NHS National Waiting Times Centre

NHS SCOTLAND

Prevention and Control of Infection Annual Report 2010/11

Approval record	Date Approved
Golden Jubilee National Hospital Prevention and Control of Infection Manager	
Golden Jubilee National Hospital Board Prevention and Control of Infection Committee	
Golden Jubilee National Hospital Clinical Governance Committee	
National Waiting Times Centre Board Chief Executive	

Golden Jubilee National Hospital
NHS National Waiting Times Centre

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1 Introduction

The following report details the activities of the Prevention and Control of Infection Team (PCIT) over 2010/11 against the planned Infection Control Programme (ICP) agreed by the Prevention and Control of Infection Committee, key stakeholders, senior and executive managers.

The Infection Control Programme is supported by a number of initiatives including the following local and national drivers;

- Scottish Patient Safety Programme (SPSP)
- National Hand Hygiene Campaign
- Health Efficiency Access and Treatment (HEAT) targets for the reduction of Clostridium Difficile infection (CDI) and Staphylococcus Aureus Bacteraemia (SAB)
- NHS Quality Improvement Scotland (QIS) Healthcare Environment Inspectorate
- NHS QIS Healthcare Associated Infection (HAI) standards
- National Meticillin Resistant Staphylococcus Aureus (MRSA) screening programme
- Monitoring of cleaning specifications
- Antimicrobial Management Team (AMT) surgical prophylaxis policies
- Changes in the collection and presentation of data
- HAI Taskforce work plan
- Local quality scheme

Close surveillance of alert organisms and conditions such as MRSA, CDI and SAB, as well as preoperative and admission screening for MRSA, are a routine part of the alert organism surveillance programme. Despite the challenges, the number of HAI from key alert organisms and conditions – including MRSA, CDI and SABs – continued to reduce over the year 2010/11.

HEAT targets for CDI and SAB are set nationally and we participate in the mandatory national return of data for these programmes, as well as Surgical Site Infection (SSI) surveillance of orthopaedic implant procedures and cardiac surgery patients.

2.0 Statistics

2.1

The number of Staphylococcus Aureus Bacteraemias (SAB) was 0.25 per 1000 acute occupied bed days .

The Prevention and Control of Infection Team (PCIT) perform root cause analysis on each Staphylococcus Aureus Bacteraemia to identify source and lessons learned.

2.2

The number of patients identified with Clostridium Difficile was 0.08 per 1000 acute occupied bed days .

2.3

Building work, renovation or refurbishment in patient care areas can significantly increase risks of infection to vulnerable patients. HAI SCRIBE (System for Controlling Risk in the Built Environment) brings together a wide range of healthcare experts to reduce this risk, by carrying out assessments and planning before and during any building work.

The number of HAI SCRIBE risk assessments carried out throughout this period was 41. After these, the Prevention and Control of Infection and Housekeeping teams keep monitoring the project until it is completed.

2.4

The risk of transmission of Transmissible Spongiform Encephalopathy (TSE), Creutzfeldt-Jakob Disease (CJD) and variant CJD need to be routinely questioned before surgery, to assess the risks of the procedure and direct decontamination processes. There was a 72% reduction in CJD enquires (six enquires as opposed to 23 in 2009/10) and this is related to a national change in how the risk of CJD is assessed.

2.5

Monitoring Framework for NHS Scotland National Cleaning Specifications.

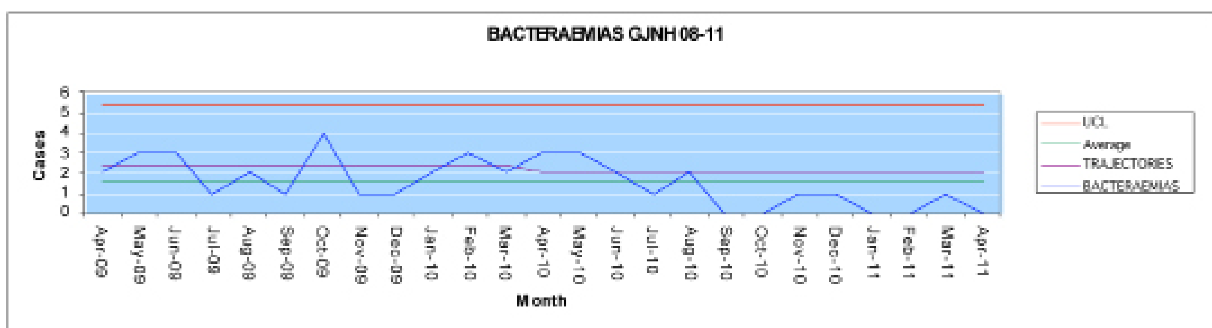
Scores are expected to be above 90% per quarter. Over the first quarter the score was 95.4%. Audit scores dropped during June and July, resulting in an 89.7% score for the second quarter. This drop (0.3% below minimum) was related to high long term sickness levels in the department. Scores picked up again and were above target for the third and fourth quarters. Department sickness levels are monitored monthly and, where necessary, appropriate action is taken with support from HR.

3 Healthcare Associated Infection

3.1

Staphylococcus Aureus Bacteraemias

Annual Incidence



Our overall SAB rate is 0.25 per 1000 acute occupied bed days (AOBD). n=13. This reduction is in line with our target.

Local approach to SAB prevention and reduction

The Golden Jubilee National Hospital SAB rates between October and December 2010 (0.16 per 1000 AOBS are marginally higher than the national average (0.159 per 1000 AOBD).

It is accepted nationally within Health Protection Scotland (HPS) that care must be taken in making comparisons, because of the specialist patient population within GJNH. The HEAT target for 2011/12 is to further reduce healthcare associated infections, so that by March 2013 NHS Boards have fewer than 0.26 SAB cases (including MRSA) per 1000 AOBD.

NHS National Waiting Times Centre
***Staphylococcus aureus* bacteraemia rates**
January 2003-December 2010
Source: Health Protection Scotland

Quarter	Number of bacteraemia			Acute occupied bed days	Rate per 1000 acute occupied bed days		
	MRSA	MSSA	SA		MRSA	MSSA	SA
Apr 09-Jun 09	1	7	8	12381	0.081	0.565	0.646
Jul 09-Sep 09	0	5	5	11637	0.000	0.430	0.430
Oct 09-Dec 09	2	4	6	12118	0.165	0.330	0.495
Jan 10-Mar 10	0	7	7	11438	0.000	0.612	0.612
Apr 10-Jun 10	1	8	9	12155	0.082	0.658	0.740
Jul 10-Sep 10	0	3	3	12438	0.000	0.241	0.241
Oct 10-Dec10	0	2	2	12570	0.000	0.159	0.159

Broad HAI initiatives which influence our SAB rate include

- hand hygiene campaign;
- MRSA screening at pre-assessment clinics and admission;
- compliance with national housekeeping specifications and
- prevention and Control of Infection Annual reviews.

