

NHS Greater Glasgow and Clyde	Paper No. 26/44
Meeting:	NHSGGC Board Meeting
Meeting Date:	30 April 2026
Title:	The Healthcare Associated Infection Reporting Template (HAIRT) for January and February 2026
Sponsoring Director:	Professor Angela Wallace, Executive Director of Nursing
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1. Purpose

The Healthcare Associated Infection Reporting Template (HAIRT) is a mandatory reporting tool for the Board to have oversight of GGCs performance with regards to the Scottish Government's Healthcare Associated Infection indicators; *Staphylococcus aureus* bacteraemias (SAB), *Clostridioides difficile* infections (CDI), *E. coli* bacteraemias (ECB), incidents and outbreaks and all other Healthcare Associated Infections' (HCAI) activities across NHS Greater Glasgow & Clyde (NHSGGC) in January and February 2026.

The full HAIRT will now be considered by the Clinical and Care Governance Committee on an ongoing basis with a summary being submitted to the NHS Board meeting.

2. Executive Summary

The paper can be summarised as follows:

- Scottish Government Standards on Healthcare Associated Infections Indicators (SGHAI) set for 2026 for SAB, CDI and ECB are presented in this report DL(2025)25. The agreed standard is that there should be no increase in the incidence (number of cases) of CDI, ECB, and SAB in the period between April 2025 and March 2026, from the 2023/2024 case numbers.
- In the most recently reported National ARHAI Data (Q3-2025) the HCAI SAB rate for NHSGGC was 21.9 which is within the control limits but above the national rate of 19.4. There were 29 healthcare associated SAB cases reported in January and 25 in February 2026, with the aim being 26 cases or less per month. We continue

to support improvement locally to reduce rates via the Infection Prevention and Control Quality Improvement Network (IPCQIN) and local SAB Groups.

- In the most recently reported National ARHAI Data (Q3-2025) the HCAI ECB rate for NHSGGC was 42.9 which is within the control limits and below the national rate of 43.2. There were 48 healthcare associated ECB cases in January and 56 in February 2026. Aim is 51 cases or less per month.
- In the most recently reported National ARHAI Data (Q3-2025) the HCAI CDI rate for NHSGGC was 16 which is within the control limits and below the national rate of 16.1. There were 27 healthcare associated CDI cases in January and 18 in February 2026. The aim is 21 or less per month.
- The following link is the ARHAI report for the period of July to September 2025. This report includes information on GGC and NHS Scotland's performance for quarterly epidemiological data on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia, and *Staphylococcus aureus* bacteraemia. [Quarterly epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland. July to September \(Q3\) 2025 | National Services Scotland](#)
- National SSI surveillance was paused in 2020 and remains paused for the foreseeable future. Local surveillance continues in the following procedures: caesarean section, hip arthroplasty and spinal and cranial surveillance in the INS.
- Clinical Risk Assessment (CRA) compliance was **94%** for CPE and **84%** for MRSA in the last validated reporting quarter (Q4 -2025). The standard is 90%. In Q4, NHS Scotland reported compliance of **86%** and **81%** respectively.
- The Board's cleaning compliance and Estates compliance are $\geq 94\%$ for January and February 2026.
- The 15th edition of the IPCQIN newsletter will be published in April 2026 and included in the next report.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- Note the content of the HAIRT report.
- Note the performance in respect of the Scottish Government Healthcare Associated Infection Indicators for SAB, ECB and CDI.
- Note the detailed activity in support of the prevention and control of Healthcare Associated Infections.

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- | | |
|--------------------|------------------------|
| • Better Health | <u>Positive</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Positive</u> impact |
| • Better Workplace | <u>Positive</u> impact |

- Equality & Diversity Neutral impact
- Environment Positive impact

6. Engagement & Communications

The issues addressed in this paper were subject to discussion with the Infection Prevention and Control (IPC) Team and the IPC Surveillance & Data Team. Comments were also taken into consideration from the below groups when reviewing the content and format following presentation:

- Partnerships Infection Control Support Group (PICSG)
- Acute Infection Control Committee (AICC)
- Board Infection Control Committee (BICC)

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

- The Infection Prevention and Control Team (IPCT)
- Partnerships Infection Control Support Group (PICSG)
- Acute Infection Control Committee (AICC)
- Board Infection Control Committee (BICC)

This paper is finally presented to the Clinical and Care Governance Committee (CCGC) for assurance.

This paper is then shared with the Board Clinical Governance Forum for information once considered by CCGC.

8. Date Prepared & Issued

Paper prepared: 17 March 2026

Paper issued: 22 April 2026

Healthcare Associated Infection Summary – January and February 2026

The HAIRT Report is the national mandatory reporting tool and is presented to the Clinical and Care Governance Committee for assurance with a summary report to the NHS Board. This is a Scottish Government requirement and informs NHSGGC of activity and performance against the Scottish Government Standards on Healthcare Associated Infections and Indicators. Other available indicators are included for assurance.

Performance at a glance relates only to the 2 months reported and should be viewed in the context of the overall trend over time in the following pages.

