

IPCT Hand Hygiene report for NHSL Board

The NHSL Infection Control Committee (ICC) in conjunction with the Hygiene Groups continue to monitor Hand Hygiene compliance across the board. Standard Infection Control Precautions (SICPs) monitoring is carried out locally and action plans are implemented in areas identified with poor compliance. The action plans are monitored at the Hospital and Health and Social care hygiene Groups.

An agreed action from ICC was that the Nurse Director for Acute agreed alongside the Chiefs of Nursing Services within the Acute Division, the Chief Nurse for Midwifery Services, the Associate Directors of Nursing within Primary Care and the Infection Prevention and Control Team would review the common themes and the key points of non-compliance within their areas of influence (see [Appendix 1](#)).

The hand hygiene compliance of Allied Health Professionals (AHP) is also reported to the Infection Control Committee and monitored via the AHP hygiene group. The SICPs monitoring tool does not allow the data entered at present to identify AHP disciplines, however work is being undertaken via the new LanQip system to have this information available.

The Infection Prevention and Control Team (IPCT) continue to carry out 2 quality assurance hand hygiene audits per hospital, per month, results of these audits are reported to the Senior Charge Nurse, Senior Nurse and Chief Nurse or Associate Nurse Director for the area.

An Infection Prevention and Control Dash Board was developed for the ICC where hand hygiene data both local and quality assured by IPC is displayed and discussed in extensive detail (see [Appendix 2](#))

As part of our HAI Breakthrough Series Collaborative a change package was developed to help guide teams to address issues within their system that may have a direct impact on outcomes for their patients. Teams will work through the aims within this package and begin to understand their current state. The change package will also help teams understand if

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any of the change ideas are embedded in their areas and will also help the team understand if particular processes require improvement, with one of the focusses being hand hygiene. Every team within the HAI Virtual breakthrough series collaborative will have different priorities, through testing of change ideas teams will learn what works and what doesn't within their system (See [Appendix 3](#)).

The IPCT have developed a hand hygiene training programme and work has commenced in the critical care areas of all 3 NHSL acute hospitals in conjunction with the hand hygiene product provider for NHSL to incorporate hand hygiene training sessions. Surgical rub training sessions will also be delivered to these areas.

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Appendix 1

SBAR Report on Thematic Analysis of Non-compliance with Hand Hygiene across NHS Lanarkshire

Situation

It has been agreed that there will be a deeper dive into areas of NHS Lanarkshire staff non-compliance with hand hygiene process measures and uniform compliance in an effort to improve outcome measures against related national targets.

Background

There was an agreed action at the NHS Lanarkshire Infection Control Committee to provide clarity on what measures of hand hygiene staff were failing on. This information will be used to inform which areas the focus should be on to improve practice.

The Chiefs of Nursing Services within the Acute Division, the Chief Nurse for Midwifery Services, the Associate Directors of Nursing within Primary Care and the Infection Prevention and Control Team were asked to review the common themes and the key points of non-compliance within their areas of influence.

The Acute Director of Nursing agreed to thematically analyse the data from this. It was agreed that the gap analysis would be available for the ICC Meeting 09-06-2021.

Assessment

A template was utilised to gather the information from each part of the organisation – North Partnership, South Partnership, Mental Health, Paediatrics, Maternity and the Acute Division. This reflects feedback from a total of 8 specific areas. The author asked for themes with hand hygiene and with uniform compliance as previous discussions at the NHS Lanarkshire ICC have indicated strong links between both. All areas returned the completed template. The list of all specific issues highlighted is shown at Table 1, as follows:

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Table 1.

Ranking	Areas of non-compliance	Total times across the system	Hand Hygiene Policy breach	Uniform Policy breach
1.	Wearing of 'fitbits' / watches	8	x	x
2.	HH Key moment 5: no hand hygiene after touching patient surroundings	5	x	
3.	Wearing of jewellery – stoned rings	5	x	x
4.	Hand Hygiene technique: not wetting hands before soap	5	x	
5.	Hair longer than collar	4		x
6.	HH key moment 1: no hand hygiene before touching patient	3	x	
7.	Nails - varnish / gel / false nails	3	x	x
8.	Lanyards in clinical areas	3		x
9.	Wearing of jewellery – earrings (all parts of ear)	2		x
10.	HH Key moment 4: no hand hygiene after touching patient	2	x	
11.	Not fully rubbing in hand gel and allowing to dry	1	x	
12.	Staff wearing fleece in clinical area – not removing to wash hands	1		x
13.	Failure to gel hands at appropriate time	1	x	
14.	HH Key moment 2: no hand hygiene prior to carrying out procedure	1	x	
15.	PPE: no hand hygiene after removing gloves	1	x	
16.	PPE: Apron usage	1		x

There were two further comments made within the feedback around missing data;

- Action plans to tackle above incomplete, and
- Multiple wards missing data (author assumes this is audit data)

Discussion

There were sixteen areas identified from local themes, from a total of eight clinical settings. The author would suggest that the top five issues could be considered 'whole system' themes.