Our overall SAB numbers are low and therefore small numbers of cases can quickly change our targeted approach to SAB reduction. The targeted approach to reduce SABs in 2010/11 focused on the reduction of Surgical Site Infection and Catheter Related Blood Stream Infections (CRBSI).

Actions to reduce SSI related SAB

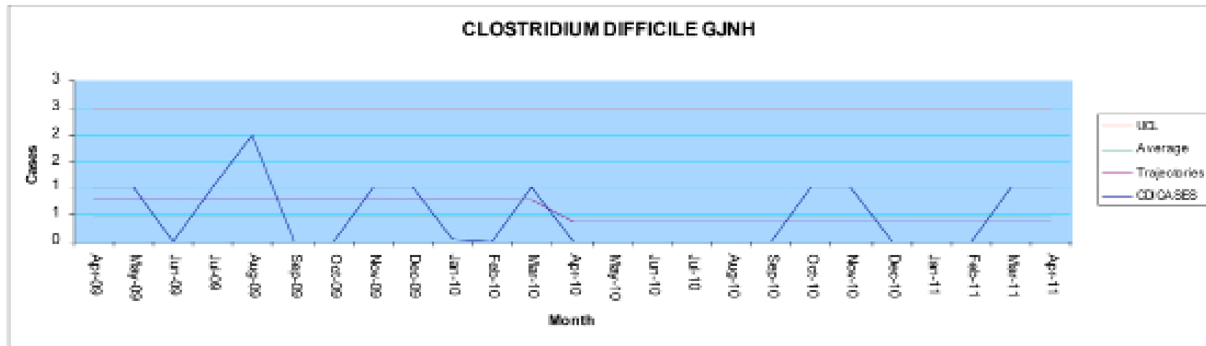
- Introduction of MRSA screening for cardiac and subsequent treatment; pre and post op as a risk reduction approach.
- Surgical Site Infection Surveillance in collaboration with Health Protection Scotland, and compared with Health Protection Agency data to allow rapid identification of increasing and decreasing trends of SSI.
- Review SSI prevention against National Institute for Clinical Excellence (NICE) best practice statement
- Proposal to standardise post op cardiac wound care, which began March 2011.

Actions to reduce CRBSI related SAB

Interventions to reduce CRBSI related SAB are lead by the Scottish Patient Safety Programme workstreams. Our Critical Care work stream has made headway with the Central Venous Catheter (CVC) insertion and maintenance bundle, where most of CRBSI SABs are identified. The Peri-op work stream identified CVC insertion bundles as part of its workplan for 2010/11 as the vast majority of central lines are inserted in theatres.

3.2

Clostridium Difficile



Annual incidence

Our overall Clostridium Difficile Infection (CDI) is 0.08 per 1000 AOBDs. Our numbers of CDI cases are low in comparison with other Boards, which is likely to relate to our specialist patient population.

Local approach to CDI prevention and reduction

Actions to reduce CDI

- Ongoing alert organism surveillance and close monitoring of the severity of cases by the PCIT.
- Introduction of monthly unit specific reporting since April 2009.
- Updated CDI policy in accordance with Scottish Guidance on prevention and control of CDI.
- Triggers for action set for each unit, with 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.
- ICN's testing SPSP Care Bundles for CDI. Although opportunities to test are limited.
- Education of staff on the prevention and care of a patient with CDI was incorporated into core training 2010.
- Antimicrobial Management Team (AMT) has introduced policy changes for surgical prophylaxis in both Orthopaedics and Cardiothoracic. CDI is predominantly an antibiotic associated disease and the proposed changes will reduce the use of specific antibiotic groups which are associated with an increased risk of CDI. Progress on implementation will be through the AMT and reported to the Prevention and Control of Infection Committee and Drug and Therapeutics Committee.
- Antimicrobial prescribing audits and monitoring of compliance with policy have been implemented by AMT.
- Quarterly HPS CDI checklists have been completed by Senior Charge Nurses since April 2010. These are reported via directorate group reports.

3.3

National HEAT Targets

We continue to work to the national targets for reduction in SAB and CDIFF infection (see charts on page 10).

The target for both has been further reduced over 2010/11. The new targets are based on 'best in class' and boards are expected to achieve the same or lower than that figure.

Our CDIFF infection reduction target in patients aged 65 and over is also due for delivery by the end of March 2013. This target is set at 0.39 cases per 1000 AOBD. Our case numbers are very small and are lower than the national target therefore we are expected to at least sustain this level and continue to reduce our CDI cases. Given this, our target is set at 0.1 per 1000 AOBD and we have again seen a sustained reduction over the past year, with a 63% reduction in CDIFF cases since April 2009.

Our SAB reduction target is 0.26 cases per 1000 AOBD. This is the new delivery target for end of March 2013. It is recognised locally and nationally at HPS and SGHD that this will be a challenge for GJNH, because of small patient numbers and the nature of our surgical and clinical interventions with high risk patients. However we still work towards this target and as you will see below we have had a good and sustained reduction in SAB over the past year, with a 52% reduction in cases since April 2009.

Quarterly rolling year Clostridium difficile Infection Cases in patients aged 65 and over per 1000 total occupied bed days for HEAT Target

C difficile only impacted at GJNH from May 08 when new services with higher risk groups were introduced.

HEAT Target increased to 50% Our current target is based on our own data and is below the national target as explained above

	Apr 07 - Mar 08	Jul 07 - Jun 08	Oct 07 - Sept 08	Jan 08 - Dec 08	Apr 08 - Mar 09	Jul 08 - Jun 09	Oct 08 - Sept 09	Jan 09 - Dec 09	Apr 09 - Mar 10	Jul 09 - Jun 10	Oct 09 - Sept 10	Jan 10 - Dec 10	Apr 10 - Mar 11
Actual Performance	0.00	0.00	0.00	0.00	0.20	0.15	0.18	0.16	0.10	0.10	0.06	0.06	0.02
Target	0.00	0.00	0.00	0.00	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10

Quarterly rolling year Staphylococcus aureus Bacteraemia Cases for HEAT Target

Because of specialist nature of services at GJNH the Staph aureus bacteraemia HEAT Target was agreed at 15% reduction over year 2010-11

	Apr 05 - Mar 06	Jul 05 - Jun 06	Oct 05 - Sept 06	Jan 05 - Dec06	Apr 06 - Mar 07	Jul 06 - Jun 07	Oct 06 - Sept 07	Jan 07 - Dec 07	Apr 07 - Mar 08	Jul 07 - Jun 08	Oct 07 - Sept 08	Jan 08 - Dec 08	Apr 08 - Mar 09	Jul 08 - Jun 09	Oct 08 - Sept 09	Jan 09 - Dec 09	Apr 09 - Mar 10	Jul 09 - Jun 10	Oct 09 - Sept 10	Jan 10 - Dec 10	Apr 10 - Mar 11
Actual Performance													32	32	31	26	27	27	24	21	13
Target													27	27	27	27	27	27	27	27	27

3.4

National MRSA Screening Programme

In April 2009 the Scottish Government Health Directorate (SGHD) announced a National MRSA Screening Programme in Scotland, based on the interim report of an MRSA Screening Pathfinder Programme. All Scottish Boards were to fully implement the national roll out by January 2010.

