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: #8/19: A comprehensive hand hygiene strategy is in place.

- 8.1 Hand-hygiene education is provided to team members and volunteers (ROP).
- 8.6: Compliance with accepted hand hygiene practices is measured (ROP).
  - 8.6.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit)
  - 8.6.2 Hand-hygiene compliance results are shared with team members and volunteers.
  - 8.6.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.

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), Clean Your Hands (Safer Healthcare Now!), Canadian Patient Safety Institute, Public

\(^1\) [www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx](http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx)  
\(^4\) [hh_monograph.pdf (jointcommission.org)](http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingHandHygiene.aspx)
Health Agency of Canada, and Infection Prevention and Control 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 safe healthcare delivery. Within Canada, since 2009 Ontario acute care facilities have been required to complete quarterly hand hygiene auditing and publicly report on this on an annual basis\(^5\). Facilities and regional health authorities in British Columbia, Alberta, Saskatchewan, Newfoundland and other Service Delivery Organizations within Manitoba all conduct ongoing hand hygiene audits.

Results are intended to be used to improve healthcare worker understanding and compliance with established hand hygiene policies and procedures\(^6\). 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 200\(^7\),\(^8\). The World Health Organization hand hygiene technical manual indicates “sample size estimates indicate that 200 opportunities per observation period and per unit of observation (either ward, department, or professional category etc.) are needed to compare results reliably. This data collection is completed through site led auditing by unit/ward/area staff at each site/program/unit/area. This is a program driven activity, not an IP&C activity. As of April 1, 2020, IP&C program staff stopped conducting hand hygiene auditing. Programs are responsible to ensure adequate data collection is occurring on an ongoing basis. When 200 opportunities/quarter are met, the audit results will track compliance at the:

1. Unit/area/program/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/program/sites (comparing compliance rates of different healthcare worker categories audited that quarter).

Reports are not created for areas with less than 200 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 IP&C hand hygiene champion and successfully achieved interrater reliability.

c. All site auditors will ensure consistency and quality of the auditing technique annually (and on an ad hoc basis based on percentages received and assessed by Regional IP&C) through concurrent auditing and comparison to the IP&C auditor/designate to help ensure interrater 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 unit’s previous quarterly hand hygiene compliance rate. Variation beyond these limits requires additional training/re-education of the site auditor.

ii. If auditors have not audited in the previous 2 quarters (6 months) or they did not collect greater than 50 opportunities during this time frame, they will not be offered inter-rater reliability testing and will be suspended from the Handy Audit program. Local audit champions are exempt from this requirement as they do not audit, but rather provide support for direct auditors. If the auditors who were suspended wish to resume auditing, they will need a refresher training education session and an inter-rater reliability test following this education. Upon completion of that, they may be reinstated as an active auditor.

2. Audit instructions for Acute, Long Term, and Community Care

a. Audits completed on 50% of all units/wards/areas/clinics per program 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.

- 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.
- Each audit will minimally consist of 200 opportunities of possible hand hygiene moments. Each auditor should be auditing for 30 minutes per week to maintain skill set.
- 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 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 quarter.

- 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. 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.

- Targets for education and improvement are to be identified by unit/ward being audited, based on the audit results.

3. Audit all programs biquarterly throughout the fiscal year (e.g., Q1 and Q3 or Q2 and Q4).
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/programs (both site and regional), and site executive in a timely manner.
   b. Quarterly reports - Reports will only be completed for units/areas/programs/sites that have collected 200 opportunities.

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. 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 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, each unit/area/program must determine their own areas 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/programs/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.