

HAND HYGINE POLICY

		POLICY	
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CONTENTS

Item	Title	Page
1.0	INTRODUCTION	3
2.0	POLICY STATEMENT	3-4
3.0	DEFINITIONS/ ABBREVIATIONS	4
4.0	ROLES AND RESPONSIBILITIES	4-5
5.0	APPROVAL	5
6.0	DOCUMENT REQUIREMENTS (POLICY DETAILS)	6-11
	6.1 Modes of transmission	6
	6.2 Breaking the chain of infection	6
	6.3 When to wash hands	6
	6.4 Before performing hand hygiene	7
	6.5 'Five moments'	8
	6.6 Hand hygiene procedure	8
	6.7 Liquid soap/ foam soap	9
	6.8 Antiseptic detergents (Chlorhexidine)	9
	6.9 Alcohol based hand rubs	9
	6.10 Surgical hand scrub	9
	6.11 Surgical alcohol based hand rub	10
	6.12 Skin care	10
	6.13 Bare below the elbows	11
	6.14 Risk assessment	11
	6.15 Equipment required for effective hand hygiene	11
	6.16 Domiciliary visits	11
7.0	MONITORING COMPLIANCE AND EFFECTIVENESS	12
8.0	TRAINING AND IMPLEMENTATION	13
9.0	IMPACT ASSESSMENTS	13
10.0	EVIDENCE BASE (Relevant Legislation/ National Guidance) and RELATED SFHFT DOCUMENTS	13-15
11.0	KEYWORDS	15
12.0	APPENDICES	
Appendix 1	Hand hygiene flow chart	16
Appendix 2	How to use soap and water (WHO 2009)	17
Appendix 3	How to use an alcohol based hand rub (WHO 2009)	18
Appendix 4	How to use a surgical alcohol hand rub (WHO 2009)	19
Appendix 5	'Five moments for hand hygiene at the point of care' poster (NPSA 2011)	20
Appendix 6	Equality Impact Assessment	21-22

1.0 INTRODUCTION

Modern healthcare has brought unprecedented benefits to generations of patients and their families. Today's healthcare, though, brings risks as well as benefits. No risk is more fundamental than the risk of infection. Direct contact with patients by means of hands of healthcare workers has long been recognised as the principle route of transmission for infections or potentially infectious agents (Pittet et al 2001, NICE 2012, NSPA 2011, WHO 2009). Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents including healthcare associated infections (HCAI's) when providing care (HPS 2012), evidence has suggested that ineffectual hand washing technique is as significant a concern as the lack of hygiene itself (Girou et al 2002). Hand hygiene is therefore an important component of a risk management strategy and clinical governance, it is imperative that timely and effective hand hygiene becomes part of the culture of the Trust's patient safety strategy.

The Health and Social Care Act 2008, states that:

'effective prevention and control of healthcare associated infections has to be embedded into everyday practice and applied by everyone. It is particularly important to have a high awareness of the possibility of healthcare associated infections in both patients and healthcare workers'.

Hand washing today is as important as it was a century ago; it is one of the most important procedures for preventing the spread of disease. It is essential that everyone takes responsibility to ensure that the care provided is carried out in a safe manner. The transmission of microorganisms from one patient to another via the hands, or from hands that have become contaminated from the environment can result in adverse outcomes.

Two routes of infection exist;

- i. microorganisms can be introduced into susceptible sites, such as surgical wounds, intravascular cannulation sites or catheter drainage systems by direct contamination or;
- ii. potential pathogens can be transmitted by hands and establish themselves as temporary or permanent colonisers of the patient and subsequently cause infection at susceptible sites.

2.0 POLICY STATEMENT

This policy outlines measures relating to hand hygiene to promote **thorough** hand hygiene amongst all healthcare staff and non-clinical staff, to prevent healthcare associated infection (HCAI), thereby reducing patient morbidity and mortality.

This policy is limited to **ALL** Trust staff and staff employed through other agencies working within the Trusts.

This clinical policy applies to:

Staff group(s)

- All clinical staff
- All non-clinical staff

Clinical area(s)

- All clinical environments
- All non-clinical areas where objects are handled which are then transferred to clinical areas e.g. medical case notes

Patient group(s)

- All patient groups – adult, maternity and paediatrics

Exclusions

- None

3.0 DEFINITIONS/ ABBREVIATIONS

Decontamination:	refers to the process for the physical removal of blood, body fluids and transient organisms
Transient organisms:	are those organisms located on the skin surface acquired by direct contact with other people, equipment or body sites as a result of everyday activities
Resident organisms/ Normal flora/ Commensals:	are those organisms found deeply seated within the epidermis, in skin crevices, hair follicles, sweat glands and beneath fingernails. Their function is to protect the skin from invasion by more harmful organisms
Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employees of the Trust including those managed by a third party on behalf of the Trust
HCAI:	Healthcare Associated Infection
IPCT:	Infection Prevention and Control Team
DIPC:	Director of Infection Prevention and Control
ICD:	Infection Control Doctor
IPCN:	Infection Prevention and Control Nurse

4.0 ROLES AND RESPONSIBILITIES

Each individual has a clinical and ethical responsibility to perform a good hand hygiene technique.

