



City Research Online

City, University of London Institutional Repository

Citation: Gould, D. J., Creedon, S., Jeanes, A., Drey, N., Chudleigh, J. H. & Moralejo, D. (2016). Impact of observing hand hygiene in practice and research: a methodological reconsideration. *Journal of Hospital Infection*, 95(2), pp. 169-174. doi: 10.1016/j.jhin.2016.08.008

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: <https://openaccess.city.ac.uk/id/eprint/15939/>

Link to published version: <https://doi.org/10.1016/j.jhin.2016.08.008>

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online:

<http://openaccess.city.ac.uk/>

publications@city.ac.uk

REVIEW

Impact of observing hand hygiene in practice and research: a methodological reconsideration

D. J. Gould ^{a *}, S. Creedon ^b, A. Jeanes ^c, N. S. Drey ^d, J Chudleigh ^e, D Morelejo ^f

^a Cardiff University, UK

^b University of Cork, Southern Ireland

^c University College Hospital, London, UK

^d City University London, UK

^e King's College, London, UK

^f Memorial University, St John's N.L. Canada

KEYWORDS

Hand hygiene

Hand hygiene audit

Hand hygiene compliance

Health care-associated infection

Hawthorne effect

Observation of practice

Words in text = 3,396

*Corresponding author: School of Healthcare Sciences, Cardiff University, Eastgate House, Newport Road, Cardiff, Wales CF24 0AB

Tel: 02920 688563

Email address: gouldd@cardiff.ac.uk

Summary

Healthcare-associated infection is spread by direct contact and the importance of hand hygiene to break the chain of infection is recognised internationally. In many countries hand hygiene is regularly audited as part of quality assurance based on recommendations issued by the World Health Organization (WHO). Direct observation is the recommended audit method but is associated with a number of disadvantages, including potential for being observed to alter usual behaviour. The Hawthorne effect in relation to hand hygiene is equated with productivity by increasing the frequency that hand hygiene is undertaken. Unobtrusive and/or frequent observation to accustom staff to the presence of observers are considered acceptable ways of reducing the Hawthorne effect but little has been written about how to implement these techniques or assess their effectiveness. There is evidence that awareness of being watched can disrupt the usual behaviour of individuals in complex and unpredictable ways other than simple productivity effect. Health workers might defer or avoid activities that require hand hygiene in the presence of auditors but these issues are not addressed in guidelines for practice or research studies. This is an important oversight with implications for the validity of hand hygiene audit findings. It needs to be considered if such findings are taken as indicators of quality of care and if the results of hand hygiene research are used to inform future policy and practice. Product uptake overcomes avoidance tactics. It is cheaper and generates data continuously to give a 24 hour picture of compliance for all clinicians without disrupting patient care. Disadvantages are the risk of over-estimating uptake through spillage, wastage or use by visitors and non-clinical staff entering patient care areas. Electronic devices can overcome Hawthorne and avoidance effects but are costly and are not widely used outside research studies.

Words in summary = 294

Introduction

Healthcare-associated infection (HCAI) is spread mainly by direct contact. Most cross-infection takes place via the hands of health workers ^{1, 2} and it is agreed that cleansing hands can break the chain of infection, thus reducing rates of HCAI ¹. The importance of hand hygiene is recognised internationally ^{3, 4} and guidelines developed by the World Health Organization (WHO) in 2009 ⁵ are credited with exerting considerable impact on hand hygiene policy and practice globally ⁶. The WHO ⁵ emphasises the importance of regular monitoring to assess health workers' hand hygiene performance. Monitoring is now undertaken routinely in many countries as part of quality assurance and is regarded as a major contributor to patient safety. Rates of hand hygiene compliance are reported to National Health Service Trust Boards, at similarly senior level in other countries and are frequently presented on the websites of healthcare providers as an indicator that infection prevention procedures are operating effectively. High levels of hand hygiene compliance are difficult to sustain ^{2, 7} and testing new interventions to enhance practice are frequently reported ⁷. Valid and reliable assessment is also essential to establish effectiveness when such interventions are evaluated ⁸. The methodology of hand hygiene audit has thus become an important area of enquiry. Audit can be undertaken by direct observation, consumption of alcohol handrub/soap or with electronic/computerised devices ⁹.

