

## Healthcare Associated Infection Reporting Template (HAIRT)

**Recommendation:** - For noting.

**Purpose of Paper:** - Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

**Key Issues to be considered:-**

Validated HPS/ISD data : Quarter 2 (April-June) 2016			
HEAT Targets	GGC	National	HEAT target
<b>SAB rate per 100,000 AOB</b>	31.4 (110 cases)	31.1	24.0
<b>CDI rate per 100,000 TOB</b>	25.3 (87 cases)	27.1	32.0

Table 1. Progress against National HAI HEAT targets, 01/04/2016 – 30/06/2016

- **110** *Staphylococcus aureus* Bacteraemia (SAB) cases were reported in the second quarter of 2016 with a rate of **31.4** cases per 100,000 AOB. This is an increase of 3.8 % upon the previous quarter and NHSGGC is marginally above the national rate of 31.1 cases per 100,000 AOB. Local surveillance for July to September (Q3) has also shown a further increase of 5.5% upon the previous quarter with **116** cases reported.
- There was a noted decrease in CDI cases between Q1-2016 (**92** cases) and Q2-2016 with **87** validated cases reported with a rate of **25.3** cases per 100,000 TOB; however Q3 has experienced a 39.1% increase in CDI cases with **121** reported at time of HAIRT compilation. The Q3 increase relates to non hospital acquired cases, and not hospital acquired cases which remain consistent with Q2 numbers.
- For the last published quarter (April - June 2016), the rate for hip arthroplasty was marginally above the national average however was within the 95% confidence intervals of the national dataset SSI rate. Local improvement actions within Orthopaedic procedures at two hospitals included in the national SSI programme are ongoing.
- The SSI rate for Caesarean section procedure category (April - June 2016) was lower than the national SSI rate and also below the national SSI 95% confidence intervals.
- Local SSI surveillance continues within the previously reported mandatory & recommended procedure categories and surveillance also commenced in July 2016 for Major Vascular Surgery, Large Bowel Surgery & specified Neurosurgical procedures.

**Any Patient Safety /Patient Experience Issues: -**

Yes, further increase in SAB in quarters 2 & 3. NHSGGC continue to undertake the implementation of a comprehensive action plan to improve performance to achieve this target.

Increase of CDI cases in Q3. As well as the ongoing IPCT surveillance and review of patient cases, prospective data is given to Antimicrobial Pharmacists to enable real time review of patients in hospital with CDI. This will enable any common features regarding previous antibiotic use or any other mitigating factors to be identified in the acute in-patient setting.

**Any Financial Implications from this Paper:** - No

**Any Staffing Implications from this Paper:** - No

**Any Equality Implications from this Paper:** - No

**Any Health Inequalities Implications from this Paper:** - No

**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:** -

No

**Highlight the Corporate Plan priorities to which your paper relates:** - Improving quality, efficiency and effectiveness.

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**Date:** 18/10/2016

# Healthcare Associated Infection Reporting Template (HAIRT)

## Section 1– Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

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

#### **Staphylococcus aureus Bacteraemia Surveillance and actions**

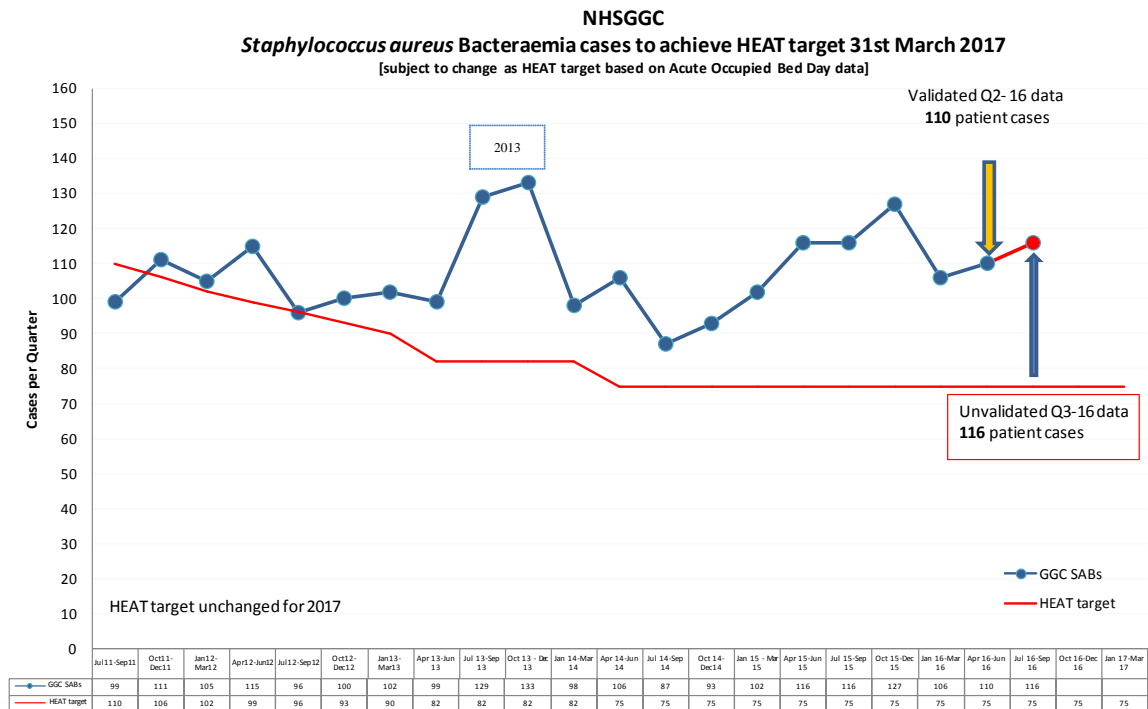


Figure 1. SAB patient cases by quarter.

