# NHS Golden Jubilee

### **Meeting: NHS Golden Jubilee Board**

### **Meeting date: 25July 2024**

### **Title: Prevention & Control of Infection Committee Annual Update**

### **Responsible Executive/Non-Executive: Anne Marie Cavanagh, Executive Director of Nursing**

### **Report Author: Heather Gourlay, Head of PCI & Sandra Wilson, Clinical Nurse Manager PCI**.

## Purpose

This Annual Update 2023/2024 has been developed on behalf of NHS GJNH by the Prevention and Control of Infection Team and Board Prevention and Control of Infection Committee and reflects local achievements influenced by our annual work programme and in response to National performance targets.

###  The update paper is presented to the Clinical Governance Committee for:

### Awareness & Discussion

### This report relates to NHS GJNH

* Annual Operation Plan
* Government policy/directive
* Local policy
* NHS GJ Board Strategy

###  Also aligning to the following NHS Scotland quality ambitions:

* Safe
* Effective
* Person Centred

 **This aligns to the following: NHS GJNH Corporate Objectives**

* High Performing Organisation – Establishing the conditions for success to enable excellent outcomes and experience for patients and staff.

## 2 Report summary

## 2.1 Situation

The Prevention and Control of Infection Committee and PCI Team co-ordinate the delivery of an extensive body of work summarised within the HAIRT report (Appendix 1). Integral to the success of the programme is the recognition that Prevention and Control of Infection does not rest solely within the domains of the Prevention and Control of Infection Committee and Team. Everyone has prevention and control of infection responsibilities from Board to ward. NHS GJ managers are supported to take a lead in ensuring national and local interventions are implemented and monitored to ensure a safe environment for patients, staff and visitors.

**2.2 Background**

This report reflects the NHS GJNH Annual HCAI update looking across the organisational performance against existing national HEAT trajectories to support identification of trends/ risks and themes for learning whilst considering this in the context of our annual IC work programme.

## 2.3 Assessment

 Appendix 1 provides a detailed year end Annual Update HAIRT report

 reflecting performance against national and local targets.

### 2.3.1 Quality/ Patient Care

Robust environmental audits of the clinical areas by the PCI team, supplemented by peer reviews ,offers assurance of compliance with standards and environmental cleanliness.

### 2.3.2 Workforce

The PCI team are all qualified Infection Control Practitioners supported by ICD, Consultant Microbiologist and more recently an innovative ID Consultant reciprocal role in conjunction with NHSGGC.

### 2.3.3 Financial

There is a potential for financial impact to the organisation in relation to outbreaks and additional environmental cleaning and litigation.

### 2.3.4 Risk Assessment/Management

There are several processes of risk assessment for HCAI related incidents from PAG (Problem Assessment Group) to Incident Management and escalation to ARHAI and SG policy unit via the Healthcare Infection Incident Assessment Tool (HIIAT) and Healthcare Infection Incident Outbreak Reporting Tool (HIIORT).

The Outbreak Reporting Tool (ORT) aims to accurately record health and care incidents and outbreaks facilitating the collation of epidemiological data and lessons learned which contribute to the development of national guidance and help inform local incident and outbreak management.

HCAI SCRIBE risk assessment captures environmental new build/refurb and unforeseen built environment incident responses. In 2023/24 we conducted 203 HAI SCRIBES a 100% increase on the previous reporting timeline and not inclusive of those related solely to Phase 2. Significant adverse event reviews and feedback are managed on a case by case basis and risk assessment is supported where required, this is further embedded within corrective action plans.

### 2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed as this paper provides a report following an analysis of data.

### 2.3.6 Other impacts

**Climate Emergency and Sustainability**

Potential for reputational impact due to the nature and content of the report.

### Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate. Out with the annual update progress is provided quarterly to the Prevention and Control of Infection Committee and Clinical Governance Committee/Risk Management Groups, and via monthly

 HAI Reporting Template (HAIRT) to the NHS Board.

### Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report, presented to:

PCIC on 13/5/24 and

Clinical Governance Risk Management Group on 23/5/24.

Clinical Governance Committee 16/7/24

## 2.4 Recommendation

* **Awareness** – For Members’ information only.

## List of appendices

The following appendices are included with this report:

* Appendix No 1 March 2024 and end of year HAIRT.

**Healthcare Associated Infection Report**

**End of year HAIRT**

**April 2023- March 2024**

**Section 1 – Board Wide Issues**

Section 1 of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual departments, please refer to the ‘Healthcare Associated Infection Report Cards’ in Section 2.

**Key Healthcare Associated Infection Headlines**

* ***Staphylococcus aureus* Bacteraemia 2023-2024**

8 cases in total / 15.34 per 100,000 total occupied bed days.

This rate exceeds the local trajectory of 11.22 per 100,000 total occupied bed days (by n=2 cases), but below national quarterly rates ranging between 18-19 per 100,000 total occupied bed days.

It should be noted however, this is improved from the local 22/23 rate of 21.37 per 100,000 total occupied bed days.

* ***Clostridioides difficile* infection 2023-2024**

3 cases / 5.75 per 100,000 total occupied bed days.

This rate exceeds the local trajectory of 1.9 per 100,000 total occupied bed days (by n=2 cases), but well below national quarterly rates ranging between 14-16 per 100,000 total occupied bed days.

* **Gram Negative/E.coli Bacteraemia (ECB)** **2023-2024**

5 cases / 9.59 per 100,000 total occupied bed days.

This rate is below the local trajectory of 15.5 per 100,000 total occupied bed days, and well below national quarterly rates ranging between 34-37 per 100,000 total occupied bed days.

* **Hand Hygiene-** The bimonthly report from March 24 indicates a combined compliance score of 99%. Next report May 24.

NHS GJ compliance has been sustained above the Scottish Government target of 90% compliance throughout 2023 -24, with the lowest bi monthly compliance reported at 97% during this period.

* **Cleaning and the Healthcare Environment -Facilities Management Tool**

**Housekeeping Compliance: 98.16**% **Estates Compliance: 97.94**%.

Both compliance rates are above national trajectories.

* **Orthopaedic Surgical Site Surveillance-** No SSI to report in March. Throughout 23/24 SSI rates remained within control limits.
* **Cardiac Surgical Site Surveillance**- 2 CABG SSI/ 1 Cardiac SSI to report in March. Throughout 23/24 SSI rates remained within control limits.

**2023/2024 HCAI Key Activity Overview**

The Prevention and Control of Infection Planned programme contains the specifics of PCIT HCAI activity and tracks its delivery. In addition to key surveillance data described in this HAIRT, below is a summary of other key activity.

**Built Environment /Hospital Expansion**

As Phase 2 Hospital Expansion moves closer to handover, PCI support and activity continues to increase in volume. In previous years, PCI activity had almost exclusively focused on the design and construction of Phase 2. From 2022 to date, construction activity has further extended into our hospital footprint with breakthroughs from Phase 2 and associated redevelopment construction

(Work Task Orders) to support planned activity and flow.

To support the planning around operational delivery of Phase 2, there has also been a marked increase in all PCI team activity in various delivery and commissioning groups.

Non expansion related HAI SCRIBE activity has almost doubled from 22/23. This work is linked to-

* Reactive estates issues/ maintenance issues e.g. water ingress
* Planned maintenance/ upgrades
* WTO 6- Lift refurb
* NHS Academy Simulation Centre
* Ultrasound Department Expansion

**Transfer of key HCAI data to Sharepoint**

In collaboration with Clinical Governance the PCIT transferred key HCAI data to Sharepoint. Aligning HCAI data location with SPSP data, has facilitated ease of access, data entry and review of HCAI data for clinical colleagues.

This key data includes-

* Standard Infection Control Precautions (SICPs) compliance data entry and outcome data allowing both individual and service overview
* Alert organism data by clinical area
* Prevention and Control of Infection Annual Review data by clinical area and service.

