







# Healthcare Associated Infection Report

## Feb 2018 data

### 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**- 1 SAB to report in February, in ICU2. 9 SABs have been reported to date; therefore the Board will not meet its own locally defined target for SAB reduction, however local forecast inclusive of the last quarter data indicates we are below the nationally defined annual HEAT target.
-  **Clostridium difficile infection**- No cases to report.
-  **Hand Hygiene**- The **bimonthly** report from January demonstrates a Board compliance rate of 97%. Next report March 18.
-  Although 90% of medical staff are compliant with the Hand Hygiene elements of Standard Infection Control Precautions, this remains below the national target of 95%. In order to optimise and sustain levels of hand hygiene compliance the Medical Director met with the Nurse Director and Senior Infection Prevention and Control Team to discuss additional improvement measures.  
The CGRMG have requested a review of the escalation within the zero tolerance algorithm. This is being co-ordinated by clinical governance and Human Resources.
-  **Cleaning and the Healthcare Environment- Facilities Management Tool**  
**Housekeeping Compliance: 98.59%      Estates Compliance: 99.48%**
-  **Surgical Site Infection**-  
CABG, Hip and Knee replacement SSI rates are within control limits.  
  
Cardiac SSI rates have breached upper control limits in February, no commonalities in surgeon, theatre or organism noted. The PCIT are working with Tissue Viability, SCNs, Nurse Practitioners and SS Clinical Governance Lead to review and optimise practices to promote SSI prevention. This increase was communicated to the cardiac teams 12<sup>th</sup> March 2018.

#### **Other HAI Related Activity**

**Problem Assessment Groups (PAG)** - Locally convened group to further investigate an HAI issue which may require additional multidisciplinary controls.

PAGs	Update
<b><i>Mycobacterium chimaera</i></b>	<b>No further updates</b> HPS will convene a further IMT to formally close the PAG – still awaited. The decontamination lead from HPS has requested a site visit to review the process in order to influence national guideline development. Meeting to agree risk assessment is planned for 28/03/18.

## ***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. More information on these organisms can be found at: [http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA: [http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=252](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252)

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. The number of patients with MSSA and MRSA bacteraemias for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemias can be found at:

<http://www.hps.scot.nhs.uk/haic/sshaip/publicationsdetail.aspx?id=30248>

### **GJNH approach to SAB prevention and reduction**

It is accepted within HPS that care must be taken in making comparisons with other Boards data because of the specialist patient population within GJNH. 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 HAI initiatives which influence our SAB rate include-**

- Hand Hygiene 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 and Peer Review monitoring
- Participation in National Enhanced SAB surveillance- gaining further intelligence on the epidemiology of SAB locally and nationally.

#### **SSI Related SAB**

- Introduction of MSSA 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.
- Standardisation of post op cardiac wound care.
- Development and implementation of a wound swabbing protocol and competency.

#### **Device Related SAB**

- SPSP work streams continue to aim to sustain compliance with PVC, CVC, PICC and IABP bundles; assessment of compliance locally aids targeting of interventions accordingly.
- Implementation of new combined PVC insertion and maintenance bundle

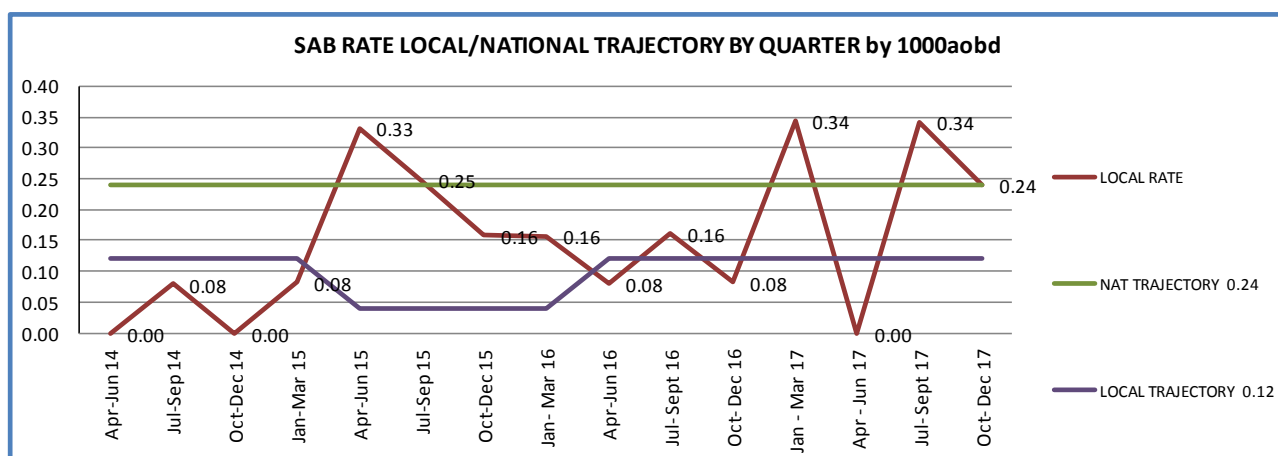
- Implementation of arterial line maintenance bundle in Critical Care.

### SAB Local Delivery Plan (LDP) Heat Delivery Trajectories

Boards are expected to achieve a rolling target of 0.24 cases per 1,000 acute occupied bed days or lower by year ending March 2018. Boards are expected to continue with these targets until reviewed late spring.

Boards currently with a rate of less than 0.24 are again expected to at least maintain this, as reflected in their trajectories. **Our local rate Oct- Dec 17 has decreased to 0.24 (n= 3) per 1000 occupied bed days. 9 SABs have been reported to date; therefore the Board will not meet its own target for SAB reduction, however local forecast inclusive of the last quarter data indicates we are below the nationally defined annual HEAT target.**