The graph above demonstrates a variation in *Staphylococcus aureus* bacteraemia (SAB) cases from 2011 onwards to a peak in the second half of 2013 and again in late 2015. Work continues through a series of education and audit initiatives, supported by a HAI Quality Improvement Facilitator who is currently applying improvement methodology to test and improve how we manage these devices. Specifically:

- Removal of insertion criteria in PVC care plan. Infections linked to PVCs are mainly associated with duration of use and inspection of the site and prompt removal if any signs of infection are present (redness, heat, inflammation). Both of these issues are recorded in the maintenance part of the care plan. The intention by changing this document is to focus on this area as the most significant point in the process. The new care plan is currently being tested in two wards in Glasgow Royal Infirmary.
- Audit of PVC use at 24 hours. It is intended that this audit will give Emergency Department (ED) staff some indication of how many of the cannulas they insert are subsequently used. If a significant number are not used, work will focus on providing a framework in which criteria are considered prior to insertion in order to reduce the number inserted *per se*. Lead ICD has agreed to engage with ED staff in order to progress this initiative.
- Community case data is still awaited.

In addition the lead ICD is currently leading on a project to screen renal patient for *S. aureus* prior to line insertion. If positive, patients will undergo decolonisation in the expectation that this will

reduce the ingress of *S. aureus* into the line at the time of insertion. This work is due to commence in November and results will be included in future reports.

A Board wide SAB reduction action plan was initiated in late 2015 and this continues to be updated each month with progress against actions and is presented at both the Acute and Board Infection Control Committee for review and discussion.

Please refer to Briefing Paper attached - **Update on progress against SGHD HEAT Target to reduce *S. aureus* bacteraemia (SAB) to a rate of 24 cases per 100,000 acute occupied bed days by April 2017** for additional information.

### Quarter 2, 2016 (April – June 2016) NHSGGC surveillance

For the last published quarter (April - June 2016), NHSGGC reported **31.4** SAB cases per 100,000 AOBs (110 patient cases). This is marginally lower than the same quarter in 2015 where 116 cases were reported, however, this is a 3.8% increase from the previous quarter (January – March 2016).

40% of these cases were hospital acquired. Detailed information on all SAB cases is included in the monthly enhanced surveillance SAB report which is issued to all Chiefs of Medicine and Chief Nurses for dissemination and review within their teams. This report incorporates the origin of SAB (as displayed in pie chart below) and also any identified causative source of bacteraemia e.g. intravenous access device.

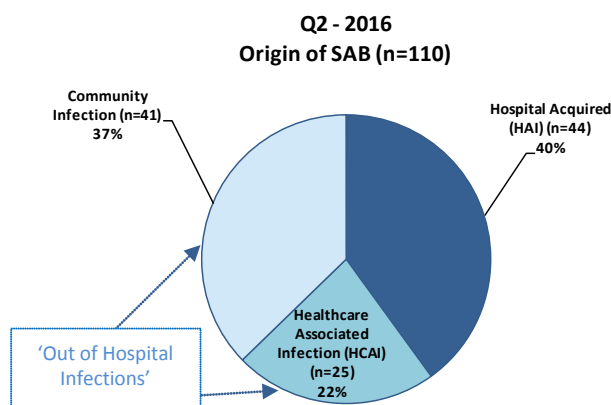


Figure 2. Origin of SAB between 01/04/16 – 30/06/16

Q2-2016	
Source of Bacteraemia (all cases)	Number of patients
IV Access Device (PVC or CVC)	28
No identifiable source of sepsis	26
Skin/soft tissue	13
Surgical site infection	10
Urinary tract infection	8
Pneumonia/respiratory infection	7
Dental	2
Discitis/Osteomyelitis	2
Endocarditis	2
Contaminant	2
Gastric /abdominal	2
Burns	2
Nephrostomy	1
Immunosuppression	1
Epidural Catheter	1

Renal Abscess	1
Septic pulmonary emboli	1
Mucositis	1
<b>Total</b>	<b>110</b>

Table 2. Source of SAB between 01/04/16 – 30/06/16

Intravenous access devices are the most common cause of SAB in GGC, followed closely by no identifiable source of sepsis. These cases are investigated thoroughly, including echocardiograms & further scanning e.g. MRI/CT/ultrasound by the clinical team and discussed in conjunction with the local Infection Prevention & Control Team and no single causative factor for SAB development has been identified.

### Quarter 3, 2016 (July – September 2016) NHSGGC surveillance

The proportion of hospital acquired cases remains unchanged from Q2 with 39% (n=45) patients developing a SAB after admission to a GGC hospital. Please note that at time of report collation, two cases are still under investigation to determine whether community or hospital acquired

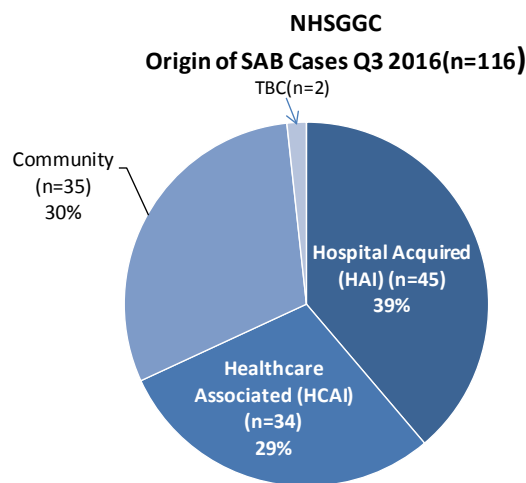


Figure 3. Origin of SAB between 01/06/16 – 30/09/16

### NHSGGC MRSA Screening Project

The Scottish Government announced new national minimum MRSA screening recommendations in 2011. National Key Performance Indicators (KPIs) have now been implemented with NHS Boards required to achieve 90% compliance with Clinical Risk Assessment (CRA) of patients to identify MRSA colonisation.

CRA compliance for Q2 (July - September) 2016 in GGC was **89%**. NHSGGC IPCT continue to encourage clinical areas to complete the CRA and education for clinical teams on how to screen and why this is required is available. Results on specific ward compliance rates are now returned monthly to the sector/directorate Senior Management Teams in order to identify areas that require support/education in relation to this screening initiative.

A comparison is provided in table 3 which shows a variable CRA compliance rate over the past four quarters.