The stated aim of the programme is "to identify patients that are colonised or infected with MRSA. These patients can then be managed appropriately to reduce the risk of self-infection and transmitting the organism to other patients. The measures aim to reduce the negative impact that MRSA has on patients and the additional burden on healthcare resources."

We have been part of the national programme for over two years and by nature of our patient population we screen all patients at pre-operative assessment clinics and on admission. The majority of our patients routinely have swabs taken from multiple sites and compliance with screening programme has improved over the two years, with the last monthly audit showing almost 100% compliance.

The report for the MRSA Screening Pathfinder Programme was finally published in February 2011 and there were changes to the recommendations for minimal screening of patients in specific acute groups.

The majority of our patients are in these acute groups, including Orthopaedic, Cardiac and thoracic, and therefore we continue to screen all patients admitted for overnight stay and all pre-assessment patients.

The change to the recommended sites for screening, with the addition of perineum (minimum is now nose and perineum), has caused some problems locally and nationally. We are currently introducing the new recommendations for in-patients and looking at how this will be best achieved in out-patient settings.

Our compliance with screening (see below) has been monitored monthly and with a few exceptions around emergency admissions we are now achieving 100% compliance. We have also added a locally set target, for patients with stays longer than 10 days to be screened on the tenth day and weekly thereafter.

	Total swabs tested	Total number of swabs MRSA positive	% of total swabs taken MRSA positive	Total number of patients tested	Total number patients MRSA positive	
Total swabs taken between Jan 10 and March 11	43627	423	1%	16918	224	1.3%

Mar-11	4WEST	3WEST	3EAST	2C	2EAST	2WEST	CCU	NSD	ICU2	ICU1	HDU3	2EAST GENERAL
OPD COMPLIANCE	NA	100%	100%	100%	100%	100%	NA	100%	100%	100%	100%	100%
ADMIT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	88% 2 patients (emergency admits and unwell) not screened at time of audit	100%	100%	100%
COMPLIANCE PLUS LAB RESULT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
>10 day stay or weekly screened carried out	100% 0	38% 5/8 patients not screened	33% 6/9 patients not screened	NA	100%	100%	NA	100%	100%	NA	100%	NA

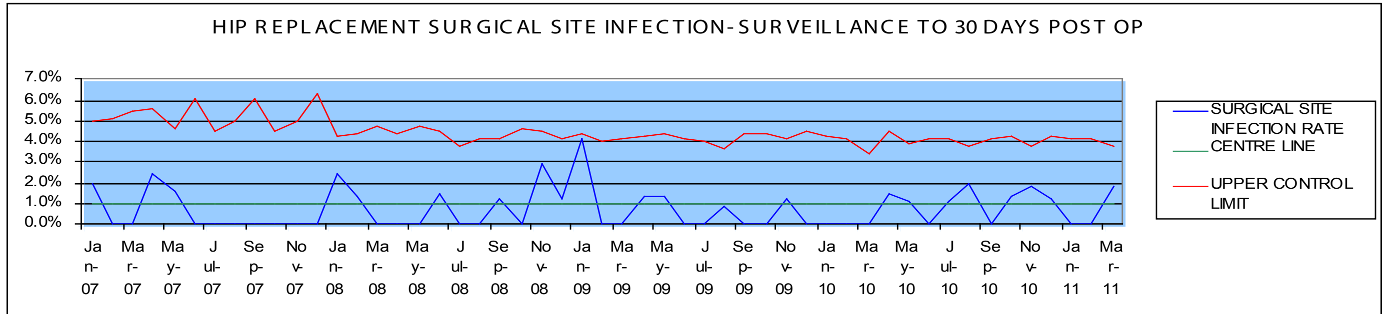
3.5

Scottish Surveillance of HAI Programme (SSHAIP)

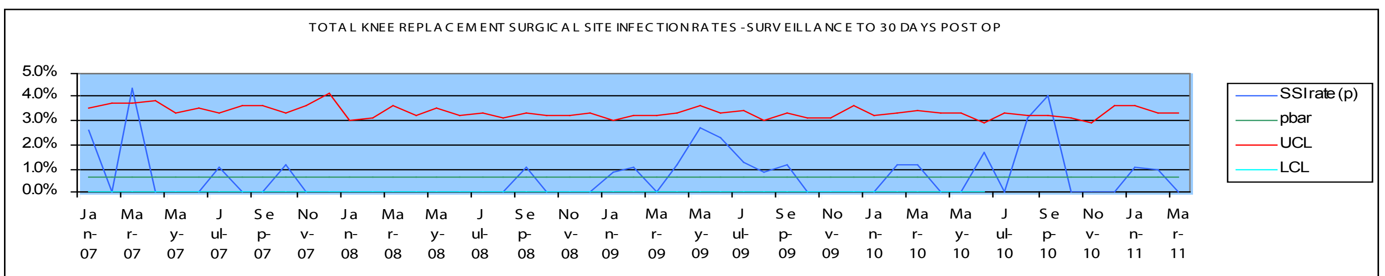
Scottish Surveillance of HAI Programme (SSHAIP) is mandatory for all hospitals. The Golden Jubilee entered the programme in 2002 for cardiac surgery and in 2004 for orthopaedic surgery.

Orthopaedic Surgery Surveillance

There had been an increase in Orthopaedic Surgical Site Infections between July and September 2010. A multidisciplinary team implemented a number of control measures in conjunction with Health Protection Scotland. Numbers of post op infections for both hip and knee implant surgery are now back within our control limits and surveillance is on going.