**Workforce**

There is national recognition that there is a need to build capacity and capability within the PCI workforce. As a starting point there has been a national focus on role clarification and career pathway. A DL communication outlining supportive role descriptors is imminent.

**National influencing factors**

During 2023/24, national priorities /publications have also influenced the work of the PCIT and NHS GJ, these include:

* IPC Workforce Strategy 2022-2024
* HCAI Strategy 2023-2025
* Green Theatres Programme

The PCIT are working closely with national groups to develop outputs to inform local Board delivery, the most recent being the ongoing review of Transmission Based Precautions (TBPs).

***Staphylococcus aureus* (including MRSA)**

*Staphylococcus aureus* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus aureus* (MSSA), but the more well-known is MRSA (Meticillin Resistant *Staphylococcus aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat.

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them.

More information can be found at: [Staphylococcus aureus bacteraemia | National Services Scotland (nhs.scot)](https://www.nss.nhs.scot/antimicrobial-resistance-and-healthcare-associated-infection/data-and-intelligence/staphylococcus-aureus-bacteraemia/)

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| **NHS GJ approach to SAB prevention and reduction**It is accepted within ARHAI that care must be taken in making comparisons with other Board SAB data because of the specialist patient population within NHS GJ. All SAB isolates identified within the laboratory are subject to case investigation to determine future learning and quality improvement. Small numbers of cases can quickly change our targeted approach to SAB reduction. **Broad HCAI initiatives which influence our SAB rate include-*** Hand Hygiene compliance and monitoring
* MRSA screening at pre-assessment clinics and admission
* Compliance with National Cleaning Standards Specifications
* Audit of the environment and practices via Prevention and Control of Infection Annual Reviews, monthly SCN led Standard Infection Control Precautions audit and CNM Peer Review monitoring
* Participation in National Enhanced SAB surveillance- gaining further intelligence on the epidemiology of SAB locally and nationally.

**SSI Related SAB*** MSSA screening for cardiac surgery and subsequent treatment pre and

 post op as a risk reduction approach* Surgical Site Infection Surveillance in collaboration with ARHAI to allow rapid identification of increasing and decreasing trends of SSI.
* Orthopaedic Prosthetic Joint Infection Audit Group scoping introduction of MSSA decolonisation pre operatively.

**Device Related SAB*** Implementation of PVC, CVC, PICC and IABP bundles; assessment of compliance locally aids targeting of interventions accordingly.
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**NHS GJ SAB HCAI Standards /AOP Trajectories**

NHS Boards are expected to achieve a reduction of 10% in the national rate of healthcare associated SAB from 2019 to 2023, with 2018/19 used as the baseline for the SAB reduction target this year. The percentage reductions will be measured against individual NHS Scotland Boards’ current levels, rather than taking a “best in class” approach as previous.

For NHS GJ this target is 11.22 per 100,000 TOBD. This remains a challenging target given NHS GJ existing low SAB rate and high risk patient population.

**End of year update**

The 23/24 local NHS GJ AOP target was not met, noting 8 cases/rate of 15.34 per 100,000 total occupied bed days.

2023/24 rate exceeds the local trajectory of 11.22 per 100,000 total occupied bed days (by n=2 cases), but below national quarterly rates ranging between 18-19 per 100,000 total occupied bed days. It should be noted however, this is improved from the local 22/23 rate of 21.37 per 100,000 total occupied bed days.



The data above reflects NHS GJ SAB isolates beyond 48hrs of admission.

**Sources of SAB**

The Prevention and Control of Infection Team work closely with the clinical teams, CG and clinical educators to gain insight into the sources of SAB acquisition and associated learning. Each SAB is subject to an enhanced surveillance process involving the PCIT, SCN and responsible consultant to determine any learning from the source of the SAB. Thereafter the Enhanced SAB surveillance reports are submitted to the relevant service clinical governance group to share potential learning and note actions required.

