivery of safer healthcare, using a behaviour change model as a framework to determine gaps in education and as such to ensure that they will be met by the newly developed education pathway.

The Senior Prevention and Control of Infection Manager is the HAI Education lead and is a member of the NES HAI education leads' group. As such, it is their responsibility to update the PCIC on any national developments in HAI education. The frequency of national meetings was reduced in 2016/2017.

The PCIT continue to deliver mandatory induction training and core training. Topics include SICPs, Transmission Based Precautions (TBPs), Aerosol Generating Procedures (AGPs) and generic HAI issues. In addition there have been awareness raising sessions linked to MRSA screening, CPE screening and Hand Hygiene.

Cleanliness Champion Programme
The Cleanliness Champion Programme, launched in 2003, was part of the Scottish Government's Action Plan to combat Healthcare Associated Infection in NHSScotland.

The Cleanliness Champion programme will be phased out in 2017 and will be replaced with the Scottish Infection Prevention and Control Education Pathway (SIPCEP). There were no new registrations accepted after 30 November 2016, however staff who registered up to this date have been given until 31 May 2017 to complete the programme. A three month exception period for completion in exceptional circumstances is available until 31 August 2017, and after this date access to the programme will close.

SIPCEP is a modular based pathway consisting of three layers: Foundation, Intermediate and Improvement.

The Foundation layer due for launch in June 2017 is available to all Scottish health and social care staff and students, and will ensure there is no gap in education provision.

The aim of the Foundation layer is to underpin knowledge and behaviours across SICP which are key to preventing Healthcare Associated Infection and is aligned to the National Infection and Prevention and Control Manual (NIPCM).

This will allow a personalised Prevention and Control of Infection (PCI) learning and progression pathway to be created for all health and social care staff. Using a flexible delivery model, the pathway will provide equality of access in response to learning needs of stakeholders, from novice to expert. The learning needs of the PCI team members are likely to be positioned at the intermediate and improvement levels of the model.

8.0 HAI outbreaks/incidents

In the event of an outbreak, the role of the PCIT is to contain and manage the outbreak, to investigate the cause and to share learning. In order to proactively manage the risk of HAIs, the PCIT team carry out monitoring and auditing of rates of infection, occurrences of specific organisms and of behavioural adherence to PCI guidelines .In 2016/17 these include:

- Participation in Heath Protection Scotland's (HPS) national response to an international alert of non-tuberculosis mycobacterium infections associated with heater cooler machines.
- Working closely with estates and the clinical team to respond to an increase in Pseudomonas aeruginosa isolates in Critical Care October to December 2016.
- A multidisciplinary review of cardiac SSI was undertaken in response to an increase identified by the surveillance process.

During all investigations, the PCIT used the national Hospital Infection Incident Assessment Tool (HIIAT) to alert relevant national bodies. Collaboration with Health Protection Scotland and the PCIT continued through each investigation and post event, producing outbreak/incident reports to identify good practice and learning from events. Learning and any further actions were shared via divisional clinical governance groups.

9.0 Cleaning and maintaining the healthcare environment

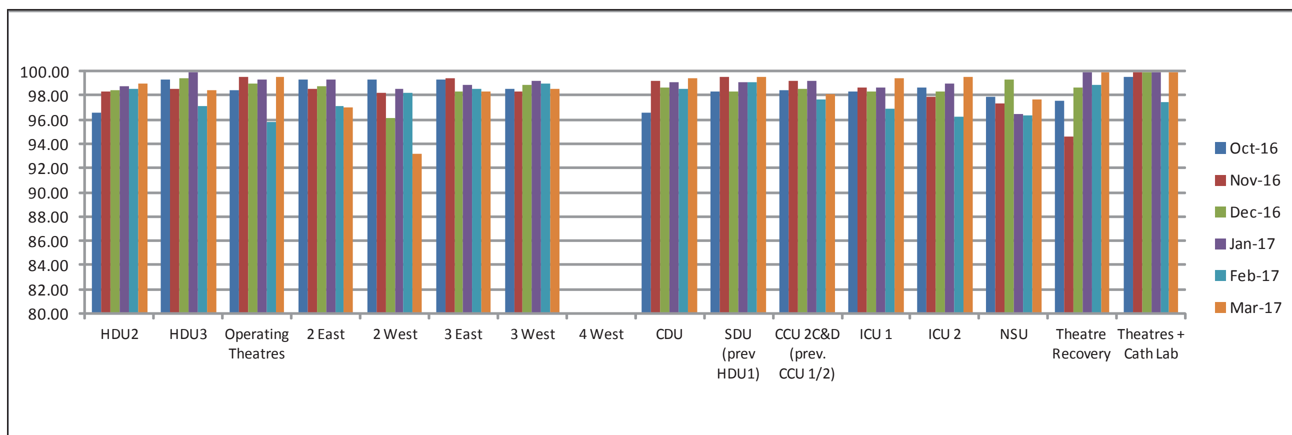
Housekeeping Facility Monitoring Tool (FMT) Audit Results Cleaning services continue to be monitored against the NHSScotland National Cleaning Service Specifications (NCSS) using the Health Facilities Scotland (HFS) Domestic monitoring tool. All healthcare facilities and component parts, e.g. wards, treatment rooms, corridors etc, are expected to be at least 90% compliant with the requirements set out in the NCSS.

