Technology for Monitoring Hand Hygiene in the 21st Century: Why Aren’t We Using It?
Prof. Mary-Louise McLaws, University of New South Wales, Australia
A Webber Training Teleclass

Mary-Louise McLaws
Professor
Epidemiology in Healthcare Infection
Infectious Diseases Control

Technology for monitoring hand hygiene in the 21st century: why aren’t we using it?

Hosted by Jane Barnett
jane@webbertraining.com

www.webbertraining.com October 19, 2016

Hand hygiene rates

What we know about hand hygiene behavior in Australia
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Australia: HHO perceived as clean

- Perform hand hygiene associated with touches in community perceived as clean
- Attitudes
- Perceived hand hygiene in your peers
- Subjective norms - Physicians
- Subjective norms - Administrators
- Effort required

Australia: HHO perceived as dirty

- After defaecation
- After gardening
- After touching someone else’s dog


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Iran: HHO perceived as clean

Perform hand hygiene associated with touches in community perceived as clean
AOR 2.1 (95% CI 1.8-2.4) P<0.0001

Perform hand hygiene associated with touches in hospital perceived as dirty
AOR 1.6 (95% CI 1.4-1.7), P<0.0001

Effort required
AOR 1.1 (95% CI 1.0-1.1), P=0.039

Subjective norms-nurses
AOR 1.1 (95% CI 1.02-1.3), P=0.025

Attitudes
AOR 0.91 (95% CI 0.8-0.9) P=0.01

R^2 0.58, P<0.001

Intention to cleanse


Iran: HHO perceived as dirty

Performs hand hygiene associated with touches in hospital perceived as clean touches
AOR 2.5 (95% CI 2.0-3.0) P<0.0001

Performs hand hygiene associated with touches in community perceived as dirty
AOR 1.5 (95% CI 1.2-1.9) P=0.901

Subjective norms-Infection Control Practitioners
AOR 1.5 (95% CI 1.2-1.8) P=0.901

Attitudes
AOR 1.1 (95% CI 1.04-1.2) P=0.091

Subjective norms-nurses
AOR 0.74 (95% CI 0.64-0.87) P=0.000

R^2 0.49, P<0.0001

Intention to cleanse


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Hand hygiene opportunities required to be observed per quarter for rates ≥60% to give reliable estimate i.e. (95CI 58%-63%)

<table>
<thead>
<tr>
<th>profession</th>
<th>5 moments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>1750 + 1750</td>
</tr>
<tr>
<td>Nurses</td>
<td>1750 + 1750</td>
</tr>
<tr>
<td>Medical students</td>
<td>1750 + 1750</td>
</tr>
<tr>
<td>Nursing students</td>
<td>1750 + 1750</td>
</tr>
<tr>
<td>Allied health</td>
<td>1750 + 1750</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8750 + 8750 = 7,500</strong></td>
</tr>
</tbody>
</table>

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Average hand hygiene burden
*per staff per day shift adjusted for number of beds*

<table>
<thead>
<tr>
<th></th>
<th>Nurse</th>
<th>Doctor</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>22</td>
<td>6</td>
<td>4:1</td>
</tr>
<tr>
<td>Surgical</td>
<td>33</td>
<td>8</td>
<td>4:1</td>
</tr>
</tbody>
</table>

Decline by 14PP-22PP in night shift

If 5 Moments aggregated for Doctors + Nurses = 100%

*Burden for Doctors vs Nurses*

<table>
<thead>
<tr>
<th></th>
<th>Moment 1</th>
<th>Moments 4/5</th>
<th>Moments 2/3</th>
<th>Burden ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday</td>
<td>5% vs 30%</td>
<td>9% vs 38%</td>
<td>2% vs 16%</td>
<td>1 : 6</td>
</tr>
<tr>
<td>Weekend</td>
<td>3% vs 27%</td>
<td>7% vs 39%</td>
<td>2% vs 22%</td>
<td>1 : 10</td>
</tr>
</tbody>
</table>

Conclusion: doctors have *very little burden*

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Hand Hygiene rate 44% to 68% ($P < 0.001$) in 521 hospitals

![Graph showing national monthly incidence rates of methicillin-resistant Staphylococcus aureus bacteremia (MRSAB)]

* Dashed line indicates National Hand Hygiene Initiative (NHII) implementation. MRSAB rates were statistically stable before implementation ($P = 0.356$) but significantly declined after ($P = 0.008$).


