Hand Hygiene Toolkit

Target: 100% compliance

November 2020

CARING FOR HEALTH

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Contents

Section 1 – Introduction

Protecting our patients and ourselves

In March 2020, Manitoba saw its first case of COVID-19. Since then, the COVID-19 pandemic has touched many lives in our region, and the public and media have become more aware of the importance of hand hygiene.

Performing appropriate hand hygiene every day is a simple but critical element of maintaining patient safety and protecting yourself from the spread of germs at work, at home and at play. At work, not cleaning your hands is not only a missed opportunity, but a clinical error. It is imperative that we practice this simple and quick patient safety measure because the evidence consistently shows us that appropriate hand hygiene is the single best way to stop the spread of germs where people mingle together.

We have set a goal of 100% hand hygiene compliance. To achieve this, we need to work together.

In July 2020, we released a brief and confidential hand hygiene survey to all WRHA staff. Almost 3.5K WRHA staff from all areas of health care completed the survey. Responses provided us with honest opinions on hand hygiene education, auditing procedures, soap and sanitizer supplies, and suggestions on how to improve hand hygiene compliance at our sites. This information has been invaluable and has guided the creation of this toolkit.

The full survey results are available at: home.wrha.mb.ca/HandHygieneSurvey2020.pdf

Already our hand hygiene compliance has gone up. Our experience in responding to COVID-19 has been an example of how everyone at our sites, from physician to security, plays a role in stopping the spread of infection through proper hand hygiene. Let's keep this momentum going and strive to reach our goal of 100% hand hygiene compliance.

Thank you for all you do. Stay safe, and stay strong.

Dr. Nancy Dixon
Chief Medical Officer, WRHA

Definitions

Patient: Patient, client, individual or resident receiving health care from a WRHA facility, program, or funded site.

Staff: All persons employed by the WRHA facilities, or WRHA funded facilities, as well as members of the medical staff, volunteers, board members, students and others associated through contracts.

Hand hygiene: A comprehensive term that applies to cleaning or washing hands.

Alcohol-based hand rub (ABHR): An alcohol-containing (60-90%) preparation (liquid, gel or foam) designed for application to the hands to kill or reduce the growth of microorganisms. Such preparations contain one or more types of alcohol with emollients and other active ingredients.

Healthcare-associated infection (HAI): An infection that was not present at time of admission to the health-care setting. (https://www.who.int/infection-prevention/publications/burden_hcai/en/) HAIs are infections that occur while receiving health care, developed in a hospital or other health care facility that first appear after a defined period of time following admission, or within a defined period of time after having received health care. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6245375/)

Health care error: A health care error is also known as a patient safety event and can be categorized in three ways:

1. Harmful incident: an event that resulted in harm to a patient.
2. Near miss: an incident that did not reach the patient, avoiding harm.
3. No-harm incident: an incident that reaches the patient but resulted in no harm.
   https://www.patientsafetyinstitute.ca/en/Topic/Pages/Patient-Safety-Incident.aspx

Plan-Do-Study-Act (PDSA) cycle: A continual improvement process that provides the opportunity to gain valuable knowledge from following the key steps of PDSA. First is developing a plan for improvement, which then moves to activating the do step, which is implementing the plan that was made. Then comes the study step, where the plan is evaluated for success as well as areas for improvement. The act step is then used to adjust the plan with the information taken from the study step, and the cycle is then repeated and tried again. These steps can be repeated endlessly for a continual cycle of learning and improvement as required (https://deming.org/explore/pdsa/).

Why hand hygiene is important

Hand hygiene is important as it protects patients from HAIs.

Hand hygiene breaks the cycle of transmission and stops microbes from moving from one person to another or from the environment to the next person. There are many scientific studies that show a continuous increase or sustained rate above 80% in hand hygiene compliance results in fewer Methicillin-resistant Staphylococcus aureus (MRSA) infections.

MRSA infections can have a substantial negative effect on an already susceptible patient and cause infections in the urine, respiratory system, wounds, surgical sites, and the blood. Sustained hand hygiene compliance rates have also shown to reduce *C. difficile* rates. By completing hand hygiene and reducing HAIs, one can positively impact a patient's care.

Hand hygiene can also impact the health of staff and protect them.

When hand hygiene is missed, not only can you infect a patient with microbes, you can also infect yourself. Transmission of organisms can occur to staff, and as stated above, hand hygiene breaks the cycle of transmission. This is especially important with the constant threat of new and emerging organisms, such as COVID-19.

What is a health care error?

Is non-compliance with hand hygiene protocols considered a health care error?
When health-care providers do not clean their hands when it has been indicated that they should, they contribute to the spread of HAIs.

HAIs affect 1 in 31 patients on any given day and are the most frequent patient safety incident in health care worldwide.

According to the World Health Organization (WHO), by correctly following hand hygiene protocols **HAIs can be reduced by at least 50%.**
(https://www.who.int/gpsc/5may/slides_for_education_session_low_res.ppt?ua=1)

Hand hygiene compliance = Safer patient care.

Culture of Safety

A culture of safety and improved quality of care is created when health care workers feel empowered and comfortable raising concerns. A culture of mutual respect, accountability, and commitment to improvement increases patient safety.

Additionally, providing opportunities for patients and families to partner with the health-care team strengthens the culture of safety. Patients and families can also be invited to participate in Infection Prevention and Control (IP&C) related quality improvement initiatives. Resources on how to involve patients and families in patient safety can be found in the British Columbia (BC) Patient Safety & Quality Council, Culture Change Toolbox, pages 27 and 28 (January, 2018).

Voice of Staff:

- *"Keep me safe at work"*
- *"Create an environment where safe work is a priority"*
- *"I know my concerns will be heard"*
- *"Provide learning opportunities that help me develop safe work skills"*

Escalation of care for hand hygiene and IP&C practices
The ability to speak up about observed lapses in others on IP&C techniques, such as challenges with performing hand hygiene and the use of personal protective equipment (PPE), creates a stronger safety culture.

Interpersonal factors such as traditional hierarchical structures, fear of appearing incompetent, and desire for autonomy can prevent health-care workers from escalating care concerns.

"A strong safety climate is positively reinforced by effective communications between members of the health-care team and frequent safety-related feedback." (Goulding et al., 2020).

Strategies to improve the escalation of care for hand hygiene include:

- Make expectations clear.
- Set expectations early.
- Standardize communication e.g. scripted responses, visual cues.
- Practice skills in a safe environment, such as in simulation.
- Explore innovative ways to engage your team in creating a culture where reminding one another about hand hygiene is fun and welcomed.
    - For example, a health care worker invites another staff member or their entire team to remind them to clean their hands, and/or, makes it a fun challenge where the health care worker shows other staff they've cleaned their hands before that staff reminds them "Let's have a challenge; if you catch me not cleaning my hands please remind me" – this is successful when the health care worker feels comfortable being reminded by team members about cleaning their hands.

The use of standardized communication, such as scripts and visual cues, allows teams to respectfully remind one another when an IP&C technique is forgotten or not performed as instructed.

General strategies to promote a culture of safety
Other strategies for creating a strong culture of safety can be found in the BC Patient Safety & Quality Council, Culture Change Toolbox (January, 2018) which is available for download at https://bcpsqc.ca/blog/knowledge/culture-change-toolbox-2/. Please visit the WRHA Quality Improvement and Patient Safety intranet page for more culture of safety resources https://home.wrha.mb.ca/quality/event-learning.php.

