

WRHA Hand Hygiene Compliance and Auditing Implementation Plan

Guidelines (from ROP Accreditation Canada)

Hand hygiene is considered the single most important way of reducing healthcare-associated infections (HAIs), but compliance with accepted hand hygiene practices is often poor. Hand hygiene is a standard expectation within all programs and is the site's responsibility to ensure it is safely practiced. Lack of compliance with Infection Prevention and Control (IP&C) policies and procedures increases transmission of infectious organisms and negatively impacts patient safety^{1,2}.

Measuring compliance with hand hygiene practices allow organizations/sites/programs/units/areas to monitor compliance with hand hygiene protocols, improve hand hygiene education and training, evaluate hand hygiene resources, and benchmark compliance practices within the organization/site/program/unit/area^{3,4}. Studies show improvements in hand hygiene compliance decreases HAIs.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Direct observation measures compliance with all four of the moments for hand hygiene:

1. Before initial patient/resident/client (PRC) contact or PRC environment contact
2. Before an aseptic or clean procedure
3. After body fluid exposure risk
4. After PRC or PRC environment contact

Standard: 2.5/21: A comprehensive hand hygiene strategy is in place.

- 2.5.1 Hand-hygiene education is provided to team members and volunteers (*ROP*).
- 2.5.6 Compliance with accepted hand hygiene practices is measured (*ROP*).
 - 2.5.6.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit).
 - 2.5.6.2 Hand-hygiene compliance results are shared with team members and volunteers.
 - 2.5.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.

Background

Healthcare regions across Canada and Manitoba currently conduct hand hygiene auditing. Guidelines from national and international IP&C organizations have repeatedly stressed hand hygiene is the single most important procedure for preventing infections. Guiding principles utilized have been provided from the World Health Organization (WHO), Clean Your Hands (Safer Healthcare Now!), Canadian Patient Safety Institute, Public Health Agency of Canada, Infection Prevention and Control Canada, Just Clean Your Hands (Ontario), and Manitoba Health.

¹ www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx

² http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf

³ <https://www.patientsafetyinstitute.ca/en/toolsResources/pages/hand-hygiene-observation-tools.aspx#:~:text=Measurement%20is%20a%20vital%20part,hygiene%20education%2C%20training%20and%20promotio>

⁴ [hh_monograph.pdf \(jointcommission.org\)](http://www.jointcommission.org/hh_monograph.pdf)



From the WHO to specific local facilities, monitoring hand hygiene has become an integral part of safe healthcare delivery. Results *are* intended to be used to improve healthcare worker understanding and compliance with established hand hygiene policies and procedures⁶. Audits are *not* intended to determine specific individual performance, rather attempt to determine facility and healthcare worker category performance. With rare exception, no individual will be singled out through auditing activities.

The acceptable minimum number of opportunities to collect per audited unit/ward is 35/month. For out-patient/community settings, the minimum number of monthly opportunities is 17. This data collection is completed through **site/service led auditing**. Sites/Services are responsible to ensure adequate data collection is occurring on an ongoing basis. When the minimum required opportunities/month are met, the audit results will track compliance at the:

1. Unit/area/service/site level (comparing compliance rates of the different units/areas/sites audited that quarter).
2. Healthcare worker level on all units/areas/sites combined (comparing compliance rates of different healthcare worker categories audited that quarter).
3. Healthcare worker level on each specific unit/area/service/site (comparing compliance rates of different healthcare worker categories audited that quarter).

Reports are not created for areas that do not meet the minimum required number of monthly opportunities.

Goals: Acute, Long Term, Rehabilitative Care and Community:

The **goal for hand hygiene compliance is 100% compliance.**

Requirements

1. Site/Area Led Auditing
 - a. Site led auditing is the standard; IP&C does not conduct hand hygiene auditing.
 - b. Site led auditing may ONLY occur once staff have:
 - i. Received WRHA IP&C [4 Moments/Hand Hygiene Auditor training](#); AND
 - ii. Buddied with the WRHA Hand Hygiene Audit Lead and successfully achieved interrater reliability.
2. Audit instructions for Acute, Long Term, and Community Care
 - a. Audits completed on 50% of all units/wards/areas/clinics per service on a quarterly basis (e.g., Medicine, Emergency, Surgery, Geri-Rehab, Critical Care/Public Health/Home Care). This will be operationalized by the site/area, following consultation with the site/area Infection Control Professional/designate or ICSA and the IP&C Epidemiologist.
 - i. Use the Handy Audit tool to conduct auditing. Ongoing access to the tool is provide by WRHA IP&C once Handy Audit training has been completed.
 - ii. Each audit will meet the minimum number of required opportunities outlined above.

⁵ <http://www.hqontario.ca/public-reporting/patient-safety>

⁶ Smiddy et. al., 2019. Efficacy of Observational Hand Hygiene Audit With Targeted Feedback on Doctors' Hand Hygiene Compliance: A Retrospective Time Series Analysis. J Infect Prev 20(4):164-170.

⁷ Sax, H., et. al. 2009. The World Health Organization hand hygiene observation method. Am J Infect Control 37: 827-34.

⁸ [World Health Organization Technical Manual.2009](#)



Reporting

All reports are created by the WRHA IP&C Epidemiologist, for distribution as appropriate.

1. Site specific
 - a. Rates reported back to the unit/area/services (both site and regional), and site executive in a timely manner.
 - b. Monthly reports - Reports will only be completed for units/areas/programs/sites that have collected the minimum required number of opportunities for their setting (i.e., 35/month for in-patient/resident areas; 17/month for outpatient/community areas).
2. Reports are generated and returned to site IP&C/designate for distribution and discussion as appropriate. Distribution includes site leadership.
 - a. A regional report is generated and distributed to WRHA senior leadership.
 - b. Site/unit/area level reports are provided from the ICP/ICSA to the site directly.
 - i. Immediate Feedback
 1. On the Spot Feedback (immediate) feedback should be provided to individual staff as well as grouped (unit/area-level) on their hand hygiene practice. This is done with the goal to alert staff to their practice and encourage improvements. Managers will also require some update as to how their unit/area is progressing after an auditing session or the day of auditing (prior to uploading data to the website).
 2. When immediate in-person feedback is given to any staff member being observed during an auditing session, the staff member can no longer be audited the rest of the auditing period. This is to eliminate bias in the data collected. However other staff members on that unit may be audited.
 - ii. Using the results of the hand hygiene audits and the regional action plan for hand hygiene rates, each unit/area/service must determine their own specific actions for improvement, and how to achieve the same. IP&C is available to work with the team to development an improvement plan.
3. Aggregate regional rates for both acute care and LTC, only, are reported to MB Health quarterly.
4. Public reporting began in late 2013. Results are posted to the WRHA Internet, similar to the reporting of WRHA outbreak and significant organism rates.

Additional Information

1. Sites/services/settings are to conduct their own audits, this includes storage and use of tablets, and counting and monitoring of opportunities collected each auditing session, to ensure the target is reached for all units audited that quarter. IP&C will continue to be available as a resource (outside of conducting audits) to ensure success of the hand hygiene program; however, they are not responsible for the ongoing organization of the auditors or the devices.