

The Champion Handwasher Hospital Campaign

“A beginning to change to a culture of safety one handwash at a time”

What:

What would Louis Pasteur (1857) in Lille, France , Florence Nightingale RN(1856) in Barracks Hospital in Scutari,Turkey, Joseph Lister MD(1860) in Glasgow Royal Infirmary, Ignaz Semmelweis MD(1864) in Austrian Medical Society and John Snow MD(1865) in London with the Broad Street Pump would say about the Champion Handwasher Hospital Campaign in 2006. Much research around hand hygiene in the past decade by many notable researchers; Maryanne McGuckin PhD, Elaine Larsen RN, PhD, Didier Petit MD, Chuck Gerba PhD and others have continued to prove what those basic tenets discovered in the mid 1800's. What will it take for Hospitals in 2006 to be more serious about nosocomial infections in their facilities that are preventable? A brief intervention in Pittsburgh has shown to reduce nosocomial infections from 64 to 1 in a 30-day period of time. The country of Switzerland has just initiated a yearlong campaign to get serious about reducing nosocomial infections. It will take a “culture of safety” change to begin to make serious progress in nosocomial infections. There are a few initiatives to make small improvements (i.e. 100,000 Lives Campaign), which look at a narrow scope that is easy to measure, instead of getting at what many HCW in Infection Control and Patient Safety know to be rampant cross-contamination behaviors that staff and visitors demonstrate regularly. There is such a behavior modification Program that will begin to initiate the “culture of safety” change that is necessary. It utilizes social marketing techniques to facilitate “traction” and improve the results as they are beginning to use in the United Kingdom and Switzerland. It uses the universal icon of “Henry the Hand Champion Handwasher” as its messenger to improve the result.

Why:

There should be NO denominator for nosocomial infections. The target should be ZERO. Of the 98,000 preventable deaths each year in hospitals, 90,000 are related to nosocomial infections. There have no been no simple Patient Safety initiatives that focus on changing to a “culture of safety” across the spectrum in the healthcare environment. This Campaign will begin that change as it emphasizes breaking down barriers of communication between traditional silos of authority: physicians, nurses, aides, clerks, families and patients. The majority of the Patient Safety initiatives have been targeting medical liability claim driven issues, not genuine patient safety issues based on mortality or morbidity. Also, there have been no grassroots initiatives from providers, only the public, accrediting bodies, employers and Health Insurers.

How to get started:

Identify an Ambassador (Champion) in your hospital to help facilitate the Campaign and to lead a Strategic Advisory Committee (SAC), which could be an existing Patient Safety or Infection Control committee to implement the Campaign. As you will see the core members of the SAC is very important to ensure its success across your facility. The members should consist of at least the Ambassador, Facilities Management representative, HR representative, PR representative, Housekeeping, clerks and Infection Control in order to facilitate implementation across the full breadth of the hospital.

When:

There are 3 specific weeks of each year that the audit (measurement) is taken; International Infection Prevention Week October 17th-23rd, National Handwashing Awareness Week 1st week of December (4th- 10th), Patient Safety Awareness Week 2nd week of March. There are 10 criteria (measures) that are on the audit tool to determine whether or not your hospital is a Champion. A grade of 70% or better denotes the “Champion Handwasher Hospital” status and 50% is passing. A key component of the Campaign is the “genuine communication” across levels of authority, which is a difficult hurdle to clear as most of the HCW have spent 12+ years in schools and other institutions being told not to question authority and do what they are told. There lies one of the inherent cultural barriers we must overcome very carefully in seeking the “culture of safety” so as not to create chaos in the work environment. So this “genuine communication” about Hand Awareness across levels of authority by design is innocuous so that there should be less initial resistance by ALL parties to participate to benefit Patient Safety. It is explicitly encouraged to take place during each of the designated weeks using the strategies of S.B.A.R. and Crucial Conversations of Healthcare by Vital Smarts that is designed to empower, otherwise not empowered staff. Practicing ones delivery about a topic so common as handwashing can aid in the development of one’s confidence in communication before it comes to more egregious breaches in patient care (medication errors or surgery errors).

Who is (are) the auditor(s):

The SAC chooses them and those individuals then report the information directly to the database. The auditors may be hospital employees, volunteers, or any patient advocate the SAC may choose.