	2015_16 Q3	2015_16 Q4	2016_17 Q1	2016_17 Q2
<b>Greater Glasgow &amp; Clyde</b>	81%	87%	79%	89%
<b>Scotland</b>	83%	80%	82%	tbc

Table 3. Quarterly screening compliance  
National Data Source: HPS MRSA Screening Team August 2016

# Clostridium difficile

## Surveillance and actions

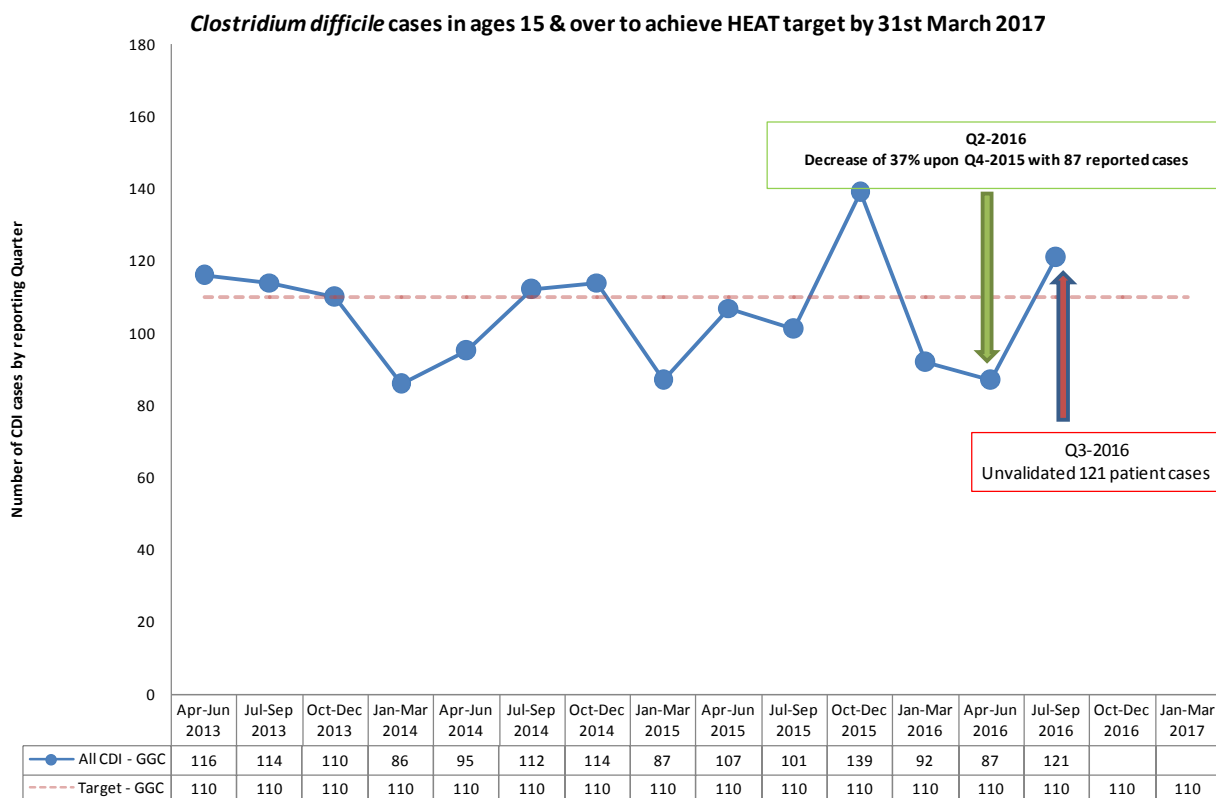


Figure 4. CDI patient cases by quarter

The graph above displays a variable number of CDI cases reported by quarter in ages 15 & over.

### Quarter 2, 2016 (April – June) NHSGGC surveillance

In the last published reporting quarter (April - June 2016), NHSGGC reported **25.3** CDI cases per 100,000 OBD (87 patient cases). This is a 37% reduction in the number of cases since the last quarter of 2015. This is **below** the NHS Scotland reported national CDI rate of **27.1** per 100,000 OBD and also **below** the 2017 HEAT requirements. The National HEAT target in ages 15 and over is **32** cases per 100,000 TOBDs.

### Quarter 3 (July – September 2016) local surveillance status

Surveillance for Q3-16 is complete and there have been **121** reported cases as 30<sup>th</sup> September (Figure 4). It should be noted that only 36% (n=43) of these cases are 'hospital acquired' and that there has been an increase in non-HAI CDI cases when compared to the previous three quarters as demonstrated in the table below. At this time the Lead Infection Control Doctor is reviewing all 121 cases in order to identify any risk factors or possible interventions.

	HAI	non-HAI	Total CDI	%HAI	%non-HAI
Q3-15	43	58	101	42.6%	57.4%
Q4-15	54	85	139	38.8%	61.2%
Q1-16	38	54	92	41.3%	58.7%
Q2-16	42	45	87	48.3%	51.7%
Q3-16	43	78	121	35.5%	64.5%

Q3-16 has noted an increase in non-HAI CDI cases upon the previous 4 quarters

43 cases (36%) were hospital acquired as displayed in table 4.

Q3- 16	
Hospital	HAI Cases
GRI	16
QEUH	13
RAH	5
BOC	3
IRH	3
GGH	1
VOL	1
RHC (ages 15 &over)	1
<b>Total</b>	<b>43</b>

Table 4. Hospital acquired CDI cases July – September 2016

Two wards at Glasgow Royal Infirmary and one ward at the QEUH had two new HAI CDI cases within 14 days. CDI trigger tool initiated and typing requested.

## Outbreaks/Exceptions

There have been three incidents/outbreaks classified as GREEN/AMBER using the Health Protection Scotland (HPS) Hospital Infection Incident Assessment Tool (HIIAT) during this reporting period.

### August 2016, Royal Hospital for Children (NICU), *Serratia Marcescens*

11 babies colonised. 3 patients remain in NICU, 5 discharged home, 2 transferred to another Health Board and 1 in Ward 3A, RHC. HIIAT GREEN. Enhanced IPC control measures in place. IPCT and clinical team are progressing with the actions.