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

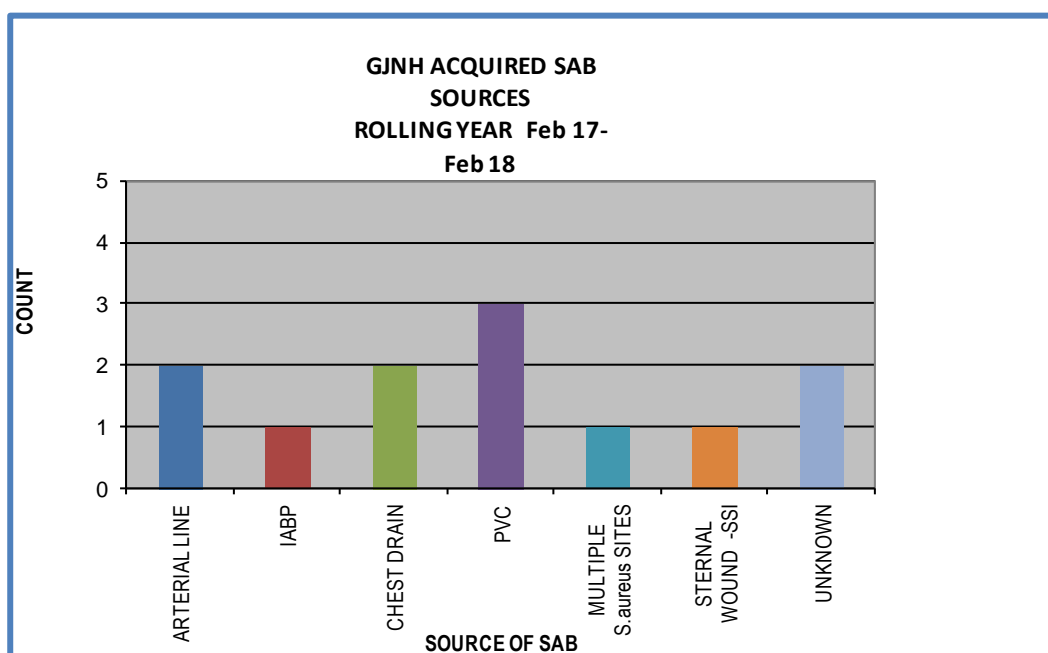
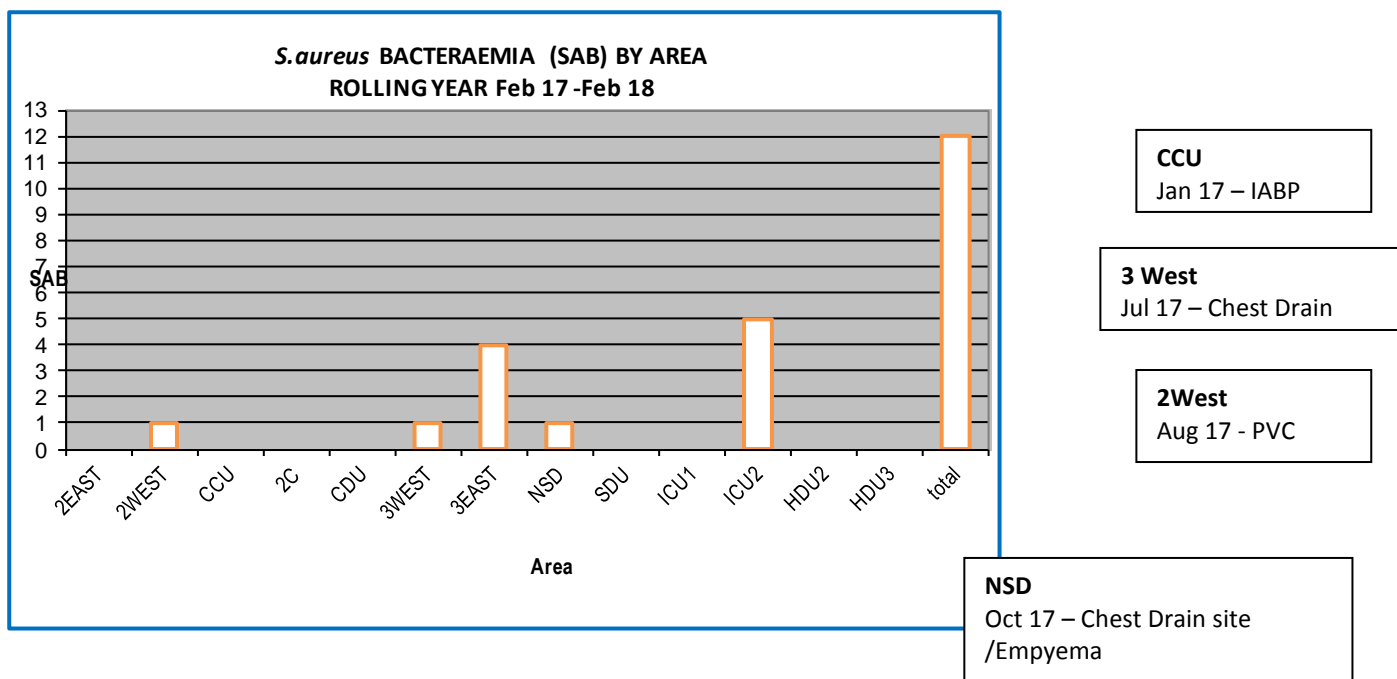


#### 3 EAST

Mar 17- x2 PVC/Multiple sources x1  
 Aug 17- PVC  
 Jan 18- SSI

#### ICU2

Aug 17- 1 IABP/1 ART LINE  
 Oct 17- 1 ART LINE  
 Dec 17- Unknown  
 Feb 18- Unknown possible IABP



Initially our SAB reduction work plan in 17/18 focused on refining the PVC maintenance and addition of PVC insertion bundle to improve compliance in 3 East. This work has now progressed to spread of the standardised PVC bundle to all clinical areas including critical care within CIS. The last PVC related SAB was in March 17. Arterial line maintenance bundles have also been developed for critical care on CIS. The aim of this bundle is to provide clear direction and documentation of care delivered during arterial line use.

Next steps include-Working with CGRMDU next steps include development of a standardised risk assessment bundle inclusive of PVC.

