Quality Improvement Plan: Improving Hand Hygiene Practices

Site Applicability

All Vancouver Coastal Health (VCH) settings, including:
Acute Units and Programs where direct patient care is provided
Community Programs where direct client care is provided
All owned/operated Long-Term Care homes where direct resident care is provided
Administrative and public settings

Scope

All VCH Staff

Purpose

Hand hygiene is one of the most effective and foundational practices for preventing transmission of microorganisms in the healthcare setting. This Quality Improvement (QI) Plan provides a coordinated, system-wide framework for strengthening hand hygiene practices across all VCH programs and care environments. By using evidence-informed QI methods, the plan supports teams to assess current performance, identify opportunities for improvement, implement targeted interventions, and measure progress over time.

Improving hand hygiene is a shared responsibility. Success requires active engagement of frontline staff, physicians, clinical and operational leaders, Infection Prevention and Control (IPAC), Quality and Patient Safety (QPS), and the patients, clients, residents, families, and visitors we serve. When hand hygiene practices are embedded consistently into everyday workflows, they contribute directly to improved safety, reduced healthcare-associated infections (HAIs), and strengthened quality of care across VCH.

Background

Evidence consistently demonstrates that adherence to the 4-Moments for Hand Hygiene reduces the risk of HAIs and improves outcomes for patients, clients, and residents.

High-performing hand hygiene programs use a multimodal improvement approach, which may include:

- Staff education and clinical coaching
- Observational auditing and timely feedback
- Readily accessible hand hygiene supplies

- Strong leadership support and role modeling
- Continuous measurement and transparent reporting
- Engaging patients, clients, residents, families, and visitors in shared responsibility

Aligning with Accreditation Canada's Required Organizational Practices (ROPs) strengthens our organizational commitment to safe care. Embedding hand hygiene expectations into daily routines ensures all programs – regardless of setting – contribute to a system-wide culture that prioritizes patient and staff safety, reduces infection risks, and upholds high standards of care.

Organizational Aim for Hand Hygiene Improvement

VCH is committed to improving and sustaining hand hygiene practices across all care settings as a foundational component of patient, staff, and visitor safety. In alignment with the BC Ministry of Health Policy Communique, the following aim has been established:

To achieve and sustain a minimum of 80% hand hygiene compliance across all Vancouver Coastal Health care settings by March 31, 2029, from current baseline performance, through coordinated local quality improvement efforts.

Overall compliance is not sufficient to demonstrate safe practice. Achievement of this aim requires balanced performance across the Moments of Hand Hygiene, with particular emphasis on Moment 1 (before patient or patient-environment contact), which represents the highest risk for transmission. Engagement and accountability at the program, unit or site level, supported through continuous QI, are the primary mechanisms for achieving this aim. Rather than relying on a single centralized plan, VCH requires local teams to develop and implement Hand Hygiene Quality Improvement (HH QI) Plans that respond to their specific practice environments, workflows, patient populations, and identified gaps.

Progress toward this organizational aim will be supported and monitored through:

- Local HH QI planning that translates organizational expectations into actionable, context-specific improvement activities.
- Active leadership oversight and frontline engagement to reinforce accountability for practice improvement.
- Use direct observational auditing and indirect monitoring methods to track performance, identify barriers, and assess the impact of interventions.
- Ongoing measurement, feedback, and refinement to support sustained improvement over time.

Together, these local QI efforts create a coordinated, system-wide approach to hand hygiene improvement that supports continuous accreditation readiness across VCH.

Components of Hand Hygiene Continuous Quality Improvement Plan

Every program or unit is required to develop a local Hand Hygiene Quality Improvement (HH QI) Plan informed by its own observational data, operational context, and patient population. Local plans ensure that improvement efforts are meaningful, targeted, and relevant to the realities of care delivery in each setting.

A strong HH QI Plan should:

1. Use locally collected data to understand current practice
    - Review baseline compliance rates
    - Identify practice gaps, barriers, and system contributors
    - Compare performance across care areas when appropriate
2. Establish clear, measurable goals
    - Develop aim statements that are specific, time-bound, and actionable
    - Align targets with BC Ministry of Health expectations (minimum 80% hand hygiene compliance)
3. Select strategies tailored to the unit or program
    - Ensure strategies address identified barriers
    - Integrate improvement activities into existing workflows
    - Use a mix of education, environmental, process, and behavioral interventions
4. Clarify roles and responsibilities
    - Identify who will lead, coordinate, audit, and report
    - Ensure leadership support for resources and follow-up
5. Monitor, evaluate and refine
    - Track compliance results regularly
    - Adjust interventions based on data and staff feedback
    - Share progress transparently with staff and leadership

A well-constructed HH QI Plan foster ownership, strengthens accountability, supports accreditation readiness, and contributes to consistent infection prevention practices across VCH.