	January 2026	February 2026	Status toward SGHAI [Based on the new DL (2025)05] from April 2025
Healthcare Associated <i>Staphylococcus aureus</i> bacteraemia (SAB)	29	25	Aim is 26 per month
Healthcare Associated <i>Clostridioides difficile</i> infection (CDI)	27	18	Aim is 21 per month
Healthcare Associated <i>Escherichia coli</i> bacteraemia (ECB)	48	56	Aim is 51 per month
Hospital acquired IV access device (IVAD) associated SAB	9	6	
Healthcare associated urinary catheter associated ECB (includes suprapubic catheter)	7	8	
Hand Hygiene	95	95	
National Cleaning compliance (Board wide)	95	94	
National Estates compliance (Board wide)	96	96	

Healthcare Associated Infection (HCAI) Surveillance

NHSGGC has systems in place to monitor key targets and areas for delivery. An electronic HCAI surveillance system supports early detection and indication of areas of concern or deteriorating performance.

***Staphylococcus aureus* bacteraemia (SAB), *Escherichia coli* Bacteraemia (ECB) & *Clostridioides difficile* infection (CDI) targets.**

SAB, ECB and CDI targets are described in DL(2025)25. The agreed standard is that there should be no increase in the incidence (number of cases) of CDI, ECB, and SAB in the

period between April 2025 and March 2026, from the 2023/2024 case numbers. The targets have been updated accordingly and displayed in this report.

Information on performance against all three targets is available to the Directorate/Division in three ways: monthly summary reports, SAB and ECB specific quarterly reports and via the micro strategy dashboard. All SABs/ECBs associated with an IVAD are followed up by an audit of PVC/CVC practice in the ward or clinical area of origin and the results are returned to the Chief Nurse for every Sector/Directorate. The analysis of the data and subsequent reports enable the IPCT to identify trends in particular sources of infections such as central line infections etc, and it also enables the IPCT to identify areas requiring further support. The data collected on all targets influences the IPC Annual Work Plan and the IPCQIN.

***Staphylococcus aureus* bacteraemia (SAB)**

	January 2026	February 2026	Monthly Aim
*Healthcare	29	25	26
Community	7	4	-
Total	36	29	-

***Healthcare associated are the cases which are included in the SG reduction target.**

Healthcare associated *S. aureus* bacteraemia total for the rolling year March 2025 to February 2026 = 358. HCAI yearly aim is 312.

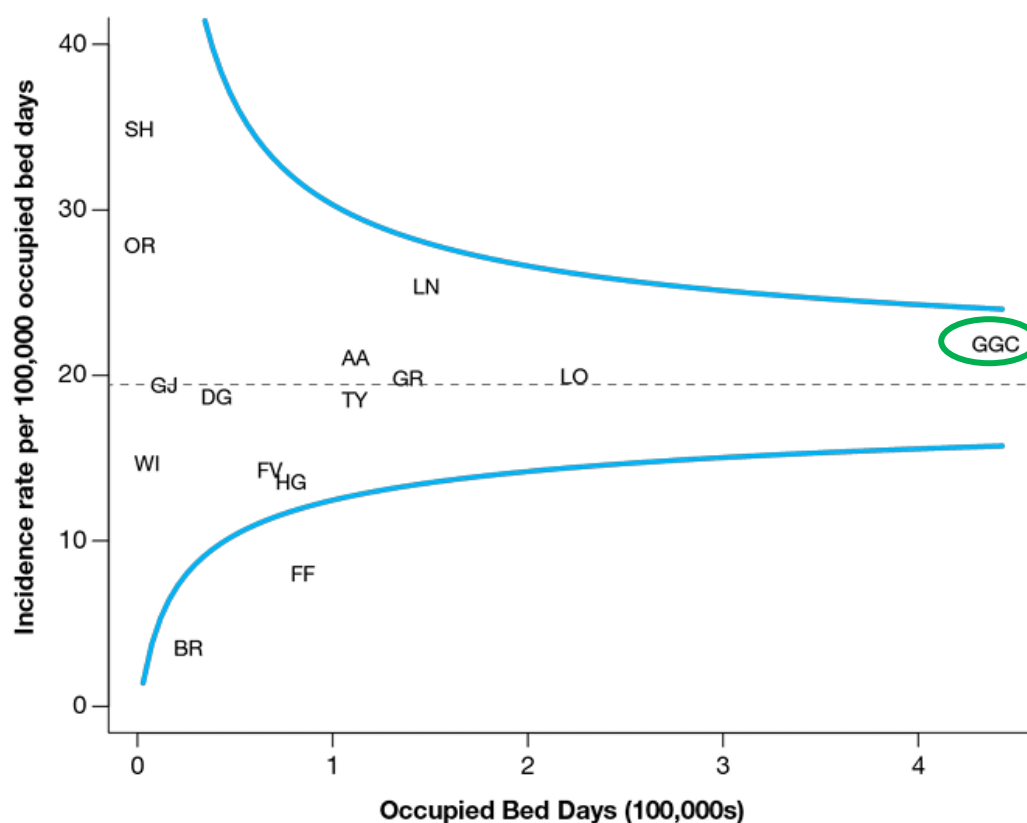
In the most recently reported National ARHAI Data (Q3-2025) the HCAI SAB rate for NHSGGC was 21.9 which is within the control limits but above the national rate of 19.4. There were 29 healthcare associated SAB cases reported in January and 25 in February 2026, with the aim being 26 cases or less per month.

We continue to support improvement locally to reduce rates via the Infection Prevention and Control Quality Improvement Network (IPCQIN) and local SAB Groups.