Direct observation has been described as the 'gold standard' approach to hand hygiene audit ¹⁰ and is favoured by the WHO⁵ because at the time the guidelines were published, it was the only method that could detect all hand hygiene opportunities, number of times an opportunity is acted on and appropriate timing of the hand hygiene event in the sequence of care. Observers witness which individuals are complying or failing to comply with hand hygiene protocols allowing them to intervene to improve performance in real time, identify barriers to compliance (e.g. poor availability of products or facilities) and make redress. Disadvantages are the time-consuming and resource-intensive nature of direct observation, need to train and periodically re-validate observers, need for reliability testing to ensure agreement between observers (inter-rater reliability), loss of data when bedside curtains are closed ⁸, assumption that hand hygiene opportunities and compliance are defined in the same way in all studies ⁸ and that audit captures only a small number of all hand hygiene opportunities that are occurring simultaneously ¹¹. Perhaps the most serious criticism is that the presence of observers has potential to influence health workers' usual behaviour

thus reducing the validity of audit findings⁸. These disadvantages are recognised by the WHO⁵.

Impact of observation on usual behaviour: historical overview

The impact of observation on employees' usual behaviour was first documented during a series of experiments at the Hawthorne Electrical Plant in Michigan, US throughout the 1920s and 1930s¹². Data collectors noticed that productivity increased regardless of the variable being manipulated and concluded that it resulted from employees' awareness that they were under scrutiny. Over the years this phenomenon has become known as the 'Hawthorne effect' and has attracted considerable attention from social scientists undertaking research in experimental and naturalistic settings^{13, 14}. The results of the Hawthorne experiments have been re-analysed numerous times and the original conclusions questioned^{13, 14} because of the large number of variables that could have affected behaviour but were not controlled¹⁵. There is confusion over a precise definition of the Hawthorne effect. It is described inconsistently with little understanding of how any resultant behaviour change is mediated or could be controlled¹⁵. Empirical research exploring association between observation and altered behaviour has been undertaken mainly in the field of education where some research teams have failed to detect systematic relationship between research participation and improved outcomes¹⁶. There is a consensus that individuals change behaviour when they are studied but not in a consistent or predictable manner^{15, 17, 18}. Identifying the Hawthorne effect and other tactics of avoidance or deferred activity is important when undertaking and interpreting the findings of hand hygiene audit given the current emphasis on hand hygiene globally and the importance of health workers' compliance.

Behaviour change during hand hygiene observation: historical overview

Although hand hygiene has attracted a great deal of attention over the last twenty years, this has not always been the case. Like the rest of infection prevention and control it was a Cinderella subject and the earliest studies, lacking methodological sophistication, overlooked the possibility that being watched might alter health workers' usual behaviour^{19, 20}. A study reported in 1994²¹ was one of the earliest to consider the Hawthorne effect. Participants were informed that hand hygiene was being observed but details of what was being documented (cleansing in relation to the activity undertaken and technique) were not disclosed in an attempt to reduce impact on usual behaviour. As hand hygiene research gained momentum the possibility that watching staff might alter usual

behaviour received greater consideration and the idea that a deliberately engineered Hawthorne effect might be used to improve compliance took shape. In the highly cited study by Pittet et al²² in the Geneva University Hospital health workers were informed that hand hygiene would be observed but did not know when audit periods were scheduled. Performance feedback was then used as part of an intervention to encourage increased hand hygiene frequency and reduce rates of HCAI. The Geneva study stimulated interest in hand hygiene and strategies to promote it. Overt observation has been since used as part of other multimodal interventions to increase hand hygiene compliance^{23, 24, 25}. This focus on hand hygiene has in turn contributed to increased awareness of the Hawthorne effect. One study reported a 55% increase in use of alcohol handrub when health workers were aware that they were being watched compared to when they were unaware²⁶. Compliance declined from 61% when doctors knew they were being observed to 44% when they were unaware²⁷ while in another study²⁸ hand hygiene compliance was reported to increase in the presence of data collectors known to staff compared to data collection by someone they did not recognise. The majority of these studies are associated with significant problems in relation to design and reporting of the audit method however. Only three studies in which overt observation with performance feedback formed part of a multifaceted intervention to enhance compliance reported adequate controls^{23, 24, 25}. In the others, lacking randomisation, it is not clear whether factors other than awareness of scrutiny could have influenced compliance. In two intervention studies that included overt observation as part of the intervention^{23, 25} data collectors did not know which centres were acting as controls and which were receiving the intervention but this information is not explicit in other studies. Lack of blinding to group allocation operates as an important source of observer bias.

