Providing Feedback on Hand Hygiene: A Multifaceted Approach

Laurie Boyer RN BScN MEd CIC CPN(c)
Manager of Patient Safety
North Bay Regional Health Centre
Consider approaches to providing feedback about hand hygiene compliance using JCYH’s multi faceted approach as the framework, at multiple levels of a healthcare organization.
The Multifaceted Program

- Education for staff about when and how to clean their hands.
- Senior management support and commitment to make hand hygiene an organizational priority.
- Environmental changes and system supports like alcohol-based hand rub at the point of care, which makes it easy for staff to clean their hands at the right time, and hand care programs.
- Resident and family engagement.
- Ongoing monitoring and observation of hand hygiene practices, with feedback to staff.
- Opinion leaders and champions modeling the right behaviour.

Higher hand hygiene compliance rates, fewer infections.
Legacy organizations
February, 2011
Why can’t they Just Clean (their) Hands?
At the **Organization** Level

- **Higher hand hygiene compliance rates, fewer infections.**
  - Education for staff about when and how to clean their hands.
  - Senior management support and commitment to make hand hygiene an organizational priority.
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Hand Hygiene Focus Group

Surgical Services
January 12, 2012

2011 rates at NBGH

NBRHC Moment 1 - Before patient/environment contact

Inpatient Surgery Moment 1 - Before patient/environment contact
Posted on the unit at the time that the focus group sessions were held...
Surgery Inpatient Staff Hand Hygiene Focus Groups
(Voice of the Customer)

This past week, two, two-hour focus group sessions were held regarding hand hygiene practices on the in-patient surgery units. 24 staff members representing all disciplines and services were in attendance.

The areas that we set out to explore with the multidisciplinary team members included:
  • the barriers (physical, organizational, cognitive and social / behavioural) to hand hygiene performance.
  • perceptions of hand hygiene guidelines, and;
  • what might be done to support improved hand hygiene performance.

The staff members present were very forthcoming and candid with their responses, and we have all learned a lot from each other! Please note that this preliminary briefing note is being prepared solely in order to provide an update to the hospital board members,
Herding Cats?

http://www.youtube.com/watch?v=Pk7yqlTMvp8
The “Top 3”? 

1. Knowledge about when and how to do HH, introspection of own practice around HH
2. Perceived lack of time to perform HH
3. More visual triggers, additional opportunity at point of care, in workflow are needed

- Having product or sink where it is needed
- Perception of risk to patient
- Triggers / barriers
- Circumstances that prevent performance of HH
- Culture, role models
- The JustCleanYourHands model itself
"If a healthcare worker washed before touching a patient every time, and never washed after touching a patient, there would be no transmission of microorganisms between patients on healthcare workers' hands. So to patients, only the before-care hand hygiene really matters."

~ Shira I. Doron, MD, MS, assistant professor of medicine at Tufts University
Where are we now? were we then?

Hand Hygiene Compliance
(Before patient and/or their environment)

Our Goal:
70%

Current Hand Hygiene Rate

Inpatient Surgery
32.20%

Current Hand Hygiene Rate

Our Goal:
70%

Inpatient Surgery
55.56%
(Before Patient/Environment)
At the Organization Level

Higher hand hygiene compliance rates, fewer infections.

- Education for staff about when and how to clean their hands.
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At the **Department** Level

**Higher hand hygiene compliance rates, fewer infections.**

- **Education for staff** about when and how to clean their hands.
- **Senior management support and commitment** to make hand hygiene an organizational priority.
- **Resident and family engagement.**
- **Environmental changes and system supports** – like alcohol-based hand rub at the point of care, which makes it easy for staff to clean their hands at the right time, and hand care programs.
- **Ongoing monitoring and observation of hand hygiene practices**, with feedback to staff.
- **Opinion leaders and champions modeling the right behaviour.**
Mind Mapping for Hand Hygiene Improvement

A tool supporting thematic analysis and communicating focus group data while continuing the dialogue

Laurie Boyer
North Bay Regional Health Centre

http://www.chica.org/conf/12_presentations/oral_wednesday_boyer.pdf
Meeting the need...prove that we mean to help...providing information...developing champions, celebrating success!
Let departments know how they are doing...
Provide their data as often as needed, if you can...

Sample Hand Hygiene Compliance Rates - Inpatient Surgery
Product placement: Go Dotty!