**SAB Sources 23/24**

Sources of SAB have been predominately line related, however all vary in line type e.g. PICC/ PVC and department. Therefore actions for prevention and learning have been department specific as opposed to wider system learning.

Following an update to national PVC guidance, the PVC bundle content and format was refreshed resulting in a 5 day PVC bundle and 24 hour PVC. Working alongside colleagues from Clinical Governance and Clinical Education these updated bundles were tested extensively across all departments.

Key changes included –

* Use of 2% chlorhexidine gluconate for PVC insertion skin antisepsis & scrub the hub.
* Pictorial description of VIP scores to aid assessment.



**CCU**

Jun 23- Arterial line

Mar 24- IABP

**HDU2**

Dec 23- SSI

**NSD**

Dec 23- Vascath

**ICU1**

Apr 23- Line. Site unknown. Multiple lines removed with clinical improvement.

**ICU2**

Aug 23-Central line

**3East**

May 23- SSI

**2 East**

June 23- PVC



**MRSA Screening Compliance**

MRSA screening promotes early identification of patients colonised or infected with MRSA. This facilitates early implementation of decolonisation / treatment with the aim of reducing the reservoir of MRSA and therefore the risk of transmission to other vulnerable patients.

Within NHS GJ MRSA screening must be completed for all elective admissions within high impact specialities e.g. ORTHOPAEDIC /CARDIAC/CARDIOTHORACIC/CARDIOLOGY and all overnight stay patients. Thereafter patients whose length of stay is 10 days or more are subject to additional screening on:

* Day 10
* And each 7 days thereafter

Screening must be completed at pre assessment where applicable, and on admission into NHS GJ. The purpose of this additional screening is to ensure that healthcare associated interventions have not significantly altered the patients’ normal flora and resistant.

Day 10 screen was identified as the initial screen date as it captures patient stay beyond routine pathways. Compliance is monitored via reviewing a sample of eligible patients against submitted MRSA screens. SCNs are informed of results at the time of audit and informed an action plan is required to improve compliance should be submitted.





In all cases screens were omitted, with the exception of two screens taken greater than 24 hours early.

**CPE screening programme- quarterly update**

Carbapenemase-producing enterobacteriacaea (CPE) Screening

In 2013, a joint Chief Medical Officer (CMO)/Chief Nursing Officer (CNO)/Chief Pharmaceutical Officer (CPO) letter CMO/SGHD(2013)14 described the emerging threat from CPE and the requirements for an acute hospital admission screening programme for CPE. DL (2017) 2 reinforced this mandatory policy requirement for CPE screening using a clinical risk assessment based approach in NHS Boards across Scotland, this guidance remains extant.

NHS Boards submit CPE screening compliance data to ARHAI. Quarterly reports from ARHAI continue to indicate NHS GJ are above national compliance rate (unpublished data).



***Clostridioides difficile* infection (previously known as *Clostridium difficile)***

*Clostridioides difficile*is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. NHS Boards carry out surveillance of*Clostridioides difficile* infections (CDI), and there is a national target to reduce these.

More information on *Clostridioides difficile* infections can be found at: [Clostridioides difficile infection | National Services Scotland (nhs.scot)](https://www.nss.nhs.scot/antimicrobial-resistance-and-healthcare-associated-infection/data-and-intelligence/clostridioides-difficile-infection/)

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| **NHS GJ approach to CDI prevention and reduction**Our numbers of CDI cases are low in comparison with other Boards, which is likely to relate 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 ARHAI 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.
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**NHS GJ CDI HCAI Standards/ AOP Trajectories**

Reduction of 10% in the national rate of healthcare associated CDI from 2019 to 2023, with 2018/19 used as the baseline for the CDI reduction target. The percentage reductions will be measured against individual NHS Scotland Boards’ current levels, rather than taking a” best in class” approach as previously. For NHS GJ this target is 1.9 per 100,000 TOBD.

This remains a challenging target given NHS GJ exceptionally low CDI rates, small numbers of cases will influence the achievement of this target.