Actions primarily driven by the IPCQIN to reduce cases include:

- Roll out of an updated PVC care plan.
- PVC sweeps in areas with cases (audit of adherence to the PVC care plan).
- Review of vascular access training implementation.
- SAB Toolbox Talks discussed with ward teams.
- Videos promoting line care for renal patients in development.
- QR codes with links to videos for patients relating to PVC care.
- Local SAB groups in place and these groups review local data and actions.

ARHAI Validated Q3 (July to September 2025) funnel plot – HCAI SAB cases



Rate: **21.9** per 100,000 OBDs.

NHSGGC rate is within the control limits for this quarter and above the national rate of 19.4.

***Escherichia coli* bacteraemia (ECB)**

	January 2026	February 2026	Monthly Aim
*Healthcare	48	56	51
Community	31	30	-
Total	79	86	-

***Healthcare associated infections are the cases which are included in the SG reduction target.**

Healthcare associated *E. coli* bacteraemia total for the rolling year March 2025 to February 2026 = 696. HCAI yearly aim is 612.

In the most recently reported National ARHAI Data (Q3-2025) the HCAI ECB rate for NHSGGC was 42.9 which is within the control limits and below the national rate of 43.2. There were 48 healthcare associated ECB cases in January and 56 in February 2026. Aim is 51 cases or less per month.

Enhanced surveillance of ECB continues and is prospectively available to view by clinicians on Microstrategy, however, teams across GGC continue to monitor and implement improvements.

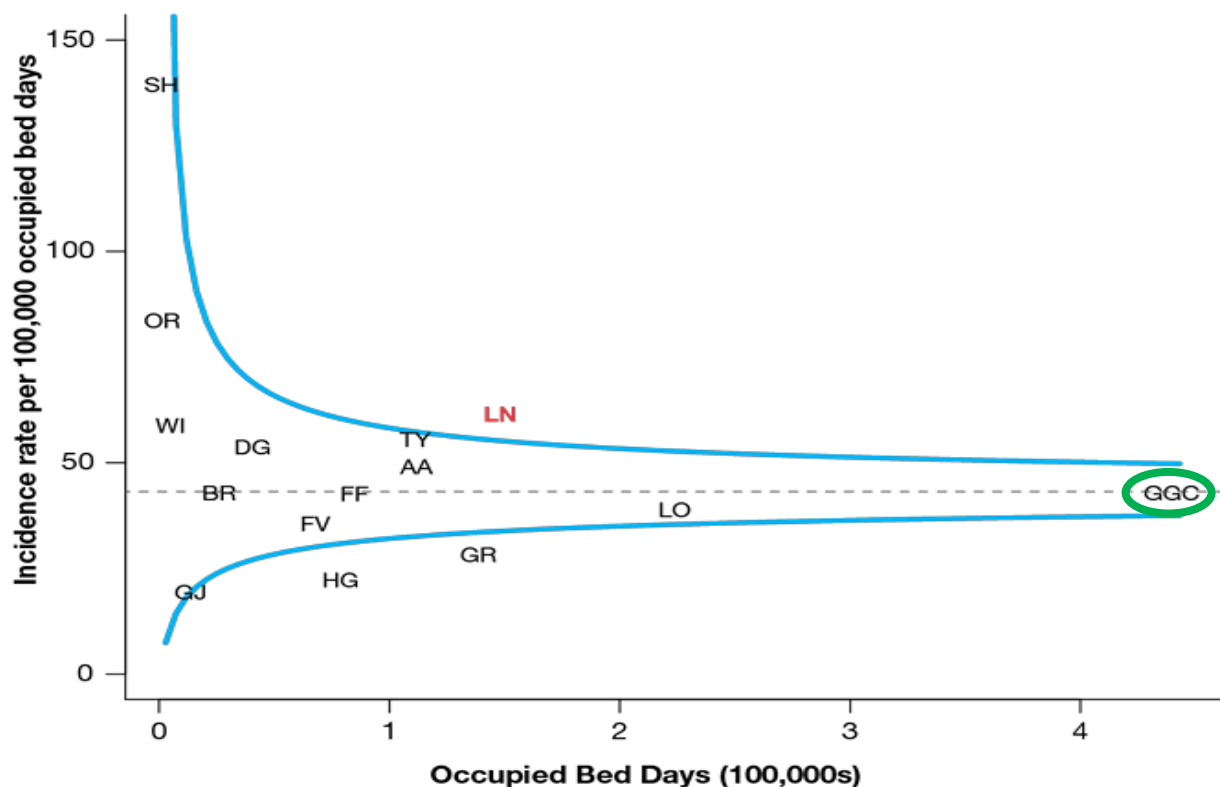
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Ward level data of entry point of bacteraemia is available via MicroStrategy. This provides real time information to clinical staff to assist in the decision to use improvement methodology to test interventions that may lead to a reduction in the number of patients with this infection.

The Public Health Scotland **Urinary Catheter Care Passport** contains guidelines to help minimise the risk of developing an infection and is available at: [HPS Website - Urinary Catheter Care Passport \(scot.nhs.uk\)](https://www.hps.scot.nhs.uk/urinary-catheter-care-passport)

The CAUTI toolbox talk has been reviewed and has been added to the IPC Intranet page.

ARHAI Validated Q3 (July to September 2025) funnel plot – HCAI ECB cases



NHSGGC rate is within the control limits for this quarter and below the national rate of 43.2.