Approaches to overcoming the Hawthorne effect during directly observed hand hygiene audits

Misleading health workers about the reason for observation is occasionally employed^{29, 30, 31, 32}. Its effectiveness in these studies has been assumed, not formally tested and in one study it was unsuccessful because health workers became aware of the real purpose of data collection³³. Misleading staff is not recommended by the WHO⁵ because it could promote distrust between clinicians and managers and is impossible to maintain if audit forms part of an intervention to promote hand hygiene. Covert observation in which health workers are neither informed that observation is taking place or told that other information is being documented, is not recommended for the same reason but has been employed in

a number of studies^{34, 35}. The WHO⁵ recommends two approaches to behaviour change during hand hygiene audit: unobtrusive observation and/or frequent observation to accustom staff to the presence of observers.

Unobtrusive observation has been employed in a number of studies^{23, 25, 36}. The authors do not provide details of how the procedure was undertaken or how its effectiveness was assessed, not surprisingly as the WHO guidelines⁵ do not give advice on either issue. Acclimatising staff to the presence of observers is a recognised technique in social science called habituation^{37, 38}. It is defined as decline in altered behaviour in response to repeatedly being observed³⁸. Although regarded as effective³⁹, habituation is seldom used in hand hygiene research and the WHO⁵ does not provide practical guidance on how it should be applied. Indication of its possible effectiveness can be traced to the work of Harbarth et al⁴⁰ in which compliance declined over a two week audit period in which staff appeared to forget about the presence of auditors. Cheng et al⁴¹ attempted to acclimatise health workers to the presence of data collectors by visiting wards regularly before audit began but do not discuss its effectiveness or the duration of data collection required before habituation was achieved, an issue seldom addressed in research looking at the effect of habituation on usual behaviour more generally³⁸. In another study⁴² health workers were observed on five occasions each two hours long in an attempt to secure habituation. They were informed that the data collector would be present before audit commenced so they would become accustomed to her presence but the point at which hand hygiene audit began was not disclosed. Increased hand hygiene frequency was noted throughout the first three observation periods and then appeared to wane but as the early data were discarded it was impossible to determine whether habituation was effective or how long it took. Chen and colleagues¹¹ combined direct observation of hand hygiene by trained auditors with a wireless data system allowing real time data input to the hospital intranet. Compliance increased with length of time that auditors remained in the clinical area during an unannounced audit period. It was hypothesised that levels of compliance would decline with their continued presence and observers were instructed to habituate health workers by staying on the unit for a short period (ten minutes) after collecting a set number of observations. Resulting reduction in hand hygiene frequency was accepted as a valid indicator of usual behaviour because rates were similar to those obtained in studies employing video-camera, which was assumed to achieve high levels of validity. This may be a false premise. Health workers may become accustomed to continual presence of the equipment but

habituation does not remove other key aspects of the data collection process that can compromise validity. Authors⁴³ employing observation by video camera do not describe training and validation of data collectors, issues that are of particular importance when large amounts of video footage are analysed. In this study⁴³ data were incomplete as it was impossible to evaluate hand hygiene performance in relation to the sequence of care: cameras were placed outside patients' rooms to avoid breaching privacy.

Although social scientists acknowledge that presence of observers in a clinical area can disrupt practice in more complex ways than a simple productivity effect, the possibility of a wider impact on hand hygiene audit data does not appear to have been addressed in guidelines for practice or research studies. This is an important oversight with major implications for the validity of audit findings. Health workers can practice avoidance tactics by moving to a location that is out of the auditor's range of vision (e.g. treatment room) resulting in under-estimate of the number of hand hygiene opportunities available and whether or not they were acted on. They can also defer clinical procedures until observation is over, especially if the audit period is brief: in many studies it is 30 minutes or less^{22, 25, 40}. Delaying activities that require multiple hand hygiene events throughout as well as before and afterwards (e.g. complex wound dressings, urinary catheterisation) results in failure to capture the full range of clinical procedures being undertaken, reducing completeness and validity of the data and compromising patient care because it is no longer delivered in a timely manner. Avoidance is less systematic than simple productivity effect, much harder to detect, allow for or overcome when hand hygiene audit is by direct observation.

