## Maryland Hospital Hand Hygiene Collaborative

### Frequently Asked Questions, Updated March 2012

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| **1. What is different about this approach to hand hygiene compliance?** | Healthcare providers across the State of Maryland are embarking on a model campaign with the potential to dramatically improve care, increase awareness among providers and consumers, and lead to savings to the healthcare system.  

The Maryland Hospital Hand Hygiene Collaborative is being conducted by the Maryland Patient Safety Center to implement recommendations from the Maryland Health Quality and Cost Council. The results of a report by the Maryland Health Care Commission’s Healthcare-Associated Infections Advisory Committee and its Hand Hygiene and Infection Prevention Subcommittee indicate considerable variability among Maryland hospitals related to hand hygiene activities. The report emphasizes the need for a common approach by hospitals to tackle this long standing compliance issue so that we can significantly impact patient quality care.  

There will be a standard with required elements that will provide for statewide comparability. Solutions are not a “quick fix”; the goal is “hardwiring” or transformational change related to healthcare-associated infections (HAIs) and hand hygiene. |
| **2. What is the goal of the collaborative?** | The ultimate goal is improving hand hygiene compliance and reducing the number of HAIs in Maryland. The AIM of the collaborative is: All Hand Hygiene Collaborative Participants Will Achieve a Hand Hygiene Compliance Rate of at Least 90% for All Units/Participants. This is an open-ended stretch goal, but one that we should all aspire to. As each hospital is unique in progress towards improved hand hygiene compliance, there will be variability in achieving a compliance rate of 90%. Each organization may select a variety of short term goals to assist in reaching the overall aim. |
| **3. Is participation in the collaborative mandatory?** | The Maryland Hospital Hand Hygiene Collaborative is voluntary. A coordinated, statewide effort is the most effective and successful approach to having a positive impact on infection prevention practices. It is significantly more efficient than the current patchwork of individual, well-intended, but divergent facility efforts. The goal of 100% participation by Maryland’s Acute Care General Hospitals ensures coordinated, comprehensive and sustainable improvement. |
| **4. What is required by hospitals to ensure full compliance and participation?** | - Use of only **UNKNOWN OBSERVERS** to observe hand hygiene compliance data reported to HandStats  
- Use **STANDARD TRAINING** program to train Observers  
- Measure hand hygiene upon **EXIT** of the patient environment (at a minimum)  
- Measure compliance in **ALL INPATIENT** and **INTENSIVE CARE** units, including Medical-Surgical, **PEDIATRICS**, Medical and Surgical Intensive Care Units, and Neonatal Intensive/Special Care Units.  
- Collect **30 OBSERVATIONS PER UNIT PER MONTH** not including blocked view. **NOTE:** Organizations that measure hand hygiene compliance upon **ENTRY** to the patient environment may include these observations in the 30 required each month, but, only **EXIT** observations will be used for the state aggregate.  
- **ENTER HAND HYGIENE COMPLIANCE DATA** by the 10th of each |
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<th>5. How were the required elements of participation determined?</th>
<th>The Collaborative relied on national and local experts as well as the findings and recommendations detailed in the Report and Recommendations on Implementation of a Statewide Hospital Hand Hygiene Campaign prepared by the Maryland Healthcare-Associated Infections Advisory Committee and its Hand Hygiene and Infection Prevention Subcommittee as a guide to the required elements. The standard methodology is based on the latest evidence-based practices and national/international experiences to date and serves as a starting point.</th>
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| 6. How is the compliance rate calculated? | There are 2 different calculations that occur:
- **Hospital-Specific Hand Hygiene Compliance Rate**
  - Numerator: Number of observed staff cleansing hands on exit or entry
  - Denominator: Number of observed staff exiting or entering a patient’s room
  - Documented monthly by unknown, trained observers
- **Maryland Aggregate Hand Hygiene Compliance Rate**
  - Numerator: Number of observed staff cleansing hands on exit only
  - Denominator: Number of observed staff exiting a patient’s room

**In order to have your hospital's rates count towards the statewide aggregate you must meet the “80/30 Rule”:**
- 80% of a hospital’s required reporting departments with at least 30 data points (exit & entry observations) for the month
- Required departments: Medical/Surgical CCU, Pediatric CCU, Adult Inpatient, and Pediatric Inpatient, NICU |
| 7. Definition of the Unknown Observer | An Unknown Observer must be a non-Infection Preventionist staff member and observe hand hygiene compliance on units other than their own. The Unknown Observer does NOT need to be "unknown" to the staff; just the TASK of completing the observations must be unknown to other staff at the time of the observation. Unknown Observers must be trained using the Johns Hopkins Medicine Standardized Training for Hand Hygiene Observers module available online and on DVD.