Getting Started – Roles and Responsibilities

Clinical leadership will identify team members who will be responsible for developing, implementing, monitoring and reporting on the HH QI plan within your program or unit. In some settings, such as community, and Long-Term Care, it may be beneficial to develop a HH QI plan for an entire site rather than creating multiple plans for individual programs operating out of the same building. This may require a coordinated approach with multiple teams.

Engage with collaborative partners to support the process. This may include your assigned infection control practitioner or quality lead. A fulsome list of collaborative partners that play a role in hand hygiene improvement activities is available in Appendix A.
Review and familiarize your program or unit with the available tools and resources that will support the development of your HH QI plan:

- Existing observational hand hygiene auditing data
- Multimodal Direct and Indirect Measurement Tools available in the Hand Hygiene Quality Improvement Toolkit and on the IPAC website under the Hand Hygiene tab.
- Connect with your local quality leader to access standardized quality improvement templates that will support the development of your HH QI plan.

Monitoring Strategy: Direct and Indirect Approaches

Direct observational hand hygiene auditing remains the gold standard for measuring hand hygiene compliance. It is the only method that captures all 4-Moments for Hand Hygiene, enables assessment of technique, and support real-time coaching and feedback.

However, direct observation is not feasible or sustainable in all care settings due to difference in care delivery models (e.g. community, homecare, outreach) and resource availability. As a result, a flexible context-driven approach to monitoring is required across VCH.

Programs and units are expected to select the most appropriate combination of data collection methods based on their care environment, patient population, and available resources. This may include direct observation, indirect measures, or a combination of direct and indirect measurement to provide a more comprehensive understanding of hand hygiene practices.

Direct Observational Auditing Conducted by IPAC
The IPAC team will continue to:

- Perform quarterly observational audits in clinical areas where auditing is already established.
- Share quarterly compliance reports with programs and units.
- Support leaders and staff to interpret results and integrate them into local QI planning.
  Note: Use of the Clean Hands app remains limited to the IPAC team.

Direct Observational Auditing Conducted by Local Teams
Where feasible, programs and units may implement local observation processes:

- Clinical leadership will designate staff to conduct unit-based auditing.
- Hand hygiene auditor training will be provided by the IPAC Hand Hygiene Coordinator.
- Local teams determine audit frequency aligned with QI priorities and compliance trends.
- Basic/manual tools available on the IPAC website are used to support data collection.
- IPAC remains available to mentor and support teams as needed.

Indirect Monitoring
In settings where direct observation is limited or not feasible, indirect methods may be used to monitor hand hygiene practices. Indirect methods may be used alongside direct observation to enhance understanding of behaviors and barriers.

Examples of indirect measures include:

- Staff self-reporting.
- Peer coaching and feedback.
- Knowledge and perception surveys.
- Patient, client, resident, family or visitor feedback.
- Hand Hygiene Product Supply bag auditing.
- Supply and product-use tracking.

These approaches:

- Expand monitoring across diverse and non-traditional care environments.
- Provide insight into behavioral patterns and local barriers.
- Reduce reliance on resource-intensive observation processes.

Expectations for Use:

- Programs relying solely on indirect monitoring should use a minimum of 2 different indirect methods to strengthen data reliability and reduce bias.
- Available tools for indirect monitoring will be basic and manual in nature for teams that are not participating in IPAC-led auditing.

Integrated Approach to Measurement
Direct and indirect methods should be viewed as complementary rather than hierarchical. While direct observation remains the preferred method where feasible, a multi-modal approach to data collection will provide a more complete and actionable picture of hand hygiene performance across the organization.

Setting Clear, Data-Driven Goals and Objectives

Effective hand hygiene improvement begins with clear, meaningful, and measurable goals. The BC Ministry of Health Policy Communique (2013) sets a minimum compliance target of 80%, but programs and units are encouraged to establish goals that reflect their unique context and improvement potential.

Setting Meaningful Aim Statements
Aim statements should be:

- Specific
- Measurable

- Time-bound
- Action-oriented

Example aims:
Increase overall hand hygiene compliance among clinical staff in the Ambulatory Care Clinic from 65% to 85% over the next 6 months.

By April 2027, clinical staff in [program/unit] will reduce inappropriate glove use by 30%, as measured through monthly glove-use audits based on Routine Practices and PCRA criteria, by implementing targeted education, visual cues, and ongoing feedback derived from direct observation and hand hygiene program resources.