MONTH /QUARTER	NO OF TKR PROCEDURES	COUNT OF INFECTIONS OVERALL	SSI RATE OVERALL	INPATIENT COUNT OF INFECTION	IN PATIENT RATE	SUPERFICIAL	DEEP	PDS-COUNT OF INFECTION	PDS RATE	SUPERFICIAL	DEEP
April- June 10	244	2	0.82%	1	0.41%	1	0	1	0.41%	0	1
Jul- Sept	274	3	1.09%	0	0.00%	0	0	3	1.09%	0	3
October	75	1	1.33%	0	0.00%	0	0	1	1.33%	0	1
November	107	1	0.93%	0	0.00%	0	0	1	0.93%	0	1
December	79	1	1.27%	0	0.00%	0	0	1	1.27%	0	1
January	81	0	0.00%	0	0.00%	0	0	0	0.00%	0	0
February	85	0	0.00%	0	0.00%	0	0	0	0.00%	0	0
March	109	2	1.83%	1	0.92%	0	1	0	0.00%	0	0



MONTH/QUARTER	NO OF TKR PROCEDURES	COUNT OF INFECTIONS OVERALL	SSI RATE OVERALL	INPATIENT COUNT OF INFECTION	IN PATIENT RATE	**SUPERFICIAL**	**DEEP**	PDS-COUNT OF INFECTION	PDS RATE	SUPERFICIAL	DEEP
April- June 10	297	2	0.67%	1	0.34%	**1**	**0**	1	0.34%	0	1
Jul- Sept	284	7	2.46%	3	1.06%	**2**	**1**	4	1.41%	1	3
October	106	0	0.00%	0	0.00%	**0**	**0**	0	0.00%	0	0
November	125	0	0.00%	0	0.00%	**0**	**0**	0	0.00%	0	0
December	87	0	0.00%	0	0.00%	**0**	**0**	0	0.00%	0	0
January	98	1	1.02%	0	0.00%	1	0	0	0.00%	0	0
February	109	1	0.92%	0	0.00%	0	0	1	0.92%	1	0
March	128	0	0.00%	0	0.00%	0	0	0	0.00%	0	0

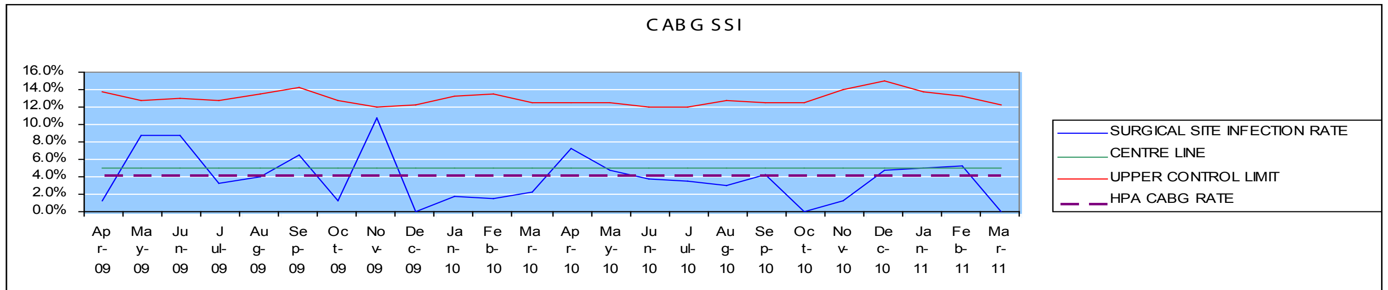
3.6

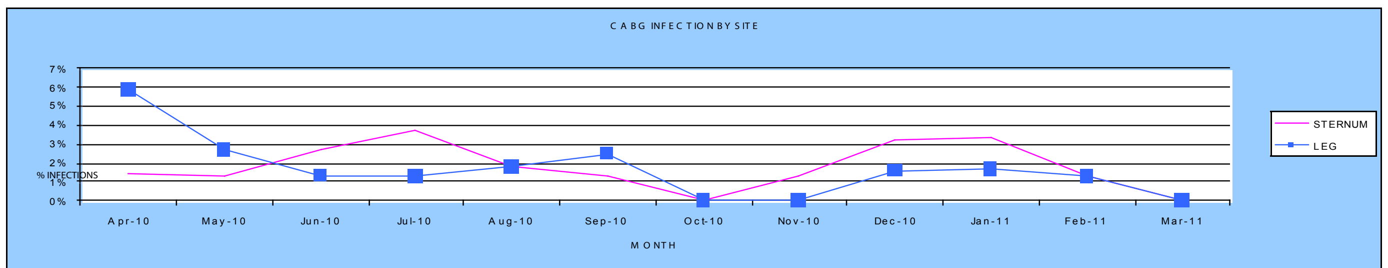
Coronary Artery Bypass Graft (CABG) and Valve Surgery Surveillance

Cardiac Surveillance is performed from surgery to 30 days post discharge. Following a meeting with epidemiologists at HPS, benchmarking of SSI rates has been agreed with HPA for CABG surgery.

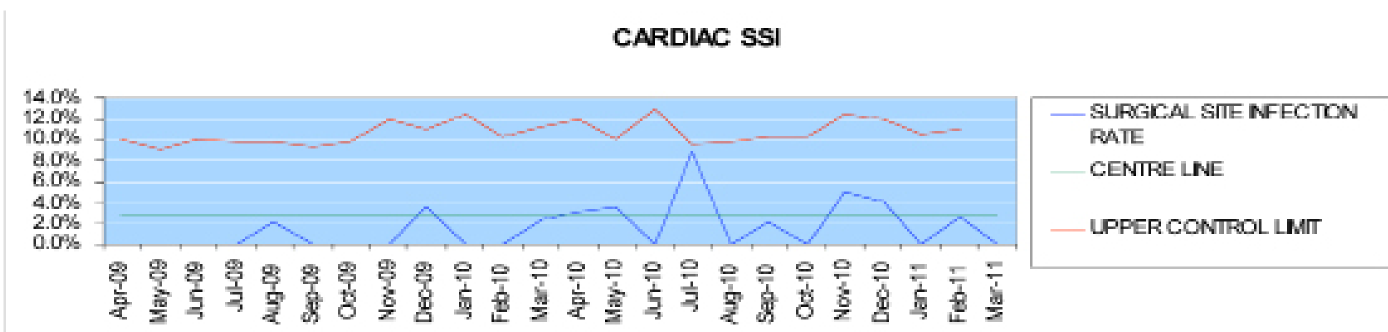
CABG and cardiac surgery has been aligned into separate groups, in order to report SSI rates in comparable to HPA. HPA rate is noted within the SPC chart for CABG, HPS data for cardiac surgery will not be available until late 2011.

All CABG and cardiac data were within control limits.