## Mini QIP Plan for: Hand Hygiene Improvement Committee  
NBRHC

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>Objective</th>
<th>Measure/Indicator</th>
<th>Current Performance</th>
<th>Target for 2013/14</th>
<th>Target Justification</th>
<th>Priority Level</th>
<th>Initiative Number</th>
<th>Planned Improvement Initiative (change ideas)</th>
<th>Methods and Process Measures</th>
<th>Goal for change ideas (2013/14)</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Safety</td>
<td>Reduce hospital-acquired infection rates</td>
<td>Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial contact multiplied by 100.</td>
<td>74%</td>
<td>80%</td>
<td>Better than provincial target (for year 2010/11 CIHI)</td>
<td>2</td>
<td>1</td>
<td>Peer Auditing - staff audit peers on inpatient units</td>
<td>% units participating</td>
<td>100%</td>
<td></td>
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<td>2</td>
<td>1</td>
<td>On-the-spot Feedback: Provide to staff for compliance and/or non-compliance. This may include a small prize for high performance.</td>
<td>High achievement awards given out - 2 per month</td>
<td>100%</td>
<td></td>
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<td>2</td>
<td>1</td>
<td>Recognition of Staff - IPC to facilitate communication to manager of staff who performs exceptional hand hygiene practice using a standard letter template with a certificate to present to staff</td>
<td>IPC communications to manager expect 2 per month</td>
<td>100%</td>
<td>IPC to communicate new initiative to managers in upcoming monthly meeting</td>
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<td>2</td>
<td>1</td>
<td>Black light travelling road show</td>
<td>Bring black light to 10 units</td>
<td>100%</td>
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<td>1</td>
<td>Compliance Rates: Enhanced Communication - quarterly rates are posted on Infection Control site (sub-site of hospital intranet) for all units - Direct communication provided to units via poster with quarterly rates specific to their unit and overall hospital</td>
<td>% communication completed within 2 weeks post-quarter</td>
<td>100%</td>
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<td>1</td>
<td>Quarterly Recognition - In person recognition of the units with the (i) highest compliance and (ii) most improved unit. This may involve the CEO and/or Senior Team.</td>
<td>staffs per year</td>
<td>100%</td>
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<td>1</td>
<td>Report Quarterly at Monthly Manager’s Meetings</td>
<td>IPC to attend and report quarterly compliance rates at manager’s meetings (4 meetings/year)</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

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**Hospital Quality Improvement Plan – “Mini-QIP” for departments, committees...**
A3 Planning: Hand Hygiene Improvement Committee

Title: Hand Hygiene Improvement 2013

Owner: HHI Cmte / Laurie Boyer  Date: Fall 2013

1. Background: What are you talking about and why?

To protect patients from Healthcare Acquired Infections (HAIs), it is imperative that everyone clean their hands before contact with the patient or the patient’s environment (Moment 1, JustCleanYourHands).

- In 2011-12 and 2012-13, the QIP measure for hand hygiene was set at 70% and was a Priority 1.
- After relocation to the new facility, hand hygiene (HH) rates dropped substantially from the legacy facilities’ respective rates.
- 70% compliance was narrowly achieved after a rigorous campaign resourced with a full-time HH Coordinator. A part-time HH Coordinator was engaged for 4 months in the winter of 2012-13
- Some departments are not meeting the 80% compliance goal
- Hospital overall met last year’s QIP goal (70%), as a priority 1 goal, tied to executive compensation.
- Results across programs are variable.
- Some programs results based on a small number of audits, questionable significance, do not contribute to the organizational goal in a meaningful way.
- 2013-14 QIP goal is 85% hand hygiene compliance for Moment 1 & 4. Hand Hygiene is a Priority 2 measure at NBRHC this year. Hand Hygiene coordinator position has ended.
- Perception that only Priority 1 goals are being actively pursued.

2. Current Conditions: Where do things stand now?

- Each program must take measures to be able to meet the goal of 80% compliance with Moment 1 on an ongoing basis
- Fishbone diagram
- Pareto (to be conducted by each team)
- 5 Whys (to be conducted by each team)
- Departments that do not submit the minimum number of audits (20 per quarter) still receive a percentage result based on the number of audits completed…there is no benefit to performing the minimum number of audits.
- Now a Priority 2 QIP goal, with discontinuation of the Hand Hygiene Lead resource with a concurrent increase to 80% compliance is not being observed or achieved by all departments.

