Hand Hygiene Policy

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Owner	Director of Infection Prevention and Control		
Author	Nurse Consultant Infection Control		
First approval or date last reviewed	June 2008, July 2011, July 2014		
Staff/Groups Consulted	Infection Control Doctor Director of Infection Prevention and Control Deputy Chief Nurse Chief Executive Matrons Infection Prevention and Control team		
Approved by IPCC	22 August 2017		
Next Review Due	August 2023		
Equality Impact Assessment Completed	Yes		

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1. RATIONALE

1.1. The hands of healthcare workers play a major role in the transmission of micro-organisms. Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HCAI), transmitted during delivery of care.

2. KEY POINTS

2.1. Hand Hygiene is the single most important measure for preventing the transmission of infection.

2.2. Hand hygiene must always be performed before and after direct patient contact, before an aseptic task, after exposure to blood or body fluids and after touching objects in the patient's immediate environment which are frequently in direct contact with the patient.

2.3. Hands must be washed with soap and water if they are visibly soiled or after caring for a patient with clostridium difficile or suspected diarrhoea and/or vomiting. In other situations alcohol hand rub is a fast and effective alternative.

2.4. Staff carrying out clinical care should wear short sleeved clothing or roll their sleeves up above the elbow. Hand and wrist jewellery should not be worn (apart from one plain ring band).

2.5. Hand hygiene facilities must be easily accessible and kept well stocked.

2.6. We work following a County wide approach of achieving 90% compliance with Hand Hygiene.

3. AIM

3.1. The aim of this guidance is to:

- To reduce the risks of infection to patients and staff.
- To set required standards for hand decontamination in line with good hand hygiene techniques.
- To ensure that all health care staff, both clinical and non-clinical, understand the importance of decontaminating their hands before and after every episode of care.
- To promote compliance.
- To detail requirements of training in hand hygiene standards.

4. DEFINITIONS

4.1. **Hand Hygiene**: refers to the process for the physical removal of blood, body fluids, dirt and transient micro-organisms from the hands.

4.2. **Healthcare Associated Infection** (HCAI): is an infection the patient acquires after admission to hospital that was not developing prior to admission.

4.3. **Alcohol Hand Rub**: an alcohol based hand decontamination preparation that encompasses agents that are either rinses or gels.

5. ROLES AND RESPONSIBILITIES

Everyone has a vital part to play in improving patient safety and all Trust employees are expected to be compliant with the hand hygiene guidelines at all times.

5.1. **Chief Executive** is responsible for

- Ensuring that appropriate systems are in place to protect patients, staff and others from HCAI's.

5.2. **Director of Infection Prevention and Control**

The Director of Infection Prevention and Control (DIPC) is responsible for infection prevention and control within the Trust and must ensure national directives are implemented.

5.3. **Infection Prevention and Control Team** (IPCT) are responsible for:

- Providing hand hygiene training as detailed in the IPC learning framework.
- Collating the results of the monthly Hand hygiene audits and providing feedback to clinical areas via email and Trust YCloud.
- Informing managers of repeated episodes of non-compliance with these guidelines.

5.4. **Matrons and Ward Managers** are responsible for:

- Ensuring that the hand hygiene guidelines are adhered to within their area.
- Ensuring hand hygiene surveillance and audit programmes are participated in to monitor the level of compliance.
- Ensuring mandatory training and infection control is attended by all their staff.
- Following up on staff non-attendance on mandatory training.
- Ensuring hand hygiene posters are displayed in prominent areas.

5.5. **Ward Housekeepers** are responsible for:

- Ensuring hand wash basins are kept clean and fully stocked with soap and paper towels.
- Ensuring alcohol gel stocks are replenished.

5.6. **Estates & Facilities** are responsible for:

- Seeking IPCT advice on hand hygiene facilities for new builds or refurbishments.

5.7. **All Staff**:

- All Trust employees, both clinical and non-clinical, have a responsibility to comply with these guidelines.
- Healthcare Workers (HCW) who have direct contact with patients are most likely to transmit infection if they do not carry out consistent and effective hand hygiene.
- All staff are expected to abide by the following:

- WHO 5 Moments for Hand Hygiene (Annex A).
- A “Bare Below the Elbow” zone approach as recommended by the Department of Health (DH).
- Attend annual mandatory training, including infection control which encompasses Hand Hygiene training.

- Failure by any member of staff to comply with this guidance or any of its associated procedures will result in consideration of the use of disciplinary actions. Responsibilities for this are defined in the Trust’s Management of Discipline Policy.

6. HAND DECONTAMINATION

6.1. When to carry out Hand Hygiene

6.2. Hands must be decontaminated:

- Before direct patient contact.
- Before an aseptic task and between each procedure when undertaking several consecutive procedures on one patient (e.g. catheter care and tracheal suction).
- After bodily fluid exposure risk, including after removal of gloves.
- After direct patient contact.
- After touching objects within the patient’s immediate environment which are frequently in direct contact with the patient (e.g. bed linen, bed rails, bedside table).