MONTH	NO OF CABG PROCEDURES	NUMBER OF INFECTIONS	STERNUM	OVERALL STERNUM RATE	SUPERFICIAL	DEEP	LEG	OVERALL LEG RATE	SUPERFICIAL	DEEP
Apr-10	63	5	1	1.5%	0	1	4	5.9%	[illegible]	0
May-10	74	3	1	1.4%	0	1	2	2.7%	2	0
Jun-10	74	3	2	2.7%	2	0	1	1.4%	[illegible]	0
Jul-10	80	[illegible]	3	3.8%	3	0	1	1.3%	0	[illegible]
Aug-10	53	2	1	1.8%	0	1	1	1.8%	[illegible]	0
Sep-10	80	3	1	1.3%	0	1	2	2.5%	0	2
Oct-10	77	0	0	0.0%	0	0	0	0.0%	0	0
Nov-10	77	1	1	1.3%	1	1	0	0.0%	0	0
Dec-10	62	3	2	3.2%	0	1	1	1.6%	0	[illegible]
Jan-11	63	3	2	3.2%	0	1	1	1.6%	[illegible]	0
Feb-11	80	2	1	1.3%	1	0	1	1.3%	[illegible]	0
Mar-11*	91	0	0	0.0%	0	0	0	0.0%	0	0



4 Hand Hygiene

National Hand Hygiene Campaign

In the expectation that the National Hand Hygiene Campaign would finish in March 2011, the exit strategy focused on embedding the good work achieved through campaign activity into the Scottish Patient Safety Programme (SPSP). This was primarily achieved by focusing on ensuring compliance with the local audits for submission to the SPSP data repository- the Extranet. This worked well with all relevant clinical areas reporting monthly. These audits were validated by the continuance of national audits on a bi-monthly basis. The national audit results from March 2010 to March 2011 are displayed below.

The figures outline that compliance was sustained at an average of 96% for the entire year. Technique compliance improved from 61% last year to an average of 81% for this year - although it must be noted that the protocol for auditing technique changed in July 2010, as per HPS guidance. However this also coincided with actions to address poor technique - promoting attendance at mandatory training, encouraging areas to take ownership of data and employ interventions for non compliance.

Compliance Staff Groups	Mar '10	May '10	July '10	Sept '10	Nov '10	Jan '11	Mar '11
Nurse	95	96	97	98	99	98	97
Medical	96	96	95	89	92	89	98
AHP	100	100	98	98	98	100	100
Ancillary/Other	96	93	90	95	96	90	98
Overall	96%	96%	96%	96%	97%	96%	98%
Correct Technique							
Nurse	55	63	93	92	91	92	85
Medical	61	78	88	88	91	85	91
AHP	67	58	86	96	88	88	84
Ancilliary/Other	63	72	92	89	93	84	81
Overall	61%	68%	90%	91%	91%	87%	85%

Mandatory Hand Hygiene Training (MHHT)

Mandatory hand hygiene training for all staff continues to be provided by both the LHBC and the PICNs. The possibility of developing a web based training programme is underway in an effort to address how training will be provided after March 2011.

Towards the end of the year the attendance figures demonstrated poor attendance – particularly from specific staff groups. This was addressed by highlighting at SMT, scheduling additional MHHT sessions and providing department specific sessions to increase attendance figures.

There has been no instruction from the HAI task force for MHHT training to be provided nationally across all boards.

Local Health Board Coordinator (LHBC) undertaking SPSP programme management

The LHBC has taken on the additional responsibility of SPSP programme management. The exit strategy has always revolved around the integration of hand hygiene activity into the SPSP programme and that audit and policy compliance would be driven by ward and department staff. There was the ongoing challenge of encouraging staff to take ownership of data - encouraging action plans and addressing poor compliance and technique locally, ensuring local audits are robust etc. Any area perceived as having a poor quality audit process was trained and advised on how to ensure a better process. In addition, each dept was issued a strategy outlining what hand hygiene activity should be undertaken in each area.

Zero Tolerance

We continue to promote the concept of zero tolerance to non compliance with hand hygiene. There were no reported incidents of any staff being subject to the ZT flowchart activity in the event of repeated non compliance with policy.

National audit tool

In January 2011 it was confirmed by HPS that the revised national audit protocol (first piloted in July) is to be employed when the national audit schedule comes to an end in March 2011. Thereafter a combined measure of both compliance and technique is to be reported. We are awaiting the schedule for this amended reporting. The amended protocol was tested In five Health Boards under the '90 day SAB improvement programme.'

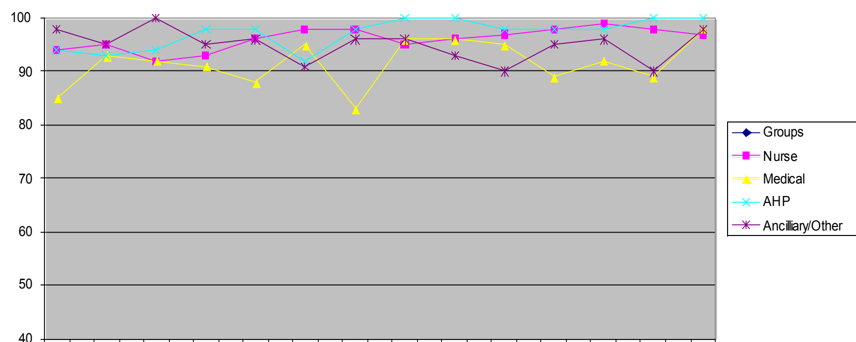
Bi-monthly National Audits

Because the national SPSP team were unable to commit to the timescale of integrating hand hygiene campaign activity into SPSP processes by March 2011, HPS announced that this schedule is to be extended until February 2012.

Role of LHBC

In August 2010 it was confirmed that there would be no further funding for the LHBC post or programme management of SPSP, once the national programme finishes in March 2011. In February 2011 LHBC central funding was however confirmed for another year, until March 2012. The remit of the LHBC over the next year is to integrate the hand hygiene campaign activity with SPSP methodology, and to use the tool for local audits too. The exit strategy here at NWTC has always been to integrate the work with SPSP, so this activity is well established here at the GJNH.

