**Topic Area: HAND HYGIENE**

*Visit the* [*HQIN Resource Center*](https://hqin.org/resource/action-plan-templates/) *to access additional action plan templates on topics including infection control, vaccination and hand hygiene.*

**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 Worksheet](https://hqin.org/resource/five-whys-worksheet/), [QAPI Fishbone Diagram](https://hqin.org/resource/qapi-fishbone-diagram/), Cause & Effect Diagram)
* Conduct a [Plan-Do-Study-Act (PDSA)](https://hqin.org/resource/plan-do-study-act-worksheet/) to test intervention, review results and adjust actions needed

**Identify Infection Prevention and Control Gaps & Areas of Opportunity:**

* [Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings | HAIs | CDC](https://www.cdc.gov/healthcare-associated-infections/php/toolkit/icar.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html)
* Review previous survey findings, federal and state regulations and CDC updates for long-term care facilities
* Check [CMS Quality Safety & Oversight (QSO) memos](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions)

The sample RCA, actions, interventions, best practices and metrics illustrated here to address identified infection prevention areas of opportunity are solely intended as example guidance. Your team should perform an infection prevention gap analysis/risk assessment and build a customized action plan to best meet the needs of your specific organization and community.

**1**

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| **Area of Opportunity** |
| Proper hand hygiene is not being performed consistently by direct care staff and other employees |
| **Root Cause Analysis** **(specify each root cause and address each within the action plan) -*See examples below-*** |
| 1. All staff do not receive the same frequency of hand hygiene education |
| 1. All staff are not audited on hand hygiene |
| 1. Hand hygiene stations are not conveniently located on the units |
|  |
|  |
| **S.M.A.R.T. Goal: (Specific, Measurable, Achievable, Relevant, Time-based)** |
| Achieve 95% compliance with hand hygiene by [SPECIFIC DATE] |

**2**

| **Project Start/ Completion Date** | **Specific Actions & Interventions** | **Person/Team Responsible**  *\*Include QAPI Committee* | **Ongoing Monitoring & Surveillance** | **Resources & Additional Comments** |
| --- | --- | --- | --- | --- |
|  | * Review hand hygiene policy and update if needed – use nationally recognized sources for guidance | Administrator, Director of Nursing, Infection Preventionist  **3** | Annually and as needed | **Ensure P&Ps are evidence-based (e.g., APIC, CDC, WHO guidelines)**   * [Hand Hygiene | APIC](https://apic.org/resources/topic-specific-infection-prevention/hand-hygiene/) (Note: Some links on this site require a subscription or membership to access the content) * [Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC](https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html) |
|  | * Develop tools to monitor and track, trend and document compliance * Establish facility baseline compliance * Institute scheduled hand hygiene audits as part of facility’s infection prevention and control program (IPCP)   **4** | Administrator, Director of Nursing, Infection Preventionist | At least quarterly | * Notify a Health Quality Innovators (HQI) Quality Improvement Advisor (QIA) at [LTC@hqi.solutions](mailto:LTC@hqi.solutions) if auditing and monitoring tools are needed * [Measuring Hand Hygiene Assurance: Overcoming the Challenges | CDC](https://stacks.cdc.gov/view/cdc/11996) * [Hand Hygiene Competency Validation | SPICE](https://spice.unc.edu/wp-content/uploads/2017/03/Hand-Hygiene-Competency-SPICE.pdf) * [Hand Hygiene Audit Tracking Tool | HQIN](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fhqin.org%2Fwp-content%2Fuploads%2F2023%2F04%2FHQIN-Hand-Hygiene-Competency-Tracking-Tool.xlsx&wdOrigin=BROWSELINK) |
|  | * Educate ALL staff on proper hand hygiene – how and when to perform hand hygiene * Use multiple modalities (posters, video, live training) to increase attention and keep hand hygiene at top of mind | Administrator, Director of Nursing, Infection Preventionist, Staff Development, Department Managers | Provide training at orientation, quarterly and as needed based on audit compliance rates and infection control concerns | * [Hand Hygiene in Healthcare Settings Promotional Materials | CDC](https://www.cdc.gov/clean-hands/hcp/clean-hands-count/?CDC_AAref_Val=https://www.cdc.gov/handhygiene/campaign/promotional.html) * [Targeted COVID-19 Training for Nursing Homes](https://qsep.cms.gov/welcome.aspx) [Note: This training requires logging in to the Quality, Safety & Education Portal (QSEP)] * [What You Need to Know About Handwashing Video | CDC](https://www.youtube.com/watch?v=fpXh2XHwMmE) * [Clean Hands in Healthcare Training | CDC](https://www.cdc.gov/clean-hands/hcp/training/) * [Hand-Hygiene Pocket Card | HQIN](https://hqin.org/wp-content/uploads/2022/11/Hand-Hygiene-Three-Card-1.pdf) * [Hand Hygiene Module | HQIN](https://hqin.org/wp-content/uploads/2023/01/Module-1-Hand-Hygiene_508.pdf) * [Simple Strategies - When to Practice Hand Hygiene | HQIN](https://hqin.org/wp-content/uploads/2020/05/Simple-Strategies-When-to-Practice-Hand_Hygiene_508.pdf) |
| **5** | * Follow up staff education with hand hygiene competency validation | Infection Preventionist, Staff Development |  | * [Hand Hygiene Competency Validation | SPICE](https://hqin.org/wp-content/uploads/2020/05/Hand-Hygiene-Competency-Validation_SPICE_4-9-20.pdf) |
| **5** | * Staff from various departments will be audited for hand hygiene compliance, 15-20 per week for 8 weeks, and until goal is met and sustained for 6 weeks   **4**   * Report weekly data to HQI, if applicable | Administrator, Director of Nursing, Infection Preventionist or designee |  |  |
|  | * Give feedback and on-the-spot education if individual hand hygiene performance does not follow guidelines   **5**   * Encourage accountability, questions and a culture of safety that is not punitive | Administrator, Infection Preventionist, Department Managers |  | * [TeamSTEPPS®3.0 | AHRQ](https://www.ahrq.gov/teamstepps-program/index.html) |
|  | * Educate residents on proper hand hygiene – how and when to perform hand hygiene * Use multiple modalities (posters, video, live training) to increase attention and keep hand hygiene at top of mind | Director of Nursing, Infection Preventionist, Staff Development, Department Managers |  | * [About Hand Hygiene for Patients in Healthcare Settings | Clean Hands | CDC](https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html?CDC_AAref_Val=https://www.cdc.gov/handhygiene/science/index.html) |
|  | * Report findings and compliance at monthly/quarterly QAPI (or other quality improvement) meetings * Report findings to all staff | QAPI Team |  | * [QAPI At a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home](https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf) |

**8**

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