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will provide specialist advice regarding hand hygiene techniques and the products to use. Hand hygiene and decontamination will be

covered in the infection prevention and control section of the Trust orientation and mandatory training.

4.4 Divisional management Team

Divisional Clinical Chairs, General managers and Heads of Nursing will ensure that the necessary management arrangements and structures are in place to support all employees to fulfil their obligations in their role of infection prevention and control practices.

4.5 Matron / Department Manager / Service Line Manager

Matron, Department Managers and Service Line Manager are responsible for ensuring that all staff accountable to them are aware of this policy and adhere to its statement. They will actively promote and support all current infection prevention and control measures. It is the manager's responsibility to investigate and rectify any discrepancies identified.

4.6 Sister/ Charge Nurse

Sister/ Charge Nurse will act as excellent role models and are responsible and accountable for infection prevention and control within their sphere of responsibility. They will ensure that all staff are aware of all relevant infection prevention and control measures.

4.7 Consultant Medical Staff

Consultant medical staff will act as excellent role models and are responsible for ensuring that their teams are aware of this policy and adhere to its statement. This will actively support all infection prevention and control measures and will have an active role in measuring outcomes and developing action plans for improvement.

4.8 Junior Medical Staff

Junior medical staff are responsible for promoting and supporting all current infection prevention and control measures.

4.9 Infection Prevention and Control Link Champions

Infection Prevention and Control Link Champions will disseminate all relevant infection prevention and control information to staff within their own work environment. With support from their Ward Sister / Departmental Leader they will ensure that all staff in their work environment are aware of this policy and adhere to its statement. They will be actively involved in auditing application of this policy

4.10 Soft and Hard FM Services

In partnership with the Trust, Skanska and Medirest will ensure that the equipment required for hand hygiene is in place, functional and clean, this includes wash hand basins with elbow operated taps, soap dispensers, towel holders and waste bins (HTM 64). Alcohol based hand rub dispensers are supplied by the Trust.

5.0 APPROVAL

This revised policy (v7.0) has been consulted on and approved at the trust's Infection Prevention and Control Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY DETAILS)

Hand hygiene is vital in facilitating the prevention and reduction of healthcare associated infections (HCAI's) (Elliot 2009). As a healthcare professional working in a clinical healthcare environment you have a duty of care to ensure that you carry out hand decontamination before and after direct patient contact (Elliot 2009).

6.1 Modes of transmission

The skin supports a wide range of microorganisms, according to Pittet et al (2001), the hands are able to transfer potentially infectious agents in two ways:

- **Transient:** microorganisms which are acquired on the hands during our interaction with the environment through work or other activities of daily living. This pathogen population is constantly changing and is easily transferred from one person or area to another. They can easily be removed by hand washing which is why hand hygiene is the single most important measure for preventing the transmission of infections (ICNA 2002). Transient microorganisms can live on the hands for many hours, the hands of healthcare workers represent a risk to patients
- **Resident (normal flora or commensal):** microorganisms which live permanently on the skin and hands of all human beings. They reside in skin crevices, hair follicles, sweat glands and beneath fingernails. Their function is to protect the skin from invasion by more harmful organisms. Whilst these are not usually implicated in infections they may enter and establish infection at times of surgery or invasive procedures such as manipulation of wound dressings, intravascular catheter sites or urinary drainage systems. They are difficult to remove, however their numbers can be reduced through exposure to bactericidal soaps and a more prolonged hand hygiene technique

6.2 Breaking the chain of infection

In preventing infection by direct contact the following measures are important:

- Effective hand hygiene is the single most important measure in the prevention of the spread of infection
- Healthcare staff should wear suitable gloves whenever there is any possibility of direct contact with body fluids or contaminated material
- The wearing of gloves does not preclude the need to wash hands effectively
- Hand jewellery, apart from one plain band must be removed before attempting hand hygiene to reduce the risk of inadequate decontamination (AfPP 2007)
- Adopt 'bare below the elbow practice' (DH 2007)

6.3 When to wash hands

There is no set frequency for hand washing, it is determined by actions – those completed and those intended to be performed (Refer to [Appendix 1](#)). However, hand hygiene must be carried out frequently with individuals constantly reflecting upon four key factors:

- The level of anticipated contact with patients, objects or equipment
- The extent of contamination that may occur within that contact
- The patient care activities being performed
- The susceptibility of that patient

Hands hygiene must be performed:

- immediately prior to each and every episode of direct patient contact / care
- following delivery of care
- after touching a patient's immediate surroundings

- immediately following any activity or contact that potentially results in the hands becoming contaminated i.e. body fluid exposure risk
- before clean or aseptic procedures

The following activities are further examples of when hand hygiene needs to be performed, this is not an exhausted list, there are probably many more examples you could think of in your area of work:

- At the start of your working day
- After you have used the toilet
- Before you prepare, handle or eat food
- When your hands are visibly soiled
- After bed making
- Before and after removing gloves
- Before entering and leaving isolation room
- Before and after administering medication
- After any microbiological contamination (e.g. wound examination, wound dressing, sputum aspiration, dentistry, podiatry etc)
- Any situation, which involves direct patient care (e.g. bathing, toileting, assisting to move)
- Before and after handling wounds, intravenous lines, urinary catheters and drainage bags, other urinary equipment and other invasive devices
- After handling dirty or contaminated laundry
- Before caring for immune-suppressed patients
- Before and after a patient consultation
- After you have used a computer keyboard
- At the end of your working day before leaving work
- After coming into contact with any pets in a patients living environment
- Before leaving a patients home

6.4 Before performing hand hygiene

Effective hand hygiene aims to prevent microorganisms on the hands being introduced and transferred to susceptible sites i.e. indwelling device sites, wounds etc, to minimise barriers to effective hand hygiene whilst in the clinical environment, staff must (Refer to [Appendix 1](#)):

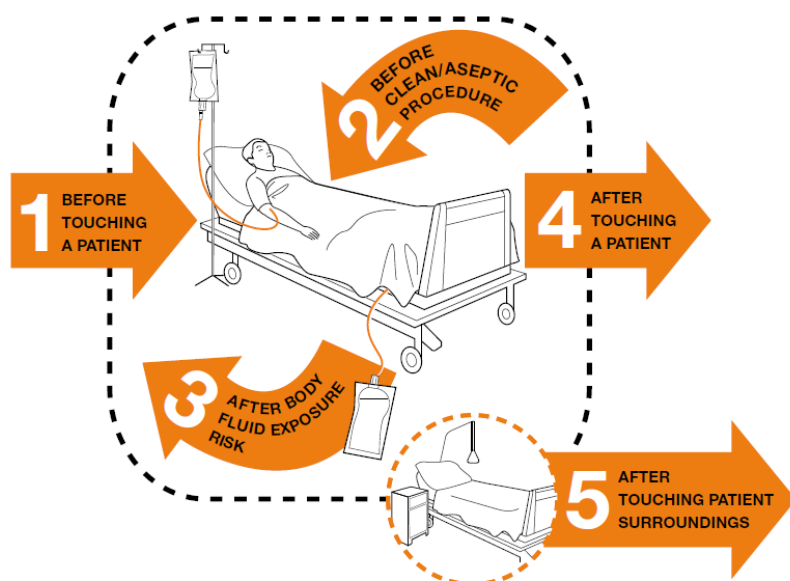
- Adhere to the 'bare below the elbow' principles (DH 2007)
- Remove all hand and wrist jewellery (a single, plain metal finger ring (no stones or engraving) is permitted but should be removed (or moved up) during hand hygiene (RCN 2009, WHO 2009, HPS 2012,))
- Ensure finger nails are clean, short (not longer than 2mm (CDC 2002, WHO 2009, HPS 2012))
- That artificial nails or nail products are not worn i.e. nail polish (Barran 2006, WHO 2009, HPS 2012)
- That cuts and/or abrasions are covered with a waterproof dressing (WHO 2009, HPS 2012)
- Ensure hands remain moisturised (WHO 2009)
- Report any skin irritation to your line manager and Occupational Health (HSE 2012)

Incorrect hand washing can result in hands remaining contaminated, long sleeves may become contaminated during patient care (Pittet 2006, WHO 2009).

6.5 'Five moments'

According to the National Patient Safety Agency (NPSA (2011) and the World Health Organization (WHO) 2009) there are 5 moments for hand hygiene at the point of care (ref to [Appendix 5](#)):

- Before direct contact with any patient/client or entering the patient surroundings
- Before a clean / aseptic procedure
- After body fluid exposure
- After patient contact
- After contact with patient/client surroundings



The patient zone, healthcare area, and critical sites with inserted time space representation of 'my five moments for hand hygiene' (WHO 2009)

6.6 Hand hygiene procedure

To ensure all surfaces of the hands are adequately decontaminated, it is helpful to use a standardised technique. There are six stages within the hand hygiene procedure, the omission of any stage within the procedure or a simple failure to follow the process will serve to increase the risk of infecting yourself or cross infecting others (Elliot 2009). To wash all surfaces thoroughly should take 10-15 seconds (ref to [Appendix 2](#)). Some areas of the hands are more frequently missed than others during hand washing, therefore it is vital that you pay attention to all areas of your hands, in particular your finger tips and nail areas. These are the area's most often in contact with the patient and be heavily contaminated with microorganisms.