Patient and Family Voice

Providing opportunities for patients and families to partner with the health care team strengthens the culture of safety. When patients and families feel empowered to speak up about care concerns, mutual transparency, trust, and understanding are created.

Voice of the Patient:

- *"Keep me Safe"*
- *"Wash your hands and keep my environment clean"*
- *"Share information about preventing infections so I can be part of the solution"*

Escalation of care for hand hygiene and IP&C practices
The ability to speak up about observed lapses in others on IP&C techniques, such as performing hand hygiene and the use of PPE, creates a stronger safety culture.

Invite patients and families to escalate care concerns.

- Invite patients and families to ask health care workers if they have washed their hands or if they should be wearing PPE:
    - Example: Health care worker says to patient and family: "You can always ask me if I have washed my hands".
    - Example: Health care worker invites patient and family to remind them to clean their hands, and/or, make a fun game. "Let's have a challenge; if you catch me not cleaning my hands please remind me" – this is successful when the health care worker feels comfortable being reminded by patients and families about cleaning their hands.
- Invite patients to clean their hands many times during the day, especially after using the washroom and before eating.
- Show patients and families good hand hygiene techniques e.g. how to use ABHR; how to wash hands with soap and water.
- Remind patients and families to "Cover your cough and clean your hands"
- Ask that families do not visit the patient if they are feeling unwell.
- Let patients know who they can speak to if they have care concerns that have not been addressed e.g. providing the name of the care manager or patient relations

The Canadian Patient Safety Institute (CPSI), WHO, and BC Patient Safety & Quality Council, Culture Change Toolbox pages 27 and 28 have several resources for the public on hand hygiene and engagement strategies. Please see the references below.

References

BC Patient Safety & Quality Council (January 2018). Culture Change Toolbox https://bcpsqc.ca/blog/knowledge/culture-change-toolbox-2/

CPSI. https://www.patientsafetyinstitute.ca/en/toolsResources/Hand-Hygiene-Fact-Sheets/Pages/default.aspx

Goulding, A.M., Wu, P.E., & Gold. W.L. 2020. A Care Escalation Framework to Address Lapses in Donning and Doffing of Personal Protective Equipment During the COVID-19 Pandemic, AJIC: American Journal of Infection Control (2020), doi: https://doi.org/10.1016/j.ajic.2020.07.040

WHO. Clean Care is Safer: Tools for Institutional Safety Climate https://www.who.int/gpsc/5may/tools/safety_climate/en/

How to Use this Toolkit

This toolkit was designed and written by the Winnipeg Regional Health Authority (WRHA) Hand Hygiene Project Team. It was written to assist leaders and hand hygiene champions to develop hand hygiene initiatives for themselves and their teams. It uses five strategies as outlined by the WHO.

1. Creating an environment for success.
2. Training and education.
3. Evaluation and feedback.
4. Reminders in the workplace.
5. Building a supportive culture.

This 5-pronged approach to hand hygiene in the WRHA aims to engage staff, improve hand hygiene compliance, increase the culture of safety within the WRHA and sustain improvements over time. This toolkit can assist you as it provides information in each of the above areas and educational and engagement activities. Some of the activities recommended in this package have been successfully used in facilities across the WRHA. Determine which might best suit your team and make hand hygiene not just part of your care, but fun as well.

Barriers to Good Hand Hygiene

Peer reviewed literature notes many types of barriers that impact positive hand hygiene activities. Some of these are:

- lack of access to point of care ABHR;
- trouble remembering to clean hands;
- workload issues/feeling rushed;
- lack of positive role models/social cohesion (if the team isn't doing it as a whole);
- lack of confidence to be a mentor;
- lack of belief in the final goal;
- lack of confidence that the goal can be achieved;
- not seeing the consequences of poor hand hygiene;
- feeling under-valued can be an emotional trigger that results in less hand hygiene;
- priorities do not include hand hygiene;
- difficult to change habits.

Where to find staff training resources

Information and resources related to the 4 Moments for Hand Hygiene is available in different formats, depending on style of learning (individual, group) and preference (LMS, PPT).

Hand hygiene resources are available at:
https://professionals.wrha.mb.ca/old/extranet/ipc/hand-hygiene.php.

Resources include hand hygiene videos, PowerPoints, posters in English and French, FAQs and eLearning modules in LMS.

For managers:
For more information on how to track staff education, visit
https://professionals.wrha.mb.ca/old/extranet/ipc/files/routine-practices/HH-TrainingTracking.pdf

See ***Where and how to get auditor training*** in Section 3 for information related to Hand Hygiene Auditor training.

Section 2 – Towards Improvement - Education & Training

Identifying and removing barriers

Barriers are hard to remove until they are identified, reviewed and examined. A survey, such as the one included in this package, can be used to determine the local barriers. Once a unit/program/area knows what barriers are affecting the staff's hand hygiene compliance, plans can be developed as a team to address these barriers.

Removing barriers requires a team approach, not a top down approach. There is a sense of ownership that occurs when staff collectively work together to determine how best to improve their own hand hygiene compliance. Multiple types of health-care worker categories (e.g., nursing, allied health, health-care aides, and physicians) must participate so mentors/influencers can be developed throughout the team and on all shifts. By working as a team, they also focus on positive changes, rather than the aspects that may seem daunting. A sense of hope is essential to make a significant change in habit that will be lasting. Hope is built through interactions with one's peers, through positive reinforcement and through success.

End discussions on the units about hand hygiene compliance with "let's agree we can improve". Managers need to put themselves in the shoes of the frontline staff and listen to their concerns. Communication is key to removing barriers.

Patients' needs should be the primary focus of all the interventions attempted. A cultural mindset of patient safety is necessary. By choosing this as a framework, teams can change the way they view hand hygiene and instead allow it to take on a more positive tone.

Hand Hygiene Education Requirements

Accreditation Canada's Required Organizational Practices (ROPs) require health-care organizations to provide hand hygiene education to their staff[1]. Their standards also state this education is to occur on hiring, and regularly thereafter[2].

The frequency of education after orientation will depend on the staff's role in preventing and controlling infections. Education requirements for hand hygiene are to occur at orientation for all staff[3] and then at least once every two years for care providers[4] to ensure continued best practice in preventing and control infections. No return demonstrations will be required with this education.

Accreditation Canada also indicates the organization is to document attendance as well as maintain a system to track who has received education, identify who requires follow-up training as well as identify individuals overdue for education[5].

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene.

Process for reporting training

1. Annually, by June 15th, each site must provide the total number of staff from each unit/program/area who have completed the annual hand hygiene education (based on fiscal year), to WRHA IP&C. Do not include individual information, only numbers.
    i. Each site/program/area will determine responsibility for annual submission of this information by the outlined due date.
    ii. Each site will provide a list of these individuals, their area of responsibility and their contact information to the WRHA IP&C epidemiologist by June 1st of each year. Only one contact individual for larger sites/programs/areas is required to submit amalgamated data.
    iii. Information not submitted by June 15th will not be included in the July annual report.
2. WRHA IP&C will report to WRHA Regional Management Council annually (July), on the number of staff from sites/programs/areas who have received hand hygiene education. Rates for current and previous year will be compared to target. This report will be based on the information provided by each site.
3. The WRHA IP&C epidemiologist will calculate compliance rates based on the information provided by each site.
4. Where there is cross over with staff working in multiple sites/programs/areas, each site/program/area will report information from the education of their own staff members as well as including these staff in their total staff counts. When a staff member's education takes place at a different site, as the staff member works in multiple locations, do not count their education at the alternative site, but continue to include this staff member in your overall staff counts. Only report training occurring at your site.
5. Annual submission of this information should be in a standardized format if completed manually, or a list through LMS is equally acceptable.
6. Submit numbers to the WRHA IP&C epidemiologist, Myrna Dyck, at mdyck5@wrha.mb.ca in an electronic format via email by June 15th the year following the fiscal year that is under surveillance (e.g., 2019/20 data would be submitted by June 15th of 2020).