Other approaches to hand hygiene monitoring

Product uptake

Product uptake has been used as an indicator of hand hygiene compliance in a number of studies either as a secondary outcome measure to corroborate the results of direct observation^{44, 45, 46, 47, 48, 49} or as the main audit method^{50, 51, 52, 53}. There is some evidence⁵⁴ that it might be a more sensitive indicator of the impact of alcohol-based antiseptics on HCAI rates than direct observation providing that uptake can be restricted to health workers only. Product uptake overcomes avoidance tactics. It is cheaper and generates data continuously to give a 24 hour picture of compliance for all clinicians without disrupting patient care. Disadvantages are the risk of over-estimating uptake through spillage, wastage or use by visitors and non-clinical staff entering patient care areas⁹.

Uptake can be under-estimated if staff use individual, portable dispensers^{55, 56}. If organisations can estimate non-clinical consumption, take into account uptake from individual dispensers and adjust their calculations, this approach could offer a useful alternative to direct observation but with loss of information: most systems do not monitor compliance for individual members of staff, professional groups, provide data on the hand hygiene event in relation to the sequence of patient care however⁵⁷. Product could be used to identify clinical areas where hand hygiene appears to be problematic⁹, however.

Electronic and computerised devices

Hand hygiene can be monitored with electronic and computerised devices that employ infra-red detection and wireless networks⁵⁷. It has been argued that staff become habituated to presence of the device when they are used continuously,⁵⁸ and there is evidence that they can overcome the Hawthorne effect. Srigley et al⁵⁹ established significantly higher hand hygiene compliance rates from alcohol handrub dispensers visible to data collectors compared to dispensers outside their field of vision. Electronic monitoring revealed significantly increased compliance rates when data collectors were present compared to 1-5 minutes immediately before their arrival. Another study⁶⁰ demonstrated strong positive correlation between the results of directly observed hand hygiene and electronic monitoring documented simultaneously. Hand hygiene was performed 24 times an hour in the presence of observers compared to eight times per hour in their absence suggesting that direct observation had a powerful Hawthorne effect. Electronic systems typically require each health worker to wear a detector. In one study where the detector was swapped between health workers instead of being worn continually by all staff all the time, compliance was lower⁶¹. From this finding it was inferred that wearing the detector resulted in a Hawthorne effect because staff were aware that individual behaviour could be identified. Again in this study there was good correlation between electronic and manual monitoring. The findings of these recent studies contrast with an earlier study by Marra⁶² where there was poor concordance between the outcomes of direct observation and electronic monitoring. Direct observation was considered less accurate in this study because the results of electronic monitoring concurred with those simultaneously obtained from product uptake which was taken as a valid indicator of performance. Electronic devices are becoming more sophisticated. Some models can provide data relating to key moments of the Five Moments of Hand Hygiene⁶³ but they are expensive to purchase and install. The amount of real

time data generated is only of value if managers have sufficient time to analyse and interpret it ⁹.

Discussion

The impact of observation on usual behaviour is more complex and less consistent than currently recognised in hand hygiene audit and research because individuals react to the knowledge that they are being watched in different, sometimes unpredictable ways ^{15, 18}. Aware of the emphasis placed on hand hygiene by managers and infection prevention teams, health workers may respond by cleansing hands more often but they may also adopt strategies to evade observation that are opportunistic and unsystematic. Findings can be context-specific making it difficult to compare audit results between different clinical settings or times of day. For example, there may be limited opportunity to improve hand hygiene performance in some hospital departments (e.g. the accident and emergency department) compared to wards through acuity of the work ⁶⁴. Repeated disillusionment at receiving unfavourable feedback could act as a disincentive to further attempts to improve performance. In these environments and perhaps more generally, direct observation should be questioned as the gold standard approach to hand hygiene audit. One of the most powerful arguments in favour of audit by direct observation, ability to intervene and correct poor practice in real time, appears to be rarely capitalised upon and there are only a few published examples ⁶⁵. Feedback is more often delayed while audit results are analysed while intervention at the point of care has the capacity to disrupt clinical practice and may be resented by staff as well as being impractical as it is likely to take place in front of patients. Finally a typical audit period can only ever capture a small number of the hand hygiene opportunities and events presented in a clinical area so it is not an efficient way of providing feedback. Although hand hygiene education and feedback are important they should not, therefore influence method of audit. Official guidelines ⁵ emphasise the importance of cleansing hands at appropriate times in the sequence of care and use of the correct product. The importance of thoroughly applying antiseptics to the entire hand surface to achieve disinfection is also recognised ⁶⁶ but these elements of hand hygiene performance are seldom addressed and cannot be determined by product uptake or most electronic systems.