21 largest Australian hospitals inverse relationship: for every 10 PP hand hygiene compliance SAB rate increased by 0.5 case/10,000 bed-days

![Graph showing rates of health care-associated Staphylococcus aureus bacteremia (SAB) and hand hygiene compliance for 21 large metropolitan public hospitals July 2010 to June 2011]


<table>
<thead>
<tr>
<th>State</th>
<th>Incidence rate ratio association</th>
<th>322 hospitals from 3 largest states:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW (n=200)</td>
<td>SAB rate and Hand Hygiene rate</td>
<td>just 1% of decrease in SAB rate can be attributed to current hand hygiene compliance rate</td>
</tr>
<tr>
<td>QLD (n=46)</td>
<td>0.97 ($p&lt;0.01$)</td>
<td></td>
</tr>
<tr>
<td>VIC (n=76)</td>
<td>0.99 ($p&lt;0.25$)</td>
<td></td>
</tr>
<tr>
<td>Aggregated hospitals (N=322)</td>
<td>0.98 ($p&lt;0.01$)</td>
<td></td>
</tr>
</tbody>
</table>

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Margin of error for the current hand hygiene compliance rates for Moment 1 (before touching a patient) collected during 1 January to 31 March, 2013 by hospital size

<table>
<thead>
<tr>
<th>National threshold (70%) compliance by hospital size</th>
<th>Proportion of hospitals (no. of hospitals at compliance levels/total number of hospitals)</th>
<th>Moment 1 rate (95% CI) (no. of Moment 1 compiled/total Moment 1 observations)</th>
<th>Average compliance rate for the hospital size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 400 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At or above threshold</td>
<td>29% (10/34)</td>
<td>70% (65%–73%)</td>
<td></td>
</tr>
<tr>
<td>Below threshold</td>
<td>71% (24/34)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>301–400 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At or above threshold</td>
<td>29% (4/14)</td>
<td>70% (65%–73%)</td>
<td></td>
</tr>
<tr>
<td>Below threshold</td>
<td>71% (10/14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>201–300 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At or above threshold</td>
<td>30% (6/20)</td>
<td>75% (70%–77%)</td>
<td></td>
</tr>
<tr>
<td>Below threshold</td>
<td>70% (14/20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>101–200 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At or above threshold</td>
<td>43% (6/14)</td>
<td>75% (70%–79%)</td>
<td></td>
</tr>
<tr>
<td>Below threshold</td>
<td>57% (8/14)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Compliance rates for all five hand hygiene moments by doctors and nurses for 1 January to 31 March 2013, by hospital size regionally and by the three largest Australian states

<table>
<thead>
<tr>
<th>Hospital size or state</th>
<th>No. of hospitals</th>
<th>Compliance rate (95% CI)</th>
<th>Percentage point difference between doctor and nurse compliance</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital size (no. of beds)</td>
<td></td>
<td>Doctors</td>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>&gt; 400</td>
<td>34</td>
<td>63% (62%–64%)</td>
<td>50% (90%–80%)</td>
<td>17</td>
</tr>
<tr>
<td>301–400</td>
<td>14</td>
<td>62% (61%–64%)</td>
<td>79% (79%–80%)</td>
<td>17</td>
</tr>
<tr>
<td>201–300</td>
<td>20</td>
<td>65% (64%–66%)</td>
<td>82% (82%–62%)</td>
<td>17</td>
</tr>
<tr>
<td>101–200</td>
<td>14</td>
<td>65% (63%–66%)</td>
<td>83% (82%–93%)</td>
<td>18</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>30</td>
<td>65% (64%–65%)</td>
<td>84% (83%–84%)</td>
<td>19</td>
</tr>
<tr>
<td>Queensland</td>
<td>19</td>
<td>61% (60%–62%)</td>
<td>79% (79%–80%)</td>
<td>18</td>
</tr>
<tr>
<td>Victoria</td>
<td>17</td>
<td>66% (67%–70%)</td>
<td>77% (77%–78%)</td>
<td>9</td>
</tr>
</tbody>
</table>

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Incorrect message we give

and

Invalid and unreliable sampling

Q. Does this mean there is little association between hand hygiene and bacteremia?

A. Yes and No
   It’s all about the auditing
Little to no relationship....yet

Why ?

We haven’t reached best practice – why ?