Process for recording education attendees

Accreditation Canada standards states each facility should have a hand hygiene training tracking system. While individual information contained in a tracking system is not required to be reported to regional IP&C, it is recommended each site develop a process for collecting and tracking information on those trained, and those requiring hand hygiene training. A spreadsheet example of a possible tracking database is provided for consideration on InSite.

While the reporting structure for each site/program/area may be different based on need, those involved in the education of staff should provide the unit/program/area managerial staff with the information for all newly trained individuals participating in education sessions.

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[1] Accreditation Canada Infection Prevention and Control ROP 6.1

[2] Accreditation Canada Infection Prevention and Control Standard 5.4

[3] Staff: All personal employed by the WRHA facilities, or WRHA funded facilities, as well as members of the medical staff, volunteers, board members, students and others associated through contracts.
Direct Care Providers: All staff who come in contact with patients, patient care environment, patient care equipment, and blood and body fluids. This includes but is not limited to Physicians, Nurses, Allied Health (Occupational Therapy, Respiratory Therapy, Physiotherapy, Speech Language Pathologist, Dietitians, Pharmacy, Lab, EKG, DI, etc.), Support Services (Health Care Aides, Home Support Workers, Housekeeping, Porters, Transfer personnel, specific volunteers, unit clerk, laboratory workers and others as deemed appropriate by each site/area/program).
Non-Direct Providers: All staff who do not have direct contact with patients, patient care environment, patient care equipment and blood and body fluids. This also includes corporate sites/areas.

[4] Definition of Staff Training Requirements
Direct Care Providers:

- On hire, routine practices education which includes hand hygiene and PPE education
- Annually after hire
- No return demonstrations

Non-Direct Providers:

- Hand hygiene education on hire

[5] Accreditation Canada Infection Prevention and Control Standard 5.4

Experiments – The Apple Experiment

Materials:
1 apple, 3 specimen containers, sharp knife, marker

Here's how:

1. Poke a few holes in each specimen container lid to allow air into the containers. This will help facilitate the growth of bacteria and mold.
2. Wash the apple, knife and your own hands thoroughly with warm water and soap. Cut the apple in 3 equal segments (remember they need to fit into the container). Place 1 segment immediately in a container, being careful not to touch the surface of the apple (use the knife tip to help guide the apple wedge into the container). Label this container "No Touch".
3. Pass 1 apple wedge to several of your colleagues prior to cleaning hands. Ask them to handle the apple wedge in their hands, making sure they touch all surfaces of the apple. Have them place the apple wedge into the next container and label the container "Dirty Hands".
4. Ask the same colleagues to clean their hands with hand sanitizer or by washing with soap & water. Ask them to handle the last apple wedge in their hands; again making sure they touch all surfaces of the apple. Have them place the apple wedge into the last container and label "Clean Hands".
5. Place the 3 containers to the side, making sure all containers receive the same lighting conditions and temperature.
6. Observe the changing conditions of the apple wedges! Changes will become apparent in approximately 2 hours.

Role Play: Using what if scenarios

Hand hygiene principles:

- Always wash hands after removing gloves
- Never wash gloved hands
- Never use the same pair of gloves for more than one patient or patient environment
- May touch more than one clean piece of equipment in the patient environment
- All multiuse patient equipment must be wiped down between patients (ie. blood pressure cuff, transfer belt, stethoscope)

The chart on the next page runs through five "what if" scenarios.

ACTION	Moment 1 Before initial patient or environment contact	Moment 2 Before aseptic/clean procedure	Moment 3 After blood or body fluids exposure	Moment 4 After patient or patient environment contact	NOTES
Take your patient to the bathroom	• Hand hygiene • Take patient to the bathroom	• Hand hygiene • put on gloves before pericare	• Remove gloves • Hand hygiene • Wash patient's hands • Take patient back to bed • Hand hygiene • Put on gloves • Take commode to bathroom to clean • Wipe down call bell and door handle, grab bar • Clean commode • Remove gloves	• Hand hygiene	**NOTE:** if you have a number of dirty cloths, place on a pad or towel on the floor to bundle and put in the soiled linen receptacle. Do not dirty cloths on the floor.
If you have to leave your patient in the bathroom to attend to another patient	• Hand hygiene • Take patient to the bathroom			• Hand hygiene • Attend to second patient	
Deliver Meal Trays	• Hand hygiene • Remove tray from cart • Place on patient overbed table without touching anyting • Remove tray lid without touching anything • If something touched, then perform hand hygiene • If did not touch anything, retrieve next meal tray and follow the same process			• Hand hygiene after all of the meal trays have been delivered to one patient room (2-4 beds)	**NOTE:** Must complete hand hygiene before delivering the next tray to the room if the patient or the patient environment is touched
Removing Dirty Linen from the Patient Room	• Hand hygiene		• Put on gloves • Remove soiled linen • Place into soiled linen receptacle	• Remove gloves • Hand hygiene	
Medication process	• Hand hygiene • Remove medication from the Pyxis • Go to nurse server and pick up MAR or use Pyxis slip as desired.	• Hand hygiene • Enter patient area • Identify patient and administer medication			

Fact sheets for each moment (Patient = Patient/Resident/Client)

Moment 1: Before coming into contact with a patient or patient environment – perform hand hygiene.

Examples (not an exhaustive list – just to be used as examples):

- Prior to entering patient room and touching patient's environment: (bed, bedside table, over-bed table, windowsill, patient lockers, patient's chair(s), etc.)
- Prior to entering patient room and touching patient
- Prior to touching patient or their environment, after touching curtain/door in a multi- patient room
- Prior to touching a patient or their environment, after touching your face/uniform/lab coat
- Prior to touching patient's equipment
- Prior to transferring patient
- Prior to shaking hands
- Prior to taking any vital signs (temperature, blood pressure, pulse)
- Prior to using a stethoscope on a patient's body
- Prior to making patient comfortable in bed
- Prior to patient's morning hygiene
- Prior to contact with patient's wheelchair or walker
- Prior to bringing patient a puzzle/exercise equipment in physiotherapy/occupational therapy
- Prior to touching a patient while assisting with their physiotherapy/occupational therapy
- Prior to putting on gloves and/or other PPE
- After touching one's face or clothes, prior to touching patient or his/her environment
- Prior to touching an IV pump

Home environment

Treatment area or clinic room

To protect the patient environment from harmful organisms carried on your hands.

Moments 2: Before aseptic/clean procedure – perform hand hygiene.

Examples (not an exhaustive list – just to be used as examples):
Note these usually follow Moment 1.
Hand hygiene is required for both Moment 1 and then Moment 2.