Accounts describing measurement of the Hawthorne or other effects of observation in hand hygiene and how to overcome them when monitoring takes place by direct observation are relatively unsophisticated and none of the

techniques presently suggested have been clearly described or evaluated. Habituation, which holds some promise, is more seldom used than unobtrusive observation. More and better quality methodological studies are required to explore how the impact of observation can be measured, allowed for and/or reduced and how to determine the effectiveness of these strategies if hand hygiene audit results are to be taken as serious and valid indicators of patient safety. Such work is important because of the imprecision of product uptake and the expense of electronic systems and their limitations. The need for such studies could be dismissed given the hallowed place occupied by hand hygiene as a key component of all infection prevention programmes: it could be argued that periodic observation is useful to infection prevention teams because it gives an idea of what is taking place in clinical areas and reminds staff of the importance of hand hygiene irrespective of results. However, there is scope for organisations to establish their own Hawthorne effect and use it to estimate 'real' hand hygiene frequency. At present it is not possible to use published figures because estimates vary between research studies and data are not collected in the same way. There is also need to explore the most helpful and meaningful audit strategies and ensure they are in place. The way that audit is undertaken tends to drift over time⁶⁵. In some organisations it is undertaken by managers, in others by infection prevention teams or local staff. Little work has been done to assess possible differences in results when audit is undertaken by different staff. Healthcare providers frequently state that they operate zero tolerance to HCAI and promote 100% hand hygiene compliance throughout their organisations. Whether such high levels are achievable in practical terms and their relationship to rates of HCAI remains unknown.

Conclusion

The Hawthorne effect and possible avoidance and deferral tactics in the presence of observers have clear implications for the validity of audit and research findings. Attention has focused mainly on unsophisticated and untested ways of avoiding it or embracing it to drive performance feedback in interventions to improve compliance. The literature is replete with studies that purport to demonstrate that interventions can increase compliance^{23, 34, 35, 50, , 67} and decrease rates of HCAI^{22, 23, 24, 25, 40, 46, 48,49, 51,53} but many of these studies are poorly controlled⁷ and repeat what has already been concluded: that if an intervention is introduced, practice will improve, at least while auditing is taking place. If the results are to be taken as a genuine reflection of quality of care, more thought should be given to the complex and under-estimated impact presented by the Hawthorne effect

given the amount of time and resources that are put into hand hygiene audits and campaigns.

References

1. Reybrouck G. The role of hands in the spread of nosocomial infections. *J Hosp Infect* 1983; **4**: 103-11.
2. Teare E L, Cookson B, French G L, Jenner E, Scott G, Pallett A, Gould D, Schweiger M, Wilson J, Stone S (1999). Leader.UK handwashing initiative. *J Hosp Infect* 1999; **43**: 1-3.
3. Boyce J, Pittet D Guideline for hand hygiene in health care settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/DSA Hand Hygiene Task Force. *Infect Control HospEpidemiol* 2002; **23**: S3-S41.
4. Cookson B, Mathal E, Allegranzi B, et al. Comparison of national and subnational guidelines for hand hygiene *J Hosp Infect*; 2009; **72**: 202-10.
5. World Health Organization 2009. Guidelines on hand hygiene in health care. WHO.Geneva.
6. Mathai E, Allegranzi B, Kilpatrick C, BagheriNejad S, Graafmans W, Pittet D. Promoting hand hygiene in healthcare through national/subnational campaigns. *J Hosp Infect* 2011; **77**: 294-8.
7. Gould DJ, Moralejo D, DreyNS, Chudleigh J H 2010. Interventions to improve hand hygiene compliance in patient care (update). *Cochrane Database of Systematic Reviews*, Issue 9. Art. No.: CD005186. DOI: 10.1002/14651858.CD005186.pub3.
8. Gould D J, Moralejo D, Drey NS, Chudleigh J. Measuring hand washing performance in health service audits and research studies. *J Hosp Infect* 2007; **66**: 109-15.
9. Gould DJ, Drey N, Creedon S 2011. Nemesis of hand hygiene audit. *J Hos pInfec*; 2011; **77**:290-93.
10. Haas J P, Larson E L. Measurement of compliance with hand hygiene *J Hosp Infect* 2007; **66**: 6-14.
11. Chen LF, Carriker CC, Staheli R et al. Observing and improving hand hygiene compliance: implementation and refinement of an electronic-assisted direct-

observer hand hygiene audit program. *Infect Control Hosp Epidemiol* 2013; **34**: 207-10.