## ***Clostridium difficile***

*Clostridium 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. More information can be found at:

<http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx>

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridium difficile* infections can be found at:

<http://www.hps.scot.nhs.uk/haic/sshaip/ssdetail.aspx?id=277>

### **GJNH approach to CDI prevention and reduction**

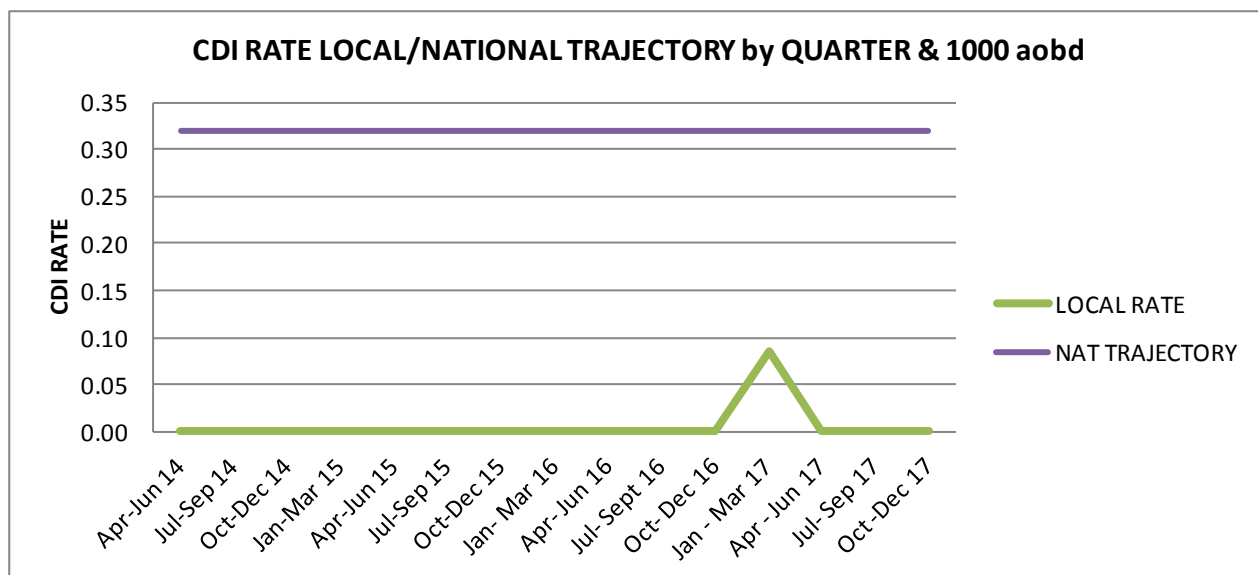
Our numbers of CDI cases are low in comparison with other Boards, which is likely to relate to our specialist patient population.

#### **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 HPS Trigger Tool if trigger is breached.
- Implementation of HPS Severe Case Investigation Tool if the case definition is met
- Typing of isolates when two or more cases occur within 30 days in one unit.

## **CDI LDP Heat Delivery Trajectories**

Boards are again expected to achieve a rolling trajectory of 0.32 cases CDI per 1,000 occupied bed days by year ending March 2018. This relates to people aged 15 and over. Boards currently with a rate of less than 0.32 will be expected to at least maintain this, as reflected in their trajectories. **Overall Oct 17- Dec 17 rate 0.0 per 1000 occupied bed days still well below the national target.**



## 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.washyourhandsofthem.com/>

NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non compliance. The hand hygiene compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national hand hygiene monitoring can be found at:

<http://www.hps.scot.nhs.uk/haic/ic/nationalhandhygienecampaign.aspx>

### GJNH approach to Hand Hygiene

The **bimonthly** report from January demonstrates a Board compliance rate of 97%.

Medical staff compliance has dropped further to 90% compliance with both opportunity and technique.

Although 90% of medical staff are compliant with the Hand Hygiene elements of Standard Infection Control Precautions, this remains below the national target of 95%. In order to optimise and sustain levels of hand hygiene compliance the Medical Director met with the Nurse Director and Senior Infection Prevention and Control Team to discuss additional improvement measures.

The following direct measures have been agreed, to be implemented as a matter of urgency ;

- Re-emphasising the collective responsibility that infection control remains "everyone's business "
- Hand Hygiene compliance must be included as a separate agenda item in the next consultant meetings
- A message to reinforce Hand Hygiene Policy to all medical staff at CME and M&M meetings
- Medical Director and Nurse Director will meet with Medical Director of Education to explore ways to help progress the GJNH HAI Education Strategy for Medical staff
- Highlight the importance of immediate escalation for non compliance as appropriate
- Full compliance by medical staff with Zero tolerance policy relating to all elements of Hand Hygiene.
- Infection Control Team to meet Medical Director and Director of Nursing monthly re the impact of the above measures and any ongoing challenges .

The attached Appendix details the key non compliance and NHSScotland mandatory expectations in regards to Hand Hygiene compliance.

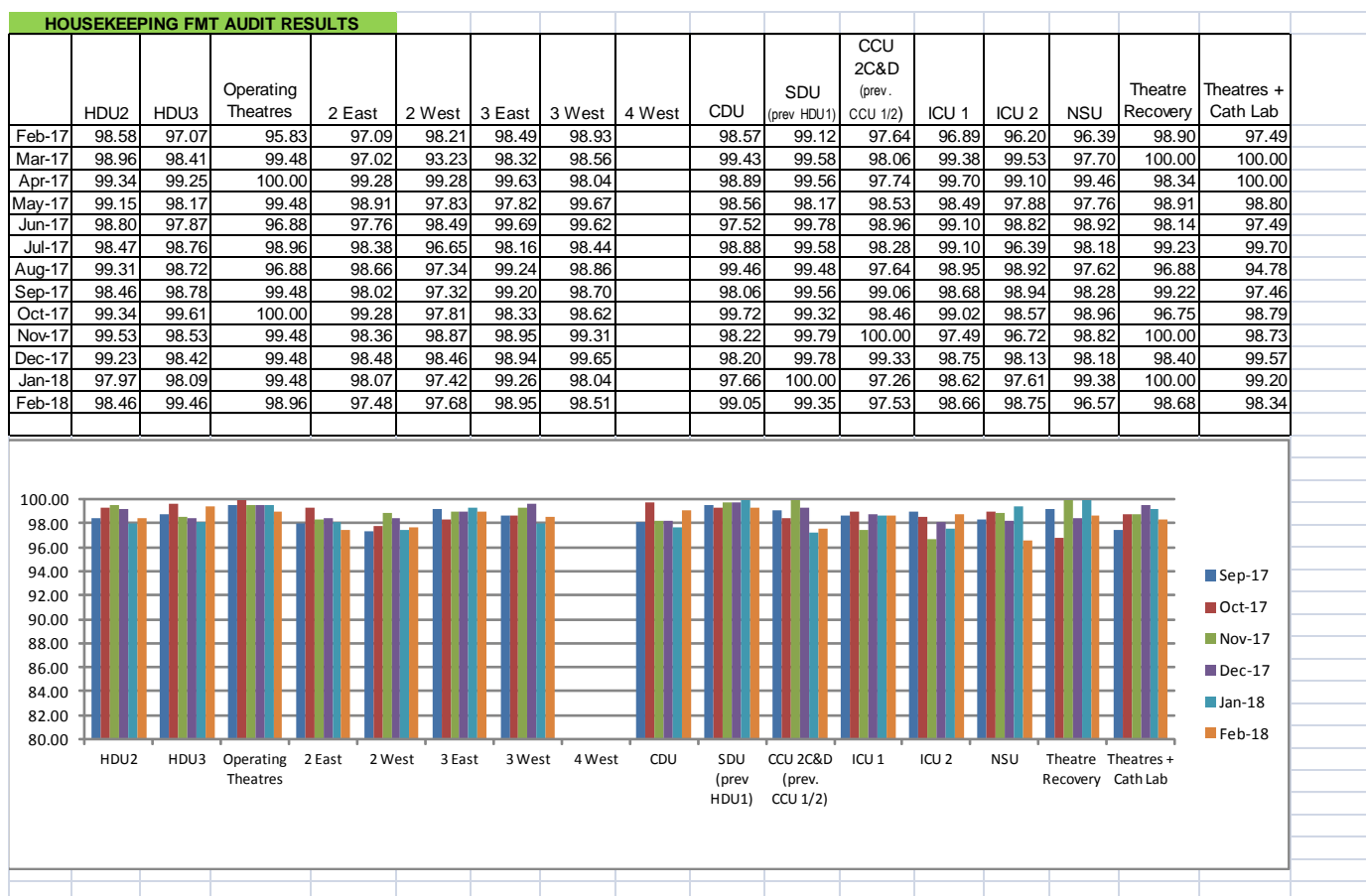
## Cleaning and Maintaining the Healthcare Environment

