Establishing a system to improve hand-hygiene compliance

as a clinical incident. The other side has instructions on how to wash your hands. These are issued during observation sessions but we plan to extend their use.

**Culture** The trust’s culture values hand hygiene and staff joining or passing through are often bemused by our ‘obsession’. Although some staff are still often non-compliant, questioning usually reveals that they are aware of the importance of hand hygiene. The most frequent query concerns when they should do it, rather than why. The issuing of cards is generally supported because it shows clearly that non-compliance is unacceptable.

**Evaluation** The combination of observation scores and clinical incident reports will be used to measure the success of our system. In the interim we are training staff in observing hand hygiene and feeding back. Our aim is for staff to monitor and improve practice in their own area. To do this we developed some rules of hand hygiene. An example is: ‘If you take off gloves you must wash or decontaminate your hands.’

**Pragmatism** It is sometimes impractical to decontaminate every time a potentially contaminated item is handled. For example, a nurse may measure blood pressure and temperature, handle the patient’s records and then check the urine drainage bag before again handling the records. Our expectation in this case would be to wash or decontaminate hands before and after this series of activities.

**Conclusion** Improving hand-hygiene compliance is not easy. The participation of all staff is vital and non-compliance must be handled equitably. Observing and scoring compliance will measure performance and identify areas for improvement. The use of warning cards will clarify for everyone when significant risks have been taken and provide an opportunity for improvement.

their hands when they should.

**Measuring compliance** We developed an observational tool based on the work of Pittet et al (2000) and Meens et al (1994), and we observed practice for 20 minutes in a defined clinical area. Hand-hygiene opportunities are compared with observed hand-hygiene practice and a score is produced. Significant observations and areas for improvement are then fed back to staff.

Observing staff and not interfering or affecting behaviour is difficult; giving feedback is even harder. Some staff see the contact they have with patients as insignificant, while others believe the risk of transmission of infection is low. Some who are offered tips for improvement see this feedback as criticism.

**Negative response to feedback** On one occasion, I was observing on a surgical ward. A senior doctor stood next to a patient, lifted her nightdress and touched her dressing. After a chat with his team, he turned to leave the ward. I stepped forward, introduced myself and asked him if we could go into the office or somewhere private. He refused and told me to tell him what the problem was. So I did.

I explained that he had not washed or decontaminated his hands before or after examining the patient and pointed out issues of patient dignity and role modelling for other staff. He was irritated and said: ‘Message received – now clear off to where you came from.’

**Reflection** I reflected on this response with the ward nurse. She felt that this was normal behaviour and that some staff ‘get away with it’. In this instance I formally reported the doctor’s behaviour to the clinical director and he was disciplined. This led to a multidisciplinary discussion about what should happen on such occasions and a conclusion was reached that everyone is equal where hand hygiene is considered.

**Poor compliance** We have observed that nurses who have a lot of contact with patients can also have very low compliance scores. Feedback and education does initially improve compliance but our experience is that subsequently scores fall back to previous levels. Some staff are persistently poor at hand hygiene, while others are excellent. A clear, consistent and unambiguous message is required.

**Card system** One solution we are now trying is based on the red and yellow card system in football. Laminated postcards are issued to persistent offenders by the infection control team. On one side, the card states that non-compliance has been observed and will be reported.