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Four out of the top five themes reflect breaches with the NHS Lanarkshire Hand Hygiene Policy, while three breach the NHS Lanarkshire Uniform Policy. Two of the top five areas reflect breaches in both Hand Hygiene and Uniform Policies.

There is one 'Key Moment' (moment 5) in the top five themes, and one breach in technique.

Recommendation

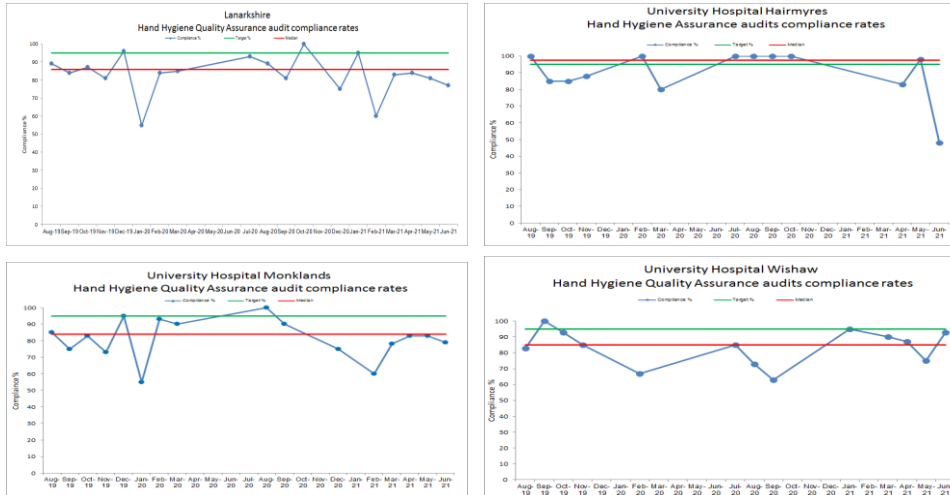
That the NHS Lanarkshire Infection Control Committee accept and note the findings, and use these to inform further discussion and next steps.

Author:
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May 24th 2021

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Appendix 2

4.1 Local Standards – Hand Hygiene IPC Quality Assurance audit compliance rates - NHSL



↑ Higher is Better

Data Interpretation: Random variation. Lanarkshire chart is showing 77% compliance for June 2021. Two audits were carried out by IPCT in UHH (48%); 4 audits in UHM (79%); and 2 audits in UHW (93%). The national target of 95% and above has not been met.

4.1.1 Local Standards – SICPs Hand Hygiene Quality Assurance audit compliance rates – University Hospital Wishaw

Month	SICP Topic	Compliance Range	Areas for Improvement noted by Senior Nurse / Senior Charge (factored into improvement plan)
May and June	Hand Hygiene	75-100%	<p>Improvements required: Medical staff non-compliance prior to touching patients, wrist watches remain an ongoing issue.</p> <p>All staff groups: Varying aspects of the 5 moments not being performed mainly before and after touching a patient.</p>

↑ Higher is Better

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4.1.2

Local Standards – SICPs Hand Hygiene Quality Assurance audit compliance rates – University Hospital Monklands

Month	SICP Topic	Total LanQIP results uploaded	Compliance Range	Areas for Improvement noted by Senior Nurse / Senior Charge (factored into improvement plan)
May 2021	Hand Hygiene	22	40-100%	10 areas had 100% compliance with the rest having compliance at 65% or above with the exception of 1 wards who had 40%. Areas for improvement were in relation to before and after touching patient, immediate surroundings, before clean aseptic procedures
June 2021	Hand Hygiene	22	60-100%	12 areas had 100% compliance over the month with the rest at 60% or above. Areas for improvement were before and after touching patients, before clean and aseptic procedures,



4.1.3

Local Standards – SICPs Hand Hygiene Quality Assurance audit compliance rates – University Hospital Hairmyres

