Hand Hygiene

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Research in Nursing

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Hand hygiene is a discipline created by each individual. Majority of the time hand hygiene and washing can be overlooked by healthcare workers. “Hand hygiene is critical to the prevention of health care-associated infection (HAI), which leads to substantial morbidity, mortality, and health care costs in the United States and around the world” (Allegranzi, Conway, Larson & Pittet, 2014, abstract para. 5). With hand hygiene being such a crucial but subtle intervention to prevention of hospital acquired infection, the low compliance rate was recognized with intervention in two thousand eleven. With the recognition, became a movement of research within health care facilities. “The objectives of this study were to (1) evaluate the degree of implementation of the MHHIS by US health care facilities; (2) examine differences in the degree of implementation by facility size, type, geographic region, and infection prevention infrastructure; and (3) suggest achievable benchmarks for implementation of hand hygiene improvement programs across a range of health care facilities” (Allegranzi, Conway, Larson & Pittet, 2014, Abstract para. 7)

The method to which was in use was a voluntary survey. The participants in the World Health Organizations hand washing movement were sent an email in regards to a voluntary survey to be evaluated for hand hygiene compliance and availability to resources within their facility. “Of 2,238 invited facilities, 168 participated in the survey”; however, of those one hundred sixty-eight only one hundred twenty-nine samples were actually used due to incompletion of the survey provided (Allegranzi, Conway, Larson & Pittet, 2014, Results para. 1). The survey is from World Health Organization’s Hand Hygiene Self Assessment Framework that is composed of “27 items grouped into 5 sections” with each section score out of one hundred and a cumulative possible score of five hundred. The scores are taken and each “health care facility [is] assigned to 1 of 4 levels of hand hygiene implementation progress: inadequate, basic, intermediate, or advanced” (Allegranzi, Conway, Larson & Pittet, 2014, Methods para. 2). The predicted time it takes to complete the entire individual survey is less than two hours.

With this survey being on a completely voluntary basis there is high variability and partial bias towards the participating facilities. This is due to the higher participating and compliant facilities more apt to volunteer for the survey. Also, bias towards a self-assessment can skew results. The ability to assess your self can be lenient at times, someone else assessing the environment may be able to pick up on cues and grade from a completely objective standpoint. The design of the survey in regards to a parallel design to the standards and appendix listed by the World Health Organization is well thought out. The questioning listed is thorough when assessing the reinforcement, encouragement and education within each facility. However, the strength of evidence resulted from the research as a whole limits itself. For example, the survey is limited to volunteers and is not random across America. Yes, the survey does involve over forty states, but the quality and quantity is seldom. Also, the survey does have some opinion based questions. For instance, the first question listed by the World Health Organization Hand Hygiene Self-Assessment Framework (2011) is “How easily available is alcohol-based handrub in your health-care facility?” (question 1.1, p. 2). ‘Easy’ is a perception that can be altered by each and every persons own experiences and can have significant change from person to person. Another dilemma that can limit the survey is the length. The estimated time to complete the survey is less than two hours; how many people will volunteer two hours of their time, for any act, that is not planned within their day or even offered an incentive? This research article was not insufficient in all categories and does have positive aspects that can be of significance to many people.

This particular research article was effective in proving the health care workers lack of compliance in hand hygiene. Not only does it prove, but also presents ways to improve hand hygiene compliance. Also, the research provided has no ethical or legal issues that arouse; which is an accomplishment in itself that can trump many other listed problems. In conclusion, the research resulted in a valid argument of increasing need of compliance in hand hygiene procedures in US healthcare facilities. The survey was able to highlight areas of improvement evidenced by “A wider use of posters or other reminders detailing hand hygiene indications and performance techniques could certainly facilitate best practices at the point of care” (Allegranzi, Conway, Larson & Pittet, 2014, Discussion para. 10). As a result of this study, nurses can be at greater attention to hand hygiene compliance of frequent and effective hand washing techniques. I can incorporate this into my clinical practice and facility by making sure that all hand sanitizer dispensers are full, readily available and encouraged in our facility. Another intervention that can be made is a presentation and education proposal. This proposal can include reviewing more quality research articles involving the latest evidenced based practice for hand hygiene. After researching hand hygiene more in depth, I can incorporate a power point presentation and hands on teaching to educate health care workers on the importance and use of effective hand hygiene.

Reference

Allegranzi, B., Conway, L., Larson, E., & Pittet, D. (2014). Status of the implementation of the World Health Organization multimodal hand hygiene strategy in United States of America health care facilities. *American Journal of Infection Control*, *42*(3), 224–230. <http://doi.org/10.1016/j.ajic.2013.11.015>

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