NHSScotland National Cleaning Services Specification (NCSS)

The revised NCSS has been published following testing within several boards. An implementation strategy was developed to assist boards introduce the revised NCSS where they felt their current process was inadequate. Following a review of our current practice and associated schedule linked to our FM performance, the PCIC has supported the continuation of our existing work schedule at this time, supported by a local risk assessment.

HOUSEKEEPING FMT AUDIT RESULTS

	HDU2	HDU3	Operating Theatres	2 East	2 West	3 East	3 West	4 West	CDU	SDU (prev HDU1)	CCU 2C&D (prev. CCU 1/2)	ICU 1	ICU 2	NSU	Theatre Recovery	Theatres + Cath Lab
Mar-16	99.02	99.80	99.48	98.05	96.49	98.53	98.06		99.72	99.80	99.14	99.02	98.65	98.31	98.92	99.56
Apr-16	99.23	99.47	100.00	96.56	96.55	98.81	99.57		98.42	99.77	99.43	99.40	98.20	98.96	98.75	99.19
May-16	100.00	99.76	99.48	98.24	96.49	99.71	99.71		99.16	99.48	99.13	97.69	100.00	98.82	98.88	99.05
Jun-16	99.54	99.48	96.35	98.42	99.12	99.18	99.35		99.15	99.54	97.92	98.15	98.05	98.43	98.66	98.81
Jul-16	98.52	99.39	99.48	97.97	98.94	99.68	99.08		99.45	99.25	97.55	99.29	98.98	100.00	97.99	100.00
Aug-16	98.14	98.96	99.36	97.42	98.41	98.35	98.80		98.84	98.94	97.08	98.41	96.27	98.92	100.00	100.00
Sep-16	97.24	97.82	98.44	98.55	98.87	97.62	97.95		96.56	98.24	97.99	97.63	98.93	97.60	100.00	98.76
Oct-16	96.56	99.28	98.44	99.29	99.31	99.31	98.59		96.61	98.38	98.41	98.32	98.67	97.92	97.51	99.52
Nov-16	98.33	98.51	99.48	98.56	98.27	99.41	98.32		99.16	99.57	99.15	98.67	97.85	97.30	94.64	100.00
Dec-16	98.42	99.46	98.96	98.79	96.15	98.29	98.83		98.65	98.31	98.52	98.31	98.36	99.29	98.69	100.00
Jan-17	98.75	100.00	99.31	99.26	98.53	98.87	99.20		99.11	99.10	99.21	98.70	98.97	96.49	100.00	100.00
Feb-17	98.58	97.07	95.83	97.09	98.21	98.49	98.93		98.57	99.12	97.64	96.89	96.20	96.39	98.90	97.49
Mar-17	98.96	98.41	99.48	97.02	93.23	98.32	98.56		99.43	99.58	98.06	99.38	99.53	97.70	100.00	100.00



10.0 Built Environment

Building work, renovation, or refurbishment in patient care areas can pose significantly increased risks of infection to vulnerable patients. HAI-SCRIBE (System for Controlling Risk in the Built Environment) engages the collaboration of expertise from a wide range of healthcare experts and directs efforts to reduce risk through assessment and planning prior to, and during, any building work. This multidisciplinary SCRIBE is followed by continuous monitoring by the Prevention and Control of Infection and Housekeeping teams for the duration of the project.

The use of HAI-SCRIBE is well established within the Golden Jubilee. Multidisciplinary representation for all works being carried out (including contractors) ensures that risks are carefully considered particularly when work is planned for patient areas. HAI-SCRIBE policy and pro-formas have been updated in line with updated HFS HAI SCRIBE documentation.

A total of 111 HAI SCRIBE risk assessments were carried out between the PCIT and Estates for planned and unplanned work activity during 2016/17.