Locally generated observational hand hygiene data are essential for shaping these goals, reviewing unit-specific trends helps teams:

- Identify practice gaps
- Understand barriers (workflow, access to supplies, workload, etc.)
- Determine priority focus areas
- Monitor progress over time and adjust action plans as needed

Clear, data-driven objectives provide direction, alignment, and motivation for sustained hand hygiene improvement.

Using Compliance Data to Guide Level of Engagement
Each program or unit's level of QI engagement should align with its observed hand hygiene performance. Compliance data help determine the urgency of improvement activities, the intensity of interventions required, and the level of support needed from leadership and IPAC.

Priority Level Framework

Priority Level	Compliance Rate	Recommended QI Actions
High Priority	≤ 69%	• Conduct a rapid review of observational data to determine patterns and critical gaps (e.g. Moments with lowest compliance, role-specific deficits). • Perform targeted root-cause analysis such as workflow mapping, supply access audits, or focused staff feedback. • Establish short-term, intensive QI goals with weekly or bi-weekly follow-up. • Implement rapid-cycle interventions (e.g. Plan Do Study Act) such as refresher education, point-of-care ABHR placement, visual cues, or targeted coaching. • Increase audit frequency to closely monitor progress.
Moderate Priority	70-80%	• Identify specific moments contributing to missed opportunities. • Develop focused improvement goals (e.g. increase Moment 1 compliance by X%). • Use targeted interventions like micro-teaching, reminders, and environmental adjustments. • Maintain regular auditing and review data monthly or quarterly to track movement toward ≥ 80%.
Maintenance Priority	>80%	• Focus on sustaining gains and preventing regression. • Celebrate successes and reinforce positive behaviors. • Engage staff in identifying new improvement opportunities. • Continue routine auditing at standard frequency. • Monitor for emerging trends, including barriers associated with onboarding new staff.

*Table adapted from Interior Health Authority: Hand Hygiene Quality Improvement Plan (2025)

How This Framework Supports QI Planning

Using a tiered engagement model helps:

- Direct resources to where they will have the greatest impact.
- Ensure high-priority areas receive timely and intensive support.
- Promote ongoing learning in areas with stable performance.
- Sustain improvement across the organization by focusing effort strategically.

Multi-Modal Improvement Strategies

Improving hand hygiene performance requires a coordinated and multi-modal approach. Effective strategies combine education, environmental supports, workflow optimization, and team engagement. Programs and units should select interventions that directly address the gaps identified through their monitoring and data review.

Education and Training

Education should be ongoing, accessible, and tailored to the needs of the care environment. Strategies may include:

- Orientation for new staff, students, and temporary workers.
- Micro-teaching during team huddles or shift changes.
- Hands-on demonstration of the 4-Moments for Hand Hygiene.
- Refresher modules or e-learning opportunities.
- Targeted coaching for roles or Moments with lower compliance.

Infrastructure and Supply Optimization

Ensuring that hand hygiene supplies are readily accessible is essential for sustaining good practice. Actions may include:

- Installing alcohol-based hand rub (ABHR) dispensers at point-of-care.
- Providing portable ABHR for outreach and community staff.
- Ensuring dispensers are full, functional, and ideally placed.
- Reviewing placement of sinks and ensuring appropriate supplies (e.g. soap, paper towels).

Staff Engagement and Culture Building

Strong engagement builds ownership and normalizes hand hygiene as part of daily practice:

- Identify and support unit-based hand hygiene champions.
- Use peer-to-peer coaching and positive reinforcement.
- Embed hand hygiene reminders into safety briefings.
- Celebrate improvements and highlight success stories.

Data-Driven Decision Making

Programs and units should use their observational and indirect monitoring data to:

- Identify patterns and trends.
- Focus interventions on Moments or roles with the greatest need.
- Evaluate the impact of changes using real-time or frequent measurement.

- Share progress transparently with staff and leadership.

Integration of QI Methodologies

Programs and units are encouraged to use evidence-informed QI frameworks such as Plan-Do-Study-Act (PDSA) cycles to drive change:

- Test small interventions.
- Review results quickly.
- Adapt based on feedback and data.
- Scale successful changes gradually.

Indicators and Metrics

Meaningful indicators and consistent measurement practices are essential for understanding performance and guiding QI efforts. Transparent reporting helps create a culture of accountability and encourages continuous improvement.

Hand Hygiene Compliance

- In areas with IPAC-led auditing, quarterly compliance data will continue to be provided by IPAC.
- In areas without IPAC-led auditing, programs and units are expected to collect, tabulate, and regularly report results from the hand hygiene measurement methods they have selected, in alignment with their local QI plans.
- Programs and units may access additional real-time or historical data through the Quality Patient Safety Hand Hygiene Dashboard.
- Programs and units monitor their own trends to track progress toward meeting or exceeding the 80% target.