Heather Gourlay- Senior Manager Prevention and Control of Infection  
Sandra McAuley- Clinical Nurse Manager Prevention and Control of Infection  
Date -28/03/18 (v2 04/05/18)

## Housekeeping FMT Audit Results

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

Integral to the updated National Cleaning Services Specifications, the Housekeeping team have reviewed existing task sheets for each area to risk assess the frequency of tasks.



## MRSA Screening Compliance

### Long Term Patient Screening

- All patients should be rescreened on Day 10 of stay and weekly thereafter.
- 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 required to improve compliance should be submitted.



Feb-18	3WEST	3EAST	2C	2D	CCU	NSD	ICU2	ICU1	HDU2	HDU3	2EAST	2WEST	Overall
SAMPLE SIZE	17	25	8	5	7	8	6	6	CLOSED	7	18	18	125
ADMIT COMPLIANCE	100%	100%	63%	100%	71%	100%	100%	100%		100%	100%	94%	95%
			3 PT'S NOT SCREENED		2 PTS'S NOT SCREENED							1 PT NOT SCREENED	
SAMPLE SIZE	1	6	NA	NA	NA	4	NA	NA		2	NA	4	17
10 DAY COMPLIANCE	100%	100%				100%				100%		100%	100%
SAMPLE SIZE	NA	1	NA	NA	NA	2	NA	NA		1	NA	3	7
7 DAY COMPLIANCE		100%				100%				100%		100%	100%

February data

Admission screens omitted in 2C and CCU. No extenuating circumstances noted.

## 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 outwith 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 Metcillin Sensitive *Staphylococcus aureus* (MSSA) and Metcillin Resistant *Staphylococcus aureus* (MRSA). More information on these organisms can be found on the NHS24 website:

*Clostridium difficile* :

[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=2139&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1)

*Staphylococcus aureus* : [http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA: [http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=252&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1)

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. difficile* and SABs. More information on these can be found on the Scotland Performs 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 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. 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 BOARD REPORT CARD

### *Staphylococcus aureus* bacteraemia monthly case numbers

	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
<b>MRSA</b>	0	0	0	0	0	0	0	0	0	0	0	0	
<b>MSSA</b>	0	3	0	0	0	1	3	0	2	0	1	1	1
<b>Total SABS</b>	0	3	0	0	0	1	3	0	2	0	1	1	1

### *Clostridium difficile* infection monthly case numbers

	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
<b>Ages15-64</b>	0	0	0	0	0	0	0	0	0	0	0	1	0
<b>Ages 65+</b>	0	1	0	0	0	0	0	0	0	0	0	0	0
<b>Ages 15 +</b>	0	0	0		0	0	0	0	0	0	0	0	0

### Hand Hygiene Monitoring Compliance (%)

	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
<b>AHP</b>		100%		100%		97%		100%		100%		96%	
<b>Ancillary</b>		100%		86%		92%		100%		95%		100%	
<b>Medical</b>		99%		100%		96%		97%		91%		90%	
<b>Nurse</b>		99%		97%		97%		98%		99%		99%	
<b>Board Total</b>		99%		98%		94%		98%		97%		97%	