***Clostridioides difficile* infection (CDI)**

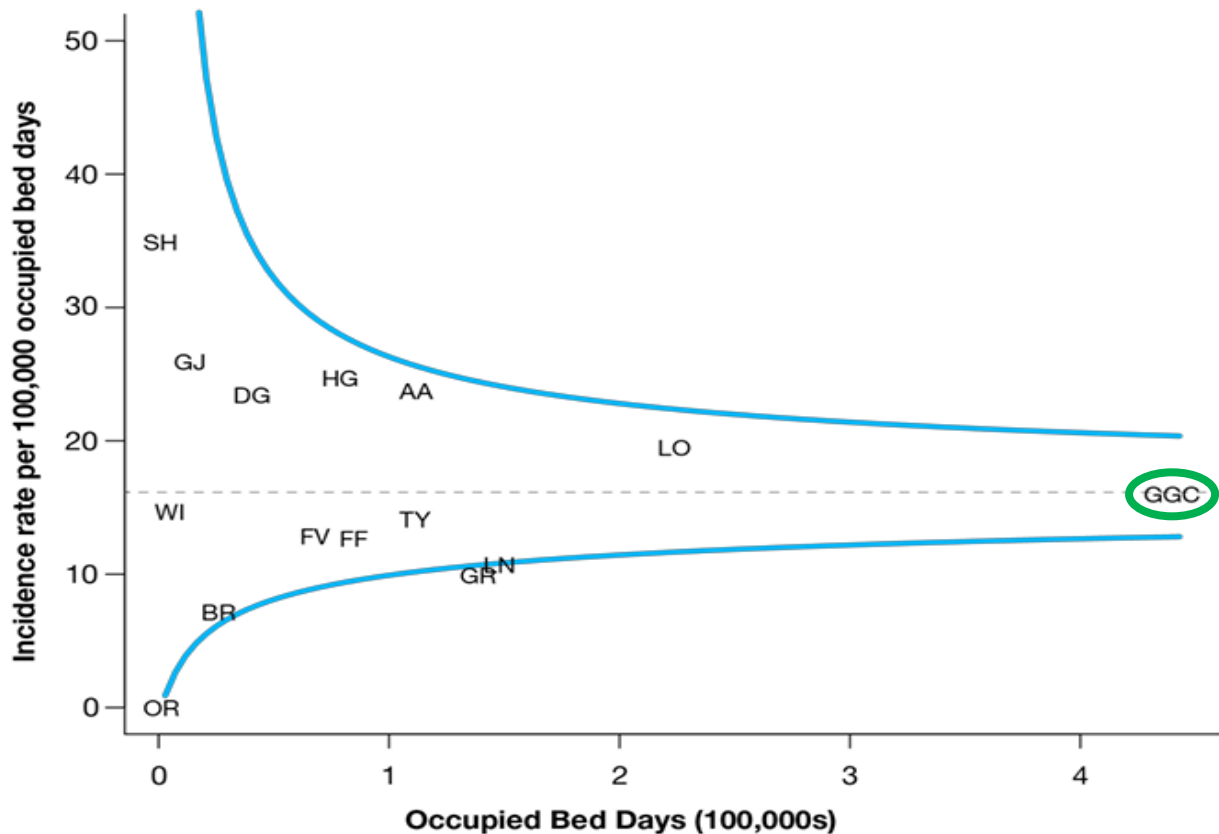
	January 2026	February 2026	Monthly Aim
*Healthcare	27	18	21
Community	6	4	-
Total	33	22	-

*Healthcare associated infections are the cases which are included in the SG reduction target.

Healthcare associated *Clostridioides difficile* total for the rolling year March 2025 to February 2026 = 240. HCAI yearly aim is 252.

In the most recently reported National ARHAI Data (Q3-2025) the HCAI CDI rate for NHS GGC was 16 which is within the control limits and below the national rate of 16.1. There were 27 healthcare associated CDI cases in January and 18 in February 2026. The aim is 21 or less per month.

ARHAI Validated Q3 (July to September 2025) funnel plot – HCAI CDI cases



Rate: **16** per 100,000 OBDs.

NHS GGC rate is below the NHS Scotland national rate of 16.1.

Methicillin resistant *Staphylococcus aureus* (MRSA) and *Clostridioides difficile* recorded deaths

The National Records of Scotland monitor and report on patients cause of death. Two organisms are monitored and reported: MRSA and *C. difficile*. The link below provides further information:

<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths>

There was one death in January 2026 and three deaths in February 2026, where hospital acquired *Clostridioides difficile* was recorded on the patient's death certificate.

There were zero deaths in January 2026 and zero deaths in February 2026 where hospital acquired MRSA was recorded on the death certificate.