- Prior to dressing change
- Prior to skin lesion care
- Prior to preparing medications or removing them from the Pyxis machine
- Prior to adding meds to the Pyxis machine/med charts
- Prior to changing TPN
- Prior to starting a peripheral IV
- Prior to changing an IV
- Prior to giving patient an IV medication
- Prior to giving a vaccination
- Prior to opening a vascular access system or draining system
- Prior to taking blood specimen from a patient
- Prior to taking a blood glucose test
- Prior to giving a patient an oral medication
- Prior to subcutaneous/intramuscular injections
- Prior to instilling eye/ear drops
- Prior to oral care
- Prior to setting up a patient's food tray
- Prior to preparing food
- Prior to feeding a patient
- Prior to giving a patient a drink of water
- Prior to inserting a catheter
- Prior to inserting an NG tube
- Prior to secretion aspiration
- Prior to putting on sterile gloves to perform any aseptic procedure

Handling dressings or touching open wounds

Performing invasive procedures

Prevents the patient's own organisms from entering his or her own body.

Moment 3: After body fluid exposure risk – perform hand hygiene.

Examples (not an exhaustive list – just to be used as examples):
Remember that after any of these activities, gloves must be removed, and hand hygiene performed prior to moving to next activity.

- After a dressing change
- After skin lesion care
- After inserting an IV
- After taking a blood specimen
- After taking a stool specimen
- After taking a urine specimen
- After cleaning up a body fluid spill
- After inserting a catheter
- After providing oral care to a patient

Clean your hands immediately after an exposure risk to body fluids (and after glove removal).

Moment 4: After contact with a patient or patient environment – perform hand hygiene.

Examples (not an exhaustive list – just to be used as examples):

- After exiting patient room and touching patient's environment: (bed, bedside table, over-bed table, windowsill, patient lockers, patient's chair(s), etc.)
- After exiting patient room and touching patient
- After touching patient's equipment and exiting the room
- After transferring patient
- After shaking hands
- After taking any vital signs (temperature, blood pressure, pulse)
- After using a stethoscope on a patient's body
- After making patient comfortable in bed
- After patient's morning hygiene
- After contact with patient's wheelchair or walker
- After bringing patient a puzzle/exercise equipment in physiotherapy/occupational therapy
- After touching a patient while assisting with their physiotherapy/occupational therapy
- Between patients while assisting with their physiotherapy/occupational therapy
- After taking off gloves

Help protect yourself and the health-care environment from harmful patient organisms.

Section 3 – Auditing & Sharing Results

Why monitor hand hygiene practice and compliance?

"Monitoring hand hygiene compliance is of crucial importance to:

- *assess baseline compliance by health-care workers (HCWs),*
- *provide feedback to health-care workers about defective practices as well as improvement,*
- *evaluate the impact of promotion interventions, and*
- *investigate outbreaks*."

https://www.who.int/gpsc/5may/monitoring_feedback/en/

- Despite the awareness of the importance of hand hygiene at identified times and point of care, members of the health care team may/not practice the 4 Moments for hand hygiene.
- Ongoing monitoring of hand hygiene practice and compliance will assist to prioritize hand hygiene.
- Monitoring hand hygiene will assist to redefine the culture at the unit level.
- Monitoring hand hygiene to promote accountability to improve health outcomes for the patient population receiving care.
- Monitoring to improve and sustain hand hygiene rates.

Informal observations and formal auditing – value of each

Informal observations:

- invites frontline staff to observe each other's hand hygiene practice and to provide "On the Spot Feedback;"
- creates a culture of safety to enhance staff knowledge, promote positive attitudes and best practice;
- engages frontline staff to identify and overcome barriers to improving hand hygiene practice i.e. insufficient time and resources;
- unit level observation to facilitate practice at point of care; and
- promotes hand hygiene champions at the unit level.

Formal auditing:

- requires hand hygiene auditor training for assessment and recording of missed opportunities for hand hygiene practice;
- creates consistency for data collection and reporting;
- is performed on a quarterly basis;
- provides quarterly hand hygiene compliance reports;
- promotes ongoing quality improvement; and
- improves hand hygiene practice and compliance.

Where and how to get auditor training

If you are chosen to assist your unit with this task, you will be trained by someone who specializes in this training and you will meet others who are also learning how to be hand hygiene auditors. At the following website, one can determine where and when the next auditor training session will be:
https://professionals.wrha.mb.ca/old/extranet/ipc/4Moments-HHAuditorTraining.php

You will need to register with the WRHA IP&C administrative assistant for the session you wish to attend.

At that training session, you will be provided the tools required to audit and following the session, you will have a buddy session with an instructor to ensure you understand. If there are further questions, there will be individuals you can contact as well as your facility/program/community area IP&C staff who will be able to assist you.

Implementation plan requirements

The WRHA IP&C program has a hand hygiene implementation plan available at:https://professionals.wrha.mb.ca/old/extranet/ipc/files/audit-tools/Audit_2_5.pdf.

It outlines when auditing should take place and what to do on the quarters that a team is not auditing. Auditing of hand hygiene compliance is to occur on a bi-quarterly basis (e.g., Q1 and Q3 or Q2 and Q4), allowing for a three-month break between auditing to review results and determine areas where improvements can be made.
The implementation plan outlines why hand hygiene auditing is required (Accreditation Canada requirement) and how auditing should be done (e.g., self auditors). The determination of which units are audited for which quarters is a site-based decision made in consultation with IP&C staff. The audits in paper format are submitted to the facility/area IP&C. The audits in electronic format are submitted to the IP&C epidemiologist. Formal analysis and reporting are completed on a quarterly basis.

Methods of sharing results and observations

Data from informal observations as well as formal hand hygiene audits is to be shared with senior leadership, management teams, and the unit. These audit results should be posted in an area visible to all, including patients (i.e., Quality Board) to increase awareness and promote accountability.

There are a number of ways to share results and observations:

- Senior leadership and management support is critical for culture change to improve hand hygiene practice
- Senior leadership and management includes executive level administration, nursing and physician groups, allied health groups and non-clinical groups who may act as change agents to promote culture change to improve hand hygiene practice

- Prioritization of hand hygiene by leaders encourages and empowers frontline staff to implement practice change to improve hand hygiene at point of care
- Share hand hygiene results with frontline staff
- Keep senior leadership, management teams and frontline staff informed of successes, challenges, and outcomes of the hand hygiene initiative

On the spot feedback - form

An “On the Spot Feedback” form exists in the WRHA for auditors to use at the end of the day to provide feedback to the units/areas about their daily hand hygiene auditing results. It breaks the numbers down into the 4 Moments and provides the unit/area an idea of what type of actions have good hand hygiene results and which require more effort. Examples of what were the frequently missed activities can be written down on the form, thus providing the unit/area with evidence they can use to focus their interventions. These are only completed at the end of the day and supplied by the auditor to the manager of the unit. The manager can then use this tool in the unit huddles that discuss hand hygiene.

Real time feedback script

The following script provides guidance on giving real time feedback (for both informal observations and formal audits).

When approaching a co-worker, facility support member or physician:

- pay attention to your tone and body language;
- assert interventions in a firm and respectful manner;
- be polite and professional; and
- promote a healthy, safe environment. People are more likely to comply if approached with compassion.

Remember: when asked, you can explain what you are doing on the unit; auditing for hand hygiene compliance. Hand hygiene audits are not a secret or a fault-finding exercise. They are a method to gather data, celebrate successes, and promote improvement. We all play a role in helping each other improve our hand hygiene success.