Posting Results

Hand hygiene compliance and QI plans must be posted in a visible area for staff, patients, clients, families and visitors such as:

- Unit quality boards.
- Staff rooms or team spaces.
- Nursing stations.
- Hallways, lobbies, or elevators (public transparency).

Posting results:

- Reinforces accountability.
- Encourages staff reflection and engagement.
- Supports Accreditation readiness.
- Signals to patients and visitors that hand hygiene is a priority.

Feedback Mechanisms

Regular and meaningful feedback is vital for sustaining improvement. Feedback increases awareness, promotes accountability, and reinforces desired behaviours. Programs and units should integrate feedback into routine communication and learning structures.

Real Time Feedback

Auditors should:

- Provide immediate coaching when a missed opportunity is observed.
- Acknowledge and reinforce correct practice.
- Use a respectful, supportive approach to build trust and promote learning.

Formal Feedback Channels

Programs and units can use multiple platforms to share data and promote discussion:

- Unit newsletters or electronic bulletins.
- Staff meetings, safety huddles, or interdisciplinary rounds.
- Quality improvement boards.
- Regular updates at unit council or quality committees.
- Visual dashboards or progress charts.

Peer Learning and Team Discussion

Programs and units are encouraged to:

- Hold brief team discussions following new data trend releases.
- Share practical strategies amongst staff.
- Invite champions or IPAC to facilitate targeted sessions.
- Encourage two-way dialogue for staff to voice challenges and propose solutions.

Sustainability and Spread

Sustained improvement depends on embedding hand hygiene practices into organizational culture, daily workflow, and staff routines. Successful strategies should not remain confined to one program or unit but be shared and scaled across programs where they are applicable.

Sustaining Improvements

To maintain long-term performance, programs and units should:

- Integrate hand hygiene checks into routine workflows and care processes.
- Continue regular auditing and feedback cycles.
- Incorporate hand hygiene into orientation, competency reviews, and ongoing training.
- Ensure consistent availability and accessibility of ABHR and other supplies.
- Support local champions and leadership engagement.

Spreading Successful Strategies

To promote spread across VCH:

- Share lessons learned, success stories, and effective tools with other units.

- Engage leadership to support replication of successful improvement activities.
- Encourage collaboration and friendly competition across units.
- Highlight high-performing programs and units and leverage their expertise as mentors.

Aligning with Organizational Priorities

Sustainable hand hygiene performance reinforces VCH's broader goals:

- We Care for Everyone
- We are Always Learning
- We Strive for Better Results

By committing to continuous learning, transparent communication, and evidence-informed improvement, VCH teams help build a culture where hand hygiene is consistently prioritized and embedded in everyday practice. Sustained success depends on collective ownership – when every unit, every program, and every individual contributes to safe and reliable hand hygiene, we strengthen the safety of our patients, our colleagues, and our communities.

Hand Hygiene is Everyone's Responsibility.

References

Accreditation Canada QMENTUM Program Standards – Infection Prevention and Control
Accreditation Canada Improving Hand Hygiene Practices – A Required Organizational Practice
British Columbia Ministry of Health (2012). Best Practices for Hand Hygiene in All Healthcare Settings and Programs
World Health Organization (2009). WHO Guidelines on Hand Hygiene in Health Care
World Health Organization (2009). A Guide to the Implementation of the WHO Multimodal Hand Hygiene Improvement Strategy

Associated Documents

Hand Hygiene Toolkit for Quality Improvement
Vancouver Coastal Health Hand Hygiene Policy
4 Moments for Hand Hygiene – Acute Care
4 Moments for Hand Hygiene – Long-Term Care
Hand Hygiene Products and Ordering Information
How to Hand Wash – Poster
How to Hand Wash – Video
How to Hand Rub – Poster
How to Hand Rub – Video
Best Practice Guideline: Hand Hygiene Infrastructure
Provincial Hand Hygiene Working Group: Best Practices for Hand Hygiene Facilities & Infrastructure in Healthcare Settings - Checklist

Definitions

Alcohol-Based Hand Rub (ABHR): A liquid, gel or foam formulation of alcohol (e.g. ethanol, isopropanol) which is used to reduce the number of microorganisms on hands in clinical situations when hands are not visibly soiled. ABHRs contain emollients to reduce skin irritation and are less time-consuming to use than washing with soap and water.

Champions: Healthcare providers who publicly share their commitment to improving hand hygiene practice in the healthcare setting.