Effective hand washing technique involves the following stages:

- Preparation: requires wetting hands under tepid running water before applying liquid soap or an antimicrobial preparation
- Washing: the procedure for hand washing can be found in [Appendix 2](#)
- Rinsing: the hands, wrists and forearms (if necessary) are rinsed thoroughly to remove all traces of soap/antimicrobial preparation
- Drying: effective drying is essential. Paper towel use is the most effective method of drying, as the friction employed for drying also assists in removing any residual bacteria

Current research advocates a variety of processes to ensure effective hand hygiene, these are described below, and the most appropriate one of these must be used by healthcare staff depending on the work that they are undertaking.

6.7 Liquid soap/ foam soap

The washing of your hands with a liquid soap or foam soap will remove dirt, organic material and transient microorganisms. This method of hand decontamination is all that is required for the majority of routine healthcare related procedures.

6.8 Antiseptic detergents (Chlorhexidine)

Aqueous, antiseptic hand washing agents are used to remove organic contamination and reduce levels of resident flora, and with repeated use, maintain low bacterial counts on the skin e.g. under sterile gloves. They may be used when caring for a patient known to be colonised or infected with an antibiotic resistant organism, prior to performing an aseptic procedure or minor surgery. The IPCT will advise when these are required, otherwise hand wash with soap and water followed with an alcohol based rub will suffice. Antiseptic products **must not** be used routinely for hand washing; prolonged repeated use of antiseptic products can damage your skin, which in turn could lead to an increased number of bacteria on your skin.

6.9 Alcohol based hand rubs

Alcohol based hand rubs are an effective method of hand decontamination in the short term, they are a useful agent for rapid disinfection of hands in both clinical areas and the community (Elliott 2009). However, they should never be perceived as an absolute substitute for the adoption of formal hand hygiene using soap and water. Alcohol based hand rubs can be used on clinically clean hands, between patients or tasks and must be available to staff as near to the point of care as possible. If hands are visibly dirty or soiled and/or when exposure to spore forming organisms, such as *Clostridium difficile* or gastrointestinal infections such as norovirus, is suspected or confirmed, alcohol based hand rubs must not be used alone and hands must be washed first with liquid soap/ foam soap and water. When applying an alcohol based rub the solution must cover all the surface of the hands and wrist and rub together until dry (Ref [Appendix 3](#)). When alcohol based hand rubs are used, healthcare workers must be aware of the following:

- Hand alcohol based rub containing 70% alcohol with an emollient must be used to ensure recommended efficacy and prevent skin dryness
- The hand alcohol based rub must be allowed to dry for it to be effective
- Hand alcohol based rub is ineffective against *Clostridium difficile* spores and may have a reduced effect against viral diarrhoea (Kramer et al 2002, Sickber et al 2005), in these circumstances soap and water must be used first then followed by an alcohol based hand rub
- Healthcare workers undertaking care in the patient home must ensure they have a personal supply of alcohol based hand rub to meet their requirements

6.10 Surgical hand scrub

Hand washing and surgical hand antisepsis are two different activities. Surgical hand antisepsis is an extension of hand washing (AfPP 2007), which only needs to be performed when surgical procedures are being undertaken. It is also defined as the antiseptic surgical scrub or antiseptic hand rubs performed before donning sterile attire preoperatively (AORN 2008). The aim is to both reduce the number of resident and transient flora to a minimum but also to inhibit their re-growth for as long as possible, not just on the hands but also on the wrists and forearms (AfPP 2007, Tanner et al 2008).

An antiseptic detergent is used prior to surgery to remove and destroy transient microorganisms and some resident microorganisms. An alcoholic based hand rub may also be used. Nail picks (disposable single use sterile ones should be used) are recommended in UK theatre practice but scrubbing brushes are no longer deemed to be necessary especially for use on skin (AfPP 2007). Surgical hand scrub should take a minimum of 2 minutes to perform and hands should be cleaned up to the elbows and dried with sterile towels.