SAMPLE SCRIPT:
Positive reinforcement:

"Hi, I'm _____ and I'm a program/unit/area/site hand hygiene auditor. A part of the auditor's job is to help work towards 100% hand hygiene compliance. To do that we point out successful and missed hand hygiene opportunities. I noticed you performed hand hygiene…

- before patient/patient environment contact.
- before aseptic/clean procedure.
- after contact with blood/body fluids/contaminated items.
- after patient/patient environment contact.

Thank you for keeping patients, staff, and physicians safe with clean hands".

Unsuccessful moment:

"Hi, I'm _____ and I'm a program/unit/area/site hand hygiene auditor. A part of our job is to help staff work towards 100% hand hygiene compliance. To do that we point out successful and missed hand hygiene opportunities. I noticed you missed performing hand hygiene…

- before patient/patient environment contact.
- before aseptic/clean procedure.
- after contact with blood/body fluids/contaminated items.
- after patient/patient environment contact.

In order to provide safe patient care, please clean your hands now".

Unit huddles

Unit huddles can be a good time to have conversations related to hand hygiene practices; whether to review formal/informal feedback or to discuss opportunities and suggestions for improvements. Unit huddles allow opportunities for all unit staff to participate, suggest improvements and discuss barriers. Huddling around a bulletin board where the results may be posted and celebrated, where suggestions can be pinned and where outcomes can be monitored for those ideas makes hand hygiene a team activity. With the whole team participating, everyone has a stake in the outcome. Healthy hand care, patient hand hygiene as well as staff results can be reviewed. Unit huddles are only short, 15-minute time frames where goals can be reviewed.

SMART goals are recommended so that any possible changes can be:

- Specific
- Measurable
- Attainable
- Realistic, and
- Timely

Using the survey to find local barriers to hand hygiene on your units/at your site/service

Background
The *Survey on Hand Hygiene - What's Working Well & What Improvements Can be Made?* was created and administered in July 2020 across the WRHA. Results from this survey were used to guide the contents of the Hand Hygiene Toolkit.

Please see the Appendix for a copy of the survey questions. Survey questions and options should not be amended, except for response options for questions 1 & 2, so comparison across the WRHA is possible.

Setting up the survey
The survey can be distributed to your teams via paper and/or electronically (e.g., SurveyMonkey); although electronic distribution is recommended to facilitate response collation. We recommend identifying a point person(s) to organize the administration of the survey and collection of the results.

Administering the survey
Your site/service may wish to implement the survey across your entire site/service or to target unit/area one by one.

The following are recommended when administering the survey.

- Identify the units/areas to be surveyed e.g., entire site or individual units/areas.
- Identify a start date for the survey.
- Identify a closing for the survey.
- Communication – memo to invite teams to complete the survey (electronically, and/or verbally e.g., team meetings, and/or via paper).
    - Memo template on next page.
- Send a reminder to staff mid-way during the data collection period to invite them to participate.
- Close the survey. After the final response date has passed; manually enter in any surveys/data received via paper.
- The survey can be used either once to identify the barriers, or it can be used twice as a pre and post to measure change.

MEMO TEMPLATE

A survey has been developed to understand our employees' perspectives on hand hygiene and identify potential barriers to address in order to increase compliance.

Hand hygiene is considered the single most important method of reducing HAIs. Hand hygiene is a standard expectation within all sites and sectors yet recent hand hygiene audits demonstrate variable compliance rates which are lower than our goal.

With the support of the Board of Directors, the WRHA has committed to a 100% hand hygiene compliance rate. Achievement of this goal requires us to take a critical look at what we are currently doing to identify improvement opportunities.

The survey is available from **date** to **date** by clicking on the following link:

Insert link to survey monkey and/or attach a paper copy of the survey.

Thank you for taking the time to give us your feedback!

Signed by site leadership e.g. CEO, CNO, CMO

Using the survey as a PDSA tool

Analyze the data
The following are suggestions for grouping the results.

- Overall results for the site and/or unit/area.
- Responses for each question sorted by discipline/primary role.
- Responses for each question sorted by unit/area.
- Review and theme the open-ended responses for questions 5, 6, 9 and 10.

Review the analysis
The results should be reviewed by the site and unit/area hand hygiene champions to determine which interventions of the toolkit to implement for the entire site or specific unit(s)/area(s).

The following may be helpful when reviewing the results.

- Were the results similar between units/areas?
- Were there any differences in responses based on discipline/primary role?
- Were there any barriers reported that are similar or unique to units/areas? See questions 6, 7, 8, 10 of the survey
- Were there any incentives or strategies identified that enhance or promote hand hygiene? See questions 3,4,5, 9, 10 of the survey
- Did the responses indicate challenges to a culture of safety regarding hand hygiene? See questions 7 & 8, and open text responses of the survey.
- Share the results with your teams.

Using PDSA as a quality improvement tool
The Institute for Healthcare Improvement (IHI) recommends the PDSA cycle as a scientific method for testing changes.

“The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned.” (IHI, 2020).

This toolkit lists interventions and strategies for enhancing hand hygiene performance. Chose/identify interventions to address the barriers or issues identified from the survey results; this may be unit/area specific and others may apply more widely to the entire site/service. When implementing the various strategies, it may be helpful to start with the top 1-3 barriers and consider ways to engage team members in the implementation of the intervention.

Using the PDSA cycle allows your teams to determine whether an intervention has been effective in creating change and if refinement to the intervention is needed to obtain the desired change. This toolkit is following a PDSA approach to improving hand hygiene rates by implementing the survey and using the results to determine interventions.

Figure from IHI

Stage	Description	Common Steps
Plan	*Plan your process, includes creating measures or data collection plan*	1. Plan the test - list the steps 2. Who, What, Where, When? 3. What are your predictions about the test/ change? 4. Create measures / data collection plan to determine if prediction succeeds
Do	*A time to try the change and observe what happens*	1. Carry out the plan, try the test 2. What happened? Document your observations 3. Begin analysis
Study	*Analyze the data and results*	1. Analyze the results /data 2. How did they compare to your predictions? 3. What did you learn? Did you meet your measurement goals?
Act	*Identify next steps based on the analysis*	1. Revise the plan based on your findings 2. What changes would you make? 3. Will you adopt this change? 4. If it met your prediction/ goals , plan and measure for your next cycle of PDSA

Resources

IHI. (2020). Science of Improvement: Testing Changes.
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

SurveyMonkey. https://www.surveymonkey.com/

Section 4 – Engagement & Communication

Engagement

- Engage and support frontline staff in practice change in a “no blame” culture.
- Engaged staff can identify barriers and provide solutions to improve hand hygiene practice.
- Ongoing discussion with frontline staff about quality improvement to ensure sustainability of practice change.
- Involving frontline staff improves buy-in and enhances accountability for the 4 Moments for hand hygiene and increases the success and sustainability of the practice change.
- Practice change based on best practice contributes to the attitudes of frontline staff to ensure hand hygiene practice occurs at point of care.

