APIC Comments on Proposed Changes to the 2020 Leapfrog Hospital Survey

Section 6D: Hand Hygiene

December 20, 2019

General

APIC applauds Leapfrog for promoting more robust hand hygiene compliance data from healthcare facilities as a means toward improving hand hygiene compliance among healthcare personnel. We agree that hand hygiene is an essential patient safety action. However, we are concerned that a non-regulatory, non-accreditation and non-recommendation making organization is guiding practice. While we recognize the importance of hand hygiene and acknowledge lapses in practice, our members have concerns that the proposed questions for hand hygiene require either an electronic monitoring system or 200 observations per unit/location per month. The Joint Commission hand hygiene monograph points out that there is no standard method for measuring hand hygiene with strengths and limitations in all methods. Our members agree that a multimodal approach is important in improving hand hygiene compliance; however, due to the limitations in all methods we believe that to prescribe a particular method of observation is overreaching. To make an informed decision on the best method of measurement for an individual facility, the pros and cons of available methods must be considered, understood and analyzed before a facility specific decision is made. Although it is only an option, installation of electronic systems is often invasive and disruptive. While the comparison to other electronic systems such as bar code medication administration is appreciated, the widespread expense across many hospitals before the technology is improved may be premature, unwarranted and wasteful.

We acknowledge that drastic action is often the only means to the end. Many suggested that zero central line-associated bloodstream infections (CLABSI) could never be achieved, yet many organizations have gone a year or more without a CLABSI. That success is most certainly from the pressures of reporting the data publicly. Were it not for the Occupational Safety and Health Administration (OSHA) issuing the Bloodborne Pathogen Standard, healthcare workers would likely not routinely wear personal protective equipment. The OSHA regulation mandated safe healthcare worker practice. Such drastic measures are often needed to change culture. APIC would welcome the opportunity to partner with Leapfrog to develop a realistic plan and timeline to achieve a more robust hand hygiene compliance measurement expectation and process.

The basis for the new survey questions is the World Health Organization (WHO) tool, yet The Joint Commission allows a facility to comply with either the Centers for Disease Control and Prevention (CDC) or WHO guidelines. While the 200 observation recommendation is consistent with the WHO guidelines, CDC guidance recommends periodically monitoring adherence and providing feedback. Requiring 200 observations would by default require facilities to adopt the WHO guidelines. Such a change would take time to implement.
**Training and Education**

APIC supports training and education related to the importance and proper practice of hand hygiene. Education and training as well as monitoring and feedback are described as “fundamental standards of care” in the CDC 2017 Healthcare Infection Control Practices Advisory Committee (HICPAC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings.iii We are not aware of any studies that have shown that a return demonstration of the use of alcohol-based hand rub (ABHR) as well as handwashing with soap and water improves compliance. The action of performing hand hygiene is different from the understanding and recognition that hand hygiene is essential to safe patient care. The six elements included in the initial and annual hand hygiene training are important; however, we believe that a facility should have the capability to identify facility specific needs for initial and annual training and receive credit for those educational items. The facility specific needs would be identified as part the facility risk assessment.

**Infrastructure**

The survey tool does not specify the sample size for the dispenser audits or the methodology. Without such guidance, it will be difficult to draw an equitable conclusion from the information collected. One facility may audit ten dispensers in an organization that has hundreds of dispensers and another organization might audit 50-100 dispensers. Such audits would be time consuming and wasteful as the measured product would be discarded. The volume of ABHR needed to perform hand hygiene is dependent on the size of an individual’s hands, the formulation of the product and the dispenser type. The general recommendation provided by the manufacturer is to rub until dry. A compromise to the wording in question 7 might be to follow manufacturer’s instructions for use rather than specify a specific time. The CDC utilizes “until dry” language.iv

**Monitoring**

**Direct Monitoring – Electronic Monitoring System**

As described in the 2019 Measure Specifications FAQs,v the goal is to determine if a multimodal approach is utilized to improve hand hygiene compliance. Rather than encouraging the use of an electronic monitoring system, APIC recommends altering the question to capture which components of a multimodal system are utilized. Analysis of those data could inform questions in future years and would allow the current electronic systems to mature and potential evidence of efficacy to emerge before widespread adoption would be expected. No single electronic system can capture all the nuances of human nature, patient care and how the two interact. In addition, since wearing of the monitoring badge is typically voluntary there may be bias in the data obtained from the system (e.g. only individuals who are compliant with hand hygiene will wear the badge). Also, a voluntary badge program may result in time and resources being diverted into ‘getting people to wear the badge’ versus ‘getting people to clean their hands’. Lastly, many hospitals have bargained-for employees (e.g. under union contracts) and the monitoring of their practices via an electronic device may be incongruent with their contract language.

Facilities validating their electronic systems would benefit from guidance on recommended methods of validation and expected frequency of validation.

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It seems contradictory to suggest that the electronic system is preferred but then suggest in question number 10 that direct observations are still needed. As above, without an indicated sample size, the term “representative sample” will be open to broad interpretation.

**Direct Monitoring – Direct Observation**

The direct observation questions (10 and 12) require that observers immediately intervene with non-compliant individuals. This may prompt behavior change, but also may result in observers being seen as the only individuals responsible for enforcing hand hygiene compliance, rather than the development of a culture where it is a shared responsibility and expectation to hold one another accountable for patient safety.

The direct observation questions (10 and 12) also require observers to obtain names of those observed. Sometimes this is possible, but often it is not (isolation gown covering badge, distance makes badge unreadable, observer doesn’t know healthcare provider by sight, etc.). It is recommended to add “when possible” to this requirement. Perhaps a more valuable piece of information is the role of the individual, so that data can be quantified by role-type and interventions can be targeted towards those groups.

In the CDC Infection Control Assessment and Response tool for dialysis, CDC recommends a minimum of 30 observations per unit/location per month.\textsuperscript{vi} The WHO recommends collection of 150-200 opportunities per month in each unit/location.\textsuperscript{vii} The Leapfrog survey criteria for direct observations is 200 observations or 1.7% of all possible hand hygiene opportunities, whichever is lower. Calculating the 1.7% of opportunities could change from month to month depending on the type of unit, acuity and time of year. For example, hand hygiene monitoring on a 15 bed rehabilitation unit would be different from a 100 bed neonatal intensive care unit. Without further instructions on the frequency of recalculating the number of opportunities, the sample size could vary across organizations.

**Culture**

APIC is in full support of senior leadership support for hand hygiene but questions verbal commitment as a valid measurement of support. For the commitment question (number 19) to hold weight, we recommend a method similar to those suggested in the CDC core elements for antibiotic stewardship such as requiring a written statement of support, integration into the quality program and committee structure, and/or salary support for stewardship activities.\textsuperscript{viii}

**Summary**

APIC appreciates the opportunity to comment on the proposed 2020 hand hygiene survey. We reaffirm our commitment to patient safety and the important role hand hygiene has in ensuring patient safety. Hand hygiene compliance has been a struggle for more than 170 years and we recognize the urgency for drastic action. We also acknowledge the limitations with both direct observations by electronic monitoring and direct observation. We feel it is imperative to be thoughtful about the approach to a drastic change in order to avoid a period of chaos that might produce data that are not accurate or direct interventions that would divert infection prevention and control resources resulting in unintended consequences. We believe an interim approach would be to establish an incremental metric(s) to achieve the 200 observations per unit recommendation. Such an approach would allow Leapfrog the ability to grade on a scale for those organizations that have fully implemented an

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electronic monitoring system or established a minimum of 200 observations per unit versus those that are in the process of such a transition. Our goals are the same - healthcare without infection.

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