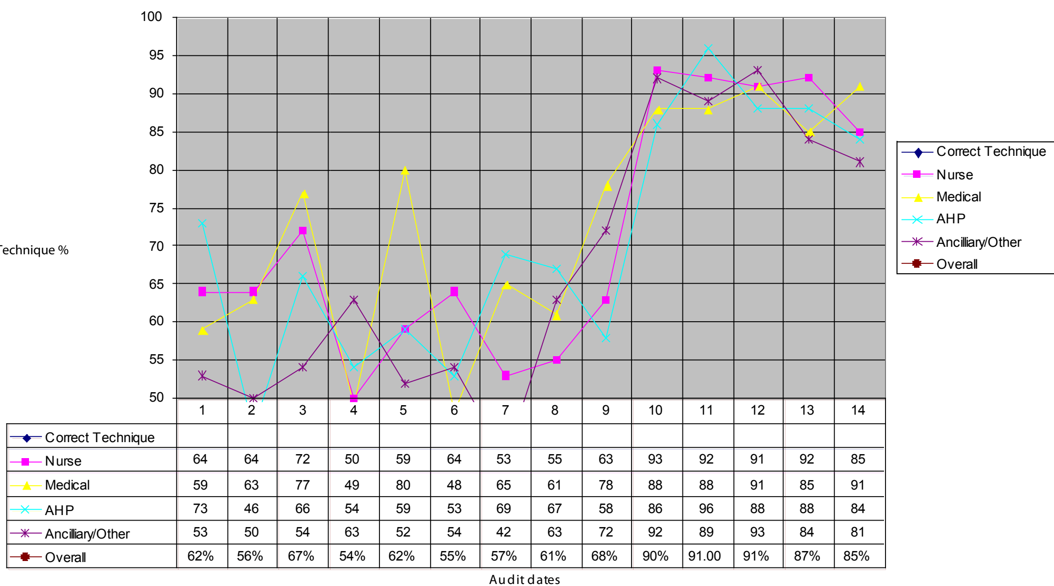
Hand Compliance Board Level (NWTC) March 2011



	Jan-09	Mar-09	May-09	Jul-09	Sep-09	Nov-09	Jan-10	Mar-10	May-10	Jul-10	Sep-10	Nov-10	Jan-11	Mar-11
Groups														
Nurse	94	95	92	93	96	98	98	95	96	97	98	99	98	97
Medical	85	93	92	91	88	95	83	96	96	95	89	92	89	98
AHP	94	93	94	98	98	92	98	100	100	98	98	98	100	100
Anciliary/Other	98	95	100	95	96	91	96	96	93	90	95	96	90	98

Audit dates

Hand Hygiene Technique Board Level (NWTC) March 2011



	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Correct Technique														
Nurse	64	64	72	50	59	64	53	55	63	93	92	91	92	85
Medical	59	63	77	49	80	48	65	61	78	88	88	91	85	91
AHP	73	46	66	54	59	53	69	67	58	86	96	88	88	84
Anciliary/Other	53	50	54	63	52	54	42	63	72	92	89	93	84	81
Overall	62%	56%	67%	54%	62%	55%	57%	61%	68%	90%	91.00	91%	87%	85%

5 Prevention and Control of Infection Link Practitioners (PCILP)

Priority drivers were developed for 2010/11 to focus the work of the PCILP network. The success of these drivers depended greatly on the commitment of the individual PCILP. PCILP competencies have been developed for 2011/12 aiming to increase PCILP collaboration. These will be reviewed at regular intervals and during PDP process.

6 Prevention and Control of Infection Policies

All Prevention and Control of Infection policies have been reviewed as per the Policy Review calendar 2009 – 2011.

Policy Reference Number	Policy	2009	2010	2011	PROGRESS	AUDITED VIA
	2010					
QPINF006: 8	Isolation Precautions – Theatre		*		REMOVED 2010	
QPINF015: 9	Pest Control Policy		*		REMOVED 2010	
QPINF026: 6	Decontamination		*		REMOVED 2011	
QPINF027: 7 Replaced by Surveillance Strategy 2010	Alert Organism Surveillance		*		REMOVED	
QPINF051: 2	SARS		*		REMOVED	
QPINF056: 3	Infection Prevention & Control in the Catering Department		*		REMOVED HELD BY CATERING	
COR-IC-POL 23	Norovirus NEW		*		COMPLETE	ISOLATION AUDIT(where applicable)
COR-IC-POL 27	Surveillance Strategy NEW		*		COMPLETE	SUREVILLANCE DATA
COR-IC-POL 40	CJD		*		COMPLETE	
COR-IC-POL 41	Infection Assessment		*		COMPLETE	INFECTION ASSESSMENT AUDIT
COR-IC-POL 42t	Ice for immunocompromised patients NEW		*		COMPLETE	ICAR
COR-IC-POL 11	Diarrhoea Policy NEW		*		COMPLETE	ISOLATION AUDIT(where applicable)
COR-IC-POL 37	Air Sample Policy NEW		*		COMPLETE	
COR-IC-POL 22	Multi drug resistant gram negative bacilli NEW		*		COMPLETE	ISOLATION AUDIT(where applicable)
COR-IC-POL 38	MSSA screening NEW		*		COMPLETE	
COR-IC-POL 39	Legionella Policy NEW		*		COMPLETE	WATER TESTING

7 Infection Control Programme (ICP) 2010/11

The ICP 2010/11 has achieved 99.3% of the projected outcomes. The only six objectives still to be met are on hold, as opposed to not completed.

8 Prevention and Control of Infection Committee

The structure around the PCIC was reviewed and sub groups were established to take forward specific operational issues. These subgroups include Tissue Viability, Built Environment (including water systems), Decontamination and Policy group. The terms of reference of the PCIC and subgroups now need to be reviewed against the new management structure.

9 Quality Improvement

The Infection, Improvement and Implementation Programme (IIIP), launched in March 2010 by NHS Quality Improvement Scotland (QIS), focused on facilitating Infection Prevention and Control Teams to increase their capacity and capability in improvement methodologies.

Although the programme is not progressing nationally the team have continued to utilise improvement methodologies, focusing on reducing Staphylococcus Aureus Bacteraemia (MRSA and MSSA) and Clostridium Difficile infection via the priority driver group. Small tests of change have been utilized in a number of projects, including improving compliance with MRSA screening and testing of blood culture packs.

10 Audit

All audits were completed in accordance with the 2010/11Audit Plan.

Audit results are reported regularly within the Prevention and Control of Infection Programme and monthly to Directorate Clinical Governance Groups. Details of each audit are held by the Clinical Effectiveness Facilitator in Clinical Governance Risk Management Development Unit.

Departmental Prevention and Control of Infection Annual Reviews are undertaken in accordance with the Audit Programme. A feedback report and action plan are issued and PCIT conduct a follow up review to ensure recommendations are implemented. A formalised follow up process has been implemented in 2011.

11 Education

Cleanliness Champion Programme

Since 2003 174 staff members of GJNH have registered to the Cleanliness Champion Programme (CCP).

To date 73 staff members have left the organisation or withdrawn from the programme, and 68 staff members currently working within the organisation have completed the CCP and at this time there are 35 members of staff in the process of completing the programme.

In addition to those staff who registered for and completed the CCP whilst working at the GJNH, there are staff within the Cardiothoracic Directorate who completed the CCP prior to transfer of services to GJNH.