### August 2016, Royal Hospital for Children, *Aspergillus*

Ward 2a Haematology/Oncology. One definite and one probable case of hospital acquired *Aspergillus*. Reported on 05/08/16. Probable case was subsequently confirmed as a case of *Candida Tropicalis*. HIIAT now GREEN however was originally assessed as AMBER by IMT. HPS were updated 17/08/16.

## Norovirus

Norovirus activity was reported in one hospital with 2 wards closed in July 2016 and in two hospitals with 3 wards closed in August 2016.

Month	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Ward Closures	0	0	1	3	2	2	2	3	6	13	3	1	3
Bed Days Lost	0	0	0	19	14	16	15	45	155	250	76	6	5

Table 5. NHSGGC Ward closures due to suspected/confirmed Norovirus.

Data on the numbers of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirusurveillance.aspx>

## Cleaning and the Healthcare Environment

All areas within NHSGGC scored **green (>90%)** in the most recent report on the National Cleaning Specification. It should be noted that data has been combined for Gartnavel General, Beatson Oncology and Homeopathic Hospital for the rates in the Gartnavel General report card. Phased migration of wards and services from Victoria Infirmary, Western Infirmary, old Southern General Hospital and some Gartnavel General Hospital specialities to the new Queen Elizabeth University Hospital, commenced April 2015. As of May 2015, previous Southern General Hospital areas, including Maternity Unit, Institute of Neurosciences, Langlands Unit and WestMARC will be reported under the new Queen Elizabeth University Hospital.

## Healthcare Environment Inspectorate (HEI)

During August and September HEI carried out two unannounced HAI inspections in NHSGGC:

- Gartnavel General Hospital, August 25<sup>th</sup> 2016 – Follow up visit to theatre area. The draft report will be submitted to NHSGGC on the 5<sup>th</sup> of October and the report will be published on the 2<sup>nd</sup> of November.
- Royal Hospital for Children, September 7 & 8 2016 – Draft report will be issued to NHSGGC on the 19<sup>th</sup> October and the report will be published on the 16<sup>th</sup> of November.

The action plans will not be completed until the draft report is issued. Actions from both of these visits will be included in the December HAIRT report.

All HEI reports for NHS Greater Glasgow and Clyde can be viewed by clicking on the following link [http://www.healthcareimprovementscotland.org/programmes/inspecting\\_and\\_regulating\\_care/environment\\_inspectorate\\_hei/he\\_i\\_reports.aspx](http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/environment_inspectorate_hei/he_i_reports.aspx)

## Other HAI Related Activity

### Statistical Process Control Charts

**All Hospital Level Statistical Process Control Charts remain within normal control limits.**

Charts for Queen Elizabeth University Hospital and Royal Hospital for Children are not statistically significant due to having less than 25 data points.

### Surgical Site Infection (SSI) Surveillance

NHSGGC participates in the Surgical Site Infection (SSI) surveillance programme that is mandatory in all NHS boards in Scotland. All NHS boards are required to undertake surveillance for hip arthroplasty and caesarean section procedures as per the mandatory requirements of HDL (2006) 38 and CEL (11) 2009. Post discharge surveillance (PDS) until day 10 post operation is also carried out for all caesarean sections performed, with the assistance of our Community Midwifery colleagues.

### Health Protection Scotland last available quarter (April-June 2016)

Category of procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National dataset SSI rate (%)	National 95% CI
Caesarean section	1425	22	1.5	(1.0, 2.3)	1.7	(1.3, 2.1)
Hip arthroplasty	426	4	0.9	(0.3, 2.3)	0.7	(0.4, 1.1)

Table 6. SSI rates for Caesarean section (inpatient and PDS to day 10), Hip arthroplasty (inpatient and readmission to day 30) procedures within NHS Greater Glasgow & Clyde, 01/04/2016 – 30/06/2016.

For the last available reporting quarter (April - June 2016), the Surgical Site Infection rate for hip arthroplasty was marginally above the national average. It should be noted that overall infection numbers are very low and are within local and national confidence intervals. A collaborative local review of these cases has been undertaken and a local improvement action plan has been instigated and is ongoing.

SSI rates for Caesarean section procedure category are below the national average, and remain within national and local confidence intervals.

It should be noted that most SSIs in this procedure category were superficial and were detected by community midwives following the patient's discharge home.

### Q2 (April - June 2016) Local SSI surveillance status

Surveillance is now complete for the quarter, and local surveillance data for April to June 2016 is displayed in table 7.

In April 2016 there was an increase in SSI cases within the caesarean section procedure category in two obstetric sites. Local prospective review of all cases was undertaken and local action plans were commenced. There was also a slight increase in cases in the repair of neck of femur procedure category. It should be noted that many patients requiring this type of surgery have other existing co-morbidities and risk factors at time of surgery.



Quarter 2 (April - June 2016) : Local SSI Surveillance status				
Category of procedure		Operations	Infections	NHSGGC SSI rate (%)
Mandatory	Caesarean section	1425	22	1.5
	Hip arthroplasty	426	4	0.9
Recommended	Knee arthroplasty	379	3	0.8
	Repair of neck of femur	404	9	2.2

Table 7. Local SSI Surveillance 01/04/16 – 30/06/16

### **Q3 (July – September) 2016 Local SSI surveillance activity**

30 day readmission surveillance is not yet complete for the quarter and updates will be provided in subsequent reports

Surgical Site Infection Surveillance (In-patient and 30 day readmission) is ongoing for the following surgical procedures:

Hip arthroplasty  
 Knee arthroplasty  
 Repair of Neck of Femur  
 Caesarean Section (In-patient & PDS to day 10)

#### **Surveillance of the following procedures commenced in July 2016**

Large Bowel surgery (GGC wide)  
 Major Vascular surgery (QEUH)  
 Craniotomy, Craniectomy & Cranioplasty (Institute of Neurological Sciences, QEUH campus)  
 Spinal surgery (Institute of Neurological Sciences)

It should be noted that the above surgical procedures will not be included in National reporting figures or published by Health Protection Scotland, therefore caution should be taken when interpreting local SSI rates in future publications, to enable local baseline data to be established.