### Cleaning Compliance (%)

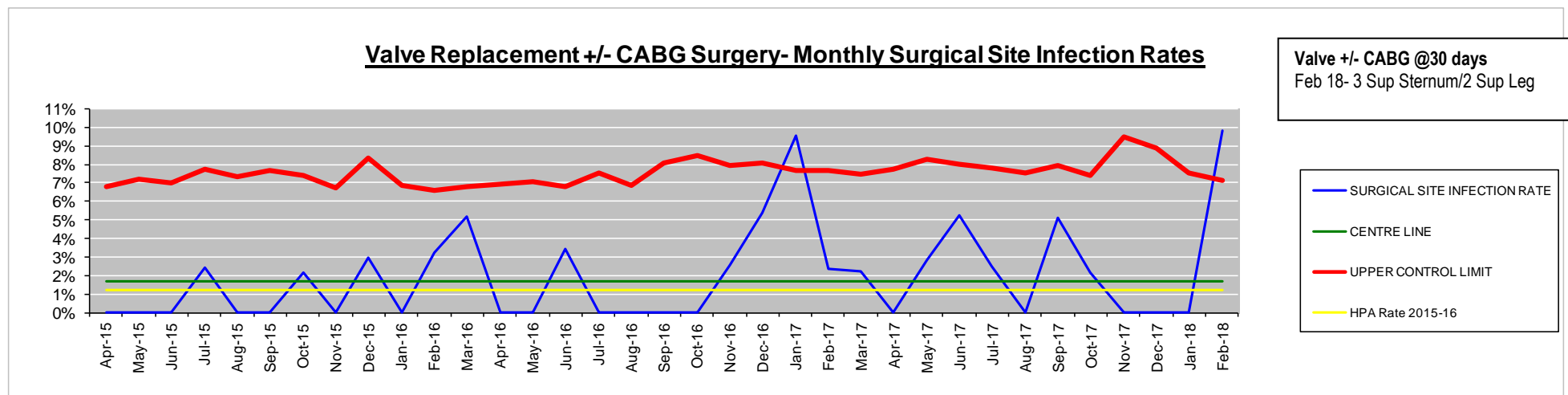
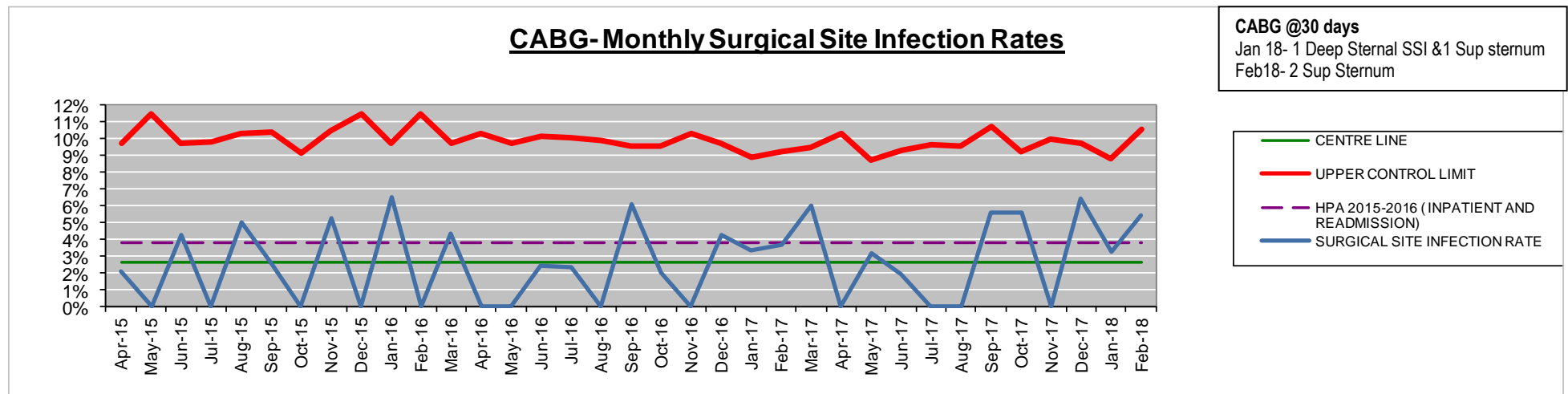
	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
<b>Board Total</b>	97.65	98.61	99.17	98.42	98.6	98.48	98.21	98.46	98.78	98.88	98.66	98.59	98.43

### Estates Monitoring Compliance (%)

	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
<b>Board Total</b>	98.75	99.34	99.15	99.04	98.9	99.17	99.06	99.34	99.31	98.48	99.52	99.48	99.37

## Surgical Site Surveillance

### CABG and CABG +/- Valve SSI Local Data



\*A surgical site infection is defined a superficial, deep or organ space infection occurring within 30 days of operation.

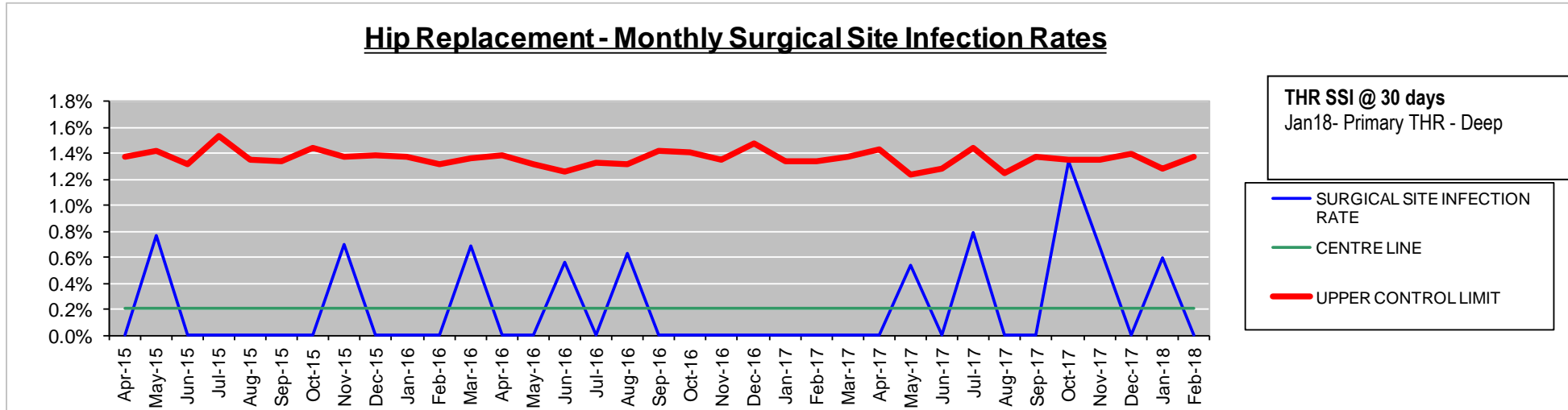
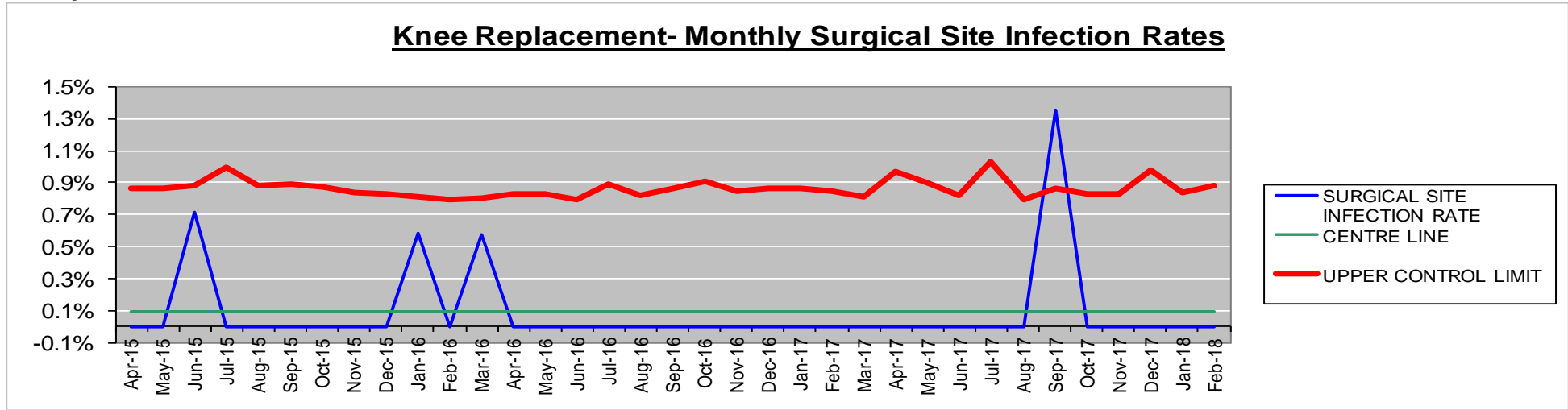
Definitions of superficial, deep and organ space are defined in Health Protection Scotland Surgical Site Infection Surveillance Protocol.