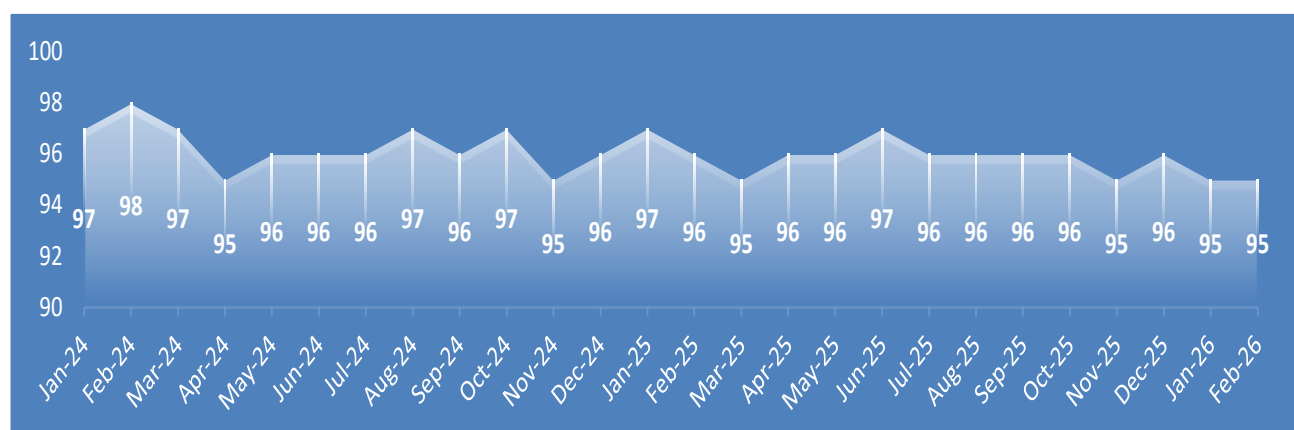
NHS GGC Hand Hygiene (HH) Monitoring Compliance (%)

In NHSGGC there is a dedicated Hand Hygiene Coordinator. This colleague supports education, innovation and audit of practice across all areas. Every month each clinical area carries out a HH audit, and the results of these are entered into the Care Assurance and Improvement Resource (CAIR) dashboard. An average of 350 audits are completed monthly. The local IPCT will also carry out HH audits if required during incidents and outbreaks of infection.

Quality assurance audits take place on a monthly basis and are carried out by the Local Health Board Coordinator (LHBC), completing ten to twenty audits monthly. These are snapshot audits focussing on wards that are consistently reporting higher or lower than average scores. The data collected from the wards and departments is collated and forms the basis of the HAIRT HH data (table below); averaged by site and as a total for the Board.

Although the audit tool used by the wards/departments and the LHBC is the same, the method of data collection is different. The LHBC undertakes a snapshot audit on a specific day whereas the ward or department will collect 20 HH opportunities over a period of a month.

Hospital site	January 2026 %	February 2026 %
Glasgow Royal Infirmary/Princess Royal Maternity	92	94
Gartnavel General Hospital/Beaton Oncology Centre	97	97
Inverclyde Royal Hospital	96	97
Queen Elizabeth University Hospital	95	95
Royal Alexandra Hospital	86	90
Royal Hospital for Children	91	90
Vale of Leven Hospital	100	94
NHSGGC Total	95	95



IPC Statutory Mandatory Training - Standard Infection Prevention and Control (SIPCs) module:

Area/Sector/HSCP	January 2026	February 2026
Acute	87%	88%
Clyde Sector	88%	88%
Diagnostics Directorate	89%	90%
North Sector	87%	88%
Regional Services	89%	90%
South Sector	90%	86%
Women & Children's	83%	84%
Partnership	90%	90%

Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services Team using the Domestic Monitoring National Tool. Areas chosen within each hospital are randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80%, a re-audit is scheduled. Estates compliance assesses whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Like the cleaning audit, scores below 80% trigger a re-audit.

Cleaning compliance:		
Hospital site	January 2026 %	February 2026 %
Glasgow Royal Infirmary	94	94
Gartnavel General Hospital	95	95
Inverclyde Royal Hospital	95	94
Queen Elizabeth University Hospital	94	94
Royal Alexandra Hospital	94	93
Royal Hospital for Children	95	94
Vale of Leven Hospital	96	95
NHSGGC Total	95	94

Estates compliance:		
Hospital site	January 2026 %	February 2026 %
Glasgow Royal Infirmary	87	91
Gartnavel General Hospital	97	98
Inverclyde Royal Hospital	94	93
Queen Elizabeth University Hospital	96	96
Royal Alexandra Hospital	96	94

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Royal Hospital for Children	95	96
Vale of Leven Hospital	99	99
NHSGGC Total	96	96

Only main hospitals are included in the tables above; however, the total percentages include all hospital sites across GG&C.

Infection Prevention and Control Quality Improvement Network (IPCQIN)

The IPCQIN continues to meet bi-monthly, with the most recent meeting on 12th February 2026 focusing on progress across existing workstreams and the development of new areas of work. The ongoing review of the work plan ensures continued alignment with current objectives and organisational priorities.

The work plan has now been refreshed to reflect these priorities. Flash reporting will also be introduced from the Mental Health IPC Support Group, strengthening shared learning across all sectors. Both the Terms of Reference and the Communication Plan have been updated and were formally approved at the February meeting.

Several workstreams are progressing well, including updates to the SICPs audit tools, development of educational videos, and continued SAB improvement work across North, South, Clyde, Regional and Paediatrics HPN services. The Network also continues to promote Quality Improvement Training and support the Vascular Access Device (VAD) Education SLWG, with ongoing PVC/CVC audit activity and findings from the Excellence in Care IPC testing due to be shared ahead of the next meeting.

The March newsletter will feature highlights from these workstreams, including SICPs audit priorities and the new VAD patient education videos. The Network will continue to use the SharePoint site to support programme management and collaboration. The next meeting is scheduled for 9th April 2026.