Poor followership
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- Behavior- rates are gamed
- Incorrect message we give

Gamed by ward staff and managers

“We’ve reached our hand hygiene KPI”

Daily average daily use in grams per room
1gm = 1 Hand Hygiene Opportunity


<table>
<thead>
<tr>
<th>Ward 1</th>
<th>o medical 3 HHOs per patient per 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o surgical 4 HHOs per patient per 24 hours</td>
</tr>
</tbody>
</table>

Average 20 patients = 70 grams

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**Gained by ward staff and managers**

“We’ve reached our hand hygiene KPI”

<table>
<thead>
<tr>
<th>Ward 1</th>
<th>Clear</th>
<th>1.23</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue</td>
<td>14.7</td>
</tr>
<tr>
<td></td>
<td>Pink</td>
<td>0.87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward 2</th>
<th>Clear</th>
<th>0.35</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blue</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>Pink</td>
<td>0.2</td>
</tr>
</tbody>
</table>

**Developed validated audit method + ‘added value’**

Automated audit system

Tested system without *nudge*

*Added value to automation using Nudge theory*

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Developed validated automated method
+ ‘added value’

- Developed a validated automated surveillance system to monitor compliance
- Transformed compliance into peer-lead behaviour change
- Pioneered - daily rates + nudge theory
- Sustained behaviour since June 2014
- Adapted nudge theory

Ethics approval: UNSW Australia; Area Health Service- test hospital

Developed validated automated system

Installed Wi-Fi
Daily compliance data gathering
- Automated numerator by depressing hand hygiene dispensers
- Use denominator from 24/7 audits of hand hygiene opportunities

Team compliance rate
Total hand hygiene compliance

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Map

Oct 2013    HHA audit
Oct 12-18 2013 24/7 audit

June - Nov 2014
Automation installation + run in

Dec 2014 - Nov 2015
Automation + Nudge

Nov 6 2015
8-hour audit

24/7 Comparisons between Medical and USA weighted adjusted daily HHOs (soap and water & ABHR)

Mean (95%CI) HHOs per patient-day in medical ward

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Australia¹</th>
<th>USA²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday (Mon-Fri)</td>
<td>77 (59-95)</td>
<td>76 (71-89)</td>
</tr>
<tr>
<td>Weekend (Sat-Sun)</td>
<td>73 (60-87)</td>
<td>68 (65-88)</td>
</tr>
<tr>
<td>24-hour period (Mon-Sun)</td>
<td>76 (65-87)</td>
<td>74 (69-84)</td>
</tr>
</tbody>
</table>

Conclusion: our estimates have validity


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DebMed® GMS™
Hand hygiene Compliance Group Monitoring System

Reality check

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### Reality check

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automation</td>
<td>40%</td>
<td>60%-80%</td>
</tr>
<tr>
<td>Without nudge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automation plus nudge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Weekly report

**DebMed® GMS™**
Hand Hygiene Compliance Group Monitoring System

HHCI: 05-Apr-2015 to 11-Apr-2015 (DAILY points)

![Weekly Report Chart]

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Transformed evidence of compliance into action using every clinician

Nudging Steps for co-operation
1: using evidence yesterday’s rate from new automated system
2: continuous improvement “Did we reach our goal rate?”
3: group mantra “Hand hygiene is for the benefit of the patient”
4: developing trust to ask for help “Nudge me”
5: practice nudging “Doctors take a moment”
6: be your goal visualise yourself cleansing your hands on entry to first patient’s room

Nudge theory
- President Barak Obama
- Prime Minister David Cameron
- Donor registration increased 38 to 60% in the US from the drivers license department
- Toilets in Amsterdam’s Schipol airport, drawings of black flies, ↓spillage 80%
- Quit smoking rates increased
- Vaccinations uptake

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Behavioural economics models
• move communities towards rational targeted purchasing / preferred behaviour patterns

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automation</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>without nudge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plus nudge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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From following to nudging

“Older doctors are very much on board [nudging]....and act as a role model, 2 consultants [1 is head of department] always cleans in and out... the rest of the team follows and do not need to be nudged.....”

From following to nudging

“Yes, daily I remind them [doctors] about the opportunities that they missed, not 7 steps, I don’t follow all the 7 steps at the hand over, but give a reminder here and there. We [all ward staff] are very motivated as a group.”
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Pioneering the *nudge*

Average Monthly Compliance in the Diffuser Ward

<table>
<thead>
<tr>
<th>Month</th>
<th>Jul-14</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>Jan-15</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>30</td>
<td>40</td>
<td>45</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td>65</td>
<td>70</td>
<td>70</td>
<td>75</td>
<td>80</td>
</tr>
</tbody>
</table>

Validity of Hand Hygiene Australia rates versus Covert Automation

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overt HHA 24/7</td>
<td>73%</td>
</tr>
<tr>
<td>Covert automation</td>
<td>40%</td>
</tr>
<tr>
<td>Overt automation + value add</td>
<td>60% - 80%</td>
</tr>
</tbody>
</table>