Hand Hygiene: A general term referring to any action of hand cleaning. Hand hygiene relates to the removal of visible soil and removal or killing of transient microorganisms from the hands. Hand hygiene in patient care may be accomplished using an alcohol-based had rub or soap and running water. Hand hygiene includes surgical hand preparation.

Hand Hygiene Moment: The point(s) in an activity at which hand hygiene is performed. There may be several hand hygiene moments in a single care sequence or activity.

Hand Hygiene Opportunity: Terminology used when performing an audit of hand hygiene. A hand hygiene opportunity is an observed indication for hand hygiene. Each opportunity should correspond to an action. Several indications for hand hygiene may come together to create an opportunity.

Hand Washing: The physical removal of microorganisms from the hands using soap and running water.

Healthcare Associated Infection (HAI): A term relating to an infection that is associated with the delivery of healthcare.

Appendix A

Roles and Responsibilities

Organizational Leadership
Organizational leaders provide the structure, resources, and oversight necessary to support consistent, system-wide hand hygiene improvement.
Key Responsibilities

- **Strategic Oversight**: Monitor hand hygiene improvement activities using qualitative and quantitative indicators (e.g. infrastructure availability, compliance rates)
- **Resource Allocation**: Ensure adequate human and financial resources for education, auditing, data systems, and infrastructure (e.g. ABHR dispensers, sinks).
- **Policy Endorsement**: Approve and promote system-wide hand hygiene policies and quality improvement plans.
- **Multidisciplinary Expertise:** Provide support for continuous improvement and problem solving around planning, implementation and review of HH QI plans from an organizational perspective.
- **Accountability Structures**: Establish governance frameworks that clarify decision-making authority and support transparent reporting.
- **Continuous Readiness:** Maintain organizational readiness for accreditation surveys by embedding hand hygiene practices into routine operations.

Program or Unit-Based Leadership
Unit and program leaders play a pivotal role in translating organizational expectations into daily practices at the point-of-care.
Key Responsibilities

- **Local Implementation**: Adapt organizational hand hygiene policies into unit-specific procedures and ensure consistent application.
- **Education and feedback**: Facilitate education, share compliance results regularly, and lead timely feedback loops.
- **Infrastructure Readiness**: Ensure accessible hand hygiene supplies and equipment, including ABHR, sinks, and necessary consumables.
- **Capacity Building**: Identify and support unit based hand hygiene champions to assist with improvement activities.
- **Coordination**: Collaborate with IPAC, Quality & Patient Safety (QPS), and other partners to develop and maintain HH QI Plans.

Front Line Staff and Physicians
Frontline staff are the primary drivers of safe care and play a central role in maintaining reliable hand hygiene practices.
Key Responsibilities

- **Compliance**: Follow the 4-Moments of Hand Hygiene consistently.
- **Engagement**: Participate in audits, education sessions, coaching, and improvement activities.
- **Role Modeling**: Demonstrate exemplary practice and encourage peers to maintain high standards.
- **Feedback Participation**: Engage in discussion about audit findings and contribute insights to support continuous improvement.

Infection Prevention and Control (IPAC)
IPAC provides specialized expertise, guidance, and data analysis to support programs and units across VCH.
Key Responsibilities

- **Technical Expertise**: Develop evidence informed guidelines, conduct audits, and provide practice recommendations.
- **Education**: Support programs and units with training resources and hand hygiene competency development.
- **Consultation**: Assist teams to develop program- or unit- specific HH QI Plans.
- **Data Analysis**: Analyze compliance trends, identify system-level risks, and share actionable findings with collaborative partners.
- **Improvement Support**: Provides mentorship during PDSA cycles and helps teams interpret local data.

Quality and Patient Safety Team (QPS) & Team Based Quality Improvement (TBQI)
These teams support structured improvement work, data literacy, and alignment with organizational quality priorities.
Key Responsibilities

- **QI Method Support:** Promote the use of QI tools (PDSA cycles, process mapping, root-cause analysis).
- **Data Interpretation:** Support teams in understanding compliance data and using dashboards effectively.
- **Coaching:** Offer facilitation, coaching, and support for HH QI planning.
- **Integration:** Ensure HH improvement aligns with broader patient safety and quality initiatives.

Accreditation Team
The Accreditation team ensures the hand hygiene framework meets or exceeds external standards.
Key Responsibilities

- **Standards Interpretation**: Provide guidance to teams regarding expectations under Accreditation Canada's requirements.
- **Documentation Review**: Ensure that compliance audits, QI plans, and posted materials are complete, accurate, and accessible.
- **Survey Preparedness**: Support continuous readiness for scheduled and unscheduled surveys through ongoing communication and targeted coaching.

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