Three types of antiseptic solutions are available (Tanner et al 2008):

- Aqueous scrubs: usually contain chlorhexidine gluconate or povidone iodine. Using aqueous solutions require a surgical scrub
- Alcohol rubs: three main types of alcohol ethanol, isopropanol and n-propanol. This involves rubbing the alcohol solution into the hands systematically following removal of visible soiling or a preliminary hand wash
- Alcohol rubs containing additional active ingredients: these include chlorhexidine gluconate, iodophors, biguanides and phenolic compounds such as hexachlorophene and triclosan

Each step of surgical 'scrubbing' consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000) for a minimum of 2 minutes, including a pre-scrub wash. During each of the steps keep hands above elbows allowing water to drain away, and avoid splashing your surgical attire. Rinse hands under running water and dry thoroughly using a sterile paper hand towel for each hand, rotating down hands to elbows before discarding

6.11 Surgical alcohol based hand rub

Alcohol hand rubs are gaining popularity as surgical scrub replacement as they save time, water and money. The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands. On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), a surgical hand scrub must be performed. Subsequent episodes of hand decontamination can be undertaken using an alcohol hand rub provided there has not been any breach of the gloves. The hand rubbing technique for surgical hand preparation must utilise the World Health Organisation (WHO) seven step technique (WHO 2009) (ref to [Appendix 4](#)):

- Put approximately 5ml of alcohol based hand rub in the palm of your left hand, using the elbow of your other arm to operate the dispenser
- Dip the fingertips of your right hand in the hand rub to decontaminate under the nails (5 seconds)
- Smear the hands on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the hand rub has fully evaporated (10-15 seconds). Repeat for opposite hand and arm
- Put approximately 5ml of alcohol based hand rub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Follow the Ayliffe hand hygiene technique up to the wrists covering the whole surface of the hand
- When the hands are dry, sterile surgical clothing and gloves can be donned

6.12 Skin care

Staff must observe their hands regularly for any signs of damage to their skin as this can provide a portal for microorganisms to enter the body. All staff must have an annual skin surveillance review by their line manager/ Infection Prevention and Control and prompt referral to Occupational Health where issues are identified (ref to Occupational Health intranet). Any cracks or breaks on the skin of the hands must be covered with a waterproof plaster/dressing, which must be replaced as necessary. If they do not heal, then Occupational Health advice should be sought. Dermatitis can be caused by sensitivity to ingredients in hand cleansers; advice should be sought from Occupational Health. Staff must only use the moisturising products available in the clinical areas as these have been specifically designed not to interact with soaps and alcohol based hand rubs (WHO 2009). Moisturisers need not be used following application of an alcohol based hand rub, as these contain emollients. If a particular soap, antimicrobial hand wash or alcohol product is causing skin irritation, advice must be sought from Occupational Health. Staff are responsible for ensuring that their hands are adequately

moisturised. Individual tubes or sealed cartridge units are the only acceptable means of dispensing moisturisers and creams.

6.13 Bare below the elbows

A 'Bare Below the Elbows' approach must be adhered to by all staff including volunteers entering clinical areas, i.e. jackets to be removed, sleeves are rolled up above the elbow, and any loose clothing such as ties are removed or appropriately secured. All wrist jewellery must be removed (plain metal wedding band permitted). Staff whose religion requires them to wear a religious symbol may do so provided that they are discrete and comply with infection prevention and control and health and safety policies and guidance, e.g. staff who are required to wear a Kara (steel bangle) may do so provided that it is pushed up the arm and taped to enable effective clinical hand washing/decontamination the Kara must be removed when scrubbing in Theatre. Alternatively, this can be worn on a necklace or placed in a pocket while undertaking clinical duties (Uniform and Dress Code Policy)

6.14 Risk assessment

All clinical activity must be based upon a risk assessment process for the likelihood of exposure to pathogenic microorganisms. This process will determine the interventions required to safely manage hand hygiene compliance. In the event that any clinical areas do not provide appropriate hand hygiene facilities, this must be highlighted on the local risk register and the IPCT informed.

6.15 Equipment required for effective hand hygiene

All hand washing sinks must comply with HTM 64 (2006) recommendations for the specific area the sink is located. All hand washing sinks must only be used for the purpose of hand washing, they must not be used to wash instruments, cups etc;

Each hand washing sink must be equipped with warm running water, ideally from a mixer tap. Hand washing sinks in clinical areas for minor surgery or aseptic procedures must be equipped with lever (elbow operated) or sensor operated taps. Disposable paper hand towels and liquid hand soap/ foam soap in wall mounted dispensers must be available at each hand washing sink in clinical areas. A foot operated pedal bin must be available at each hand washing sink for the hygienic disposal of paper hand towels (used hand towels do not have to be disposed of as clinical waste unless contaminated by blood or body fluids). A hand washing poster (laminated) demonstrating an effective hand washing technique must be displayed near every hand washing sink in each clinical area. Alcohol based hand rub **must not** be mounted near hand washing sinks (DH 2012).