## 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 (also broken down into MSSA and MRSA) and *Clostridium 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 out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. 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 HAI activities at local level than is possible to provide through the national statistics.

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

*Clostridium 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). More information on these organisms can be found on the HPS website:

*Clostridium difficile*:

<http://www.hps.scot.nhs.uk/haic/sshap/clostridiumdifficile.aspx?subjectid=79>

*Staphylococcus aureus* Bacteraemia:

<http://www.hps.scot.nhs.uk/haic/sshap/mrsabacteraemiasurveillance.aspx?subjectid=D>

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 targets associated with reductions in C.diff and SABs. More information on these can be found on the Scotland Performs website:

<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance>

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

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board 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 on the Health Facilities Scotland website:

<http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

#### Understanding the Report Cards – 'Out of Hospital Infections'

*Clostridium difficile* infections and *Staphylococcus aureus* (including MRSA) bacteraemia cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes and. The final Report Card report in this section covers 'Out of Hospital Infections' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

**NHS GREATER GLASGOW & CLYDE**

**REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	4	1	1	1	3	2	4	2	6	1	1	2
<b>MSSA</b>	35	47	39	38	32	41	24	46	37	18	33	37
<b>Total SABS</b>	<b>39</b>	<b>48</b>	<b>40</b>	<b>39</b>	<b>35</b>	<b>43</b>	<b>28</b>	<b>48</b>	<b>43</b>	<b>19</b>	<b>34</b>	<b>39</b>

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	15	17	22	18	11	9	14	13	12	10	16	9
<b>Ages 65 plus</b>	20	19	39	24	11	21	26	22	21	9	28	30
<b>Total Ages 15 plus</b>	<b>35</b>	<b>36</b>	<b>61</b>	<b>42</b>	<b>22</b>	<b>30</b>	<b>40</b>	<b>35</b>	<b>33</b>	<b>19</b>	<b>44</b>	<b>39</b>

**Hand Hygiene Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>AHP</b>	98	98	97	98	98	97	97	97	97	97	99	98
<b>Ancillary</b>	93	91	94	95	94	94	93	93	92	94	91	95
<b>Medical</b>	95	96	95	96	95	94	96	96	95	96	95	95
<b>Nurse</b>	98	98	99	99	99	99	99	99	98	98	99	99
<b>Board Total</b>	<b>97</b>	<b>97</b>	<b>98</b>	<b>98</b>	<b>98</b>	<b>97</b>	<b>98</b>	<b>98</b>	<b>97</b>	<b>97</b>	<b>98</b>	<b>98</b>

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.1	96.0	95.9	95.9	95.6	96.2	95.8	95.6	95.8	95.8	95.7	95.9

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.8	97.1	96.0	97.4	95.6	96.1	97.7	97.5	97.1	97.6	98.4	98.5

**GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY**

**REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	0	1	0	0	0	0	0
<b>MSSA</b>	5	4	6	6	3	6	2	6	6	2	2	2
<b>Total SABS</b>	5	4	6	6	3	6	3	6	6	2	2	2

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	1	3	2	5	3	0	2	1	2	1	3	0
<b>Ages 65 plus</b>	3	2	5	2	4	4	6	6	2	0	3	3
<b>Ages 15 plus</b>	4	5	7	7	7	4	8	7	4	1	6	3

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	95.8	95.6	96.1	95.9	95.7	96.0	96.0	95.9	96.0	95.9	95.6	95.8

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	98.9	99.0	98.9	99.4	98.9	99.5	99.6	99.5	99.5	99.6	99.7	99.6

**ROYAL ALEXANDRA HOSPITAL  
REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	0	1	0	0	0	1	0
<b>MSSA</b>	5	4	2	2	1	3	1	2	0	0	2	1
<b>Total SABS</b>	5	4	2	2	1	3	2	2	0	0	3	1

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	0	1	0	0	0	0	0	1	0	0	0
<b>Ages 65 plus</b>	2	1	3	5	0	0	2	1	0	3	3	0
<b>Ages 15 plus</b>	2	1	4	5	0	0	2	1	1	3	3	0

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.1	97.2	96.5	96.7	96.5	96.8	96.2	96.5	96.7	96.0	96.8	96.6

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.9	98.2	99.3	98.5	98.9	99.0	98.5	99.2	98.9	97.7	98.9	97.3

**INVERCLYDE ROYAL HOSPITAL  
REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>MSSA</b>	3	0	1	0	1	1	1	0	1	0	1	0
<b>Total SABS</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	0	0	0	0	2	0	0	0	1	0	0
<b>Ages 65 plus</b>	0	0	0	0	1	0	2	1	0	0	0	0
<b>Ages 15 plus</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.2	96.4	96.3	95.3	95.6	97.2	95.2	96.0	96.7	95.4	95.8	95.9

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	98.4	98.0	98.6	96.6	97.7	98.5	97.3	97.3	98.4	96.6	97.1	97.5

**VALE OF LEVEN HOSPITAL  
REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>MSSA</b>	0	1	0	1	0	0	1	0	0	0	1	0
<b>Total SABS</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Ages 65 plus</b>	1	0	2	0	0	0	0	0	1	0	1	0
<b>Ages 15 plus</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	97.4	96.8	97.0	96.8	96.5	96.9	97.0	97.2	97.0	97.0	97.3	97.0

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	99.0	99.5	99.7	99.4	99.3	99.4	99.3	99.6	99.3	99.2	99.1	99.5

**GARTNAVEL GENERAL HOSPITAL  
REPORT CARD**

Figures combined for Gartnavel General Hospital, The Beatson WoSCC and Homeopathic Hospital.