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**End of year update**

The 23/24 local NHS GJ AOP target was not met, noting 3 cases / 5.75 per 100,000 total occupied bed days.

This rate exceeds the local trajectory of 1.9 per 100,000 total occupied bed days (by n=2 cases) but well below national quarterly rates ranging between 14-16 per 100,000 total occupied bed days.

All CDI cases were isolated incidents not connected in time/ place or person, occurring in patients with complex medical needs.

**Gram Negative/E.coli Bacteraemia**

Escherichia coli (E. coli) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of E. coli live harmlessly in your gut, some types can cause illness. E. coli bacteraemias can be as a result of an infection such as:

•urinary tract

•surgery

•inappropriate use of medical devices

E. coli is currently the most common cause of bacteraemia in Scotland. As a result, its reduction has been added as a new HAI Standard target. More information can be found at: [HPS Website - Protocol for National Enhanced Surveillance of Bacteraemia (scot.nhs.uk)](https://www.hps.scot.nhs.uk/web-resources-container/protocol-for-national-enhanced-surveillance-of-bacteraemia/)

**NHS GJ ECB HCAI Standards/ AOP Trajectories**

In recognition of Boards difficulty in achieving the previous target, DL 2023 06 requests Board to achieve a reduction of 25% in healthcare associated E. coli bacteraemia by 2023/24 year end.

For NHS GJ, this 25% reduction is target based on 22/23 data and is 15.5 per 100,000 TOBD.

All ECB isolates identified within the laboratory are subject to case investigation to determine future learning and quality improvement.

**End of year update**

The 23/24 local NHS GJ AOP was met, noting 5 cases / 9.59 per 100,000 total occupied bed days.

This rate is below the local trajectory of 15.5 per 100,000 total occupied bed days, and well below national quarterly rates ranging between 34-37 per 100,000 total occupied bed days.



**Hand Hygiene**

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at: <http://www.nipcm.hps.scot.nhs.uk>

NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non-compliance.

**NHS GJ approach to Hand Hygiene**

The bimonthly report from March 24 indicates a combined compliance score of 99%.

In all non-compliances, the opportunity to perform hand hygiene was not taken.

NHS GJ compliance was sustained above the Scottish Government target of 90% compliance over 2023 -24, with the lowest bi monthly compliance reported at 97% during this period.

Of the five key moments, it is noted moment 1: Before Touching a Patient, and moment 4: After Touching a Patient, were consistently omitted throughout the bi monthly audits with compliance ranging between 86%-99%.

The importance of taking the opportunity to perform hand hygiene will be highlighted via service governance groups during HAIRT discussions. PCINs will liaise with Communications to improve messaging promoting the five key moments to improve staff knowledge and understanding of the importance of compliance with each of these.

The current Hand Hygiene product contract expires in October 2024, having been previously granted an extension period during COVID recovery. No further extension can be applied to the existing contract, therefore NHS National Services Scotland (NSS) has convened a Commodity Advisory Panel (CAP). NHS GJ is represented by Prevention and Control of Infection and Procurement. Work is underway to agree the specifications of this tender and thereafter invite supplier interest. Whilst NHS GJ has used the same product successfully for a number of years, it is the expectation that NSS will stock the first ranked supplier, with an option for Boards to order direct from lesser ranked suppliers. The outcome of this process may affect the product used locally moving forward. Where this is the case the PCIT will work closely with Occ Health, Health and Safety and Estates to address the wider impact.