6.16 Domiciliary visits

Staff involved in domiciliary visits will be faced with varying standards of cleanliness. Staff must have access to equipment to enable effective hand decontamination. Hand washing should take place in a sink that is clean and free from articles; if this is not possible then care should be taken to avoid splashing. The patient or patient's family or carer should be asked to provide liquid soap and paper towels (kitchen roll will suffice) for use by healthcare staff. Where this is unavailable personally assembled hand hygiene packs can be used. This will be a wipe-able bag e.g. sealable freezer bag containing:

- Liquid soap
- Paper hand towels
- Alcohol based hand rub

Alternatively hand hygiene packs are available from NHS supplies, however this may not be a cost effective option, dependent on the number required within the service area. Inclusion of disposable plastic aprons and gloves is also recommended.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Infection Prevention and Control	Hand hygiene technique Skin integrity Hand hygiene compliance	Glow and Tell audits Annual Hand Skin Surveillance Form Hand Hygiene Audit Observation in practice	As required As required Monthly On-going during visits to clinical areas	Training and Development Training and Development IPCC Individual/ Line manager
Professional Education and Training	Hand hygiene technique	Glow and Tell audits	Annually	Training and Development
Link Nurses	Hand hygiene technique Hand hygiene compliance	Glow and Tell audits Hand Hygiene Audit	Annually Annually	Infection Prevention and Control Team
Line Managers for clinical staff	Skin integrity	Annual Hand Skin Surveillance Form	Annually	Occupational Health (if issues identified)
Facilities Management	Subcontractors compliance	Assurance from subcontractors	Annually	Infection Prevention and Control Team

8.0 TRAINING AND IMPLEMENTATION

In conjunction with the training needs analysis, staff must be aware of their responsibility to attend appropriate training. All Training Sessions are outlined in the Trusts Training, Education and Development Opportunities Resource File. It is mandatory for new starters to attend the Trust orientation training, which includes infection prevention and control, in order to ensure that all staff remain aware of the importance of hand hygiene, on-going training will be provided in the Trust mandatory training. Attendance and follow up of non-attendance at training will be via the processes outlined in the current Trust mandatory training policy. Subcontractors ie Medirest and Skanska to ensure all their staff receive adequate training to ensure they are compliant with the essence of this policy

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix 6](#)
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Association for Perioperative Practice (AfPP). 2007. *Standards and recommendations for safe perioperative practice*. 2nd Edition. AfPP (www.afpp.org.uk)
- Association of perioperative Room Nurses (AORN). 2008. *Perioperative standards and recommended practices denver*
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Related SFHFT Documents:

- Personal Protective Equipment Policy (ICP9)
- Isolation Precautions for Patients with Confirmed or Suspected Infectious Illness Policy (ICP31)
- Decontamination and Disinfectant Management of Healthcare Equipment within Healthcare Settings Policy (ICP40)
- Safe Linen Management Policy (ICP10)
- Blood and body fluid spillage policy (ICP4)
- Infectious Outbreak / Incident Policy including major outbreak (ICP27)
- Hand surveillance annual form (Occupational Health)
- Uniform and Dress Code policy (Human Resources)