Outbreaks or Incidents in January and February 2026

Outbreaks / Incidents

Outbreaks and incidents across NHSGGC are identified primarily through ICNet (surveillance software package), microbiology colleagues or from the ward. ICNet automatically identifies clusters of infections of specific organisms based on appendix 13 of the National Infection Prevention & Control Manual (NIPCM) to enable timely patient management to prevent any possible spread of infection. The identification of outbreaks is determined following discussion with the Infection Control Doctor/Microbiologist. In the event of a possible or confirmed outbreak/incident, a Problem Assessment Group (PAG) or Incident Management Team (IMT) meeting is held with staff from the area concerned, and actions are implemented to control further infection and transmission.

The ARHAI Healthcare Infection Incident Assessment Tool (HIIAT) is a tool used by the IMT to assess the impact of the outbreak or incident. The tool is a risk assessment and allows the IMT to rate the outbreak/incident as **RED**, **AMBER**, or **GREEN**.

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All incidents that are HIIAT assessed are reported to the Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) group.

ARHAI are informed of all incidents and they onward report to the Scottish Government Health and Social Care Directorate (SGHSCD) on any incidents/outbreaks that are assessed as amber or red.

HIIAT **GREEN** – reported 1 in January and 6 in February 2026.

HIIAT **AMBER** - reported 0 in January and 1 in February 2026.

HIIAT **RED** – reported 0 in January and 2 in February 2026.

(COVID-19 and Influenza Incidents are now included in the above totals but not reported as individual incident summaries)

Outbreaks/Incidents (HIIAT assessed as AMBER or RED excluding COVID-19 and Influenza A)

Glasgow Royal Infirmary - Group A Streptococcus species (iGAS)

There have been a very small number of cases of the same type of Group A Streptococcus (iGAS) infection within a ward at the Glasgow Royal Infirmary. The cases have epidemiological links to the ward and crossed over in the ward between 6th to 7th February 2026 and therefore possible cross transmission is confirmed.

The ward was paused for admissions on 8th February 2026 and re-opened once cases were transferred out on 9th February 2026. The ward was terminally cleaned on 8th February 2026 and again on 9th February 2026 when cases were isolated elsewhere. All other patients with wounds were screened and results were negative.

SICPs audit carried out by IPCT 21st January 2026 and the score was 73%. Issues were identified with management of care equipment, care of the environment, safe management of linen, management of blood and body fluids and safe disposal of waste. Issues were addressed with ward management and estates issues escalated to the relevant teams. Estates carried out a ward walk round to review the issues raised.

Hand Hygiene audit was carried out on 10th February 2026, opportunities taken 70% and combined compliance 70%. Action plan is now complete, and ward level IPC education was arranged for all staff group including visiting AHPs.

The incident was HIIAT assessed as **RED** on 6th March 2026 due to death of a patient and then **GREEN** on 9th March 2026 and closed due to no further positive cases.

Healthcare Improvement Scotland (HIS)

An unannounced inspection of the QEUH Maternity Unit was undertaken by HIS on 27th and 28th January 2026 and was followed up by a further inspection visit on 16th February 2026.

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HIS provided positive feedback that staff were welcoming, compassionate, and delivering good-quality care, with effective multidisciplinary team working observed. A number of concerns were identified as part of the initial feedback, including infection prevention and control practice and the environment. Additional concerns related to inappropriate equipment storage in corridors and non-clinical spaces.

A communication pack and daily checklists were issued for shift leaders to support consistent oversight, and deep dive walkarounds were undertaken across all maternity sites with Estates, Facilities, IPC, and Acute Division leadership and immediate actions were taken to ensure sustained improvement.

The follow up inspection team recognised clear improvements in IPC, the environment, and staff practices. The final report will be published in due course.

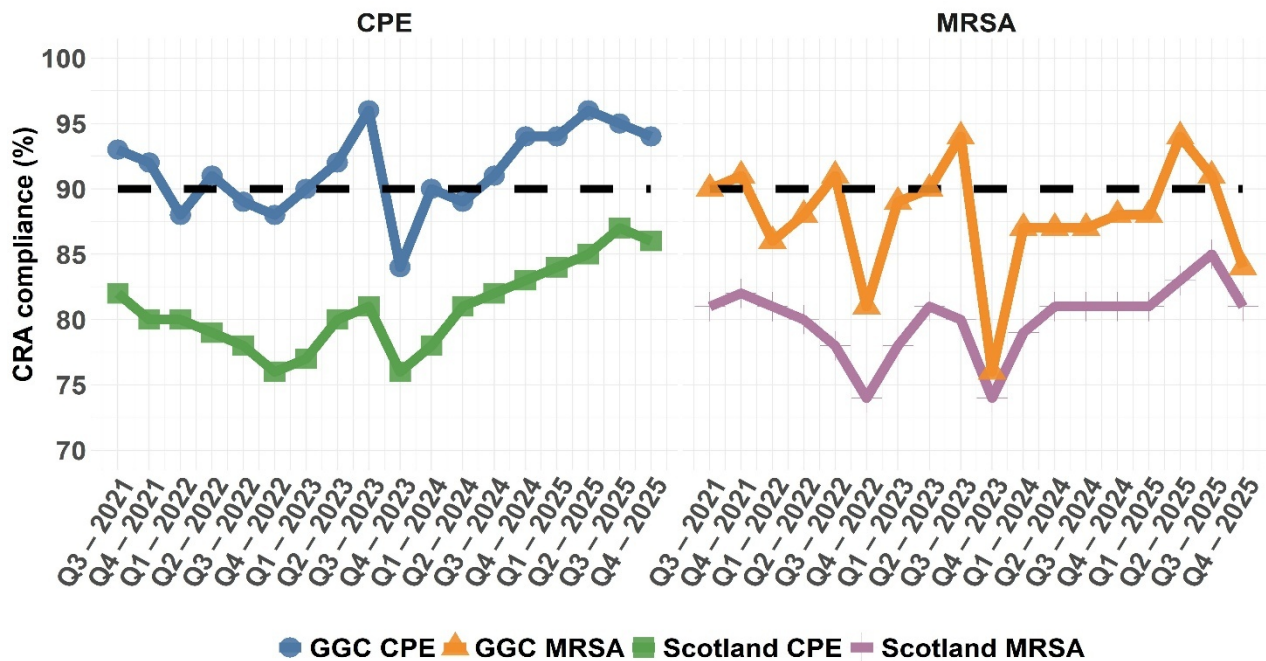
All HIS reports and action plans for previous inspections can be viewed by clicking on the link below:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services/find_nhs_hospitals.aspx