SICP Topic				Hand Hygiene	
Average Compliance for UHH (%)				95%	
Site RAG				G	
Directorate	Total LanQuip Results Uploaded	Range	Average Compliance per directorate (%)	Staff Group	Themes and areas for improvement noted by Senior Nurse / Senior Charge Nurse
Surgical	8/8	80 – 100%	92.9	Varied	Before and after touching patients, patient surroundings and wetting hands prior to soap
Medical	6/6	90 – 100%	97	Mainly Medics	Actioned at time of non-compliance
Emergency & Receiving	4/4	90 – 100%	96	AHP, CSW, Med Students	Varied, leaving surroundings, wetting hands prior to soap
Care of the Elderly	6/6	90 – 100%	96	Varied	Leaving surroundings, wetting hands prior to soap



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4.1.4

Local Standards – SICPs Hand Hygiene Quality Assurance audit compliance rates – H&SCPS - North

May & June reports	Total staff	Staff Compliant	%
Hand Hygiene Audit	929	899	97




4.1.5

Local Standards – SICPS Hand Hygiene Quality Assurance audit compliance rates – H&SCPS - South

May & June reports	Total staff	Staff Compliant	%
Hand Hygiene Audit	506	494	97



Appendix 3



NHS Lanarkshire

Safe in Our Hands

**Healthcare Associated Infection
Breakthrough Series Collaborative**

Change package May 2021

What is a Change Package

A change package is group changes that are able to improve our processes and outcomes for our patients and staff. When we use improvement methodology to implement changes in our system we learn through the use of measurement if these changes are making an impact.



HAI Change Package

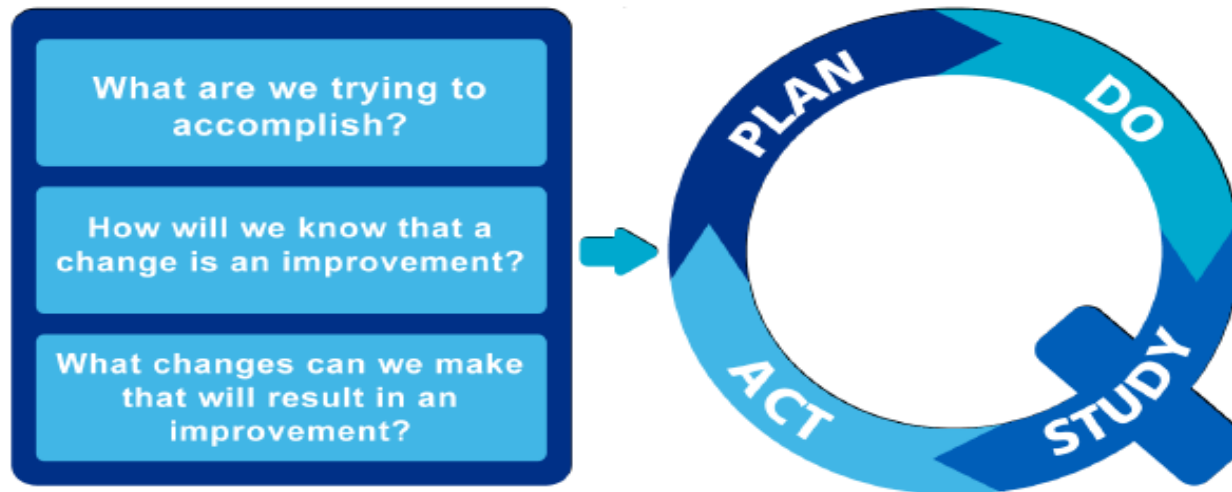
As part of our HAI Breakthrough Series Collaborative this change package can be used to help guide teams to address issues within their system that may have a direct impact on outcomes for their patients. Teams will work through the aims within this package and begin to understand their current state. The change package will also help teams understand if any of the change ideas are embedded in their areas and will also help the team understand if particular processes require improvement, for example PVC insertion, hand hygiene.

Every team within our HAI Virtual breakthrough series collaborative will have different priorities, through testing of change ideas teams will learn what works and what doesn't within their system.

Testing ideas takes time in order to create reliability in our systems and not all tests of change will lead to an improvement. It is just as valuable to learn from what did not work as it is to learn from what did work. You can learn and adapt your change ideas to suit your area.