3. Goal: What specific outcome is required?

- Department to conduct individualized project charter to address hand hygiene improvement.
- Since the indications for hand hygiene and barriers to hand hygiene compliance can vary based on the group, environment of care, and other factors, it is important that groups consider their own situation and decide how best to address HH compliance in the specific situations they encounter.

4. Analysis: Why does the problem or need exist?

- Fishbone diagram
- Pareto (to be conducted by each team)
- 5 Whys (to be conducted by each team)
- Departments that do not submit the minimum number of audits (20 per quarter) still receive a percentage result based on the number of audits completed…there is no benefit to performing the minimum number of audits.
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5. Recommendations: What do you propose and why?

- Departments to conduct individualized project charter to address hand hygiene improvement.
- Since the indications for hand hygiene and barriers to hand hygiene compliance can vary based on the group, environment of care, and other factors, it is important that groups consider their own situation and decide how best to address HH compliance in the specific situations they encounter.

6. Plan: How will you implement?

- Invite teams that are struggling to perform the minimum number of audits and/or not meeting the 80% goal to avail themselves of the assistance of the HHI Cmte.
- Teams to establish individualized plan for improving HH
- HH audit numbers and compliance data to be returned to active project groups on a monthly basis for the period of the project (normally organization received this information quarterly)
- Project leads to post/otherwise communicate progress to goals back to team
- Designated department lead to develop plan with their colleagues, involve project sponsor, receive and report back data to stakeholder group
- Liase with HHI Cmte designate, attend HHI mtgs during the project period to report progress, request assistance and ideas

Typical Gantt chart for HH improvement at the department level

7. Followup: How will you ensure ongoing PDCA?

- 3 months of adequate numbers of audits submitted
- 3 months of meeting compliance requirement
- Continue quarterly return of data
- Project lead to monitor data for areas of concern
- Report out challenges and successes (blog, staff meetings, management meetings, HHI Cmte)

See fishbone diagram:

Next slide
Contributing factors: fishbone diagram (Ishikawa)
At the Department Level

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At the **Individual** Level

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Senior management support and commitment to make hand hygiene an organizational priority.
Doing the math...

“Giving healthcare professionals individual feedback on hand hygiene made them twice as likely to wash their hands or use soap.”

| Step | BEFORE initial resident/resident environment contact | WHEN? | Clean your hands when entering:
  - before touching resident or
  - before touching any object or furniture in the resident’s environment
WHY? | To protect the resident/resident environment from harmful germs carried on your hands |
|------|----------------------------------------------------|-------|--------------------------------------------------|
| Step | BEFORE aseptic procedures | WHEN? | Clean your hands immediately before any aseptic procedure (e.g., oral dental care, eye drops, catheter insertion and changing a dressing)
WHY? | To protect the resident against harmful germs, including the resident’s own germs, entering his or her body |
| Step | AFTER body fluid exposure risk | WHEN? | Clean your hands immediately after an exposure risk to body fluids (and after glove removal)
WHY? | To protect yourself and the health care environment from harmful resident germs |
| Step | AFTER resident/resident environment contact | WHEN? | Clean your hands when leaving:
  - after touching resident or
  - after touching any object or furniture in the resident’s environment
WHY? | To protect yourself and the health care environment from harmful resident germs |
Observation and providing feedback
All signs indicate...
At the **Individual** Level

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Next steps...

• Toolkit for consistent training of auditors?
• Adopt a common auditing philosophy
• Ensure auditors (and HCWs) know if Moment 1 is different in various settings (e.g., mental health lodges)
• Simulation/practice for auditors in providing and receiving feedback?
• Let departments know of Hand Hygiene Improvement Committee’s new focus and new process, availability to assist with local improvement teams.
• Ensure a system in which enough audits are done in each department that they can receive meaningful data.
Thank you

And,
Kim Carter
Patty Byers
Kathy Walsh
Marilyn Foster
Coretta Tremblay
Leslie King
Anne Sevigny
Catherine Morland
Sue Fitzer

HHI Committee, NBRHC
Board of Directors & Leadership Team, NBRHC
Dottie the Hospital Clown
(Diane Szewczyk)