**Summary of Non Compliance**



|  |  |
| --- | --- |
| **AREA AUDITED**  | **COMPLIANCE**  |
| ICU 1 | 95% |
| ICU 2 | 95% |
| RADIOLOGY | 95% |
| CCU | 95% |
| HDU 2 | 100% |
| HDU 3 | 100% |
| 2 EAST | 100% |
| 4 EAST | 100% |
| OPD | 100% |
| ORTHO OPD | 100% |
| 2 WEST | 100% |
| 3 WEST | 100% |
| EYE CENTRE PRE /POST OP | 100% |
| EYE CENTRE TH 1 | 100% |
| EYE CENTRE TH 4 | 100% |
| **95% Compliance or above** |  |
| **80% - 94% Compliance**  |  |
| **Below 80% Compliance** |  |

**Cleaning and Maintaining the Healthcare Environment**

2023/24 Activity

The National Cleaning Services Specification sets out the requirements for the minimum frequency and method of cleaning carried out by the domestic staff group, with all healthcare facilities and component parts (wards, corridors etc.) expected to be at least 90% compliant. NHS GJ reached an overall compliance above 98% throughout 23/24.

Expansion

The HK team have worked closely with the expansion team and associated delivery groups. Key activity includes-

* Recruitment of staff and associated training
* Refurbishment of GJ mop laundering facility complete March 2024.Reduction of disposable mop use projected 24/25
* Phase 2 Room data has been assigned national cleaning codes and shared with NSS for upload to national FMT Synbiotix system
* Preparation of unit specific tasks sheets
* Recruitment and development of new HK supervisor post holders.

Consultation of the NHSScotland National Cleaning Services Specification (SHFN 01-02) is ongoing with further final consultation to DSEG awaited pending SLWG review.

Contribution to national strategies via the Domestic Services Expert Group is ongoing to support recruitment, such as job title, Jobtrain barriers and career pathways development to encourage applicants to consider a career within support services.

**Housekeeping FMT Audit Results**





**Enlarged image available at the end of HAIRT**

**Healthcare Associated Infection Reporting Template (HAIRT)**

**Section 2 – Healthcare Associated Infection Report Cards**

The following section is a series of ‘Report Cards’ that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections *(*alsobroken down into MSSA andMRSA) and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by ARHAI. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HCAI activities at local level than is possible to provide through the national statistics.

**Understanding the Report Cards – Infection Case Numbers**

*Clostridioides difficile* infections (CDI)and *Staphylococcus aureus* bacteraemia(SAB)cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA).

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the “out of hospital” report card.

**Targets**

There are national annual operating plans associated with reductions in HCAI. More information on these can be found on the Scottish Government website.

**Understanding the Report Cards – Hand Hygiene Compliance**

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

**Understanding the Report Cards – Cleaning Compliance**

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found here:

[Facilities Monitoring Report | National Services Scotland (nhs.scot)](https://www.nss.nhs.scot/publications/facilities-monitoring-report/)

**NHS BOARD REPORT CARD**

***Staphylococcus aureus* bacteraemia monthly case numbers**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov****23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **MRSA**  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **MSSA** | 1 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 |
| **Total SABS** | 1 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 |

***Clostridioides difficile* infection monthly case numbers**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov****23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **Ages15-64** | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Ages 65+** | 1 | 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 |

***E.Coli* bacteraemia monthly case numbers**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov 23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **ECB** | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 0 |

**Hand Hygiene Monitoring Compliance (%)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov****23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **Nurse** |  | 98 |  | 98 |  | 99 |  | 99 |  | 99 |  | 99 |
| **Medical** |  | 98 |  | 95 |  | 95 |  | 94 |  | 96 |  | 95 |
| **AHP** |  | 98 |  | 100 |  | 95 |  | 100 |  | 100 |  | 100 |
| **Ancillary/Other** |  | 100 |  | 88 |  | 85 |  | 96 |  | 92 |  | 100 |
| **Board Total** |  | 98 |  | 97 |  | 97 |  | 98 |  | 98 |  | 99 |

**Cleaning Compliance (%)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov****23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **Board Total** | 97.77 | 97.37 | 98.64 | 97.94 | 98.02 | 98.76 | 98.1 | 98.39 | 97.9 | 98.9 | 98.76 | 98.16 |