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Teams can start to understand how they are doing against the aims of the collaborative. By understanding our baseline we can proceed to improvement planning and prioritise changes that need to take place within your areas. Our collaborative will use the Model for Improvement (Add link) this acts as a compass to identify your starting baseline point and guide you in the right direction for your improvement ideas.



(With thanks to Humber Teaching Hospital Trust)

Our HAI Priorities

Reduction in
Healthcare/
Community
Associated

Reduction in
Healthcare/
Community
Associated



Reduction in
Healthcare/
Community
Associated

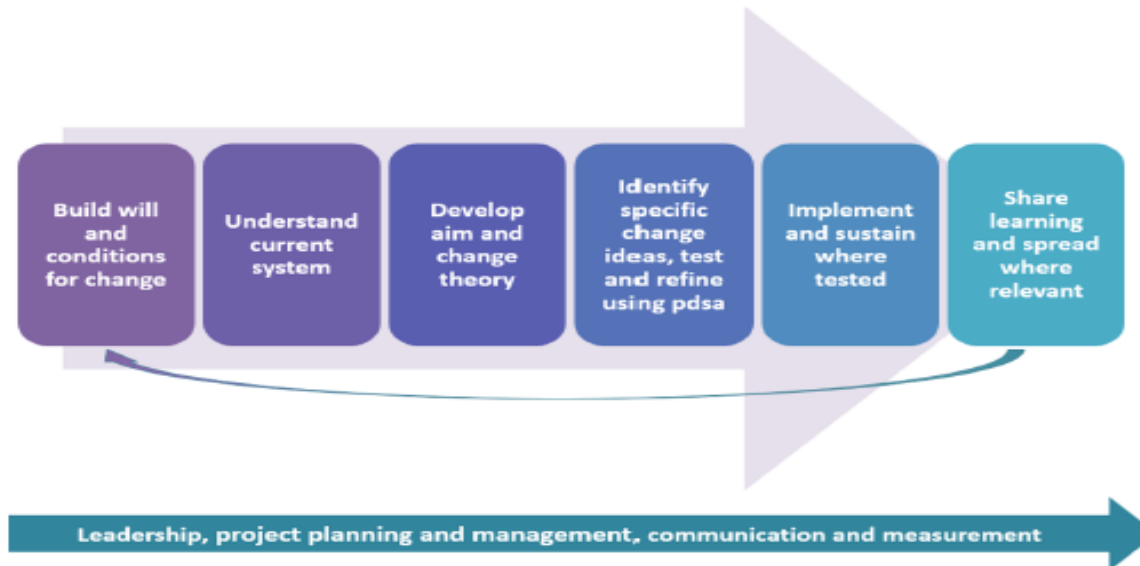
Reliable
Standard
Infection and
Control
Precautions

Aim for hand
hygiene to be
above 95%
compliance

Making improvements in Healthcare Associated Infection

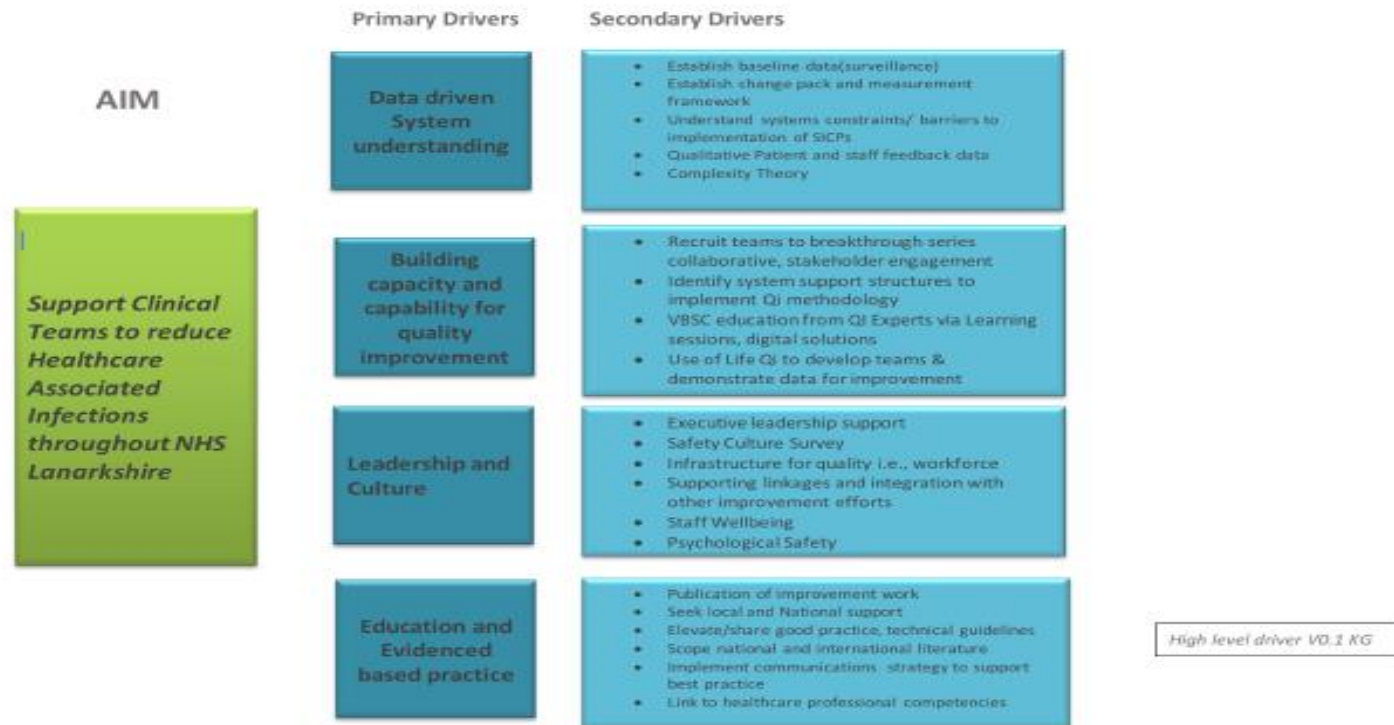
How do we know that our changes have made an improvement?