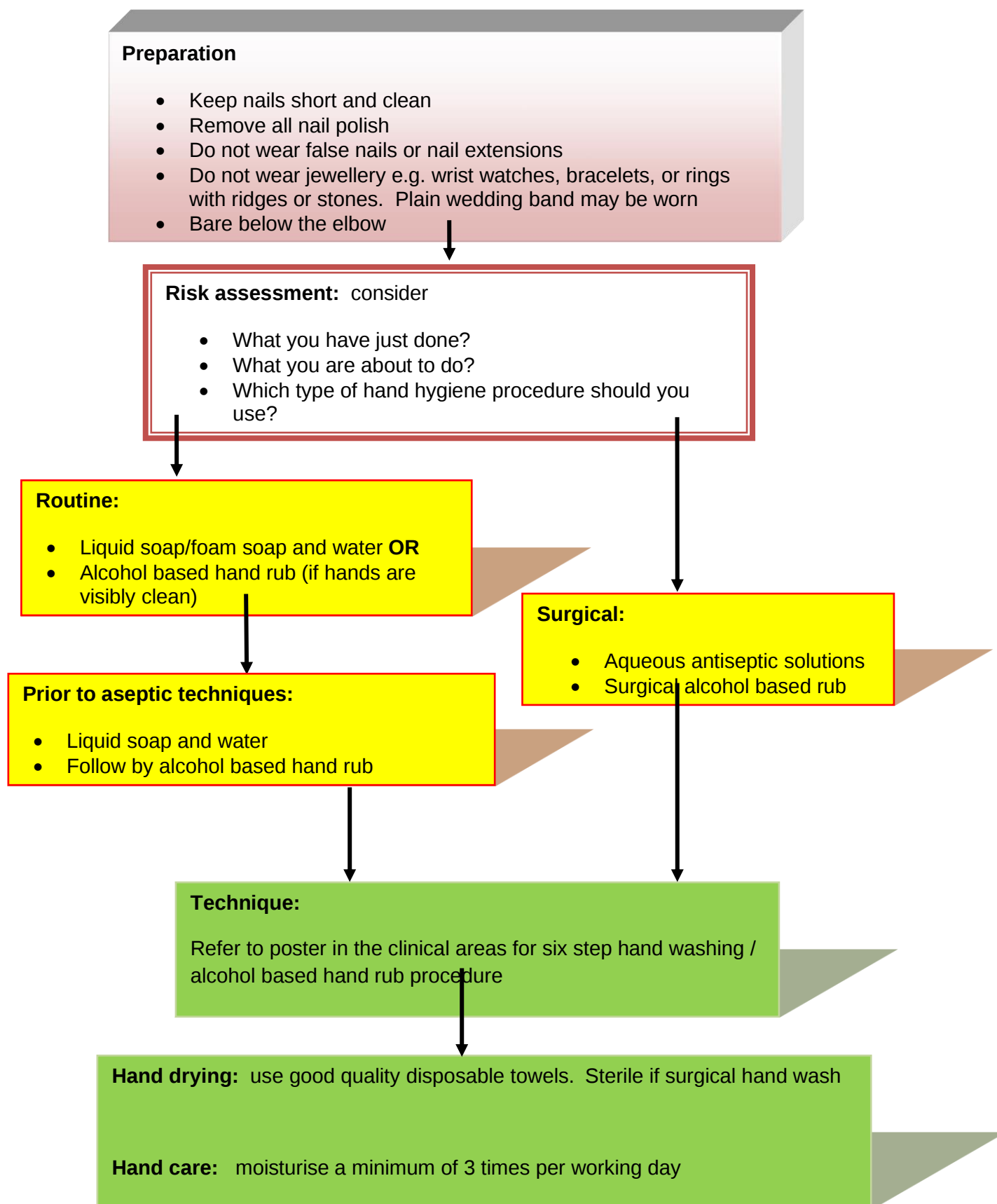
11.0 KEYWORDS

Washing; cleaning; Alcohol based hand rub; Surgical scrub; Five moment moments; Liquid; Soap and water; antiseptic detergents (chlorhexidine);

12.0 APPENDICES

- refer to list in contents table

Appendix 1 - Hand hygiene flow chart

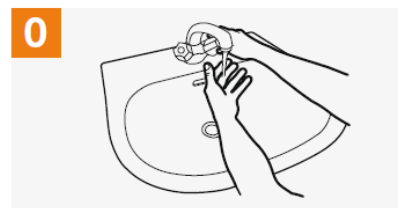


Appendix 2: How to use soap and water (WHO 2009)

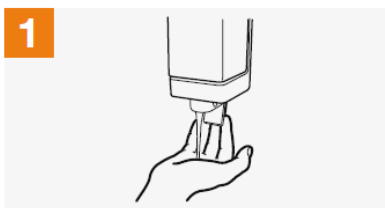
Hand Hygiene Technique with Soap and Water



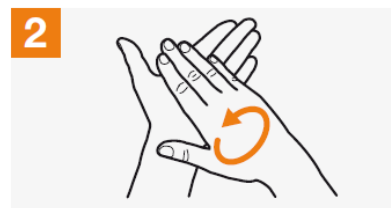
Duration of the entire procedure: 40-60 seconds



Wet hands with water;



Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



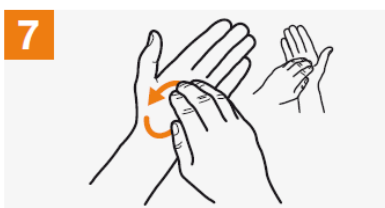
Palm to palm with fingers interlaced;



Backs of fingers to opposing palms with fingers interlocked;



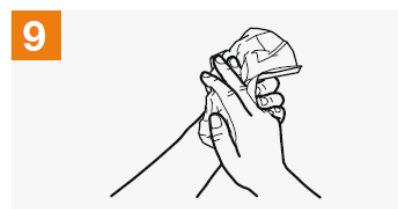
Rotational rubbing of left thumb clasped in right palm and vice versa;



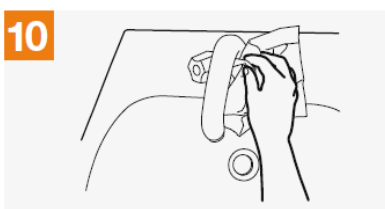
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



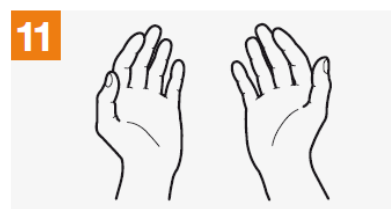
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.

Appendix 3: How to use an alcohol based hand rub (WHO 2009).