Reminders

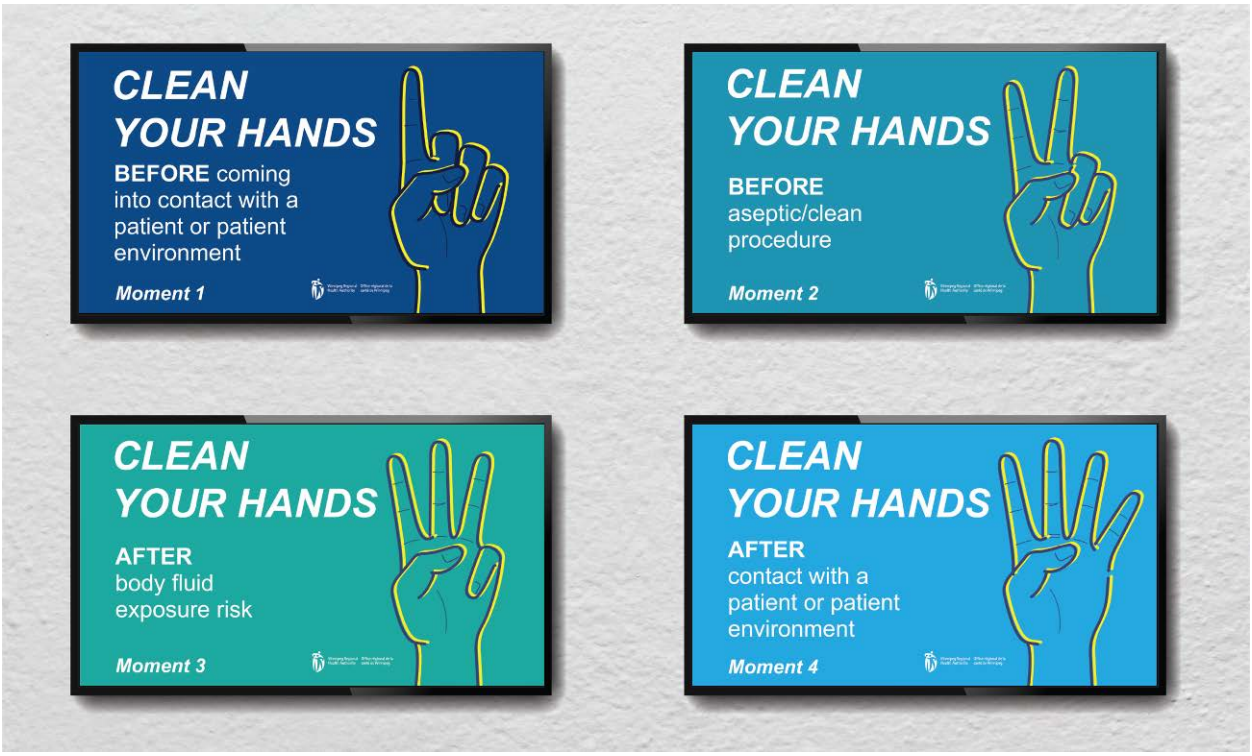
- Frequent messaging and communication are essential to improving hand hygiene practice and compliance.
- Verbal and written communication to senior leadership, management teams and frontline staff.
- Culture change requires concise and consistent messaging.
- Share and celebrate successes.

Posters and other creative materials

These resources are available at
https://professionals.wrha.mb.ca/old/extranet/ipc/hand-hygiene.php

4 Moments for Hand Hygiene Posters

4 Moments for Hand Hygiene TV Screen Images



4 Moments for Hand Hygiene Quick Reference Sheet

CLEAN YOUR HANDS

BEFORE coming into contact with a patient or patient environment

Examples (not an exhaustive list):

- Prior to entering patient room and touching patient's environment.
- Prior to entering patient room and touching patient.
- Prior to touching patient or their environment, after touching curtain/door in a multi- patient room.
- Prior to touching a patient or their environment, after touching your face/uniform/lab coat.
- Prior to touching patient's equipment.
- Prior to transferring patient.
- Prior to shaking hands.
- Prior to taking any vital signs.
- Prior to using a stethoscope on a patient's body.
- Prior to making patient comfortable in bed.
- Prior to patient's morning hygiene.
- Prior to contact with patient's wheelchair or walker.
- Prior to bringing patient a puzzle/exercise equipment in physiotherapy/occupational therapy.
- Prior to touching a patient while assisting with their physiotherapy/occupational therapy.
- Prior to putting on gloves and/or other PPE.
- After touching one's face or clothes, prior to touching patient or his/her environment.
- Prior to touching an IV pump.

CLEAN YOUR HANDS

BEFORE aseptic/clean procedure

NOTE: Hand hygiene is required for both Moment 1 and then Moment 2.

Examples (not an exhaustive list):

- Prior to dressing change.
- Prior to skin lesion care.
- Prior to preparing medications or removing them from the Pyxis machine.
- Prior to adding meds to the Pyxis machine/med charts.
- Prior to changing TPN.
- Prior to starting a peripheral IV.
- Prior to changing an IV.
- Prior to giving patient an IV medication.
- Prior to giving an injection/vaccination.
- Prior to opening a vascular access system or draining system.
- Prior to taking blood specimen.
- Prior to taking a blood glucose test.
- Prior to giving a patient an oral medication.
- Prior to subcutaneous/intramuscular injections.
- Prior to instilling eye/ear drops.
- Prior to oral care.
- Prior to setting up a patient's food tray.
- Prior to preparing food.
- Prior to feeding a patient.
- Prior to giving a patient a drink of water.
- Prior to inserting a catheter.
- Prior to inserting an NG tube.
- Prior to secretion aspiration.
- Prior to putting on sterile gloves to perform any aseptic procedure.

CLEAN YOUR HANDS

AFTER body fluid exposure risk

NOTE: After any of these activities, gloves must be removed and hand hygiene performed prior to moving to next activity.

Examples (not an exhaustive list):

- After a dressing change.
- After skin lesion care.
- After inserting an IV.
- After taking a blood specimen.
- After taking a stool specimen.
- After taking a urine specimen.
- After cleaning up a body fluid spill.
- After inserting a catheter.
- After providing oral care to a patient.

CLEAN YOUR HANDS

AFTER contact with a patient or patient environment

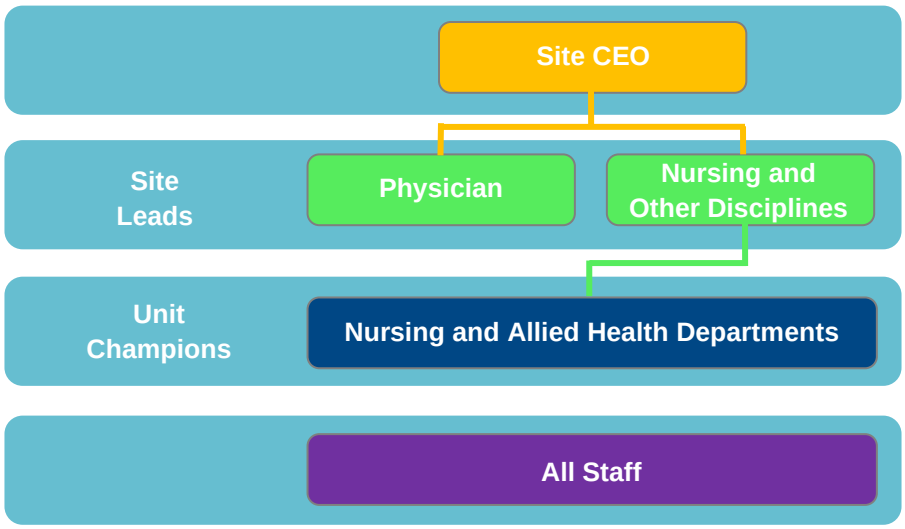
Examples (not an exhaustive list):

- After exiting patient room and touching patient's environment.
- After exiting patient room and touching patient.
- After touching patient's equipment and moving out of the room.
- After transferring patient.
- After shaking hands.
- After taking any vital signs.
- After using a stethoscope on a patient's body.
- After making patient comfortable in bed.
- After patient's morning hygiene.
- After contact with patient's wheelchair or walker.
- After bringing patient a puzzle/exercise equipment in physiotherapy/occupational therapy.
- After touching a patient while assisting with their physiotherapy/occupational therapy.
- Between patients while assisting with their physiotherapy/occupational therapy.
- After taking off gloves.

