

Table 1: Results of Patient/Visitor Hand Hygiene Audits of Staff in Pilot Units/Clinic				
Inpatient Pilot Units				
Month	Number of "Yes" Observations <sup>1</sup>	Number of "No" Observations <sup>2</sup>	Total Number of Observations	Observed Compliance (%)
August	7	0	7	100%
September	6	0	6	100%
October	3	2	5	60%
November	4	0	4	100%
December <sup>3</sup>	4	0	4	100%
Total	24	2	26	92%
Outpatient Pilot Clinic				
August	21	2	23	91%
September	12	0	12	100%
October	20	4	24	83%
November	8	0	8	100%
December	5	0	5	100%
Total	66	6	72	92%
Total Combined Inpatient & Outpatient Pilot Units/Clinic				
August	28	2	30	93%
September	18	0	18	100%
October	23	6	29	79%
November	12	0	12	100%
December	9	0	9	100%
Total	90	8	98	92%

<sup>1</sup> Number of observations entered by patients or visitors where they answered "Yes" to the question "Did the staff member(s) caring for you (or the patient you are with) wash their hands or use hand sanitizer (Purill) when entering your room/care area?"

<sup>2</sup> Number of observations entered by patients or visitors where they answered "No" to the question "Did the staff member(s) caring for you (or the patient you are with) wash their hands or use hand sanitizer (Purill) when entering your room/care area?"

<sup>3</sup> Through December 31, 2024.

effectiveness of engaging patients and visitors in hand hygiene interventions. The results of this pilot suggest that this novel approach warrants further investigation and broader implementation as part of larger efforts improve HCW hand hygiene compliance and reduce healthcare-associated infections.

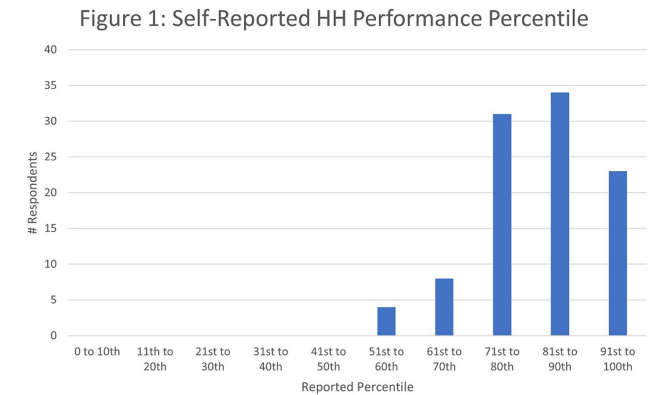
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**Presentation Type:**  
Poster Presentation  
**Subject Category:** Hand Hygiene  
**Overestimation of Personal Hand Hygiene Performance and Barriers to Hand Hygiene among Healthcare Providers**  
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**Introduction:** Hand hygiene (HH) performance in our facility declined during the COVID-19 pandemic and failed to return to baseline despite a widespread education campaign and increased HH rounding. To better understand provider perceptions and inform future interventions, we conducted a survey examining self-perception of HH performance, factors determining HH practices, barriers to adherence, and burnout. **Methods:** The survey assessed self-perceived HH performance relative to peers, perceived opportunities for improvement, barriers to HH, factors causing variation in personal HH practice (workload/acuity, peers, time of day, patient characteristics), and self-reported burnout using a validated, single-item burnout scale. Surveys were conducted in-person with clinical providers on one high-performing and three lower-performing intensive care units. All available clinical team members were included; non-clinical staff were excluded. Self-perception of performance was compared by unit, role, years of experience, and burnout rating using the Kruskal-Wallis test. Analyses were completed in SAS 9.4, Cary, NC. **Results:** One hundred surveys were completed. One person declined. The majority of those surveyed believed themselves to be in the top quartile of HH performers (87%). The actual HH compliance measured on these 4 units for 1/2024-11/2024 was 65% based on 7726 total directly observed opportunities. No one selected bottom or bottom 3rd quartiles. Figure 1 shows responses by percentile

self-ranking. There was no difference in perceived performance by unit ( $p=0.4006$ ), years of experience ( $p=0.9679$ ), or burnout ( $p=0.2621$ ). Non-clinical “other” type providers perceived performance to be slightly higher than clinical provider types: mean 91st percentile versus 82nd for prescribing providers, 84th for students, and 81st for nurses/nurse assistants,  $p=0.0353$ . Empty HH dispensers was the most frequent barrier cited, by 77%. A point prevalence survey on these 4 units completed the week after the survey ended verified that 22% (25/113) of dispensers were empty, however, in all of the 25 except for 1, there was a filled dispenser within 8 feet of the empty one. **Discussion:** HH performance was perceived to be better than average by the majority of inpatient healthcare providers (HCP) surveyed, despite data from these units indicating opportunities. Empty dispensers were consistently cited as a barrier, but likely could have been surmounted by a few steps based on the locations of the next available filled dispensers. Further improvement in HH will be difficult without efforts to move perception closer to reality for individual HCPs. Video footage or re-enactments of an observed care episode may help identify opportunities for improvement.

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**Presentation Type:**  
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**Improving Hand hygiene Compliance at Selected Health Facilities in Uganda Using the WHO Multimodal Strategy**  
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**Background:** Uganda has a high prevalence of healthcare associated infections (HCAs) with 28% often linked to inadequate hand hygiene practices among health workers. Hand hygiene is one of the most important measures in reducing the transmission of nosocomial infections. Implementing a world health organization (WHO) multimodal hand hygiene improvement strategy has shown influence on health workers’ behaviors, knowledge and practices. We aimed at evaluating hand hygiene compliance among health workers before and after implementation of the WHO multimodal improvement strategy at select health facilities(HF) in Uganda. **Method:** 27 health facilities were randomly selected from two regions in Uganda to implement the WHO multimodal hand hygiene improvement strategy over a period of 4 weeks. Before the interventions, healthcare worker’ (HCW) compliance with hand hygiene during routine patient care was directly observed using the WHO hand hygiene observation tool. Interventions included; weekly onsite mentorships focusing on Training and education, provision of locally produced alcohol-based hand rubs (ABHR), soap, and placement of reminders such as posters at point of care areas to emphasize the importance of hand hygiene. HCWs from different facility departments were designated to champion hand hygiene. We