Hand Hygiene Technique with Alcohol-Based Formulation

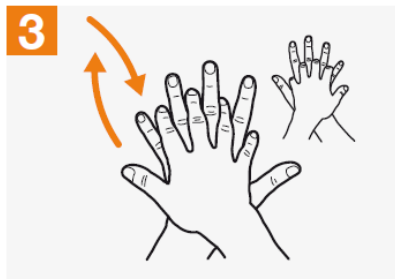
Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



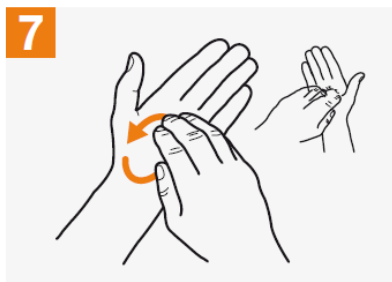
Palm to palm with fingers interlaced;



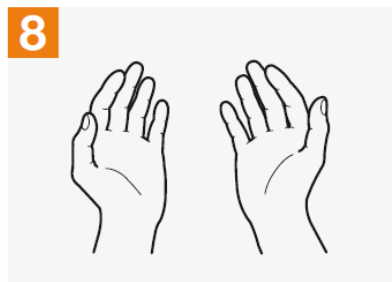
Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

Appendix 4: How to use a surgical alcohol hand rub (WHO 2009)

1.



Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the dispenser.

2.



Dip the fingertips of your right hand in the handrub to decontaminate under the nails (5 seconds).

3.



3. Images 3 – 7. Smear the handrub on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds). Repeat for opposite hand and arm.

4.



5.



6.



7.



8.



9.



Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Rub both hands in the same time up to the wrists, and ensure that all the steps presented in images 9 – 14 are followed. Repeat for opposite hand and arm.

Cover the whole surface of the hands up to the wrist with alcohol-based hand rub, rubbing palm against palm with a rotating movement.

10.



Rub the back of the hands up to the wrist with alcohol-based handrub, rubbing palm against palm with a rotating movement.

11.



Rub the back of the left hand, including the wrist, moving the right palm back and forth and vice-versa.

12.



Rub palm against palm back and forth with fingers interlinked.

13.



Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa.

14.

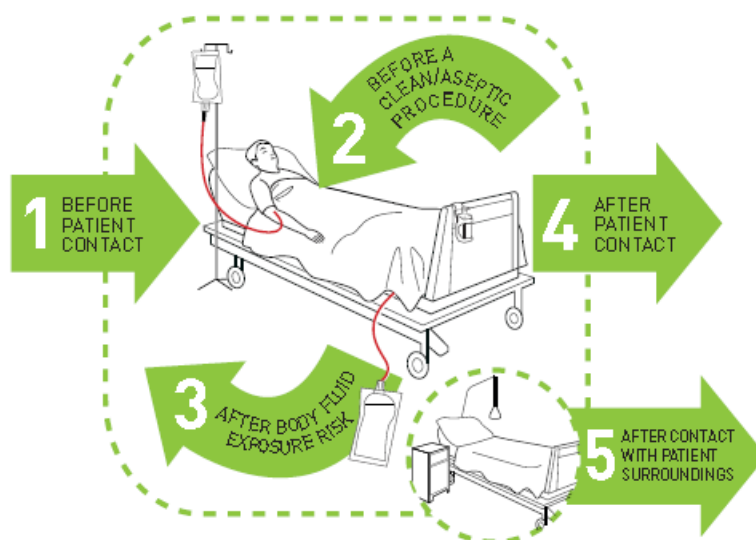


When the hands are dry, sterile surgical clothing and gloves can be donned.

Adapted from World Health Organization

Appendix 5: 'Five moment' poster (NPSA 2011)

Your 5 moments for hand hygiene at the point of care



1 BEFORE PATIENT CONTACT	WHEN? Clean your hands before touching a patient when approaching him/her WHY? To protect the patient against harmful germs carried on your hands
2 BEFORE A CLEAN/ASEPTIC PROCEDURE	WHEN? Clean your hands immediately before any clean/aseptic procedure WHY? To protect the patient against harmful germs, including the patient's own, from entering his/her body
3 AFTER BODY FLUID EXPOSURE RISK	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) WHY? To protect yourself and the healthcare environment from harmful patient germs
4 AFTER PATIENT CONTACT	WHEN? Clean your hands after touching a patient and her/his immediate surroundings when leaving the patient's side WHY? To protect yourself and the healthcare environment from harmful patient germs
5 AFTER CONTACT WITH PATIENT SURROUNDINGS	WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched WHY? To protect yourself and the healthcare environment from harmful patient germs

Based on WHO poster 'Your 5 moments for hand hygiene' and reproduced with their kind permission



APPENDIX 6 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Hand Hygiene Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 12/10/2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	None	None
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None

Marriage and Civil Partnership	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None
What consultation with protected characteristic groups including patient groups have you carried out? NA			
What data or information did you use in support of this EqIA? NA			
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? Nil			
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.			
Name of Responsible Person undertaking this assessment: Sally Palmer			
Signature:			
Date: 12/10/2021			