-27PP difference

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8-hour audit

1,159 HHOs collected automatically >3 times HHA sample

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>86% (95% CI 83%-90%)</td>
<td>75% (95% CI 70%-79%)</td>
</tr>
<tr>
<td>Doctors</td>
<td>88% (95% CI 76%-94%)</td>
<td>62% (95% CI 52%-71%)</td>
</tr>
<tr>
<td>Moment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>74%</td>
<td>79%</td>
</tr>
<tr>
<td>2</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>3</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>4</td>
<td>92%</td>
<td>82%</td>
</tr>
<tr>
<td>5</td>
<td>85%</td>
<td>44%</td>
</tr>
<tr>
<td>Total</td>
<td>85%</td>
<td>70%</td>
</tr>
</tbody>
</table>

What makes a ward a diffuser ward?

“...senior doctors, I know them well, we can talk about personal things and socialise easily”

“The senior doctors now nudge each other as they move in and out of the patient’s room”

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Immediate deaths and adverse events

Slow transmission of pathogens

hard killers

soft killers

Audit Tool

http://www.who.int/gpsc/Simay/tools/evaluation_feedback/en/

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Hand Hygiene Australia methodology

Teaching hospitals 2450 from 6 wards
1 ICU+ 2 high risk wards+ 4 other wards

Geneva  n~350 HH rate=80% (95%CI 76%-84%)

But HHA 350 per ward
If HH rate = 65% (95%CI 60%-70%) Unreliable at 10PP width
If HH rate = 70% (95%CI 65%-75%)

keep the baby! by changing our focus
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Mindfully selected diffusers to lead ward and hospital

Diffuser ward

Non diffuser ward

Can nudge be adapted elsewhere?

*Nudge* works with

❤️ *leader is a diffuser*

diffuser is not always *clinically perfect*

*Does nudge need to be led by doctor?*

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Can’t lead unless you follow

---

NSW collaborates – select differs who follow then lead

SUPPLEMENT
A statewide approach to systematising hand hygiene behaviour in hospitals: Clean hands save lives, Part I
Annette C Fairlie, Kimberley R Fitzpatrick, Mary Louise McLaws and Clifford F Hughes

CLEAN HANDS SAVE LIVES
Culture change for hand hygiene: Clean hands save lives, Part II
Kimberley R Fitzpatrick, Annette C Fairlie, Mary Louise McLaws and Clifford F Hughes

SUPPLEMENT
Improvements in hand hygiene across New South Wales public hospitals: Clean hands save lives, Part III
Mary Louise McLaws, Annette C Fairlie, Kimberley R Fitzpatrick and Clifford F Hughes

SUPPLEMENT
More than hand hygiene is needed to affect methicillin-resistant Staphylococcus aureus clinical indicator rates:
Clean hands save lives, Part IV
Mary Louise McLaws, Annette C Fairlie, Kimberley R Fitzpatrick and Clifford F Hughes

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Followership success: rolled out 2012 to all Australian public ICUs

Conclusions

Automation provides superior data

Human auditors - in situ contemporaneous education

“Take a moment” nudging some improvement but more likely proxy for high functioning ward

Diffusers - followers - leaders - improve hand hygiene
Technology for Monitoring Hand Hygiene in the 21st Century: Why Aren’t We Using It?
Prof. Mary-Louise McLaws, University of New South Wales, Australia
A Webber Training Teleclass

Move from auditing for data

Stop just documenting → leads to “gaming”
Instead provide immediate feedback at time of observation “take a moment”
Document → number of time correction feedback given

21st century replace human auditing with automation

Saves $US 124,000 per hospital per year Page K et al JMI 2014;88:141-8
Daily/weekly feedback to correct team efforts

Coming Soon

October 20  (FREE Teleclass)
THE HISTORY OF CBIC AND WHY CERTIFICATION IS STILL IMPORTANT TODAY
Certification Board of Infection Control

October 27  ANTIMICROBIAL ENVIRONMENTAL SURFACES IN HEALTHCARE SETTINGS – CAN THEY BE BENEFICIAL?
Prof. Jean-Yves Maillard, Cardiff University, Wales

November 10  NOROVIRUS AND HEALTHCARE FACILITIES: HOW TO KEEP THE VIRUS OUT AND WHAT TO DO WHEN IT GETS IN
Dr. Ben Lopman, Centers for Disease Control and Prevention, and
Prof. Miren Ituriza-Gomara, University of Liverpool

November 23  AIR TRAVEL AND INFECTION CONTROL
Dr. Paul Edelson, CDC, JFK Airport Quarantine Station, New York

December 8  VIABILITY OF BACTERIA ON FABRICS

www.webbertraining.com/schedulept.php

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