Through 'Measurement' by using Driver Diagrams we set out our aims, how much do we want to achieve by when. The measurement framework that supports those Aims will help teams monitor their progress throughout the collaborative helping them achieve breakthrough improvement that can be shared across the system to help other teams. This is called spread, with spread the whole system benefits. Below (Healthcare Improvement Scotland, Improvement Journey)



The following tools will help your team move to the next steps and understand our NHSL aims

High level Driver Diagram for the HAI Improvement Collaborative



High level driver V0.1 R/G

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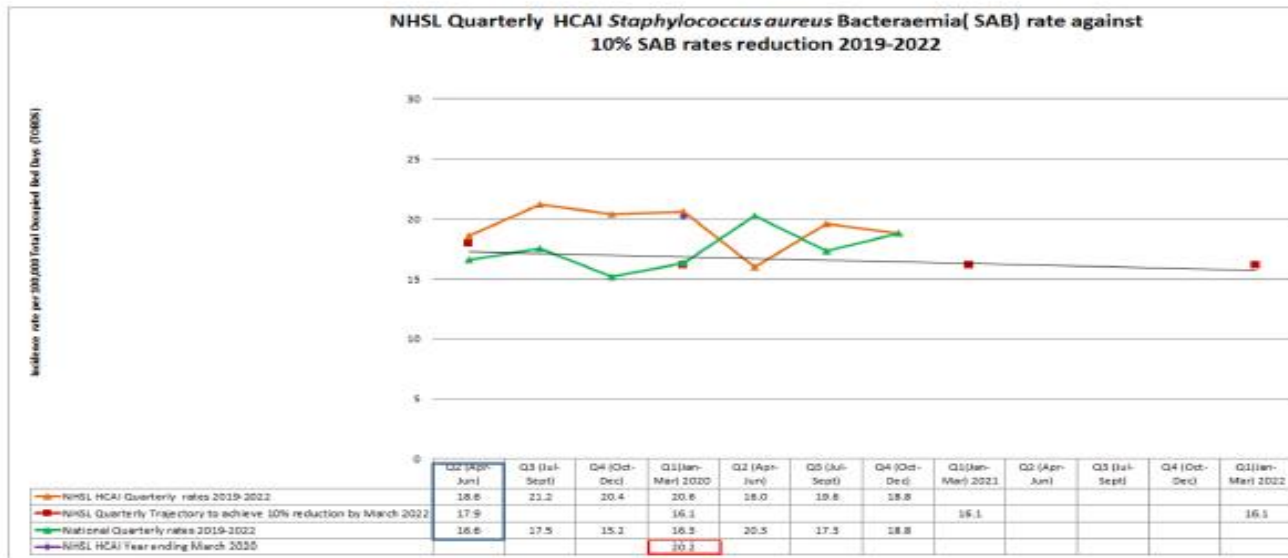
What are our aims as a HealthBoard