Heather Gourlay- Senior Manager Prevention and Control of Infection

Sandra McAuley- Clinical Nurse Manager Prevention and Control of Infection

Date -28/03/18 (v2 04/05/18)

Orthopaedic SSI Local data



\*A surgical site infection is defined 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.



## HAIRT Table of Abbreviations

AHP	Allied Healthcare Practitioner
CABG	Coronary Artery Bypass Graft
CCU	Coronary Care Unit
CDI/C. <i>difficile</i>	Clostridium Difficile Infection
CVC	Central Venous Catheter
DMT	Domestic Monitoring Tool
E.coli	Escherichia coli
FMT	Facilities Monitoring Tool
GJNH	Golden Jubilee National Hospital
GP	General Practitioner
HAI	Healthcare Associated Infection
HAIRT	Healthcare Associated Infection Report Template
HA MRSA	Hospital Acquired Meticillin Resistant Staphylococcus aureus
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
ICAR	Infection Control Audit Review
LDP	Local Delivery Plan
MRSA	Meticillin Resistant Staphylococcus Aureus
MSSA	Meticillin Sensitive Staphylococcus Aureus
NAT	National
NCSS	National Cleaning Standard Specification
PAG	Problem Assessment Group
PCIC	Prevention & Control of Infection Committee
PCINs	Prevention & Control of Infection Nurses
PCIT	Prevention & Control of Infection Team
PICC Line	Peripherally inserted central catheter line
PNE	Patient Notification Exercise
PVC	Peripheral Venous Cannula
SAB	Staphylococcus aureus bacteraemia
SCN	Senior Charge Nurse
SICP s	Standard Infection Control Precautions
SPSP	Scottish Patient Safety Programme
SSI	Surgical Site Infection
TBPs	Transmission Based Precautions
THR	Total Hip Replacement
VAP	Ventilator Associated Pneumonia



## **Golden Jubilee Foundation**

### **Hand Hygiene Compliance Report Prepared by Susan Robertson 22/02/2018**

#### **Background:**

Hand hygiene is considered an important practice in reducing the transmission of infectious agents which cause Healthcare Associated Infections.  
(NPCIM, 2012)

The Scottish Government in line with the Department of Health recommendation, and as part of the development of NHSScotland uniform policy, have deemed that clinical staff in NHSScotland should be “bare below the elbows.

Furthermore to ensure that NHS boards do not become complacent about the importance of hand hygiene, and to ensure good practice becomes embedded in the service, the Cabinet Secretary for Health and Wellbeing announced on the 26 January 2009 that all NHS boards must adopt a zero tolerance approach to non-compliance with hand hygiene.  
(SGHD, CEL 5 (2009))

#### **Responsibilities:**

Within GJF, hand hygiene compliance data is recorded by staff group, compliance with key moment, opportunity taken and hand hygiene technique.

Data for 20 observations per department /per month is documented by the Senior Charge Nurse / nominated deputy.

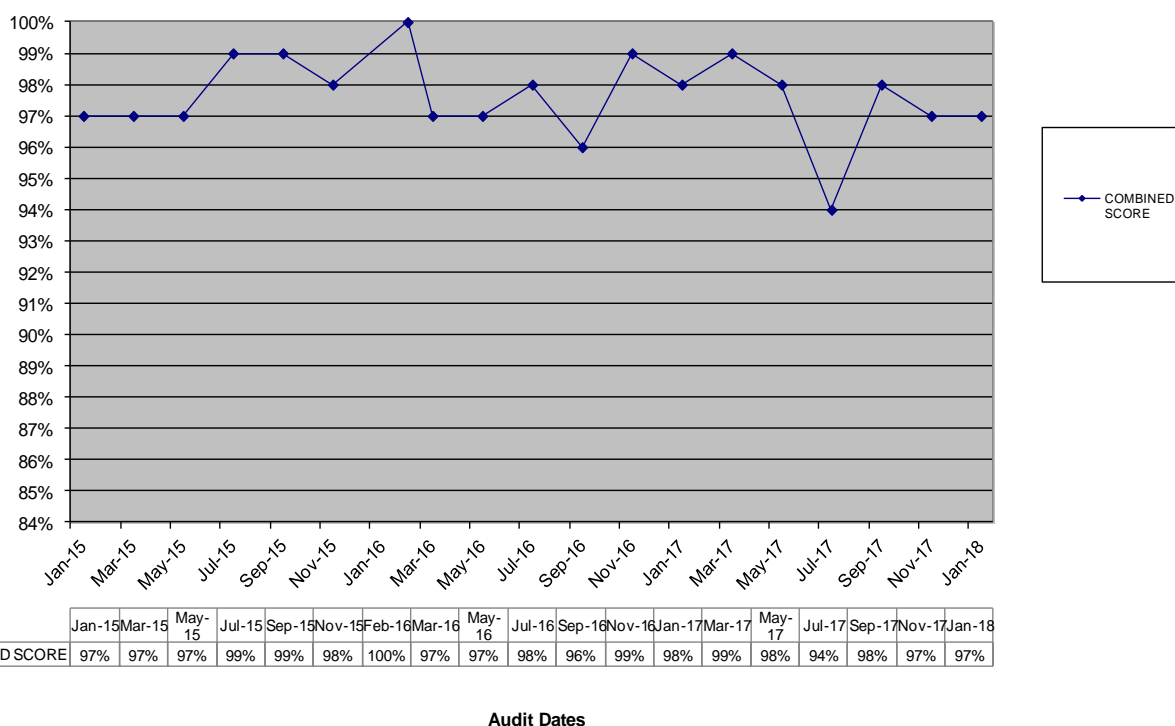
The SCN may identify issues resulting in a non-compliance that can be managed and dealt with quickly and easily on a day to day basis at a local level.