Section 5 – Performance Monitoring & Accountability

Responsibility matrix – lines of accountability

The CEO/COO is ultimately responsible for the sites hand hygiene performance. The remaining roles and responsibilities can be tailored based on site culture and resources.



Roles and Responsibilities

CEO/COO: Ultimate responsibility for the sites hand hygiene performance.

- Establish and emphasize site-wide commitment creating a culture that values and actively promotes appropriate hand hygiene practices.
- Identify the key leaders in your organization who can oversee implementation.
- Provide the support required (financial, human) for successful implementation and maintenance of hand hygiene improvement measures.
- Hold programs and services accountable to adherence with the regional processes and requirements outlined, as part of the site's internal responsibility system.
- Visible role modelling.
- Know best practices, as it relates to hand hygiene and the 4 moments for hand hygiene.
- Speak to improvement actions in progress in all forums that present themselves (i.e., meetings, with staff on unit, with visitors).
- Know the rates to helps motivate staff and sustain the program. If you can't measure it, you can't change it.

Site leads: Individuals dedicated to overcoming resistance and improving hand hygiene compliance.

- Report to CEO/COO at least quarterly with hand hygiene status and any associated measures.
- Know best practices, as it relates to Hand Hygiene and the 4 moments for hand hygiene.
- Promote best hand hygiene practices.
- Visible role-modelling.
- Support compliance.
- Hold others accountable to adherence with the processes and requirements outlined as part of the site's internal responsibility system.
- Speak to improvement actions in progress in all forums that present themselves (i.e., meetings, with staff on unit, with visitors).
- Assist in problem solving regarding hand hygiene and infection safety.
- Know and remind site of hand hygiene compliance data regularly.

Unit champions: Health care providers who publicly share their commitment to improving hand hygiene practice.

- Report to Site Champion at least quarterly with hand hygiene status and any associated measures.
- Promote best hand hygiene practices.
- Visible role-modelling.
- Know best practices, as it relates to hand hygiene and the 4 Moments for hand hygiene.
- Attend auditor training up to but not including buddy shifts to develop an understanding and familiarity of the auditing process and expectations.
- Collaborate with Site Leads and IP&C on improvement activities and outcomes.
- Support compliance by using creative cues and providing instant feedback.
- Know and remind unit/area of their hand hygiene compliance data regularly. Share information for educational purposes and/or to provide feedback and encouragement as change begins to occur.
- Lead improvement measures identified by manager.
- Celebrate co-worker(s) going above and beyond the call of duty with respect to hand hygiene by nominating them as a hand hygiene hero.
- Peer-to-peer coaching and mentorship.
- Formal and informal education.
- Create additional methods that support compliance in their areas and then share their success stories with other departments (e.g., purple elephant in the room by the ABHR – recognizable cue that's fun and non-threatening).
- Speak to improvement actions in progress in all forums that present themselves (i.e., meetings, with staff on unit, with visitors).
- Assist in problem solving regarding hand hygiene and infection safety.

Note: the unit champion is NOT the hand hygiene auditor.

All staff:

- Know best practices, as it relates to hand hygiene and the 4 Moments for hand hygiene.
- Role model the act of hand hygiene and the right behaviour.
- Collaborate with unit champion on improvement activities and outcomes.
- Know their hand hygiene compliance data.
- Participate in improvement measures identified by manager.
- Ensures colleagues are as involved as possible.
- Peer-to-peer coaching and mentorship.
- Share success stories and challenges as opportunities for learning.
- Assist in problem solving regarding hand hygiene and infection safety.

Performance monitoring

Monitoring template: A site-based monitoring template should be created to follow results at a unit level.

Site based: Quarterly audit results will be reviewed at a unit, program, and site level to assess progress, identify areas for celebration and/or areas for improvement, and to support ongoing planning.

Region based: Ongoing progress and quarterly audit results will be reviewed with sites at scheduled site and executive operations meetings. Sites will have an opportunity to highlight progress and provide a countermeasure summary for any areas that are off track.

Hand Hygiene Compliance Downward Trends

If hand hygiene compliance starts to trend in a downwards direction, it is a good opportunity to re-evaluate the practices that are going on in your unit/area. The manager should work with staff in a team approach to determine areas where improvements can be made. Sometimes small habits can have a significant effect on hand hygiene compliance rates (touching hair or glasses). Working together to change not only your own habits, but your colleagues around you will require open communication in a non-threating way. Do you feel comfortable reminding each other when you see missed hand hygiene opportunities happening? Can you track what sorts of activities these usually are?

Using a PDSA cycle, determine what changes you wish to make and make these behaviour changes. Then when the hand hygiene of your unit/area is audited again, you will see the results of your change. Did it make a difference or not? Do you still have to make additional changes to create a positive trend in hand hygiene compliance?

Continued Hand Hygiene Compliance Downward Trends

If the hand hygiene compliance rates continue to drop, then greater measures must be taken. Root cause analysis might be useful to determine where these healthcare errors (hand hygiene misses) are taking place and what are the reasons behind the actions.

If necessary, the manager may need to make hand hygiene a performance issue.

Accountability for hand hygiene compliance flows up the change of command, thus management of poor compliance also flows down the chain of command. If the downward trend continues for two quarters of auditing, unit management is required to notify their facility senior leadership. This report must also include actions they will be taking to remediate the trend.

When facility leadership receives this report, they are required to share this with regional executive staff and indicate what changes will be put into place prior to the next time this unit/area is audited.

Section 6 – Appendices (Resources)

A. On the Spot Feedback Form

Unit _____
Date _____

4 Moments – overall impression of the day's observations

1. Before initial patient/patient environment contact
   ☐ Good ☐ Needs improvement ☐ Poor

2. Before an aseptic or clean procedure
   ☐ Good ☐ Needs improvement ☐ Poor

3. After exposure to blood and body fluids
   ☐ Good ☐ Needs improvement ☐ Poor

4. After patient/patient environment contact
   ☐ Good ☐ Needs improvement ☐ Poor

# of successes: _____ # of misses: _____ Total: _____ %: _____

Comments:
_____
_____
_____
_____
_____
_____
_____
_____

Respectful Workplace Comment:
_____
_____

CARING FOR HEALTH
Winnipeg Regional Health Authority Office régional de la santé de Winnipeg

B. Survey on Hand Hygiene - What's Working Well & What Improvements Can be Made?

Introduction

Hand hygiene is considered the single most important method of reducing HAIs. Hand hygiene is a standard expectation within all sites and sectors yet recent hand hygiene audits demonstrate variable compliance rates which are lower than our goal.

With the support of the Board of Directors, the WRHA has committed to a 100% hand hygiene compliance rate. Achievement of this goal requires us to take a critical look at what we are currently doing to identify improvement opportunities.

Thank you for taking the time to give us your feedback!

Questions

1. Please choose your primary WRHA work unit.
   (List all applicable units/areas of work for your site/facility/service.)