Standards on Healthcare Associated Infections and Indicators on Antibiotic Use
CNO Letter, Scottish Government
10 October 2019

Standards		Benchmarking		2021/2022 Target	2023/2024 Target
		National rate Year-end Mar 2019 (100,000 TOBDs)	NHSL rate Year-end Mar 2019 (100,000 TOBDs)	NHSL rate Year-end Mar 2022 (100,000 TOBDs)	NHSL rate Year end March 2023 (100,000 TOBDs)
Gram-negative bacteraemia standard	Reduction of 50% in healthcare associated <i>E. coli</i> bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22. 2018/19 should be used as the baseline for <i>E. coli</i> bacteraemia reduction	38.4	44.7	33.5	22.4
Staphylococcus aureus bacteraemia (SAB) standard	Reduction of 10% in the national rate of healthcare associated SAB from 2019 to 2022, with 2018/19 used as the baseline for the SAB reduction target	16.8	17.9	16.1	
Clostridioides difficile infection (CDI) standard	Reduction of 10% in the national rate of healthcare associated CDI from 2019 to 2022, with 2018/19 used as the baseline for the CDI reduction target	14.7	16.5	14.8	
Indicators		Benchmarking		2021/2022 Target	
		National rate 2015/2016	NHSL rate 2015/2016	NHSL rate Year-end Mar 2022	
Antibiotic use	A 10% reduction of antibiotic use in Primary Care (excluding dental) by 2022, using 2015/16 data as the baseline (items/1000/day).				
	Use of intravenous antibiotics in secondary care defined as DDD / 1000 population / day will be no higher in 2022 than it was in 2018	National rate 2018	NHSL rate 2018	NHSL rate Year-end Mar 2022	
	Use of WHO Access antibiotics (NHSE list) ≥60% of total antibiotic use in Acute hospitals by 2022				

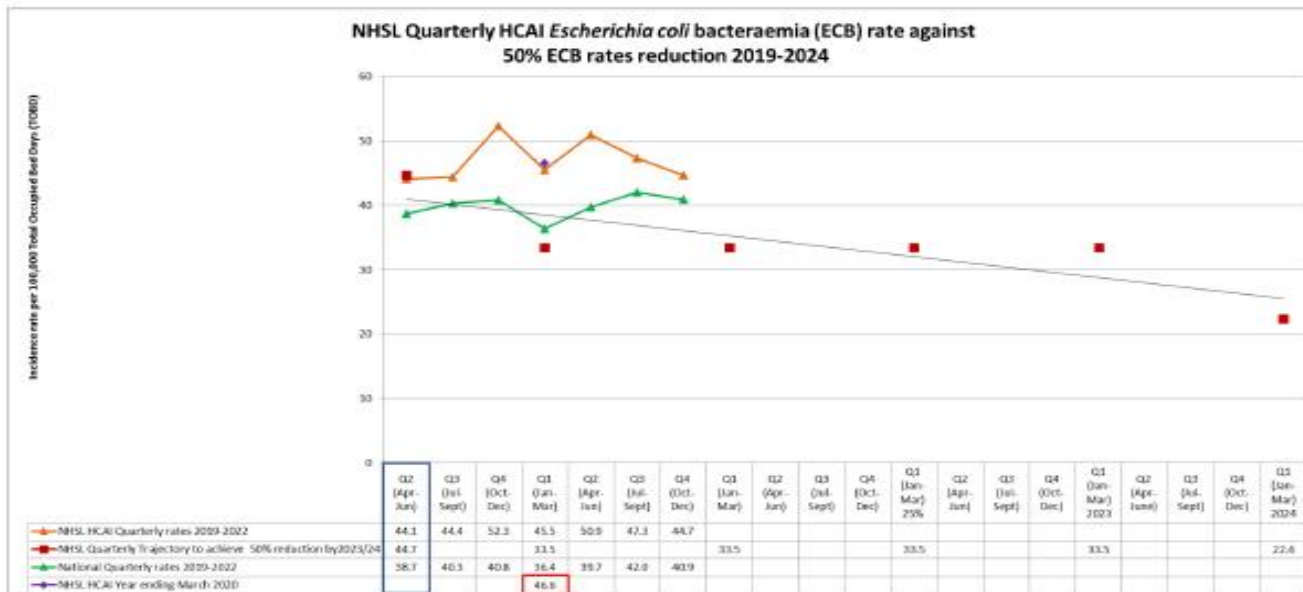
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AIM 10% reduction in HCAI Staphylococcus Aureus Bacteraemia by March 2022