6.3. In addition, hand hygiene should be performed between clinical areas, before handling food, after visiting the toilet, after handling specimens, clinical waste, used laundry or contaminated equipment and whenever hands feel unclean or are visibly dirty.

6.4. Bare Below the Elbow

6.5. Bare Below the Elbow is a standard applied to uniform code to improve standards of hand hygiene, it incorporates common sense precautions that promote the best standards of practice.

6.6. Annex B provides guidance for all members of staff. Any clinical member of staff within the designated clinical zone is required to:

- Wear short sleeves or roll long sleeves and secure firmly.
- Remove wrist watches.
- Wear no hand jewellery other than a plain band.
- Keep nails short.
- Wear no nail varnish or false nails.

6.7. Hand Cleaning Techniques

6.8. This is a process which removes and/or destroys transient micro-organisms from the hands by washing with soap and water or disinfection with an alcohol hand rub.

6.9. All staff must ensure they carry out effective hand cleaning using the correct techniques so that all areas of the hands are cleaned using a systematic method. See Annex C (Hand Wash) and Annex D (Hand Rub) for pictorial guides to hand decontamination techniques.

6.10. **Use of Alcohol Hand Rubs**

6.11. Alcohol hand rubs are effective on hands that are not physically soiled with dirt or organic matter providing they are correctly used. The method of application is the same as for hand washing in that all surfaces of the hand must be cleansed.

6.12. Alcohol hand rub is provided in all clinical areas, at hand hygiene stations on entry to wards, outside side rooms and bays and at every patient's bedside. It can be used by all staff, patients and visitors.

6.13. The following activities are examples of when an alcohol hand rub can be used:

- On entering and leaving all clinical areas.
- Before and after every patient contact if hand washing is not indicated.
- After touching a patient curtain area.

6.14. **Use of Soap and Water**

6.15. The following activities are examples of when hands must be washed using soap and water:

- When hands are visibly soiled.
- After removal of disposable examination gloves.
- Following accidental contact with blood or body fluids.
- After any microbial contamination (contact with soiled wound dressing, after wound examination and when performing sputum aspiration).
- Before aseptic technique.
- Before preparing, handling, serving or eating food.
- After handling soiled linen and laundry.
- After dealing with patients who have symptoms of diarrhoea and/or vomiting, e.g. clostridium difficile or Norovirus.

7. HAND CARE

7.1. Regular hand washing or a poor hand washing technique can result in dry, sore hands. In addition to discomfort, cracked skin is more likely to harbour micro-organisms. To help prevent this the following actions should be taken:

- Always wet hands before applying soap.
- Ensure hands are rinsed and dried thoroughly.

- Apply an emollient cream regularly to protect skin from the drying effects of regular hand washing.

- If a particular hand hygiene product causes skin irritation, seek occupational health advice.

- Cover cuts or abrasions on hands or forearms with a waterproof plaster or dressing.

- Nail brushes should not be used (except disposable brushes for theatre use) as these can damage skin.

8. APPLICABILITY

8.1. These guidelines apply to staff employed by the Trust. Patients, visitors and the general public will be made aware of these guidelines as required.

9. TRAINING

9.1. All staff are required to attend Infection Control training, which includes hand hygiene, as part of the induction process on commencement of employment with the Trust. Staff are further required to attend mandatory training as specified in the Staff Mandatory Training Passports.

10. IMPLEMENTATION, MONITORING & EVALUATION

10.1. Hand hygiene training is an essential part of infection control standards. Staff booked onto training will be monitored through the Yeovil Academy. Records of attendance on training will be kept in the Yeovil Academy, details of which are sent monthly to managers for recording and checking purposes through the HR dashboard. Non-attendance will be followed up through the Academy staff and managers informed.

10.2. Monitoring of Hand Hygiene compliance on wards is carried out by the Hand Hygiene Champions through monthly audits. These are then reported through the Associate Directors of Nursing to the Infection Prevention & Control Committee. The results of the audits are included monthly in the Patient Safety and Quality Report which is presented through the Patient Safety Steering Group.

10.3. The ICT requests a minimum of 20 observations be submitted on a monthly basis to validate the audit. Fewer than 20 submissions will generally not be sufficient to reflect Hand Hygiene practice within the clinical area. Therefore, any audits with less than 20 observations will trigger a review by the ICT.

The review will look at the number of submissions in conjuncture with Hand Hygiene compliance scores and decide if any further action required. If further action is required this will then be discussed with the ward/department Sister and become part of the ward's/department's work plan where applicable.

11. REFERENCES TO OTHER POLICIES/GUIDELINES

11.1. Management of Discipline Policy

11.2. Mandatory Training Policy

12. ANNEXES

12.1. WHO 5 Moments for Hand Hygiene (Annex A).

12.2. Bare Below the Elbow (Annex B)

12.3. How to Hand Wash (Annex C)

12.4. How to Hand Rub (Annex D)

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: Hand Hygiene Guidelines

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	

		Yes/No	Comments
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed **Peter White** Date: August 2017