**Estates Monitoring Compliance (%)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr****23** | **May****23** | **Jun****23** | **Jul****23** | **Aug 23** | **Sept****23** | **Oct****23** | **Nov****23** | **Dec** **23** | **Jan 24** | **Feb 24** | **Mar****24** |
| **Board Total** | 98.94 | 97.31 | 97.81 | 96.91 | 98.87 | 97.32 | 98.14 | 96.4 | 97.16 | 94.01 | 95.23 | 97.94 |

**Surgical Site Infection Surveillance- Orthopaedic Local data**

 

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| **Hip Arthroplasty SSI** |
| Number of Procedures | Month | Type of SSI | Status |
| 112 | Apr 23 | 0 | Confirmed |
| 144 | May 23 | 0 | Confirmed |
| 134 | June 23 | 0 | Confirmed |
| 126 | July 23 | 1 Superficial | Confirmed |
| 179 | Aug 23 | 1 Organ Space | Confirmed |
| 148 | Sept 23 | 0 | Confirmed |
| 140 | Oct 23 | 0 | Confirmed |
| 153 | Nov 23 | 1 Superficial | Confirmed |
| 137 | Dec 23 | 0 | Confirmed |
| 136 | Jan 24 | 1 Deep | Confirmed |
| 145 | Feb 24 | 0 | Confirmed |
| 138 | Mar 24 | 0 | Unconfirmed |

**\***A surgical site infection is defined as a superficial, deep or organ space infection occurring within 30 days of operation. Definitions of superficial, deep and organ space are defined in Health Protection Scotland Surgical Site Infection Surveillance Protocol.

 

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| **Knee Arthroplasty SSI** |
| Number of Procedures | Month | Type of SSI | Status |
| 137 | Apr 23 | 0 | Confirmed |
| 134 | May 23 | 1 Superficial | Confirmed |
| 140 | June 23 | 0 | Confirmed |
| 152 | July 23  | 1 Superficial | Confirmed |
| 164 | Aug 23 | 0 | Confirmed |
| 157 | Sept 23 | 0 | Confirmed |
| 112 | Oct 23 | 0 | Confirmed |
| 162 | Nov 23 | 0 | Confirmed |
| 138 | Dec 23 | 1Superficial | Confirmed |
| 142 | Jan 24 | 0 | Confirmed |
| 147 | Feb 24 | 0 | Confirmed |
| 148 | Mar 24 | 0 | Unconfirmed |

\*A surgical site infection is defined as a superficial, deep or organ space infection occurring within 30 days of operation. Definitions of superficial, deep and organ space are defined in Health Protection Scotland Surgical Site Infection Surveillance Protocol.

**Surgical Site Infection Surveillance- CABG Local data**



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| **CABG SURGERY SSI** |
| Number of Procedures | Month | Type of SSI | Status |
| 45 | Apr 23 | 3 Superficial Sternum ( One a source of SAB in May) | Confirmed |
| 48 | May 23 | 0 | Confirmed |
| 38 | June 23 | 0 | Confirmed |
| 46 | July 23 | 0 | Confirmed |
| 57 | Aug 23 | 1 Superficial Sternum | Confirmed |
| 51 | Sept 23 | 1 Superficial Sternum | Confirmed |
| 65 | Oct 23 | 0 | Confirmed |
| 56 | Nov 23 | 0 | Confirmed |
| 47 | Dec 23 | 3- 1 Organ Space Sternum/ 2 Leg | Confirmed |
| 31 | Jan 24 | 0 | Confirmed |
| 44 | Feb 24 | 0 | Confirmed |
| 54 | Mar 24 | 2 –Sternum | Unconfirmed |

**Surgical Site Infection Surveillance- Valve Replacement +/- CABG Local data**



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| **Valve Replacement +/- CABG SSI** |
| Number of Procedures | Month | Type of SSI | Status |
| 32 | Apr 23 | 2- 1Superficial Sternum/1 Superficial Leg | Confirmed |
| 27 | May 23 | 0 | Confirmed |
| 31 | June 23 | 0 | Confirmed |
| 36 | July 23 | 0 | Confirmed |
| 19 | Aug 23 | 0 | Confirmed |
| 40 | Sept 23 | 0 | Confirmed |
| 34 | Oct 23 | 1Superficial Sternum | Confirmed |
| 36 | Nov 23 | 0 | Confirmed |
| 30 | Dec 23 | 0 | Confirmed |
| 42 | Jan 24 | 1 Superficial Leg | Confirmed |
| 31 | Feb 24 | 0 | Confirmed |
| 32 | Mar 24 | 1  | Unconfirmed |





