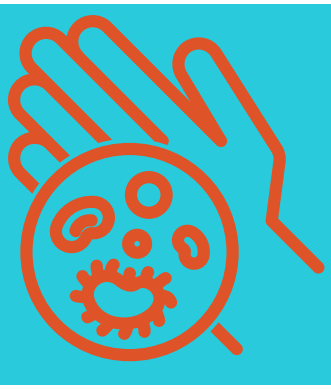
Interior Health

Hand Hygiene Quality Improvement Plan

Facility: _____

Unit: _____

Date/Quarter:



Responsible Manager: _____ **Hand Hygiene Champion**: _____

Providing the safest care possible for patients, residents, clients, and health care providers depends on consistent and reliable hand hygiene. To support this, all healthcare sites and units are expected to maintain an active and ongoing commitment to hand hygiene improvement. This document outlines the expectations for developing, implementing, and reviewing unit-specific Quality Improvement (QI) action plans based on compliance data and identified challenges. The intent is to help teams sustain evidence-based infection prevention practices, address barriers, and strengthen a culture of safety.

These QI action plans should be reviewed at minimum on a quarterly basis alongside hand hygiene compliance rates to assess progress, identify persistent or emerging barriers, and guide next steps. Action plans should also be shared with Infection Prevention and Control (IPAC) and colleagues to promote alignment and shared learning across teams.

If assistance is needed in developing or refining QI action plans, units are encouraged to reach out to their local Infection Control Professional (ICP) or email IPAC@interiorhealth.ca.

Regular review and collaboration ensure that:

- Evidence-based infection prevention practices remain embedded in daily workflows,
- Teams remain responsive to changes in compliance performance, and
- A culture of safety and accountability is consistently promoted across the organization.

By aligning with Accreditation Canada's Required Organizational Practices (ROPs) and making hand hygiene improvement a routine practice, each unit contributes to a system-wide approach that prioritizes patient safety, reduces healthcare-associated infections, and enhances overall quality of care.

Key Terms

Hand Hygiene Peer Reviewer: A trained individual responsible for observing, assessing, and providing feedback on hand hygiene practices to ensure compliance with established standards.

Hand Hygiene Champion: A frontline staff member who promotes hand hygiene best practices through education, role modeling, and peer engagement to foster a culture of safety.

Engagement & Quality Board: A visual aid to display ongoing unit and facility quality improvement initiatives.

Technique: An assessment measure designed to target the quality of which hand hygiene is occurring. For example, the use of glow germ to visually observe hand hygiene effectiveness.

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Hand Hygiene QI Action Plan Priority Table

The Hand Hygiene QI Action Plan Priority Table is designed to guide QI efforts by categorizing hand hygiene compliance rates into three priority levels—high, moderate, and maintenance. Each category reflects the focus of action required to improve or sustain hand hygiene practices within clinical areas.

By aligning compliance rates with tailored QI focus areas, this tool supports infection prevention and control, clinical managers, and unit leaders with:

- Identifying areas requiring immediate intervention.
- Strategically allocating resources and education.
- Promoting accountability and staff engagement.
- Sustaining improvements through targeted reinforcement.

Use the table regularly to review performance data and trends, guide discussions during huddles or QI meetings, and inform data-driven decisions for hand hygiene improvement initiatives.

Priority Level	Compliance Rate	QI Focus Areas
High Priority	**≤ 69%**	• Immediate review of barriers to compliance. • Intensive staff re-education and training. • Leadership visibility and accountability. • Auditing methods and observer reliability. • Focus groups or surveys to identify root causes.
Moderate Priority	**70–80%**	• Targeted coaching and reminders. • Workflow improvements (accessibility to hand hygiene products). • Peer champions or unit-based HH leads. • Reinforce positive behaviors. • Evaluate times of non-compliance (e.g., shift changes, task specific, etc.).
Maintenance Priority	**> 80%**	• Recognition and reward programs. • Ongoing monitoring and feedback. • Sustain gains through visual cues and leadership rounding. • Periodic refreshers and competency assessments. • Benchmarking across units/sites. • Strive for excellence!

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Auditing Methodology

Accurate and meaningful QI plans depend on reliable hand hygiene audit data. Assessing auditing methodology and ensuring enough trained peer reviewers to meet quarterly quota numbers are essential to produce valid results. These elements should be reassessed quarterly to support effective QI planning, identify true areas for improvement, and ensure strategies are based on strong data, ultimately enhancing patient safety and fostering a culture of continuous improvement.