The Project Team understands that many participants are concerned that an “Unknown” person will stand out on the unit. To minimize this we suggest that you utilize people that are not assigned to the unit 100%, but do have a reason to be on the unit. Refer to the following link concerning unknown observers:
| 8. Use of HandStats for optional units | Any unit reporting hand hygiene observations in HandStats must use the standard methodology including optional units (ex. ED, Outpatient, Perioperative, Behavioral Health, Postpartum, Rehabilitation). |
| 9. When will I be required to submit hand hygiene compliance data? | Data collection and submission commences the first day of the month. The previous month’s data must be submitted AND approved by the 10th day of the following month in order to generate your monthly hospital-specific hand hygiene report card that accurately profiles your organization’s participation in the Collaborative. The report card provides |
your organization with essential information on your required units, observations, compliance with the 80/30 rule, and your organization’s hand hygiene compliance rate compared to the Maryland State aggregate rate.

Hand hygiene observation/compliance data will be entered via the Handstats website in one of two ways:
- real time via your hand held device that is linked to the HandStats website,
- after observations have occurred via a hard copy observation tool

Process outcomes will be entered via the MPSC website biannually.

### 10. How will required data reporting work?

Participants will report two types of measures: hand hygiene observation data or outcome data and process measures data. Process data will be submitted via the MPSC website and outcome data via the Johns Hopkins Health System (JHHS) website [http://www.handstats.org](http://www.handstats.org).

Johns Hopkins Health System will manage the hand hygiene compliance database, Handstats, on a designated secure server. They will ensure the confidentiality and security of all data, using HTTPS protocol to provide encryption and secure identification of the server. Access to organizational data is restricted to those users defined by each organization and is password protected.

Hospitals will have access to their own organizational, role specific and unit specific hand hygiene compliance data to drive improvement. Over time, aggregate de-identified compliance data, once vetted, will be made securely available. At all times hospital specific data and specific identity will be withheld.

### 11. Is there a cost to participate?

**Direct Costs:**
- There are no direct registration costs
- Other material costs such as paper, copying, communication/campaign materials as needed/desired
- Costs to create/modify the data collection tool
- Salary costs for hand hygiene observer training and observation time

**Indirect Costs:**
- Time required to communicate organizational commitment to and participation in the statewide hand hygiene campaign to employees/local community
- Team meeting time out of required job duties to plan, implement, and evaluate progress
- Team participation in off-site learning sessions, conference calls, and webinars
- Time spent by the Infection Preventionist to provide guidance and oversight
- Time for observers to participate in and complete the statewide training program

### 12. How do I sign up to become a HandStats administrator?

There are two types of data Administrator designations possible in the HandStats application:
- Hospital Administrator-manages the database for their organization
- System Administrator-manages the data base for their system of hospitals

**Contact Janel Handy at handyj@dfmc.org to register**
13. Are 30 observations per unit a large enough sample size to truly measure compliance and progress?

Of course the more data the better but that is not always feasible. For example, to be 95% confident that a change of 10% in HH compliance is statistically significant from one month to another you would need more than 100 observations per unit which is not feasible for most hospitals. When looking at unit level data, it is important to look at trends overtime since you will not be able to detect a significant difference between two time points on the graph unless the compliance has changed markedly. It is also beneficial to look at the quarterly charts generated by HandStats which aggregate data over 3 months so you have a larger sample size at each time point.

If you are introducing a new hand hygiene intervention on a unit and it is important for you to detect the difference from one time period to another, you can conduct more observations on that unit for that time period. Looking at data over time via run charts is a better approach for quality improvement projects than pre-post/two time point comparisons especially because what we are really focusing on is sustainability over time.