12. Roethlisberger FJ & Dickson WJ *Management and the Worker*; Harvard University Press. Cambridge: 1939.

13. Kompier MAJ. The 'Hawthorne effect' is a myth, but what keeps the story going? *Scand J Work Environ Health* 2006; **32**: 402-12.

14. Levitt SD, List JA. Was there really a Hawthorne effect at the Hawthorne Plan? An analysis of the original illumination experiments. *Am J Appl Econ* 2011; **3**: 224-38.

15. Adair JG. The Hawthorne effect. A reconsideration of the methodological artifact. *J Appl Psychol* 1984; **69**: 334-45.

16. Holden JD. Hawthorne effect and research into professional practice. *J Eval Clin Prac* 2008; **7**: 65-70.

17. Diaper G. The Hawthorne effect: a fresh examination. *Educ Stud* 1990; **16**: 261-7.

18. McCambridge J, Witton J, Elbourne DR. Systematic review of the Hawthorne effect: new concepts are needed to study research participation effects. *J Clin Epidemiol* 2014; **67**: 267-77.

19. Albert R, Condie F. Hand washing patterns in medical intensive care units. *New Eng J Med* 1981; **304**: 1465-6

20. Quaraishi, ZA, McGuckin M, Blals FX et al. Duration of handwashing in intensive care units. A descriptive study. *Am J Infect Control* 1984; **18**: 83-7.

21. Gould, DJ 1994. Nurses' handwashing practice: results of a local study. *J Hosp Infect*; **28**: 15-30.

22. Pittet D, Hugonnet S, Mourouga P et al. Effectiveness of a hospital-wide programme to improve compliance with hand hygiene. *Lancet* 2000; **356**: 1307-12.

23. Ho M, Seto W, Wong L, Wong T. Effectiveness of multifaceted hand hygiene interventions in long-term care facilities in Hong Kong: a cluster-randomized controlled trial. *Infect Control HospEpidemiol*2012; **33**: 761-7.
24. Martin-Madrazo C, Canada-Dorado A, Salinero-Fort M et al. Effectiveness of a training programme to improve hand hygiene compliance in primary care *BMJ Pub Health* 2009; **9**: 1-8.
25. Mertz D, Dafoe N, Walter SD, Brazil K, Loeb M. Effect of a multifaceted intervention on adherence to hand hygiene among healthcare workers: a cluster-randomized trial. *Infect Control HospEpidemiol*2010; **31**: 1170-6.
26. Eckmanns T, Bessert J, Behnke M, Gastmeier P, Ruden H. Compliance with antiseptic hand rub use in intensive care units: the Hawthorne effect *Inf Control HospEpidemiol* 2006; **27**: 931-34.
27. Pittet D, Simon A, Hugonnet S, Pessoa-Silva CL, Sauvan V, Perneger TV. Hand hygiene among physicians: performance, beliefs and perceptions. *Ann Intern Med* 2004; 141 1-8.
28. Kohli E, Ptak J, Smith S *et al*. Variability in the Hawthorne Effect with regard to hand hygiene performance in high- and low-performing inpatient care units *Infect Control HospEpidemiol* 2009; **30**: 232-36.
29. Al-Damouk M, Pudney E, Bleetman A. Hand hygiene and aseptic technique in the emergency department. *J Hosp Infect* 2004;**56**: 137-141.
30. Dedrick R, Sinkowitz-Cochran R, Cunningham C., Muder R., Perreuah P, Ccardo D, Jernigan J.. Hand hygiene practices after brief encounters with patients: an important opportunity for prevention. *Infect Control HospEpidemiol* 2007;**28**: 341-45.
31. Van de Mortel, M. & T., Murgo, M. An examination of covert observation and solution audit as tools to measure the success of hand hygiene interventions. *Am J Infect Control* 2006; **34**: 95-99.

