

Letter to the Editor*

Clean care for all—it's in your hands: The May 5, 2019, World Health Organization's "SAVE LIVES: Clean Your Hands" campaign

Alexandra Peters MA¹, Tcheun Borzykowski MS¹, Ermira Tartari MS¹, Claire Kilpatrick MSc²,
Safiah Hwai Chuen Mai PhD², Benedetta Allegranzi MD² and Didier Pittet MD, MS, CBE¹

¹Infection Control Program and WHO Collaborating Center on Patient Safety, University of Geneva Hospitals and Faculty of Medicine, Geneva, Switzerland and

²Infection Prevention and Control Global Unit, Department of Service Delivery and Safety, World Health Organization, Geneva, Switzerland

Quality healthcare should be available to everyone. The World Health Organization's (WHO's) concept of universal health coverage (UHC) ¹ embodies the urgent need for access to healthcare for all people around the world. In addition to access, the concept of UHC incorporates the critical element of the necessary quality of delivered healthcare services. Infection prevention and control (IPC), with hand hygiene as the most effective measure, is a practical and evidence-based approach with a demonstrable impact on quality of care and patient safety across all levels of the health system.

Each year, the WHO "SAVE LIVES: Clean Your Hands" campaign aims to bring people together in support of hand hygiene improvement globally on or around May 5th.² This year's theme for global annual hand hygiene day reflects a strong focus on providing clean care, equally protecting all patients and healthcare workers from infection and antimicrobial resistance transmission, across all countries, including in low-resource settings.

The WHO urges ministries of health, healthcare facility leaders, IPC leaders, healthcare workers, and patient advocacy groups to contribute to effective IPC action including hand hygiene as a

cornerstone of quality in healthcare (Table 1). The WHO invites all healthcare facilities to join the 2019 WHO Global Survey on IPC and Hand Hygiene using 2 validated assessment tools: one for evaluating the core components of IPC program and the other for a deep dive into hand hygiene activities (<https://www.who.int/infection-prevention/campaigns/ipc-global-survey-2019/en/>).

On a facility level, the use of these tools gives institutions a clear understanding of the strengths and weaknesses of their IPC and hand hygiene program and recommends concrete actions to address existing gaps. These tools allow institutions to improve their IPC practices and policies in concrete and measurable ways, at their own speed and in their own context. The surveys are anonymous, and global results will be made available using only aggregated data. Thus, facilities and ministries of health can commit fully to working on improving IPC and patient safety without fear of scrutiny or possible negative repercussions.

Table 1. The May 5, 2019, World Health Organization "SAVE LIVES: Clean Your Hands" Campaign Calls to Action

Campaign Participants	Call to Action
Healthcare workers	"Champion clean care—it's in your hands."
IPC leaders	"Monitor infection prevention and control standards—Take action and improve practices."
Healthcare facility leaders	"Is your facility up to WHO infection control and hand hygiene standards? Take part in the WHO survey 2019 and take action!"
Ministries of health	"Does your country meet infection prevention and control standards? Monitor and act to achieve quality universal health coverage."
Patient advocacy groups	"Ask for clean care—it's your right."

Note. IPC, infection prevention and control; WHO, World Health Organization.

Author for correspondence: Didier Pittet, E-mail: Didier.pittet@hcuge.ch

Cite this article: Peters A, *et al.* (2019). Clean care for all—it's in your hands: The May 5, 2019, World Health Organization's "SAVE LIVES: Clean Your Hands" campaign. *Infection Control & Hospital Epidemiology*, 40: 735–736, <https://doi.org/10.1017/ice.2019.86>

*Article type has been corrected since original publication. A corrigendum notice detailing this change was also published (DOI: [10.1017/ice.2019.140](https://doi.org/10.1017/ice.2019.140)).



Fig. 1. May 5, 2019: "Clean care for all—it's in your hands!" The May 5, 2019, World Health Organization "SAVE LIVES: Clean Your Hands" campaign slogan and main promotional image (2019 hashtags: #HandHygiene #InfectionPrevention #HealthForAll). Campaign participants are invited to submit photos or selfies of them holding a board with the slogan and hashtags at www.CleanHandsSaveLives.org.