In order to monitor progress all staff currently working through the CCP have been asked to update a student list with modules they have completed to date, and to update this list on completion of each module. It is anticipated that the programme will be completed within six months.

The Prevention and Control of Infection Team delivers an annual programme to all members of staff and includes Induction, Core training and Mandatory annual updates.

The HAI Education Group is a subgroup of the Prevention and Control of Infection Committee and is be responsible for ensuring that mandatory training is being delivered. The PCIM is the HAI Education lead and is a member of the NES HAI Education Lead Group, with a responsibility for updating the committee on any developments in HAI education.

All staff delivering care must include HAI education in their Personal Development plan for Knowledge and Skills Framework.

A new e-learning programme -e-JuBe has been implemented in the Board. A Hand Hygiene module has been developed and we await HPS National Hand Hygiene Policy update prior to going live.

12 Cleaning Services/Housekeeping April 2010-March 2011

		Total Value of Items Checked	Total Value of Items Passed	Total % Pass	Peer Review	Public Involvement
Month 1	**Apr**	4 901	4 826	98.5	YES	YES
Month 2	**May**	4 950	4 918	99.4	YES	NO
Month 3	**Jun**	10 617	9 792	92.2	YES	YES
Month 4	**Jul**	11 398	10 116	88.8	YES	YES
Month 5	**Aug**	12 316	11 037	89.6	YES	YES
Month 6	**Sep**	10 459	9 489	90.7	YES	YES
Month 7	**Oct**	11 028	9 845	89.3	YES	YES
Month 8	**Nov**	13 225	12 299	93.0	YES	YES
Month 9	**Dec**	10 370	9 676	93.3	YES	YES
Month 10	**Jan**	10 604	9 746	91.9	YES	YES
Month 11	**Feb**	13 254	12 244	92.4	YES	YES
Month 12	**Mar**	9 316	8 511	91.4	YES	YES
Quarter 1	**Apr-Jun**	20 468	19 536	95.4	x	x
Quarter 2	**Jul-Sep**	34 173	30 642	89.7	x	x
Quarter 3	**Oct-Dec**	34 623	31 820	91.9	x	x
Quarter 4	**Jan-Mar**	33 174	30 501	91.9	x	x

The housekeeping department continues to work towards the national cleaning specifications and the 90% compliance audit target. There has been a marked improvement over the past year and the addition of a night shift has allowed better access to areas that are difficult to clean, including theatres and catheterisation laboratories. Proposals are being prepared to look at increasing the night shift over weekends to cover any emergency cleans in theatres.

Audits continue to be supported by peer review and public involvement.

5 Tissue Viability

The Tissue Viability service continues to be facilitated by one Tissue Viability Nurse.

The service is currently under review to establish how best to meet the increasing demands of the Health board since the expansion of the Heart & Lung centre for the West of Scotland.
The Tissue Viability plan for 2010 will be based around the activities outlined within the Infection Control Programme 2010.

Work has been ongoing throughout 2010 with the National Tissue Viability Nurses Association Scotland (NATVNS) and QIS, to help implement the National Tissue Viability Programme for Pressure Ulcer Prevention. The Tissue Viability Nurse is the local facilitator for the Health board.

Implementation of the Programme began in 2009 and continues with improvements being made. A working group was developed in the thoracic ward and staff attended the QIS Learning Sessions in 2010 and 2011 with the Tissue Viability Nurse. A Pressure Ulcer Prevalence Audit is planned for April 2011 which will allow a review of how pressure ulcer prevention and treatment is progressing.

Wound assessment and accurate documentation are two critical elements of effective wound care. The initial and ongoing assessments provide the information on which the subsequent plan of care is based. Documentation provides a record and evaluation of the wound status, informing changes to the plan. National documentation, from the National Tissue Viability Programme has been implemented gradually within the Health board since 2009.

Education and training are ongoing in order to ensure compliance in completing the documents accurately and when required.

Policies are in place and reviewed with updates due in 2011.

Tissue Viability Link Practitioners have been established for each clinical area, and monthly meetings with the Tissue Viability Nurse have been arranged for each. Education and training is ongoing to enhance their role within wound care, allowing them to support colleagues.

Negative Pressure Wound therapy is actively used in the Board with various types being evaluated in 2010. Training continued to be provided and competencies in Negative Pressure Therapy are being created for all nursing staff to achieve in 2011. Refresher sessions for all staff to attend to maintain their skills and competency will be planned in 2011.

Education is ongoing within Tissue Viability with sessions provided during the induction and hospital core training days attended annually by all staff.Ad hoc training continues as required, either at patient bedside when reviewing and advising on a wound, or as requested by the clinical areas.
Tissue Viability Educational sessions will be offered in 2011 allowing staff time to update their knowledge and broaden their understanding of the use of wound management products.

A Tissue Viability Group was established in March 2011 to report directly to the Prevention and Control of Infection Committee. The aim of the group is support the management of the Health Board's Tissue Viability Service in order to maintain quality.

Profiling surfaces are still ordered externally on a rental basis to meet the needs of the Health board. The efficiency of this service is being reviewed and monitored during 2011. Plans are underway for 2011 to establish an internal store of profiling equipment for Critical Care.

In 2010 the Tissue Viability Service became involved in the dressing management of Ventricular Assisted Devices. This involved developing guidelines and educating staff, patient carers and members of the Primary Care Team. This work will continue in 2011.

The development of the Wound Clinic has continued during 2010 and 2011 to help manage outpatients with any wound issues. Referrals are taken from Primary Care, consultants, senior nursing staff & cardiac rehab nurses.

Work was undertaken in 2010 to review wound management products used within the health board. Changes have been made to ensure appropriate cost effective products are used. This work will continue into 2011 to help achieve a more efficient method of managing the stock of wound products.

14 HEI Inspection

An HEI inspection took place in February and the report was published on 21 March 2011.
The report detailed all the areas inspected and resulted in only one requirement (linked to the QIS HAI standards) and seven recommendations related to national policy or best practice.
An action plan has been agreed and work is underway to complete this, and is reported via the Prevention and Control of Infection Committee. The next inspection could be announced or unannounced and therefore our challenge is to continue to maintain our high standards and improve on this first inspection. Get it right first time, every time.

Infection Control Doctor	Dr Teresa Inkster
Senior Manager Prevention and Control of Infection	Robert Gray
Prevention and Control of Infection Nurses	Sandra McAuley, (Senior Nurse) Susan Emmerson, Lorna Walls
Tissue Viability Nurse	Annette Hollis
Local Health Board Coordinator, Hand Hygiene / SPSP Programme Manager	Bernadette McCulloch
Housekeeping Operational Manager	Lynn Moffat
Secretary MRSA Programme Assistant	Sheena Finlayson Annemarie Kennedy

Supported by the Laboratories, the Prevention and Control of Infection Link Practitioners, Cleanliness Champions, Clinical Educators, Housekeeping Department and of course All Hospital Staff.