How Many Peer Reviewers Trained? *

0	☐	1-3	☐	4-6	☐	7-9	☐	≥10	☐

**Zero peer reviewers must be priority in short term QI Plan. The minimum number of peer reviewers required to meet quarterly quotas will vary based on site/unit.*

When are Observations Completed?

Daily	Weekly	Per Set	End of Month
☐	☐	☐	☐

Who Submits Observations to Clean Hands System?

Individual Peer Reviewers*	Hand Hygiene Champion	Manager
☐	☐	☐

*If individual staff submitting is there a reminder process from site leadership: Yes ☐ No ☐

Evaluation (Check Yes/No & Fill in Compliance %)

Time Frame	Quota's Completed		Compliance %*
Last Month	Yes ☐	No ☐	
Last Quarter**	Yes ☐	No ☐	
Last Year	Yes ☐	No ☐	

** Compliance below 69% for **one** quarter, consult IH HH Action Plan toolkit and collaborate with infection prevention for hand hygiene improvement strategies.*

*** Insufficient observations for more than **one** quarter, please prioritize additional peer reviewer training. Consult infection prevention for further assistance as needed.*

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Communication (Check all applicable items)

According to the Interior Health Hand Hygiene Policy 3.6.8, it is essential that hand hygiene audit results are communicated clearly by posting them quarterly in public-facing areas to promote transparency and awareness among health care providers, patients, and visitors. Additionally, all hand hygiene signage throughout the facility should be reviewed and verified for currency at least annually to ensure information remains accurate and aligns with current standards. Site leadership is responsible for ensuring this annual review is completed to support a strong culture of safety and infection prevention.

What Locations are Audit Results posted?

Engagement & Quality Board	Staff Rooms	Nursing Stations	Meeting Rooms	Public Facing
☐	☐	☐	☐	☐

Where is Hand Hygiene Signage posted?

Facility Wide

Facility Entrances*	Unit Entrances	Washrooms	Dining/Kitchen	Nursing Stations	Medication Rooms	Engagement & Quality Board**/ Common Areas
☐	☐	☐	☐	☐	☐	☐

** Hand hygiene best practice information must be available for clients and visitors.*

*** Ongoing site-specific meetings to support hand hygiene practices are suggested.*

Patient Care Areas*:

Patient Room Entrances	Hand Hygiene Sinks	ABHR Dispensers	Patient Washrooms	Inpatient Kitchens	Soiled Utility Rooms
☐	☐	☐	☐	☐	☐

**Hand hygiene patient pamphlet should be available at each bedside upon admission.*

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Quality Improvement Action Plan

*Complete each category in point form

*Consult *IH Quality Improvement Toolkit* and *IH Hand Hygiene Action Plan Toolkit* for resources and QI ideas.

Review compliance and QI reports for site/unit and conduct Root Cause Analyses for each identified gap or opportunity:

- Determine contributing factors, events, system issues and processes involved.
- Utilize RCA tools as appropriate (e.g., 5 Whys, Fishbone, Improvement Tracker).
- Develop QI action plan tailored to factors/gaps/opportunities identified.
- Conduct Plan-Do-Study-Act (PDSA) cycles to test intervention, review results, and adjust actions as needed.

Improvement Target – Aim Statement	Measure	Action	Purpose	Time Frame

Improvement Target – Aim Statement	Measure	Action	Purpose	Time Frame

✓	✗
• Consult with Infection prevention early during action plan development. • Have more than one action plan if multiple improvement areas identified. • Identify a site/unit hand hygiene champion • Have a mix of peer reviewers. • Consult with IPAC to support opportunistic peer reviewer training. • Communicate site specific submission goals and targets to peer reviewers. • Support peer reviewer anonymity. • Consult with IPAC for hand hygiene education strategies. • Use active communication strategies. Example: meetings or huddles. • Use SMART process during goal development. • Share your QI action plans with your Infection Control Professional.	• Rely on a single peer reviewer. • Rely on Quarterly Audit targets. • Use non established auditing process. • Apply fault-based focus to percent compliance. • Use only passive communication strategies. Example: Signage at entrance.

Additional Notes

Effective Date	October 2025		
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Partners Reviewed			
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Owner	Infection Prevention and Control		
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