The Prevention and Control of Infection Team further scrutinise the data to ensure robust systems and processes are in place to assure GJF that areas for improvement are identified and the necessary improvements are recommended/ implemented.



## Data analysis report: January 2018 - GJF Combined Score 97%

### HH Combined (Opportunity and Technique)Score



## Summary of Compliance by Staff Group

The table below shows the percentage scores for “opportunity taken” together with the total number of opportunities observed for each staff group.

	<i><b>Nurse</b></i>	<i><b>Medical</b></i>	<i><b>AHP</b></i>	<i><b>Ancillary/Other</b></i>
Golden Jubilee Foundation	99% (184)	90% (54)	96%(54)	100% (8)

## Summary of Compliance by Key Moment

The table below shows the percentage scores for “opportunity taken” together with the total number of opportunities observed for each key moment.

	<i><b>Before Patient Contact</b></i>	<i><b>Before Aseptic Task</b></i>	<i><b>After Body Fluid Exposure Risk</b></i>	<i><b>After Patient Contact</b></i>	<i><b>After Contact with Patient's Surroundings</b></i>
Golden Jubilee	95% (113)	100% (41)	100% (32)	98% (48)	95% (66)

Heather Gourlay- Senior Manager Prevention and Control of Infection  
 Sandra McAuley- Clinical Nurse Manager Prevention and Control of Infection  
 Date -28/03/18 (v2 04/05/18)

Foundation					
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### Summary of Correct Technique by Staff Group

The table below shows the percentage scores for “correct technique” together with the total number of opportunities taken for each staff group.

	<i><b>Nurse</b></i>	<i><b>Medical</b></i>	<i><b>AHP</b></i>	<i><b>Ancillary/Other</b></i>
Golden Jubilee Foundation	99% (184)	90% (54)	96%(54)	100% (8)

### Summary of Compliance with Key Moments and Correct Technique

The table below shows the percentage scores for “correct technique” together with the total number of opportunities taken for each key moment.

	<i><b>Before Patient Contact</b></i>	<i><b>Before Aseptic Task</b></i>	<i><b>After Body Fluid Exposure Risk</b></i>	<i><b>After Patient Contact</b></i>	<i><b>After Contact with Patient's Surroundings</b></i>
Golden Jubilee Foundation	95%	100%	100%	98%	95%

January 2018 - bimonthly hand hygiene audit actions:

Staff within GJF actively promote good hand hygiene practice and challenge non-compliance.

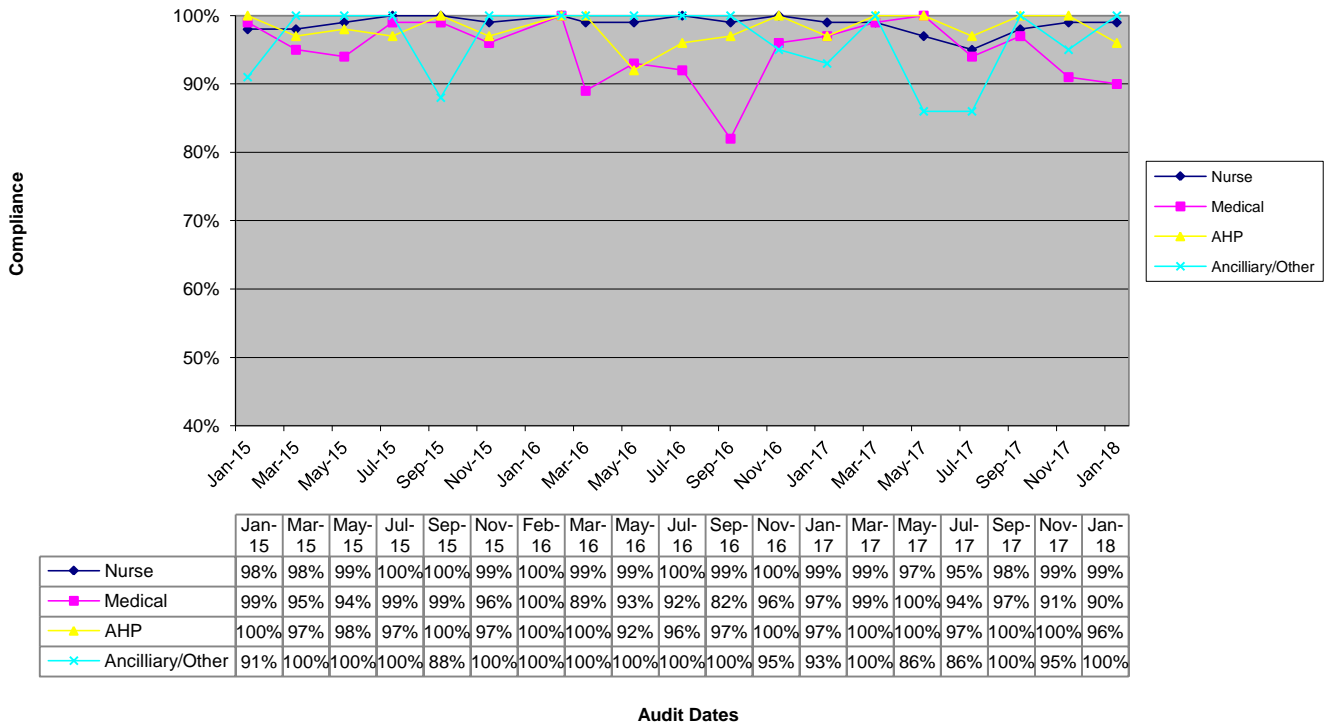
All non compliant staff were spoken to at the time of episode and reminded of their responsibilities and requirement to comply with Standard Infection Control Precautions (SICP's), of which hand hygiene is a critical element.

It has been reported however that nursing staff are reporting feeling intimidated when challenging staff from different disciplines as a result of behaviours they have been subject to, and as a result are less inclined to continue to challenge non compliance.