APPENDIX 1-AUDIT PROGRAMME 10/11

1. ICAR ORTHO OPD	SE	COMPLETE
2. Isolation Audit	LW	COMPLETE
3. MRSA Audit	LW	COMPLETE
4. Cleaning Schedule Audit	LW	COMPLETE
5. Surveillance Audit	SM	COMPLETE
6. SEA Audit Feedback	SE	COMPLETE
7. Waste Audit- 3 East, 3West	LW	COMPLETE
1. ICAR 4 WEST	LW	COMPLETE
2. ICAR 3 EAST	SM	COMPLETE
3. Isolation Audit	LW	COMPLETE
4. MRSA Audit	LW	COMPLETE
6. Cleaning Schedule Audit	LW	COMPLETE
7. Surveillance Audit	SM	COMPLETE
8. SEA Audit Feedback	SE	COMPLETE
9. Waste Audit - Radiology	LW	COMPLETE
10. HK PEER REVIEW	SE	COMPLETE
1. ICAR ICU1	SE	COMPLETE
2. ICAR ICU2	SE	COMPLETE
3. Theatres Review	SM	COMPLETE
4. MRSA Audit	LW	COMPLETE
5. SPC Audit	LW	COMPLETE
6. Cleaning Schedule Audit	LW	COMPLETE
7. Isolation Audit	LW	COMPLETE
8. SEA Audit Feedback	SE	COMPLETE
9. Waste Audit - 4 West	LW	COMPLETE
10. 2 WEST- repeat SP Audit	Jan Drain	COMPLETE
1. ICAR HDU2	SE	COMPLETE
2. ICAR HDU3	SE	COMPLETE
3. ICAR CATH LAB	SE	COMPLETE
4. MRSA Audit	LW	COMPLETE
6. Cleaning Schedule Audit	LW	DONE IN AUG
7. Surveillance Audit	SM	COMPLETE
8. Isolation Audit	LW	COMPLETE
9. SEA Audit Feedback	SE	COMPLETE
10. Waste Audit - NSD	LW	COMPLETE
1. ICAR NSD	SM	N/A AWAIT TRANSFER FROM HDU2
2. 3 WEST	SM	COMPLETE
3. MRSA Audit	LW	COMPLETE
5. Cleaning Schedule Audit	LW	COMPLETE
6. Isolation Audit	LW	COMPLETE
7. SEA Audit Feedback	SE	COMPLETE
8. Waste Audit- 2C, CCU	LW	COMPLETE

1. ICAR CCU	SE	COMPLETE
2. ICAR 2C	SM	COMPLETE
3. NSD	SM	N/A AWAIT TRANSFER FROM HDU2
4. ICAR RADIOLOGY	SE	COMPLETE
5. MRSA Audit	LW	COMPLETE
7. Cleaning Schedule Audit	LW	COMPLETE
8. Surveillance Audit	SM	COMPLETE
9. Isolation Audit	LW	COMPLETE
10. SEA Audit Feedback	SE	COMPLETE
11. Waste Audit- Cath Lab, Cardiac Services	LW	COMPLETE
1. Theatres Review	SM	COMPLETE
2. MRSA Audit	LW	COMPLETE
4. SPC Audit	LW	COMPLETE
5. 2 WEST ICAR	LW	COMPLETE
6. 2 East General ICAR	SE	COMPLETE
7. 2 East Ortho ICAR	SE	COMPLETE
8. Radiology ICAR	SE	COMPLETE
9. Cleaning Schedule Audit	LW	COMPLETE
10. Isolation Audit	LW	COMPLETE
11. SEA Audit Feedback	SE	COMPLETE
12. Waste Audit- OPD, Ortho OPD	LW	COMPLETE
13. Review updated ICAR	ALL	SATSIFACTORY- REVIEW 6/12
14. Evaluate use of Enhanced SAB Surveillance form	ALL	ADAPT TO INCLUDE REVIEW TEAM
1. MRSA Audit	LW	COMPLETE
	LW	COMPLETE
3. Surveillance Audit	SM	Not completed-STC
4. Isolation Audit	LW	COMPLETE
5. SEA Audit Feedback	SE	COMPLETE
6. Waste Audit- ICU1, ICU2	LW	COMPLETE
7. Infection Assessment Audit	LW	COMPLETE
8. NSD	SM	INCOMPLETE DONE IN DEC
1. ICAR CARDIAC SERVICES	SE	NOT COMPLETED SEE JAN
2. ICAR CDU	SM	NOT COMPLETED SEE JAN
3. MRSA Audit	LW	COMPLETE
5. Cleaning Schedule Audit	LW	Completed start of Jan 2011 due to ward closures.
6. Isolation Audit	LW	COMPLETE
7. SEA Audit Feedback	SE	COMPLETE
8. Waste Audit- Arthroplasty	LW	COMPLETE
9. NSD ICAR	LW	COMPLETE
1. ICAR CATH LAB	SE	COMPLETE
2. Theatres review (3rd Friday of month)	ALL	COMPLETE
3. MRSA Audit	LW	COMPLETE
5. Cleaning Schedule Audit	LW	COMPLETE
6. Surveillance Audit	SM	COMPLETE
7. Isolation Audit	LW	COMPLETE
8. SEA Audit Feedback	SE	COMPLETE

10. ICAR CDU	SM	COMPLETE
11. ICAR CARDIAC SERVICES	SE	
1. ICAR OUTPATIENTS	SE	NOT COMPLETED –ACCESS ISSUES.RESCEDULED IN APRIL
2. ICAR REHAB	LW	COMPLETE
3. MRSA Audit	LW	COMPLETE
4. SPC Audit	LW	COMPLETE
5. Cleaning Schedule Audit	LW	COMPLETE
6. Isolation Audit	LW	COMPLETE
7. SEA Audit Feedback	SE	COMPLETE
8. Waste Audit -2 East, 2West	LW	COMPLETE
9. Peer Review HK	SM	COMPLETE
1. MRSA Audit	LW	COMPLETE
3. Cleaning Schedule Audit	LW	COMPLETE
4. Surveillance Audit	SM	COMPLETE
5. Isolation Audit	LW	COMPLETE
6. SEA Audit Feedback	SE	COMPLETE
7. Waste Audit- Rehab	LW	COMPLETE
8. Peer Review HK	SE	INCOMPLETE- CANCELLED BY HK RESCEDULED