

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/area³. Studies show improvements in hand hygiene compliance decreases HAIs.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices⁴. 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.

From the WHO to specific local facilities, monitoring hand hygiene has become an integral part of safe healthcare delivery⁵. 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.

Goals:

The goal for hand hygiene compliance is 100% compliance across all settings.

Requirements:

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

Hand hygiene reports are not created for areas that do not meet the minimum number of monthly opportunities outlined above.

1. Site/Area Led Auditing
 - a. Site/area led auditing is the standard; IP&C does not conduct hand hygiene auditing.
 - b. Site/area 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 or specified local audit champions and successfully achieved interrater reliability.
2. Audit instructions for Acute, Long Term, and Community Care
 - a. Audits should be 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 provided by WRHA IP&C once Handy Audit training has been completed.
 - ii. Each audit will meet the minimum number of required opportunities outlined above.
 - iii. Define target areas through specific site/program individual(s) and the site ICP(s)/designate. Factors involved in decision making should include outbreaks/clusters, high risk patients, high risk areas, and previous audit analysis results. Sites/services involved in outbreaks/clusters are to be audited while outbreak is ongoing (for that month) in addition to their usual auditing quarter. As 50% of units are audited within any one quarter, the other 50% should be selected for auditing the next fiscal quarter
 - iv. Rotate audits throughout the site with an initial focus on units/wards with outbreaks, as well as other high-risk areas, and high-risk patient populations
 - v. Maintain consistent audit groupings so comparisons can be made over time
 - b. Over the fiscal year, alternate between auditing and education, which is developed and led

- by the unit/ward. IP&C is available as a resource.
- i. Targets for education and improvement are to be identified by unit/ward being audited, based on the audit results and the recommendations outlined in the regional action plan.
3. Audit all services biquarterly throughout the fiscal year (e.g., Q1 and Q3 or Q2 and Q4).
 4. Auditors: Sites/Services should consider the number of auditors identified for each area. Auditors require dedicated training time, and must meet a minimum number of collected opportunities in 6 months to maintain auditor status. Consider the minimum monthly number of required opportunities when determining the number of auditors for the site/service/area.
 - a. Each auditor should be auditing for *30 minutes per week* to maintain skill set.
 - b. Auditors are required to maintain familiarity, consistency, and quality in auditing.
 - i. The auditing technique is assessed annually, and on an ad hoc basis (based on percentages received and assessed by Regional IP&C) through concurrent auditing and comparison to the Regional IP&C auditor/designate to help ensure **interrater reliability**.
 - a. To maintain consistency between auditors, and therefore quality of audit results, a deviation of +/- 10% is acceptable at the time of inter-rater reliability assessment. Additionally, this compliance rate must also be within 10% of the unit's previous monthly hand hygiene compliance rate. Variation beyond these limits requires additional training/re-education of the site auditor.
 - ii. **Auditors must have collected 50 opportunities in 6 months (approximately 8/month) to be eligible for inter-rater reliability testing, and will be suspended from the HandyAudit program.** Local audit champions are exempt from the auditing opportunity requirement as they do not audit, but rather provide support for direct auditors. Local audit champions are required to audit *30 minutes per month* to maintain their skill level. They will receive an annual IRR to ensure continued program understanding as they are resources for other direct auditors. **For suspended auditors who wish to resume auditing, a refresher training education session is required, including an inter-rater reliability test following this education.** Upon completion of these, they may be re-instated as an active auditor.

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). At the site level, at least 1/3 of the facility's units must collect the required number of opportunities to result in a site level report.

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 the WRHA senior leadership team.
 - b. Site/unit/area level reports are provided from the ICP or ICSA to the site directly.
 - i. Immediate Feedback
 - a. 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).
 - b. 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 individual auditing session (e.g., 20 minutes). 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 acute care and LTC, only, are reported to MB Health quarterly.
4. Public reporting began in late 2013. Results are publicly [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 month. 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, [number of opportunities completed](#), or the devices.

References:

1. Hospital Quality Ontario. (2024). Hospital Patient Safety: Provincial Hand Hygiene Results. Retrieved from: [Ontario Hospital Patient Safety Measurements – Health Quality Ontario \(HQQ\)](#)
2. Joint Commission. (2009). *Measuring Hand Hygiene Compliance: Overcoming the Challenges*. Retrieved from: [Joint Commission: Measuring Hand Hygiene Adherence](#)
3. Pittet, D. (2001). Improving Adherence to Hand Hygiene Practice: A Multidisciplinary Approach. *Emerging Infectious Diseases*, 7(2), 234-240. <https://doi.org/10.3201/eid0702.700234>
4. Standard Precautions for All Patient Care. (2024). *Perform hand hygiene*. Retrieved from: CDC Infection Control [Standard Precautions for All Patient Care | Infection Control | CDC](#)
5. World Health Organization & WHO Patient Safety. (Eds). (2009). *WHO guidelines on hand hygiene*. Retrieved from: [WHO guidelines on hand hygiene in health care](#)
6. Smiddy et. al., 2019. Efficacy of Observational Hand Hygiene Audit with Targeted Feedback on Doctors' Hand Hygiene Compliance: A Retrospective Time Series Analysis. *Journal of Infection Prevention* 20(4):164-170.