2. Please choose the designation that best describes your profession or role at the site.
   a. Physician
   b. Nurse - RN/RPN/LPN
   c. Health Care Aide (HCA)
   d. Ward Clerk/Unit Clerk
   e. Social Work
   f. Respiratory Therapy
   g. Occupational Therapy
   h. Physiotherapy
   i. Pharmacy
   j. Diagnostic Imaging
   k. Dietary
   l. Environmental Services/Housekeeping
   m. Administrative Assistant
   n. Coordinator
   o. Facility Management/Maintenance
   p. Supervisor/Manager/Leadership
   q. *(List any additional designations/roles that may have been omitted)*

3. How do you perceive your own hand hygiene compliance (or practice)?
   a. 100% of the time
   b. Between 85-99% of the time
   c. Between 75-85% of the time
   d. Between 50-75% of the time
   e. Less than 50% of the time

4. How has COVID-19 impacted your hand hygiene compliance (or practice)?
   a. It has increased. b. It has stayed the same.

5. What would, or does, prompt you to perform hand hygiene (select all that apply):
    a. Helps keep me safe
    b. Helps keep my patient/client/resident safe
    c. Hand hygiene is a routine habit for me
    d. Being nudged or reminded
    e. Seeing others performing hand hygiene
    f. Public reporting of hand hygiene audit results
    g. Awareness that not performing hand hygiene can negatively impact patients/clients
    h. Peer recognition
    i. Leadership recognition
    j. Professional responsibility
    k. Other

6. What are the challenges for you to perform hand hygiene (select all that apply):
    a. Time
    b. Patient/Client/Resident behaviour
    c. Conflicting priorities
    d. Skin irritation caused by hand hygiene products
    e. Inaccessible hand hygiene supplies
    f. Patient/Client/Resident needs perceived as a priority over hand hygiene
    g. Insufficient feedback on how I'm doing with hand hygiene
    h. Forgetting to perform hand hygiene
    i. Lapses in awareness that result in missed hand hygiene opportunities
    j. Being distracted by interruptions
    k. Not seeing others performing hand hygiene
    l. Knowledge of hand hygiene practice and when it's required
    m. Nothing prevents me
    n. Other

7. Are you comfortable asking other staff to perform hand hygiene?
    a. Yes b. No

8. Are you comfortable asking physicians to perform hand hygiene?
    a. Yes b. No

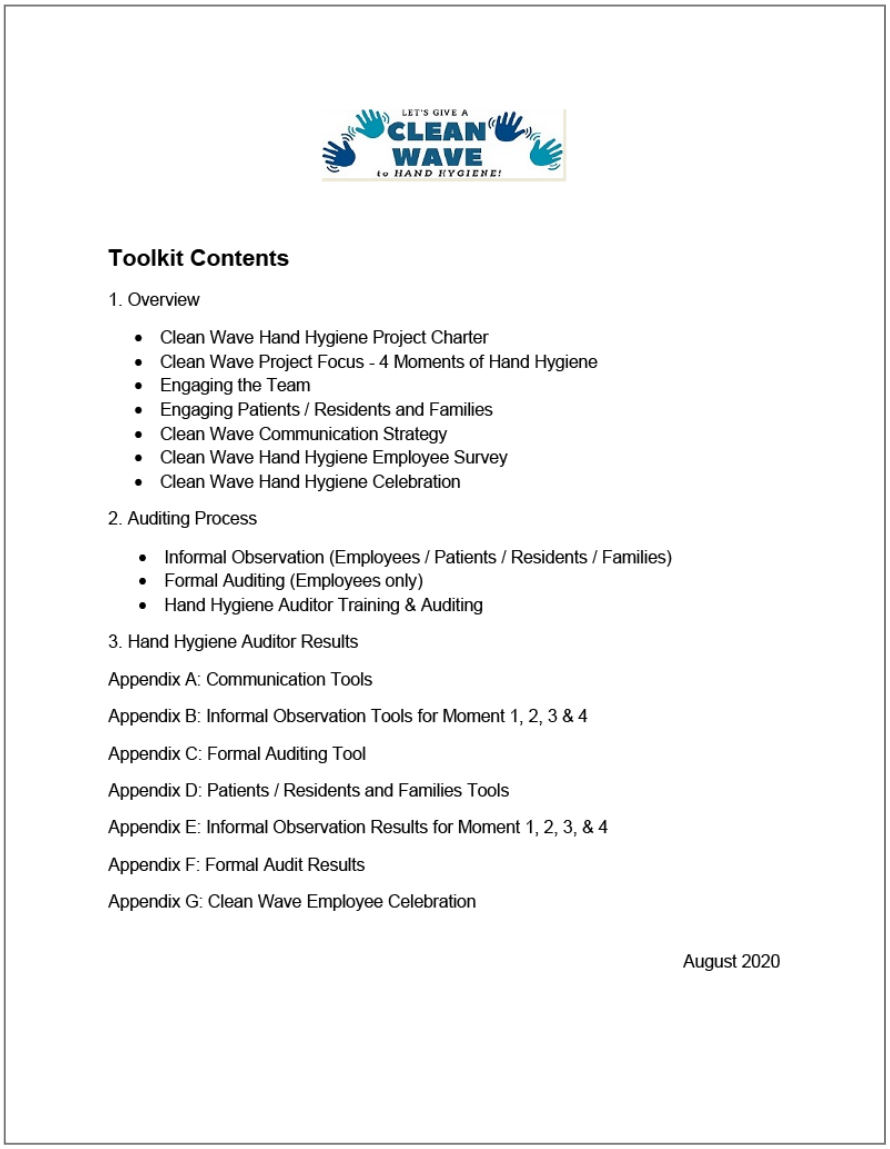
9. Please provide suggestions for hand hygiene improvement (select all that apply):
    a. Education
    b. A reminder or nudge, such as a visual cue to prompt you and your colleagues when hand hygiene is expected
    c. Seeing others performing hand hygiene
    d. On the spot feedback by a colleague
    e. Other communication reminders, such as screen savers and banners
    f. General auditing
    g. Auditing with feedback at the end of the day
    h. Competitions between units or sites
    i. Other

10. Please provide any suggestions for improving hand hygiene rates:
    a. Open text

C. Clean Wave Campaign

The Clean Wave Campaign took place at Deer Lodge Centre from summer 2019 to winter 2020. The campaign achieved great success, bringing the site's hand hygiene compliance from 66% to 90%. The package linked below includes a wealth of resources such as panning documents, posters, a survey, outlines for formal and informal auditing processes, etc.

home.wrha.mb.ca/CleanWaveCampaignBooklet.pdf



LET'S GIVE A CLEAN WAVE to HAND HYGIENE!

Toolkit Contents

1. Overview

- Clean Wave Hand Hygiene Project Charter
- Clean Wave Project Focus - 4 Moments of Hand Hygiene
- Engaging the Team
- Engaging Patients / Residents and Families
- Clean Wave Communication Strategy
- Clean Wave Hand Hygiene Employee Survey
- Clean Wave Hand Hygiene Celebration

2. Auditing Process

- Informal Observation (Employees / Patients / Residents / Families)
- Formal Auditing (Employees only)
- Hand Hygiene Auditor Training & Auditing

3. Hand Hygiene Auditor Results

Appendix A: Communication Tools

Appendix B: Informal Observation Tools for Moment 1, 2, 3 & 4

Appendix C: Formal Auditing Tool

Appendix D: Patients / Residents and Families Tools

Appendix E: Informal Observation Results for Moment 1, 2, 3, & 4

Appendix F: Formal Audit Results

Appendix G: Clean Wave Employee Celebration

August 2020