Globally, this survey will allow the WHO to provide a situational analysis of progress of current IPC and hand hygiene activities around the world and inform future efforts and resource use for IPC capacity building and improvement. Global surveys using the hand hygiene self-assessment framework were also conducted in 2011 and 2015,^{3–5} making this year's survey even more crucial for tracking the implementation of hand hygiene and IPC on a global scale (Fig. 1).

Each improvement in IPC contributes toward quality UHC. “Clean care for all—it's in your hands!”

Acknowledgments. The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated. WHO takes no responsibility for the information provided or the views expressed in this paper.


Financial support. This work is supported by the World Health Organization (WHO), Geneva, Switzerland, and the Infection Control Program and WHO Collaborating Center on Patient Safety (SPCI/WCC), University of Geneva Hospitals and Faculty of Medicine, Geneva, Switzerland; hand hygiene research activities at the SPCI/WCC are also supported by the Swiss National Science Foundation (grant no. 32003B_163262).

Conflicts of interest. Didier Pittet works with WHO in the context of the WHO initiative “Private Organizations for Patient Safety—Hand Hygiene.” All listed authors declare no financial support, grants, financial interests or consultancy that could lead to conflicts of interest.

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Real-world challenges in infection prevention: Differential implementation between stable and unstable patients may influence clinical effectiveness of interventions

Westyn Branch-Elliman MD, MMSc^{1,2,3}  and Marin Schweizer PhD⁴

¹VA Boston Healthcare System, Boston, Massachusetts, ²VA Center for Healthcare Organization and Implementation Research, Boston, Massachusetts, ³Harvard Medical School, Boston, Massachusetts and ⁴University of Iowa and Iowa City VA Health Care System, Iowa City, Iowa

To the Editor—We read “Implementation Strategies to Reduce Surgical Site Infections: A Systematic Review”¹ by Ariyo et al with great interest. Identifying ways to improve implementation and uptake of infection prevention interventions is critical as the field moves toward translating and implementing evidence-based findings into day-to-day clinical practice.

A key finding of the systematic review by Ariyo et al was that few high-quality trials have examined different implementation strategies in infection prevention. Adding to the limitations of the current literature identified in the outstanding review, some of our recent work across multiple procedural and surgical specialties highlights the challenges in bringing infection prevention practices to the bedside and operating room. In particular, we found that implementation of prevention practices is unevenly applied across the spectrum of care. This variation in effective implementation may lead to significant bias and confounding that impacts the apparent benefits of different infection prevention interventions.

Author for correspondence: Westyn Branch-Elliman, Email: wbranche@bidmc.harvard.edu.

Cite this article: Branch-Elliman W and Schweizer M. (2019). Real-world challenges in infection prevention: Differential implementation between stable and unstable patients may influence clinical effectiveness of interventions. *Infection Control & Hospital Epidemiology*, 40: 736–737, <https://doi.org/10.1017/icc.2019.87>

A consistent finding across multiple specialties and clinical care areas has been that more stable patients receive more systematic, protocolized care. Processes of care are standardized and systematically applied to the stable, elective patient population. However, that is not true for more urgent or emergent cases, which tend to be identified for surgical procedures in inpatient settings. This inherently sicker and higher-risk population may be less predictable and more difficult to track and control, with environmental barriers to implementation that do not exist for the outpatient population.

We have identified these findings across different types of invasive procedures and using different methodologies. For example, during qualitative interviews with frontline electrophysiologists, we learned that,

“[Cardiac device] patients come [to the electrophysiology laboratory] from a million different routes. They can be outpatients, they can be hospital to hospital transferred, they can be patients who present through the ER, they can come urgently from outpatient clinics. They can be transferred from another institution. [For all elected cases], ones who are scheduled [outpatients] get [chlorhexidine] at home, [the patients] do the cleaning process themselves . . . If the patient is [in the hospital], the nurses try to do the [chlorhexidine] on the day prior, but that is not uniform. For patients who are transferred from another hospital, they may have a temp wire and then go directly to the [electrophysiology] lab. From an infectious