32. Potts V, Devine A, Cartright A. Hand hygiene pays off. *Canadian Nurse* 2010; **106**: 12-14.
33. Whitby M, McLaws ML, Slater K, Tong E, Johnson, BI. Three successful interventions in health workers that improve compliance with hand hygiene: is sustained replication possible? *Am J Infect Control*, 2008; **36**:349-355.
34. Mayer J, Mooney B; Gundlapalli A; Harbarth S, Stoddard S, Rubin MA, Eutropius L, Brinton, B; Samore, MH. Dissemination and sustainability of a hospital-wide hand hygiene program emphasizing positive reinforcement. *Infect Control HospEpidemiol*2010; **32**: 59-66.
35. Tromp M, Huis A, de Guchteneire I, van der Meer J, van Achterberg T, Hulscher M, Bleeker-Rovers C. The short-term and long-term effectiveness of a multidisciplinary hand hygiene improvement program. *Am J Infect Control* 2012; **40**:732-6.
36. Helder OK, Brug J, Looman CW, van Goudoever JB, Kornelisse RF. The impact of an education program on hand hygiene compliance and nosocomial infection incidence in an urban neonatal intensive care unit: an intervention study with before and after comparison. *Internat J Nurs Stud* 2010; **47**:1245-52.
37. Baum C, Forehand R, Zegiob L. A review of observer reactivity in adult-child interactions. *J Psychopath Beh Assess* 1979; 1: 167-178.
38. McCall G. Systematic field observation. *Ann ReviSociol* 1984; **10**: 263-82.
39. Rankin C, Abrams T, Barry R, Bhatnagar S, Clayton D, Colombo J, Coppola G, Geyer M, Glanzman D, Marsland, S, Mcsweeney F, Wilson D, Wu CF, Thompson R. Habituation revisited; an updated and revised description of the behavioral characteristics of habituation. *Neurobiol Learning Memory*DATE; **92**: 135-38.
40. Harbarth S, Pittet, D, Grady L, Zawacki, A, Potter-Bynoe, G, Samore, MH, Goldman, DA et al. Interventional study to evaluate the impact of an alcohol based hand gel in improving hand hygiene compliance. *Paed Infect Dis J* 2002; **21**: 489-495.

41. Cheng VC, Tai JW, Chan WM, Lau EH, Chan JF, To KK, Li IW, Ho PL, Yuen KY. Sequential introduction of single room isolation and hand hygiene campaign in the control of methicillin-resistant *Staphylococcus aureus* in intensive care units. *BMC Infect Dis* 2010; **10**:263-65.
42. Creedon SA. Health care workers' hand decontamination practices: compliance with recommended guidelines. *J AdvNurs* 2005; 51: 208-216.
43. Armellino D, Hussain E, Schilling ME, Senicola W, Eichorn A, Dlugacz Y, Farber BF. Using high-technology to enforce low-technology safety measures: The use of third-party remote video auditing and real-time feedback in healthcare. *Clin Infect Dis* 2012; **54**: 1-7.
44. Lee, T C, Moore, C, Raboud, J *et al.* Impact of a mandatory infection control surveillance program on noscomial acquisition of methicillin-resistant *Staphylococcus aureus*. *Infect Control HospEpidemiol*2009; **30**: 249-56.
45. Ebnother, C, Tanner, B, Schmid, F, La Rocca, V, Heinzer, I, Bregenzer, T. Impact of an infection control program on the prevalence of nosocomial infections at a tertiary care center in Switzerland. *Infect Control and HospEpidemiol* 2008; **29**: 38-43.
46. Rose, L, Rogel, K, Redl, L, Cade, J F. Implementation of a multimodal infection control program during and Acinetobacter outbreak *IntCrit Care Nurs* 2009; **25**: 57-63.
47. Sanchez-Paya, J, Fuster-Perez, M, Garcia-Gonzalez, R M, Gracia-Rodriguez, P, Garcia-Shimizu, A, San Juan-Quiles, R, Casas-Fischer, A *et al.* Evaluation of a program for updating recommendations about hand hygiene *An SistSanitNavar* 2007;**30**:343-352.
48. Pessoa-Silva, C L, Hugonnet, S, Pfister, R, Touveneau, S, Dharan, S, Posfay-Barbe, K, Pittet, D. Reduction of health care associated infection risk in neonates by successful hand hygiene promotion *Pediatrics* 2007; **120**: 382-90.
49. Johnson, P D R, Martin, R, Burrell, L J, Grabsch, E A, Kirsas, S W, O'Keeffe, J, Mayall, B C *et al.* Efficacy of an alcohol/chlorhexidine hand hygiene program in a

hospital with high rates of nosocomial methicillin-resistant *Staphylococcus aureus* (MRSA) infection. *Med J Aust* 2005; **183**: 509-514.

50. McGuckin, M, Shubin, A, McBride, P, Lane, S, Strauss, K, Butler, D, Pitman, A. The effect of random voice hand hygiene messages delivered by medical, nursing and infection control staff on hand hygiene compliance in intensive care *Am J Infect Control* 2006; **34**: 673-75.