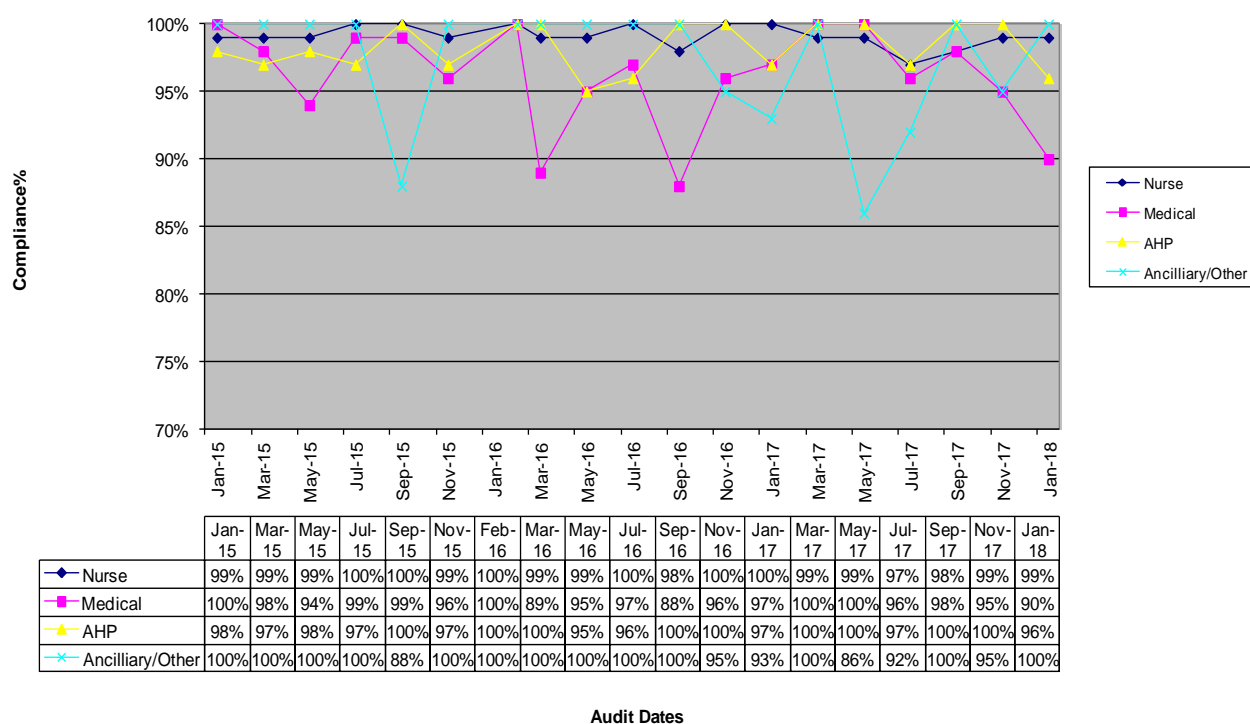
Instances of sustained non compliance have been escalated where required in accordance with GJF “Zero Tolerance” algorithm.

## Compliance Run Charts

**HH "Correct Technique" Compliance Board Level**



### HH "Opportunity Taken" Compliance Board Level



### Summary of Non Compliance

DEPARTMENT	COMPLIANCE
OPD	80%
ENDOSCOPY	90%
PACU	90%
TH 9	95%
2D	100%
2 EAST	100%
3 WEST	100%
CCU	100%
ICU 1	100%
ICU 2	100%
NSD	100%
CDU	100%
SDU	100%
HDU 2	100%
RADIOLOGY	100%
COMPLIANCE	

95% COMPLIANCE OR ABOVE	
80-94% COMPLIANCE	
BELOW 80%	

DEPARTMENT	STAFF GROUP	KEY MOMENT	OPPORTUNITY TAKEN	CORRECT TECHNIQUE
OPD	D	1	NO	NO
OPD	D	5	NO	NO
OPD	A	1	NO	NO
OPD	A	5	NO	NO
ENDOSCOPY	D	1	NO	NO
ENDOSCOPY	D	1	NO	NO
PACU	N	1	NO	NO
PACU	N	4	NO	NO
TH 9	D	1	NO	NO

## 5 Key Moments Definition and Rationale:

<b>1 BEFORE PATIENT CONTACT</b>	<b>WHEN?</b> Clean your hands before touching a patient when approaching him or her <b>WHY?</b> To protect the patient against harmful germs carried on your hands
<b>2 BEFORE AN ASEPTIC TASK</b>	<b>WHEN?</b> Clean your hands immediately before any aseptic task <b>WHY?</b> To protect the patient against harmful germs, including the patient's own germs, entering his or her body
<b>3 AFTER BODY FLUID EXPOSURE RISK</b>	<b>WHEN?</b> Clean your hands immediately after an exposure risk to body fluids (and after glove removal) <b>WHY?</b> To protect yourself and the health-care environment from harmful patient germs
<b>4 AFTER PATIENT CONTACT</b>	<b>WHEN?</b> Clean your hands after touching a patient and his or her immediate surroundings when leaving <b>WHY?</b> To protect yourself and the health-care environment from harmful patient germs
<b>5 AFTER CONTACT WITH PATIENT SURROUNDINGS</b>	<b>WHEN?</b> Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient <b>WHY?</b> To protect yourself and the health-care environment from harmful patient germs

(WHO, 2018)

## Table of Staff Group Definitions:

Staff Group	Definition
Nurse (N)	All nurses, midwives, health visitors – both registered and non-registered, i.e. including healthcare support.
Medical (D)	All doctors and dentists – qualified and in-training, including consultants, GPs, staff and associate specialists.
Allied Health Professionals (A)	Arts therapists, podiatrists, dieticians, occupational therapists, orthoptists, physiotherapists, radiographers, speech and language therapists, prosthetists and orthotists, and including healthcare support that work within these groups, e.g. dietetic assistants.
Ancillary staff and others (O)	Pharmacists, psychologists, Medical Technical Officers (MTO) or Healthcare Scientists, for example, cardiac, respiratory and audiology technicians, phlebotomists, medical photographers, medical records staff, domestic staff, housekeeping staff, porters, catering staff

(HPS, 2007)

## REFERENCES

Health Protection Scotland (HPS), (2015), National Prevention and Control of Infection Manual (NPCIM)

Health Protection Scotland (HPS), (2007), National Hand Hygiene NHS Campaign

SGHD. CEL 5 (2009). Zero Tolerance to Non Hand Hygiene Compliance. 2009: SGHD, Edinburgh.

World Health Organisation (2018), Five Moments for Hand Hygiene  
[http://www.who.int/gpsc/tools/Five\\_moments/en/](http://www.who.int/gpsc/tools/Five_moments/en/)