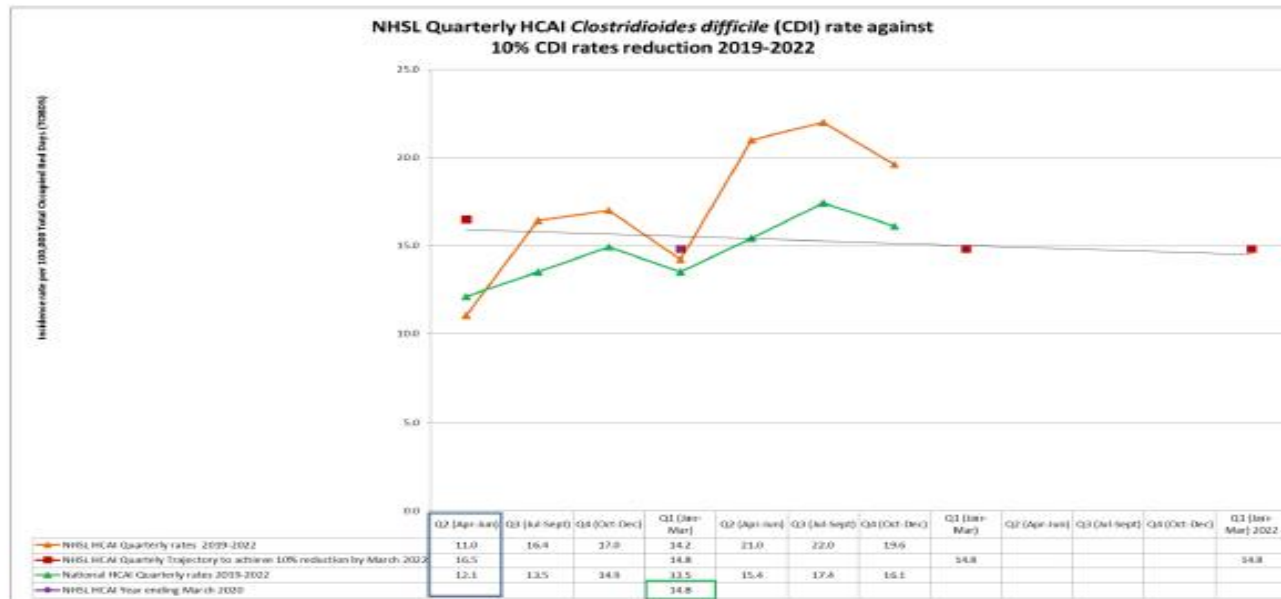
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AIM 50% Reduction of HCAI Escherichia coli bacteraemia by 2024



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AIM 10% Reduction of HCAI clostridioides difficile (CDI) by March 2020