51. Miyachi, H, Furuya, H, Umezawa, K, Itoh, Y, Ohshima, T, Miyamoto, M, Asai, S. Controlling methicillin-resistant *Staphylococcus aureus* by stepwise implementation of preventive strategies in a university hospital: impact of a link-nurse system on the basis of multidisciplinary approaches *Am J Infect Control* 2007; **35**: 115-121.

52. Harrington, G, Watson, K, Bailey, M, Land, G, Borrell, S, Houston, L, Kehoe, R, *et al.* Reduction in hospitalwide incidence of infection or colonization with methicillin-resistant *Staphylococcus aureus* and use of antimicrobial hand-hygiene gel and statistical process control charts *Infect Control HospEpidemiol* 2007; **28**: 837-844.

53. Thomas, M, Gillespie, W, Krauss, J *et al* Focus group data as a tool in assessing effectiveness of a hand hygiene campaign *Am J Infect Control*; 2006; **33**: 368-373.

54. Sroka, S, Gastermeier, P, Meyer, B 2010. Impact of alcohol hand rub use on methicillin-resistant *Staphylococcus aureus*: an analysis of the literature *J Hosp Infect* 2010; **74**: 204-10.

55. Boscart, V M, McGilton, K S, Levchenko, A, Hufton, G, Holliday, P, Fernie, G R. Acceptability of a wearable hand hygiene device with monitoring capabilities *J Hosp Infect* 2008; **70**: 216-222.

56. Kinsella, G, Thomas, A N, Taylor, R J. Electronic surveillance of wall-mounted soap and alcohol gel dispensers in an intensive care unit *J Hosp Infect* 2007; **66**:34-39.

57. Dawson CH, McKrill JB. Review of technologies available to improve hand hygiene compliance: are they fit for purpose? *J Infect Prev* 2014;**15**: 222-228.

59. Srigley JA, Furness CD, Baker GR, Gardam M. Quantification of the Hawthorne effect in compliance monitoring: a retrospective cohort study. *BMJ Qual Saf* 2014; **23** 974-80.
60. Hagel S, Reischkle J, Kesselmeier M et al. Quantifying the Hawthorne effect in hand hygiene compliance through comparing direct observation with automated hand hygiene monitoring. *Infect Control Hosp Epidemiol* 2015; **36**: 957-62.
61. Cheng VCC, Tai J, Ho SKY, Hung KN, Ho PL, Yuen KY. Introduction of an electronic monitoring system for monitoring compliance with Moments 1 and 4 of the WHO 'My 5 Moments for Hand Hygiene' methodology. *BMC Infect Dis* 2011;11 151-63.
62. Marra AR, Moura DF, Paes AT, dos Santos OF, Edmond MB. Measuring rates of hand hygiene adherence in the intensive care setting: a comparative study of direct observation, product usage and electronic counting devices. *Infect Control Hosp Epidemiol*; 2010; **31**: 796-801.
63. Sax, H, Allegranzi, B, Uckay I, Larson E, Boyce J, Pittet. My five moments for hand hygiene: a user-centred design approach to understanding, training, monitoring and reporting hand hygiene. *J Hosp Infect* 2007;**67**: 9-21.
64. Jeanes, A, Coen, P, Wilson, APR, Drey, N, Gould, D J 2015. Collecting the data but missing the point: validity of hand hygiene audit data. *J Hosp Infect*; 90 156-162.
65. Fuller C, Michie S, Savage J, McAteer J, Besser S, Charlett, A and Hayward, A, Cookson, BD and Cooper, BS and Duckworth, G and Jeanes, A and Roberts, J and Teare, L and Stone, S. The Feedback Intervention Trial (FIT) — Improving Hand-Hygiene Compliance in UK Healthcare Workers: A Stepped Wedge Cluster Randomised Controlled Trial. *PLoS ONE* 2012: e41617.
66. Widmer, A F, Conzelmann, M, Tomic, M et al 2007. Introducing alcohol-based rub for hand hygiene. The critical need for training. *Infect Control Hosp Epidemiol* 2007; **28**: 50-54.

67. Yeung WK, Tam WS, Wong TW. Cluster randomized controlled trial of a hand hygiene intervention involving pocket-sized containers of alcohol-based hand rub for the control of infections in long-term care facilities. *Infect Control Hosp Epidemiol* 2011; 32, 67-76.

Conflicts of interest: SC received financial support to undertake research from Ecolab.