**Staphylococcus aureus bacteraemia monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	1	0	0	0	0	0	0
<b>MSSA</b>	0	2	0	2	0	1	0	3	0	1	2	0
<b>Total SABS</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>0</b>

**Clostridium difficile infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	1	0	0	0	0	1	0	0	1	0	0
<b>Ages 65 plus</b>	1	0	2	1	1	2	1	1	2	0	3	0
<b>Ages 15 plus</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>0</b>

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	97.1	97.3	97.2	97.1	97.0	96.8	96.6	96.3	96.1	96.6	97.3	97.0

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	98.1	98.9	98.1	98.4	98.6	99.1	98.2	99.0	98.6	99.0	98.7	99.1



**QUEEN ELIZABETH UNIVERSITY HOSPITAL**

**REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	1	0	0	1	0	0	0	0	1	0	0	0
<b>MSSA</b>	1	3	1	6	4	2	2	7	2	4	4	7
<b>Total SABS</b>	2	3	1	7	4	2	2	7	3	4	4	7

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	3	4	2	2	0	1	0	2	2	3	2	2
<b>Ages 65 plus</b>	3	2	7	1	0	1	3	3	6	1	2	3
<b>Ages 15 plus</b>	6	6	9	3	0	2	3	5	8	4	4	5

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	95.0	95.9	94.8	95.2	93.9	94.3	95.0	94.0	95.0	95.3	95.5	95.9

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	99.9	99.9	99.9	99.9	99.8	99.5	99.9	99.8	99.9	99.8	99.9	99.8

**ROYAL HOSPITAL FOR CHILDREN**

**REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	1	0	0	0	0	0	0	0	0	0	0	0
<b>MSSA</b>	4	2	1	2	1	2	0	3	2	1	1	0
<b>Total SABS</b>	5	2	1	2	1	2	0	3	2	1	1	0

***Clostridium difficile* infection monthly case numbers (in ages 15 & over only)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Ages 65 plus</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Ages 15 plus</b>	0	0	0	0	0	0	0	0	0	0	0	0

**Cleaning Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	96.5	96.7	96.8	96.2	96.4	96.6	95.8	96.5	96.8	96.0	96.9	96.5

**Estates Monitoring Compliance (%)**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Board Total</b>	99.3	99.7	99.6	99.8	99.8	99.8	99.7	99.6	99.7	99.3	99.8	99.5

**NHS GREATER GLASGOW & CLYDE  
COMMUNITY HOSPITALS REPORT CARD**

The community hospitals covered in this report card include:

- Lightburn Hospital
- Drumchapel Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital
- Ravenscraig Hospital
- Stobhill Hospital

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	0	0	0	0	0	0	1	0	0	0	0	0
<b>MSSA</b>	2	1	2	0	1	2	1	1	2	0	0	2
<b>Total SABS</b>	2	1	2	0	1	2	2	1	2	0	0	2

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Ages 65 plus</b>	1	1	0	0	0	1	1	0	1	0	0	0
<b>Ages 15 plus</b>	1	1	0	0	0	1	1	0	1	0	0	0

**NHS GREATER GLASGOW & CLYDE  
OUT OF HOSPITAL REPORT CARD**

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

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>MRSA</b>	2	1	1	0	3	1	1	2	5	1	0	2
<b>MSSA</b>	15	30	26	19	21	24	16	24	24	10	20	25
<b>Total SABS</b>	17	31	27	19	24	25	17	26	29	11	20	27

***Clostridium difficile* infection monthly case numbers**

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
<b>Ages 15-64</b>	11	9	17	11	8	6	11	10	7	4	11	7
<b>Ages 65 plus</b>	9	13	20	15	5	13	11	10	9	5	16	24
<b>Ages 15 plus (Total)</b>	20	22	37	26	13	19	22	20	16	9	27	31

**Data for *Clostridium difficile* Infection (CDI) cases in ages 15 plus:**

60% of all CDI cases reported in NHSGGC between September 2015 and August 2016 are attributed as *Out of Hospital* infections.

**Data for *Staphylococcus aureus* bacteraemia (SAB) cases:**

60% of all *Staphylococcus aureus* Bacteraemia cases reported in NHSGGC between September 2015 and August 2016 are attributed as *Out of Hospital* infections.

## GLOSSARY

ACDP	<b>Advisory Committee on Dangerous Pathogens</b>
AMT	<b>Antimicrobial Management Team</b>
AOBD	<b>Acute Occupied Bed Days</b>
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
BICC	<b>Board Infection Control Committee</b>
CDI	<b><i>Clostridium difficile</i></b> Infection
CEL	<b>Chief Executive Letter</b> issued by Scottish Government Health Directorates (SGHD)
CMO	<b>Chief Medical Officer</b>
CVC	<b>Central Vascular Catheter</b>
<i>C. difficile</i>	<b><i>Clostridium difficile</i></b> also referred to as <b><i>C. diff</i></b> is a Gram-positive spore-forming anaerobic bacteria. <i>C. difficile</i> is the commonest cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
Code of Practice	<b>Code of Practice</b> The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. <a href="http://www.scotland.gov.uk/Publications/2004/05/19315/36624">http://www.scotland.gov.uk/Publications/2004/05/19315/36624</a>
GRO	<b>General Registers Office</b>
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now <b>Healthcare Associated Infection</b> . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for S.aureus Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See <a href="http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf">http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf</a>
HAI SCRIBE & HBN 30	Scottish Health Facilities Note 30: version 3. Infection Control in Built Environment: Design and Planning.
HCW	<b>Healthcare Worker</b>
HDL	<b>Health Department Letter</b>
HEAT Target	<b>Health Efficiency and Access to Treatment.</b> Targets set by the Scottish Government.
HH	<b>Hand Hygiene</b>
HIS	<b>Health Improvement Scotland</b>
HPS	<b>Health Protection Scotland</b>
ICN/T/O/D/M	<b>Infection Control Nurse / Team / Officer / Doctor / Manager</b>
ICP	<b>Infection Control Programme</b>
KPI	<b>Key Performance Indicator</b>
LHBC	<b>Local Health Board Co-ordinator (Hand Hygiene)</b>
MRSA	<b>Meticillin resistant <i>Staphylococcus aureus</i>.</b> A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	<b>Meticillin Sensitive <i>Staphylococcus aureus</i></b>
NCIC	<b>Nurse Consultant Infection Control</b>
PCAT	<b>Primary Care Audit Tool</b>
PDS	<b>Post Discharge Surveillance (Caesarean Section procedures only)</b>
PFPI	<b>Public Focus Patient Involvement</b>
PHPU	<b>Public Health Protection Unit</b>
PPI	<b>Public Partners Involvement</b>
PVC	<b>Peripheral Vascular Catheter</b>
SAB	<b><i>Staphylococcus aureus</i> Bacteraemia</b>
SIRN	<b>Scottish Infection Research Network</b>
SOP	<b>Standard Operating Procedure</b>
SPC	<b>Statistical Process Control (Charts)</b>
SPSP	<b>Scottish Patient Safety Programme</b>
SSI	<b>Surgical Site Infection</b>
TOBD	<b>Total Occupied Bed Days</b>
VRE	<b>Vancomycin resistant enterococcus</b> - an alert organism A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.