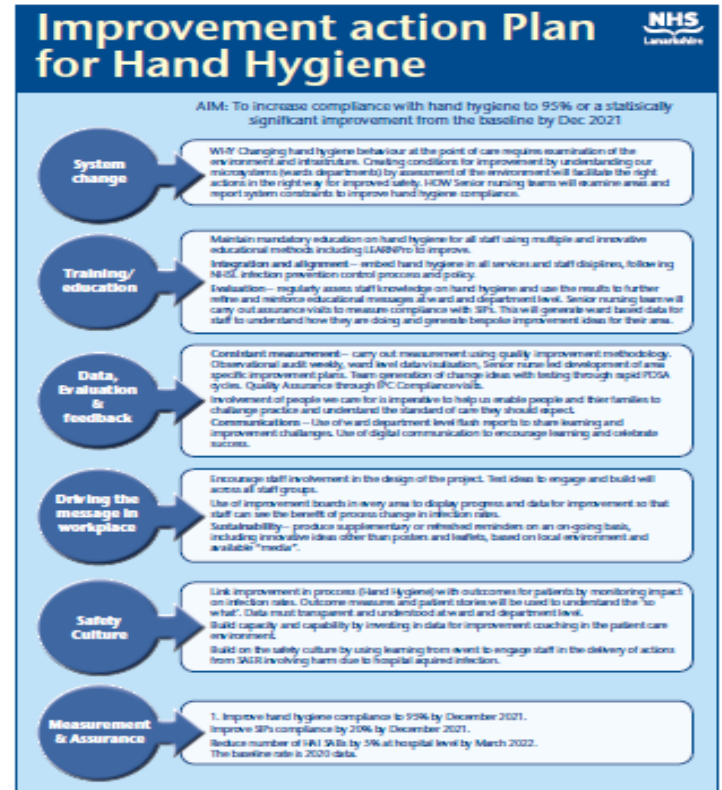
Hand Hygiene

As a process measure hand hygiene impacts on our outcome measures. Our compliance target is **95%**. Some areas will have sustainability already and this will not require a quality improvement focus. For areas that require improvement in this area the collaborative will support Improvement planning *and data collection to understand if any of our change ideas result in improvement.*

Our Measure

Compliance with hand hygiene
Measure it - 5 opportunities per week to understand process compliance

Blood stream infections are a significant healthcare associated infection. A series of evidence based interventions is the most effective way to reduce blood stream infections overall.



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Invasive devices are a major source for blood stream infections in the acute and community sectors and improvement in the incidence of these infections can be achieved by improving practice in relation to the insertion and maintenance of invasive devices by the use of care bundles.

Key to reducing the incidence of blood stream infections due to resistant organisms is the appropriate use of antimicrobials, but it is also important to ensure that blood stream infections when they do occur are correctly treated with appropriate antimicrobials. The interventions and how they should be applied are all listed in the previous sections of this document

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Standard Infection Control Precautions (SICPs)

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.

SICPs and transmission based precautions underpin routine safe practice and break the chain of infection which protects the people that use our services, visitors and staff. There is often no way of knowing who is infected, so by applying standard infection control precautions and transmission based precautions to all people at all times, best practice becomes second nature and the risk of infection is minimised.

As a team pre work prior to Learning session one should focus on any areas for Improvement in SICPs process measurement. The measurement framework for SICPS can be found in the link below

Our Measures (link below)

<https://www.nipcm.hps.scot.nhs.uk/media/1179/sicp-compliance-v30.xlsx>



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Scoping your challenges - *Why do we have this Problem ?*

For example - Healthcare/Community associated SAB- Device related



Ask the team to populate ideas that could change practice to prevent the problem. Build a wall of ideas in your department and let the entire team contribute to the design of the Improvement AIM

The team will start to form change ideas which will contribute to the overall driver diagram detailing the AIM and ideas to get there. This work will prepare teams for the first learning session and give all teams the opportunity to share ideas and learning



Team planning

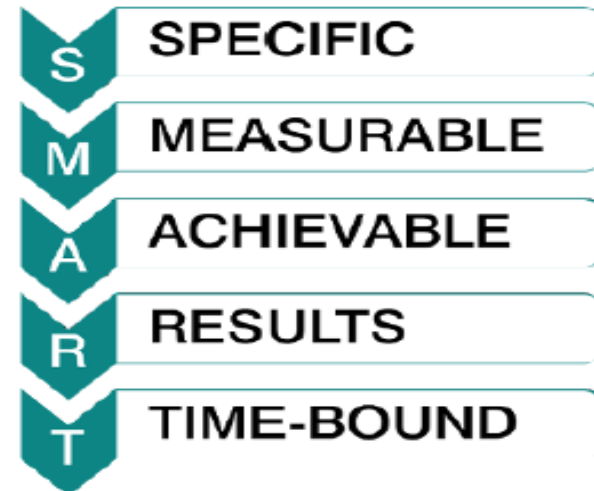
Your first team meeting is the start of your improvement planning. Understand what your team want to achieve and think about what changes you can make to achieve your Aims.

THE team AIM should be **SMART**

For example,

The labour ward will increase hand hygiene compliance above 95% by March 2022

To learn more about developing an aim statement please refer to the [Institute for Healthcare Improvement website](#). The IHI have also developed a webpage with [tips for setting aims](#). You may need to take a moment and register with the [IHI](#) for more in-depth information.



Useful links

<https://www.hps.scot.nhs.uk/web-resources-container/healthcare-associated-infection-annual-report-2019/>

<https://www.nipcm.scot.nhs.uk/about-the-manual/>

<https://www.nipcm.scot.nhs.uk/resources/literature-reviews/>

<https://www.hps.scot.nhs.uk>

<https://learn.nes.nhs.scot/2482/infection-prevention-and-control-ipc-zone>

<https://learn.nes.nhs.scot/3393/infection-prevention-and-control-ipc-zone/sipcep-foundation-layer>