Multi-drug resistant organism screening

As part of the national mandatory requirements, each board is expected to screen specific patients for resistant organisms. These are Carbapenemase producing Enterobacteriaceae (CPE) and MRSA. The decision to screen depends on the outcome of a clinical risk assessment performed on all admissions. On a quarterly basis we assess compliance of completing this risk assessment to provide assurance of effective screening and this is reported nationally. The national expectation of compliance is **90%** (black dashed line). National data for Q4 has been validated and included. The 90% compliance standard for Q4 has been achieved for CPE but not for MRSA by NHS GGC. IPCT will continue to work towards achieving 90% for MRSA by supporting front line clinical teams through education and improvement initiatives to promote the completion of this assessment.

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Last validated quarter 4 - October to December 2025		NHSGGC 94% compliance rate for CPE screening	Scotland 86%
		NHSGGC 84% compliance rate for MRSA screening	Scotland 81%

We continue to support clinical staff to implement this screening programme, and work is currently underway with eHealth to incorporate this information electronically into the patient admission eRecord. MRSA screening compliance will be a focus during routine ward visits during 2026.

APPENDIX - 1

Healthcare Associated Infection Reporting Guidance, Glossary, Definitions and Infection Control Targets

Purpose:

This paper can be referred to when reading the HAIRT Summary Reports, it covers any Scottish Government guidance and aims relating to Infection Prevention and Control (IPC), list of abbreviations and definitions for some of the medical terms or infection types mentioned in the HAIRT Summary reports. It also includes some systems and processes that have been put in place by IPC to reduce the harm from infections and prevent them from happening.

Glossary of abbreviations

Following feedback from stakeholders, below is a list of abbreviations used within this report:

AOP	Annual Operational Plan
ARHAI	Antimicrobial Resistance Healthcare Associated Infection
CDI	<i>Clostridioides difficile</i> infection
CNOD	Chief Nursing Officer Directorate
CPE	Carbapenemase producing Enterobacteriaceae
CVC	Central Venous Catheter
Datix	The software used by NHS Greater Glasgow and Clyde for clinical and non-clinical incident reporting (and managing complaints and legal claims) and forms part of the Risk Management Strategy. It is a web-based application that allows any staff member with access to StaffNet to report an incident.
ECDC	European Centre for Disease Control
HAI	Hospital Acquired Infection (not present or incubating on admission to hospital and arising \geq 48 hours after admission). Please note this excludes COVID-19 cases (hospital onset currently thought to be >14 days).
HCAI	Healthcare Associated Infection
HEI	Healthcare Environment Inspectorate
HIIAT	Healthcare Infection Incident Assessment Tool
HPV	Hydrogen Peroxide Vapour
IMT	Incident Management Team
IPCAT	Infection Prevention and Control Audit Tool
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention and Control Team
IVAD	Intravenous/Intravascular Access Device
MRSA	Meticillin Resistant <i>Staphylococcus aureus</i>
NES	NHS Education for Scotland
PAG	Problem Assessment Group
PEG	Percutaneous Endoscopic Gastrostomy
PICC	Peripherally Inserted Central Catheter
PVC	Peripheral Vascular/Venous Catheter
SAB	<i>Staphylococcus aureus</i> bacteraemia
SG	Scottish Government
SGHSCD	Scottish Government Health and Social Care Directorate
SICPs	Standard Infection Control Precautions
SPC	Statistical Process Control: An analytical technique that plots data over time. It helps us understand variation and in so doing, guides us to take the most appropriate action. SPC is a good technique to use when implementing change as it enables us to understand whether changes made have resulted in an improvement.
SSI	Surgical Site Infection

UCC
UTI

Urinary Catheter Care
Urinary Tract Infection

***S. aureus* and *E. coli* bacteraemias**

Definition of a bacteraemia

Bacteraemia is the presence of bacteria in the blood. Blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly accomplished by blood cultures) is always abnormal. It is distinct from sepsis, which is the host response to the bacteria. Bacteria can enter the bloodstream as a severe complication of infection, (like pneumonia, meningitis, urinary tract infections (UTI) etc.), during surgery, or due to invasive devices such as peripheral vascular catheters (PVC), Hickman lines, urinary catheters etc. Transient bacteraemias can result after dental procedures or even brushing of teeth although this poses little or no threat to the person in normal situations.