**NHS Greater Glasgow & Clyde**  
**Infection Prevention and Control Team**

**Purpose:** Update Paper

**From:** Infection Prevention and Control Team (IPCT)

**To:** NHS Board

**Date:** 26/09/2016

**Subject:** Update on progress against SGHD HEAT Target to reduce *S. aureus* bacteraemia (SAB) to a rate of 24 cases per 100,000 acute occupied bed days by April 2017

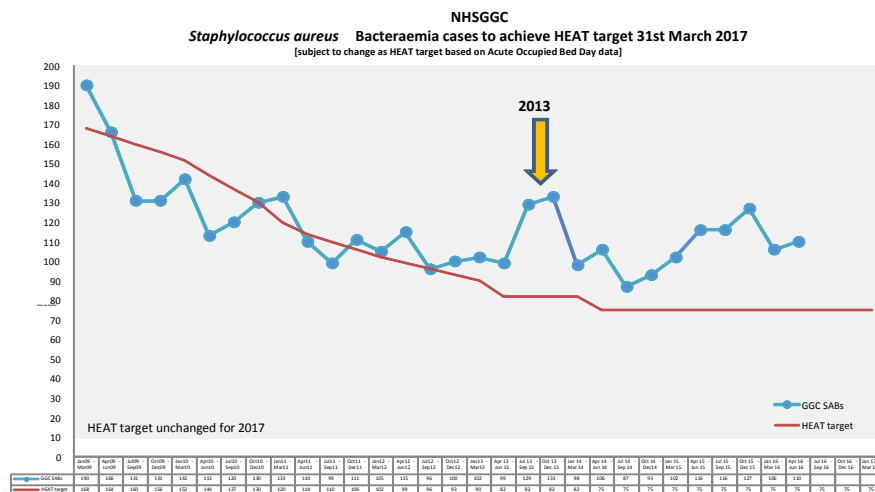
**Background**

The current National HEAT Target required all Boards in Scotland to achieve a rate of 24 cases of *S. aureus* bacteraemias (SABs) per 100,000 acute occupied bed days (AOBDs) or lower by 31 March 2017.

This target was first introduced in 2009 and NHSGGC initially made significant progress against the target (figure 1) until 2013, however, as illustrated below NHSGGC have had limited success in maintaining and improving the rate. The reasons for this are currently unknown but changes in the population e.g. increase in age, number of chronic conditions, and increased use of invasive devices, are all factors which could be influencing the rate. In addition, the proportion of patients presenting who have had no healthcare contact in the 30 days prior to their positive blood culture, i.e. community cases, is increasing and interventions to prevent infection in this group are difficult to identify and implement.

The year-end figures are the most accurate representation of rates.

**Figure 1**



As far as possible, NHSGGC have shared information and developments, and have collaborated with other boards to try and reduce the rates. At present NHSGGCs Quality Improvement Facilitator (QIF) is working with Health Improvement Scotland to test new initiatives and processes, e.g. acronym to try and encourage clinicians to think about why they are inserting cannula in order to try and prevent cannulation if possible.

**Figure 2** is a comparison of how NHSGGC is performing in relation to other boards.

**Figure 2**

**Rate per 100,000 AOBDS NHS Scotland and Comparable Boards** (This is the most up to date information as of 26.09.16 – comparable data for quarter two 2016 will be issued in October)

	<b>Q1-2016 (Jan - Mar)</b>	<b>SAB</b>	<b>Year end March 2016</b>
Highland	26.8	Highland	25.5
<b>Greater Glasgow &amp; Clyde</b>	<b>29.4</b>	Ayrshire & Arran	27.1
Grampian	30.4	Grampian	29.7
Lothian	32.8	Lothian	30.5
Ayrshire & Arran	33.6	<b>Greater Glasgow &amp; Clyde</b>	<b>33.3</b>
Lanarkshire	36.5	Lanarkshire	33.3
Tayside	41.6	Tayside	35.0
<b>Scotland</b>	<b>32.6</b>	<b>Scotland</b>	<b>32.4</b>

**Actions Complete**

**Guidance / Education**

A full set of guidance documents were developed and promoted locally by Practice Development Nurses and IPC Nurses in wards and departments and reinforced during all educational sessions linked to the use and management of Intravascular Devices (IVDs). Care plans were also developed and made available to staff the aim of which was to capture key points of care in a tick box format to reduce the burden on clinical staff. The care plans were based on templates developed by NHS Ayrshire and Arran.

A short video on the correct management of PVC was developed in 2016 and disseminated via the Chief of Medicine and the Chief Nurses.

**Antimicrobial Management Team (AMT)**

Information on cases of SAB is referred to the AMT by the IPC Data Team and a review is undertaken to ensure that patients are on the correct treatment regimen. The AMT are also reviewing all cases for six months post infection to try and demonstrate the long term consequences of this infection.

**Audit**

We know from information collected that intravascular devices (IVDs) account for about a third of all hospital acquired SAB infections. In 2012 care plans and guidance documents were developed to support the implementation of the Health Protection Scotland National Care Bundles to prevent infections caused by Peripheral Vascular Cannula (PVC) and Central Venous Catheters (CVC).