14. Should the hand hygiene protocol monitor both hand washing upon entry to and exit from the patient room?

Observation of EXIT hand hygiene compliance was adopted as a collaborative requirement since it represented what the Maryland Healthcare Commission Health Care Associated Infections (HAI) Advisory Committee had consensus on in terms of one common measure that could be accomplished by all hospitals. This is not to say that hospitals should only measure that. Using HandStats the hospital can enter data for ENTRY & EXIT along with other HH opportunities such as prior to invasive procedures. HandStats data charts will reflect what they have decided to measure.

A majority of participants reported they were already observing compliance at various other points of care and we encourage that practice. Since the collaborative however uses EXIT as a common metric, this metric will be used for benchmarking purposes among hospitals across the state.

15. What is the Hawthorne Effect and how does it impact hand hygiene compliance?

Improvement in performance, as by workers or students, resulting from mere awareness that experimental attempts are being made to bring about improvement.

A few studies concerning the Hawthorne effect are listed below:


2) **Compliance with antiseptic hand rub use in intensive care units: the Hawthorne effect.** Eckmanns T, Bessert J, Behnke M, Gastmeier P, Ruden H. Institute of Hygiene and Environmental Medicine, Charité University Medicine Berlin, Berlin, Germany. tim.eckmanns@charite.de *Infect Control Hosp Epidemiol.* 2006 Sep;27(9):931-4. Epub 2006 Aug 22.

3) **Systematic review of studies on compliance with hand hygiene guidelines in hospital care.** Erasmus V, Daha TJ, Brug H, Richardus JH, Behrendt MD, Vos MC, van Beeck EF. Department of Public Health, Erasmus University Medical Center Rotterdam, Rotterdam, The Netherlands. v.erasmus@erasmusmc.nl *Infect Control Hosp Epidemiol.* 2010 Mar;31(3):283-94.


### 16. What are the ethical implications of the "unknown observer" approach if they do not stop an unsafe practice when it is observed?

Unknown observers often stay outside of patient rooms and therefore rarely observe any ‘high risk contact’ cases such as missing hand hygiene prior to invasive procedures which can pose this kind of ethical dilemma. To address such risks, it is very important to create systems to capture practices prior to high risk contacts – e.g. checklists and unit-based monitors. A high unit safety culture that encourages, recognizes and rewards team members who ‘speak up’ when unsafe practices are taking place should also be emphasized.

The Hawthorne effect can be used to support a responsible culture and improve hand hygiene practices. Examples include:

- When organizational and unit leaders round and provide feedback
- When video cameras are installed
- When staff are encouraged to monitor and remind each other about the importance of hand hygiene

When healthcare workers feel there is always ‘someone watching’, hand hygiene adherence rates can improve.
17. Isn’t this really an attempt to implement statewide reporting?
The patient is at the heart of this effort. Historically, our individual organizational efforts have been fragmented and have not led to significant, lasting, improvement in hand hygiene compliance. As such, we have not been able to effect wide-spread reduction in HAIs. To date, there is no aggregate statewide data to serve as a basis for comparability among hospitals regarding hand hygiene compliance. Measurement and data force improvement and the collaborative will serve as a platform for consistency and sustainability. This will further potentiate our own current improvement efforts.

Our ability to use this model for sharing evidence-based practice and strategies has proven successful in past state-wide initiatives. As a state, we are embarking on a model campaign with the potential to dramatically improve care, increase awareness among providers and consumers, and lead to savings in the healthcare system. A requirement for public reporting has not yet been determined. The outcomes of the collaborative may, in part, provide information/evidence to assist in forming that decision.

18. Are there other types of supporting initiatives that may be implemented to improve compliance?
Hospital teams will perform an organizational assessment and audit of the current hand hygiene program. Once reviewed, other/new strategies may be selected for implementation. Strategies could include: campaign branding by the facility, addition of new members to the multidisciplinary HH team, hand hygiene education, signage, environmental enhancements, improved reporting process, new tool development, enhanced communications concerning HH, and others.