11.0 National Groups

The Prevention and Control of Infection Team represent GJNH on a number of National Groups:

- Scottish Antimicrobial Prescribing Group (SAPG)
- Environmental and Equipment Decontamination (Expert Advisory) Steering Group
- Commodity Advisory Panel (CAP) / (Technical User’s Group) TUG Groups
- National Infection Prevention and Control Manual Consensus group
- HAI Education Leads Group
- Domestic Services Expert Group
- Infection Control Manager Forum.
- Senior Infection Control Nurse Forum.
- HPS SSI Collaborative.

- CPE Short Life Working Group.

12.0 Horizon Scanning 2017/18

Prevention and Control of Infection continues to evolve, as do the organisms which we monitor. This is a constant challenge with regards to resource, education, application of control measures and eradication. Utilisation of National and International data fed via HPS Current and Emerging threat reports allows the team to be sighted on current issues and alter our work plan accordingly.

Recognised work plan priorities for 2017/2018 include:

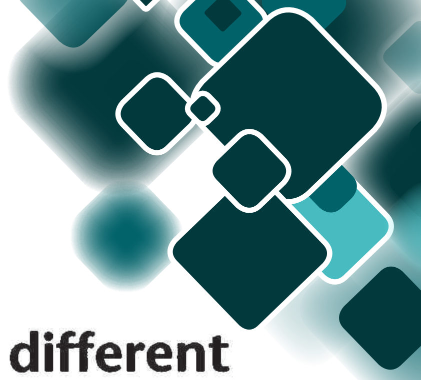
- Planning, Design and maintenance of a safe environment in relation to Board expansion
- Implementation of NES SIPCEP
- Respond to local and national priorities identified within the 2016/17 PPS
- Introduction of National CPE screening KPIs
- Introduction of National Catheter Passport
- Rolling HEAT trajectory for SAB/CDI
- Antimicrobial resistance threat and compliance with local policy.

Table of abbreviations:

AGPs	Aerosol Generating Procedures
AHP	Allied Healthcare Practitioner
AMT	Antimicrobial Management Team
CABG	Coronary Artery Bypass Graft
CAP	Commodities Advisory Panel
CCU	Coronary Care Unit
CDI/C.difficile	Clostridium Difficile Infection
CEL	Chief Executive Letter
CPE	Carbapenamase-producing Enterobacteriaceae
CRA	Clinical Risk Assessment
CVC	Central Venous Catheter

DMT	Domestic Monitoring Tool
E.coli	Escherichia coli
FM	Facilities Monitoring
FMT	Facilities Monitoring Tool
GJNH	Golden Jubilee National Hospital
GP	General Practitioner
HAI	Healthcare Associated Infection
HAIRT	Healthcare Associated Infection Report Template
HA MRSA	Hospital Acquired Meticillin Resistant Staphylococcus aureus
HDL	Health Department Letter
HDU	High Dependency Unit
HEI	Healthcare Environment Inspection
HFS	Healthcare Facilities Scotland
HH	Hand Hygiene
HIEAT	Health, Improvement, Efficiency and Access to services
HIIAT	Hospital Infection Incident Assessment Tool
HIS	Healthcare Improvement Scotland
HPA	Health Protection Agency
HPS	Health Protection Scotland
IABP	Intra aortic balloon pump
IC	Infection Control
ICAR	Infection Control Audit Review
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
KPI	Key Performance Indicators
LDP	Local Delivery Plan
MRSA	Meticillin Resistant Staphylococcus Aureus
MSSA	Meticillin Sensitive Staphylococcus Aureus
NAT	National
NCSS	National Cleaning Standard Specification
NES	NHS Education Scotland
NIPCM	National Infection Prevention and Control Manual
NSD	National Services Division
PAG	Problem Assessment Group
PCI	Prevention and Control of Infection
PCIC	Prevention and Control of Infection Committee
PCINs	Prevention and Control of Infection Nurses
PCIP	Prevention and Control of Infection Programme
PCIT	Prevention and Control of Infection Team
PICC Line	Peripherally inserted central catheter line
PNE	Patient Notification Exercise
PPS	Point Prevalence Survey
PVC	Peripheral Venous Cannula
SAB	Staphylococcus aureus bacteraemia
SACCS	Scottish Adult Congenital Cardiac Service
SAPG	Scottish Antimicrobial Prescribing Group
SCN	Senior Charge Nurse
SCRIBE	System for Controlling Risk In the Built Environment
SEHO	Scottish Executive Health Department
SICP s	Standard Infection Control Precautions
SIPCEP	Scottish Infection Prevention and Control Education Pathway

SPSP	Scottish Patient Safety Programme
SSHAIP	Scottish Surveillance of HAI Programme
SSI	Surgical Site Infection
TBPs	Transmission Based Precautions
THR	Total Hip Replacement
TUG	Technical Users Group
VAP	Ventilator Associated Pneumonia



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