



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 infection, yet compliance with hand hygiene protocols is 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.

Hand hygiene audits allow organizations to monitor compliance with hand hygiene protocols, improve hand hygiene education and training, evaluate hand hygiene facilities, and benchmark practices within the organization¹. Studies show improvements in hand hygiene compliance decrease the number of healthcare-associated infections.

Standard: #6 and #8/15: The organization implements a comprehensive hand hygiene strategy.

- 6.2 The organization provides client, families, and visitors with access to hand hygiene resources and PPE based on the risk of transmitting microorganisms.
- 8.1 The organization provides hand-hygiene education to staff, service providers, and volunteers (ROP).
- 8.6: The organization measures its compliance with accepted hand-hygiene practices (ROP).

Background

Healthcare regions across Canada 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), Stop! Clean Your Hands (Safer Healthcare Now!), Canadian Patient Safety Institute, Public Health Agency of Canada, and Infection Prevention and Control Canada (formerly known as Community and Hospital Infection Control Association of Canada) as well as Just Clean Your Hands (Ontario). All provide similar process recommendations.

From the WHO to specific local facilities, monitoring hand hygiene has become an integral part of IP&C programs. Within Canada, since 2009 Ontario acute care facilities have been required to complete quarterly hand hygiene auditing and publically report on this on an annual basis². Facilities and regional health authorities in British Columbia, Alberta, Saskatchewan, Newfoundland and other regions within Manitoba all conduct ongoing hand hygiene audits. A variety of methods are used, and not all sites/regions are publicly reporting results.

¹ <https://www.patientsafetyinstitute.ca/en/toolsResources/pages/hand-hygiene-observation-tools.aspx#:~:text=Measurement%20is%20a%20vital%20part,hygiene%20education%2C%20training%20and%20promotio>
[n.](#)

² <http://www.hqontario.ca/public-reporting/patient-safety>

Results *are* intended to be used to improve healthcare worker understanding and compliance with established hand hygiene policies and procedures³. 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.

Published, validated references indicate the acceptable minimum number of observations to collect per audited unit/ward/area is 200⁴. This data collection is completed through self-auditing by unit/ward/area staff at each facility/program/clinic. This is a program driven activity, not an IP&C activity. IP&C program staff will no longer be a part of auditing activities as of April 1, 2020. Programs are responsible to ensure adequate data collection is occurring on an ongoing basis. When 200 observations are met, the audit results will track compliance at the:

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

Reports are not created for areas with less than 200 observations.

Goals

Acute, Long Term, Rehabilitative Care and Community: Increased compliance over time both within each program and within the site as a whole.

- The **goal for hand hygiene compliance is 80%, with an overall target of 100% compliance**. This goal must be reached consistently (i.e., $\geq 80\%$ for at least 2 consecutive audits) to be considered a consistent reliable rate⁵.

Recommendations

1. Self-auditing
 - a. Self-auditing by the site is the standard.
 - b. Self-auditing may **ONLY** occur once staff have:
 - i. Received WRHA IP&C [4 Moments/Hand Hygiene Auditor training](#); AND
 - ii. Buddied with the WRHA IP&C hand hygiene champion.
 - c. All self-auditors will ensure consistency and quality of the auditing technique annually through concurrent auditing and comparison to the IP&C auditor/designate to help ensure inter-rater reliability.
 - i. 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

³ 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.

⁴ Sax, H., et. al. 2009. The World Health Organization hand hygiene observation method. Am J Infect Control 37: 827-34.

⁵ http://www.who.int/patientsafety/information_centre/Last_April_versionHH_Guidelines%5B3%5D.pdf



unit's previous quarterly hand hygiene compliance rate. Variation beyond these limits requires additional training/re-education of the self-auditor.

- d. If 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 day. This is to eliminate bias in the data collected.

2. Acute, Long Term, and Rehabilitative Care

- a. Audits completed on 25 – 50% of all units/wards per program on a quarterly basis (e.g., Medicine, Family Medicine, Surgery, Dialysis, Emergency, Critical Care). This will be operationalized by the site, following consultation with the site Infection Control Professional and the IP&C Epidemiologist. Audits within facilities are to be ramped up to include more units/wards within a program within the designated quarter.
 - Use the WRHA Hand Hygiene Observation Tool to conduct auditing. The tool is available at: http://www.wrha.mb.ca/extranet/ipc/files/audit-tools/Audit_2_2.pdf
 - Each audit will minimally consist of 200 observations of possible hand hygiene moments
 - 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/programs involved in outbreaks/clusters are to be audited every 6 months. As 25 – 50% of units/wards within each program are audited within any one quarter, different units/wards within the same program should be selected for auditing the next fiscal year
 - 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
 - Maintain consistent audit groupings so comparisons can be made over time
- b. Alternate between auditing and education, which is developed and lead by the unit/ward. IP&C is available as a resource.
 - Targets for education and improvement to be identified by unit/ward being audited
- c. Re-audit programs at least once within the fiscal year.
 - Units/wards with compliance rates consistently greater than 80% overall compliance (i.e., 2 audits in a row), as well as lower risk areas (e.g., out-patient settings) may be reassessed on a less frequent basis, with a minimum of once annually

3. Community Settings

- a. Audits completed on 25 – 50% of all areas/programs on a quarterly basis (e.g., primary care sites, home care clinics, public health areas). This will be operationalized by the program, following consultation with the Community Infection Control Professional and the IP&C Epidemiologist.
 - Use the WRHA Hand Hygiene Observation Tool to conduct auditing. The tool is available at: http://www.wrha.mb.ca/extranet/ipc/files/audit-tools/Audit_2_2.pdf
 - Each audit will minimally consist of 200 observations of possible hand hygiene moments



- Define target areas through specific area/program individual(s) and the Community ICP. Factors involved in decision making should include outbreaks/clusters, high risk patients, high risk areas, and previous audit analysis results. Areas/programs involved in outbreaks/clusters are to be audited every 6 months. As 25 – 50% of units/wards within each program are audited within any one quarter, different units/wards within the same program should be selected for auditing the next fiscal year
 - Rotate audits throughout the program with an initial focus on areas with outbreaks, as well as other high-risk areas, and high-risk patient populations (pediatrics)
 - Attempt to maintain consistent audit groupings so comparisons can be made over time
- b. Alternate between auditing and education, which is developed and lead by the program. IP&C is available as a resource.
- Targets for education and improvement to be identified by the area being audited
- c. Re-audit programs at least once within the fiscal year.
- Areas with compliance rates consistently greater than 80% overall compliance (i.e., 2 audits in a row)
4. Personal Care Homes (PCH)
- a. Hand hygiene monitoring continues in the LTC Program. The IP&C Epidemiologist assists as requested with analysis and returns results to the LTC Program for review and follow-up.

Reporting

1. Site specific
 - a. Rates reported back to the unit/ward/floor, programs (both site and regional), and site executive in a timely manner.
 - b. Using the results of the hand hygiene audits, each unit/ward/area must determine their own areas for improvement, and how to achieve the same.
2. Public reporting began in late 2012. Results are posted to the WRHA Internet, similar to the reporting of WRHA outbreak and significant organism rates.

Additional Information

1. Sites/programs/settings are to conduct their own audits. IP&C will continue to be available as a resource to ensure success of the hand hygiene program.
2. All audits completed in paper format are to be submitted to site IP&C for data entry. This is sent forward to the IP&C Epidemiologist for analysis.
3. Audits completed in electronic format, are to be collected and amalgamated at the site. This is sent forward to the IP&C Epidemiologist.
4. A report is generated and returned to site IP&C for distribution and discussion as appropriate. Distribution includes site leadership.