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	<p>An updated IPC Audit was launched in 2015 and part of this audit tool monitors compliance with PVC and CVC bundles. Every ward is audited at least yearly and this information is returned to Directorate Teams monthly. Accepting that some of the paperwork involved in this process can be perceived to be cumbersome a review of all care plans and documentation is currently in progress lead by the IPC Quality Improvement Facilitator (QIF).</p> <p><b>Governance</b></p> <p>All SABs cases trigger a process of review. The ward is visited and information is collected. Each complex case is discussed with an IPC doctor and then this information is returned to clinicians who are asked to consider this in their review. Each Division/Directorate also receive a summary report every three months. In 2016, in order to link this work more closely with the mainstream clinical governance processes, IPCTs have been instructed to log any SABs which were potentially avoidable or which contributed or caused the death of the patient into the Clinical Governance Reporting System (Datix). This now triggers a multi-disciplinary review of the case and this information is discussed at the Board Clinical Governance Committee.</p>
<b>Actions Ongoing</b>	<p><b>Community</b></p> <p>Thirty per cent of all SABs are now defined as community acquired. A short-life working group (SLWG) was set up and met in February 2016 for the first time to review Community SAB Data from October 2014 to March 2016 and to identify areas where focussed improvement work could be implemented. Two SAB Groups were identified for further exploration; illicit drug use and those with diabetes.</p> <p>Representatives from Public Health who sit on the SLWG were able to advise that a number of control measures are already in place in response to the ongoing HIV outbreak and these may be useful in relation to SAB reduction. Information produced by the Scottish Drugs Forum (SDF) in relation to <i>Staphylococcus aureus</i> and people who use drugs is being reviewed by the Addictions Team, for possible dissemination and to highlight SABs as a risk for this patient population. It should be noted that it is extremely difficult to modify risk behaviours in this particular group.</p> <p>The second group reviewed SABs in diabetic patients (n= 29 for date range October 2014 to March 2016). Permission to review GP notes has been given and work is ongoing to identify if diabetic patients had any contact with community services in the 30 days prior to blood being taken and if so, who they were in contact with and if any intervention(s) took place.</p> <p><b>TIMESCALE:</b> Analysis of data should be complete by November 2016. A subsequent action plan if appropriate will be submitted to BICC for approval in January 2017.</p>



### **Testing for *S. aureus* in Renal Dialysis Patients**

Thirty per cent of individuals have nasal carriage of *S. aureus* increasing to 50% of hospitalised patients. Evidence from the literature suggests that a substantial proportion of *S. aureus* bacteraemia are of endogenous origin, i.e. they originate in the patient's nose. The scientific literature suggests that decolonising patients who are natural carriers of *S. aureus* may reduce the incidence of infection. Although *S. aureus* is not part of any national screening policy, in this specific group of patients it may be useful in preventing SABs. In collaboration with Renal Services Clinicians, all renal haemodialysis patients will be screened for *S. aureus*. It is planned that this screening process will commence in November 2016. If patients are positive they will be commenced on a decolonisation regimen to reduce the amount of bacteria on their skin and nose and this in turn should reduce SABs. Depending on the impact, this may be extended to other high-risk groups.

**TIMESCALE:** This project will commence in November 2016.

### **Paediatrics and Neonatology**

Interventions to reduce SABs in neonates and children are extremely complicated. Neonates especially are much less tolerant to the insertion of vascular access devices because of their fragility. The Chief Nurse for Paediatrics and Neonates is currently chairing a quality improvement group to look at the literature and policies and procedures in relation to the use of these devices in this group of patients. Some key initiatives currently ongoing are:

- Education on the use of IVDUs in paediatrics.
- Education regarding the use of an aseptic non-touch technique.
- SLWG established in RHC to review CVAD guidance for RHC and to review practice in Ward 2A Haematology.

**TIMESCALE:** This group is ongoing. Timescales for key milestones have yet to be agreed.

### **IPC Quality Improvement Facilitator (QIF)**

In collaboration with Health Improvement Scotland (HIS) a QIF was appointed to test using improvement methodology new ways of managing IVDs. This work is currently ongoing in Glasgow Royal Infirmary (GRI) directed by a SLWG of clinical staff based in GRI and includes the following work strands:

- Avoiding the use of IVDs in the first instance. Decision making acronym to encourage clinical staff to consider if the device is necessary in the first place.
- Audit of how many of the IVDs are used in practice. This will support the use of tools detailed in the above bullet.
- Update and testing of new PVC Care Plan (2 wards in GRI) with scheduled PDSA cycles
- Testing of methods to encourage clinical staff in Emergency Departments and Theatres to complete insertion criteria.
- Ward based education.
- PVC Driver Diagram developed
- Education resource for clinical staff

**TIMESCALE:** Testing of the 2 wards in GRI will go on until December 2016. Reliability testing will continue for 6 months after the new templates have been agreed. Roll-out plan to be agreed at AICC and with HIS.

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	<p><b>Policy</b></p> <p>The Vascular Access Policy is currently being reviewed. This work is being lead by Practice Development. Key changes to this policy will be the management of Peripherally Inserted Central Venous Catheters and Mid-Lines (both of which can be used for up to 30 days without the risks associated with CVCs).</p> <p><b>TIMESCALE:</b> Still to be confirmed.</p>
<b>Planned Actions</b>	<ul style="list-style-type: none"> <li>• Assessment of junior medical staff induction to ensure this includes information on aseptic technique and care and insertion of PVC and CVCs.</li> <li>• Active promotion of antibiotic review to optimise timely IV to oral switch (reduces the need for IVDs).</li> <li>• Incorporation of antibiotic review into ward round checklist.</li> <li>• Identify optional processes for communicating meaningful feedback of ward level SAB data to ward staff, e.g. patient stories.</li> <li>• Highlight availability of NHS Safety Card 'making your stay with us safe'.</li> <li>• Review the current Adult and Children Vascular Access Device Policy.</li> <li>• Incorporation of PVC and CVC care plans into e-forms.</li> </ul>
<b>Recommendation</b>	Note to support the action taken and those proposed. All actions will be monitored on an ongoing basis via the AICC.