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| AHP | Allied Health Professional |
| ARHAI | Antimicrobial Resistance and Healthcare Associated Infection |
| AOP | Annual Operating Plan |
| CABG | Coronary Artery Bypass Graft |
| CG | Clinical Governance |
| CAUTI | Catheter Associated Urinary Tract Infection |
| CGC  | Clinical Governance Committee |
| CCU | Coronary Care Unit |
| CDI/C.*difficile* | *Clostridioides difficile* infection |
| CMO | Chief Medical Officer |
| CNM | Clinical Nurse Manager |
| CNO | Chief Nursing Officer |
| COVID-19 | Coronavirus disease 2019 |
| CPE | Carbapenamase-producing enterobacteriacaea |
| CPO | Chief Pharmaceutical Officer |
| CVC | Central Venous Catheter |
| DMT | Domestic Monitoring Tool |
| DSEG | Domestic Services Expert Group |
| ECB | Escherichia coli bacteraemia |
| FMT | Facilities Monitoring Tool |
| GI | Gastro Intestinal |
| GJF | Golden Jubilee Foundation |
| GJNH | Golden Jubilee National Hospital |
| HCAI | Healthcare Associated Infection |
| HAIRT | Healthcare Associated Infection Report Template |
| HIIAT | Healthcare Infection Incident Assessment Tool |
| HLD | Heart and Lung Division |
| HA MRSA | Hospital Acquired Meticillin Resistant *Staphylococcus aureus* |
| HEAT  | Health Improvement, Efficiency, Access to treatment, and Treatment  |
| HEI | Healthcare Environment Inspection |
| HFS | Healthcare Facilities Scotland |
| HH | Hand Hygiene |
| HIS | Healthcare Improvement Scotland |
| HPA | Health Protection Agency |
| HPS | Health Protection Scotland |
| IABP | Intra-aortic balloon pump |
| IC | Infection Control |
| IMT | Incident Management Team |
| MRSA | Meticillin Resistant *Staphylococcus aureus* |
| MSSA | Meticillin Sensitive *Staphylococcus aureus* |
| NA  | Not Applicable |
| NCSS | National Cleaning Standards Specification |
| NHSGJ | NHS Golden Jubilee |
| NHSH | NHS Highland |
| NSD  | National Services Division |
| PAG | Problem Assessment Group |
| PCIC | Prevention & Control of Infection Committee |
| PCIN | Prevention & Control of Infection Nurses |
| PCIT | Prevention & Control of Infection Team |
| PCIAR | Prevention and Control of Infection Annual Review |
| PICC | Peripherally Inserted Central Catheter |
| PVC | Peripheral Venous Cannula |
| SAB | *Staphylococcus aureus* bacteraemia |
| SBAR | Situation Background Assessment Recommendations |
| SCN | Senior Charge Nurse |
| SCRIBE | Systems for Control Risk in the Built Environment |
| SG | Scottish Government |
| SGHD  | Scottish Government Health Department |
| SHFN | Scottish Health Facilities Note |
| SICP | Standard Infection Control Precautions |
| SLWG | Short Life Working Group |
| SPSP | Scottish Patient Safety Programme  |
| SSI | Surgical Site Infection |
| TBP | Transmission Based Precautions |
| THR | Total Hip Replacement |
| TKR | Total Knee Replacement |
| TOBD | Total Occupied Bed Days |
| VIP | Visual Infusion Phlebitis  |
| VRE | Vancomycin Resistant Enterococci |

HAIRT Table of Abbreviations

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