Bacteraemia can have several important health consequences. The immune response to the bacteria can cause sepsis and septic shock which has a high mortality rate. Bacteria can also spread via the blood to other parts of the body (haematogenous spread), causing infections away from the original site of infection, such as endocarditis (infection of the heart valves) or osteomyelitis (infection of the bones). Treatment for bacteraemia is with intravenous antibiotics often for a prolonged period, e.g. in cases of *S. aureus* bacteraemia, 14 days of antibiotic therapy is normally required.

Origin Definitions for Bacteraemia Surveillance

<https://www.ARHA1.scot.nhs.uk/web-resources-container/protocol-for-national-enhanced-surveillance-of-bacteraemia>

<p>Healthcare Associated Infection</p>	<p>Hospital Acquired Infection</p> <p>Positive blood culture obtained from a patient who has been hospitalised for ≥48 hours. If the patient was transferred from another hospital, the duration of in-patient stay is calculated from the date of the first hospital admission.</p> <p>If the patient was a neonate / baby who has never left hospital since being born. OR The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. OR A patient who receives regular haemodialysis as an out-patient. OR Contaminant if the blood aspirated in hospital. OR If infection source / entry point is surgical site infection (SSI). <i>[This will be attributed to hospital of surgical procedure]</i></p>
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	<p>Healthcare Associated Infection</p> <p>Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:</p> <p>Was hospitalised overnight in the 30 days prior to the positive blood culture being taken. OR Resides in a nursing, long-term care facility or residential home. OR IV, or intra-articular medication in the 30 days prior to the positive blood culture being taken, but excluding IV illicit drug use. OR Had the use of a registered medical device in the 30 days prior to the positive blood culture being taken, e.g. intermittent self-catheterisation or Percutaneous Endoscopic Gastrostomy (PEG) tube with or without the direct involvement of a healthcare worker (excludes haemodialysis lines see HAI). OR Underwent any medical procedure which broke mucous or skin barrier, i.e. biopsies or dental extraction in the 30 days prior to the positive blood culture being taken. OR Underwent care for a medical condition by a healthcare worker in the community which involved contact with non-intact skin, mucous membranes or the use of an invasive device in the 30 days prior to the positive blood culture being taken, e.g. podiatry or dressing of chronic ulcers, catheter change or insertion.</p>
Community Acquired Infection	<p>Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any of the criteria for healthcare associated bloodstream infection.</p>

***Escherichia coli* bacteraemia (ECB)**

NHSGGC's approach to ECB prevention and reduction

E. coli is one of the most predominant organisms of the gut flora, and for the last several years the incidence of *E. coli* isolated from blood cultures, i.e. causing sepsis, has increased to the point that it is the most frequently isolated organism in the UK. As a result of this, the HAI Policy Unit has now included *E. coli* as part of the AOP targets. The most common cause of ECB is from complications arising from UTIs, hepato-biliary infections (gall bladder infections) and infections associated with urinary catheters. It should be acknowledged that there is limited number of possible interventions to target ECB because infections are often spontaneous and not associated with health care or health care interventions.

***Clostridioides difficile* infection (CDI)**

Reporting to ARHAI of *C. difficile* infections has been mandatory for many years in NHS Scotland. NHSGGC has met its targets over the years and has maintained a low rate of infection. Similar to the SAB target, the new target set for 2019-2024 is based on our Board's rate rather than an overall national rate.

C. difficile can be part of the normal gut flora and can occur when patients receive broad-spectrum antibiotics which eliminate other gut flora, allowing *C. difficile* to proliferate and cause infection. This is the predominant source of infection in GGC. *C. difficile* in the environment can form resilient spores which enable the organism to survive in the environment for many months, and poor environmental cleaning or poor hand hygiene can lead to the organism transferring to other patients, leading to infection. Another route of infection is when a patient receives treatment to regulate stomach acid which affects the overall pH of the gut allowing the organism to proliferate and cause infection.

Origin definitions for *Clostridioides difficile* infections

Local Enhanced CDI Surveillance in NHSGGC: Definition of Origin

Hospital acquired CDI is defined as when a CDI patient has had onset of symptoms at least 48 hours following admission to a hospital.

Healthcare associated CDI is defined as when a CDI patient has had onset of symptoms up to four weeks after discharge from a hospital.

Indeterminate cases of CDI is defined as a CDI patient who was discharged from a hospital 4-12 weeks before the onset of symptoms.

Community associated CDI is defined as a CDI patient with onset of symptoms while outside a hospital and without discharge from a hospital within the previous 12 weeks; or with onset of symptoms within 48 hours following admission to a hospital without stay in a hospital within the previous 12 weeks.

NHSGGC's Approach to CDI Prevention and Reduction

Similar to our SAB and ECB investigations, patient history is gathered including any antibiotics prescribed over the last several months. Discussions with the clinical teams and microbiologists assist in the determination and conclusion of the significance of the organism, as occasionally the isolation of the organism can be an incidental finding and not an infection. Data is shared with the antimicrobial pharmacists to identify any issues with prescribing and incidence of infections are discussed at the Antimicrobial Utilisation Committee.

Meticillin resistant *Staphylococcus aureus* (MRSA) and *Clostridioides difficile* recorded deaths

The National Records of Scotland monitor and report on a variety of death causes recorded on the death certificate. Two organisms are monitored and reported; MRSA and *C. difficile*. Please click on the link for further information:

<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths>