North Tees and Hartlepool NHS
NHS Foundation Trust

Policy Title: Hand Hygiene Policy
Reference & Version No: IC2 Version 8
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Validated By: Infection Control Committee
Ratified By: Patient Safety Committee
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Related Documents: IC17 Standard Precautions to Prevent the Spread of Infection Policy HR18 Uniform and Personal Appearance Policy HR 45 Effective Management of Mandatory Training
This policy is intended for: All Trust Staff and Contractors

Summary

Hand hygiene is recognised as one of the most important measures in reducing healthcare associated infection.

This policy provides guidance on:

- Process of hand hygiene
- Appropriate hand decontamination preparation
- Audit
- Training requirements

It is vital that all staff are aware of reasons for hand hygiene and the consequences of non-compliance.

The Trust is committed to the fair treatment of all, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependants, sexual orientation, trade union membership or non membership, working patterns or any other personal characteristic. This policy and procedure will be implemented consistently regardless of any such factors and all will be treated with dignity and respect. To this end, an equality impact assessment has been completed on this policy.

CONTENTS

1. Introduction

Healthcare acquired infection (HCAI) is estimated to cost the NHS in England £1 billion per year, and to cause 5000 deaths. Around 1 in 9 patients acquire an HCAI which can result in an increased stay in hospital, further care and treatment, and an adverse outcome for the patient. **Hand hygiene is recognised as one of the most important procedures for preventing the spread of infection.**

This policy will:

- set out the standard for hand hygiene and decontamination for **all** healthcare personnel, including Trust employees, contractors, students and agency staff.
- clearly identify the hand cleaning preparations to use depending on the clinical situation.
- identify the training requirements for all staff in relation to hand hygiene.

2. Process

Hands **must** be decontaminated **before and after** each episode of direct patient contact, **including before and after glove use** as described by the World Health Organisation "5 moments for hand hygiene" initiative (see Appendix 1)

A greater level of hand hygiene must be achieved before any surgical procedure, as greater numbers of skin flora must be removed. This is usually only required in operating departments or prior to certain invasive techniques e.g. central line insertion.

2.1 Preparation:

- Keep nails short and clean.
- Jewellery must not be worn by clinical staff. Wedding rings if worn must not compromise hand hygiene.
- **Do not** wear acrylic nails, nail varnish or nail extensions.
- Wristwatches **must not** be worn in clinical areas.
- Cuts and abrasions must be covered with a waterproof dressing.

2.2 Washing (See Appendix 2 for "6 step technique"):

- Must be carried out when hands are visibly soiled, when caring for patients with diarrhoea, and after using the toilet.
- Wet hands under tepid running water.
- Apply soap solution. The solution must come into contact with all surfaces of the hand for at least 10 seconds.
- Rinse thoroughly under running tepid water
- Do not turn taps off directly with clean hands i.e. use elbows for appropriate taps, or if in a clients home use paper towel to turn off taps

2.3 Drying:

- Dry hands thoroughly with a sufficient quantity of paper towels.

2.4 Alcohol hand rub:

- Alcohol hand rubs are an acceptable alternative to hand washing, other than in special situations as described below, and **provided that the hands are not visibly soiled.** Hands that are visibly soiled or contaminated with organic matter must be washed. Hands should also be washed at regular intervals throughout the day to remove any build up of gel which may cause hands to become sticky.
- Alcohol hand rub will also be available in appropriate wall or surface mounted dispensers within wards and departments for staff, patient and visitor use, locker mounted dispensers or personal containers carried by individual members of staff.
- **Please note that risk assessment must be used and where patients are assessed as high risk of ingestion of the alcohol hand rub due to confusion or alcohol dependency, the hand rub must be removed from the immediate vicinity**

2.5 Special situations:

- During a viral diarrhoea/vomiting outbreak situation or when caring for patients with Clostridium difficile or diarrhoea of any cause on a ward or department, **hand washing** rather than the use of gel is the required method of hand decontamination.

2.6 Products:

- Bar soap **must not** be used as the bar rapidly becomes contaminated with skin bacteria and gram negative bacilli.
- There is no evidence to support the general use of antimicrobial agents (e.g. Hibiscrub). Liquid soap is generally less abrasive and therefore more user friendly.
- Antimicrobial solutions should be used before surgical procedures or invasive treatments.

2.7 Skincare:

- Skin damage is often associated with poor hand washing technique and inadequate rinsing of detergent. Frequency of use may also cause some damage by removing natural oils from the skin.
- All liquid soaps and alcohol hand rubs recommended by the Infection Prevention and Control team (IPCT) contain emollients and moisturisers.
- Apply a hand reconditioning cream as recommended by the IPCT, which is available via Supplies Department, regularly to protect skin from the drying effects of regular hand decontamination. A wall mounted single dispense product must be used.
- Non intact skin must be covered with a waterproof dressing.

- Any person complaining of skin irritation after use of any hand hygiene product should seek advice from the Occupational Health Department.
- Anyone with skin problems which prevent them from complying with regime is advised to contact the Occupational Health Department for advice.
- Staff who enter client's homes should carry their own supply of soap, alcohol hand rub and reconditioning cream

2.8 Patient/public involvement:

- Patients and carers will be encouraged to ask staff if they have decontaminated their hands prior to delivery of care or physical contact. Posters, badges and other materials will be used in clinical areas to ensure patients and carers feel able to challenge staff of any designation.
- Visitors will be required to decontaminate their hands using alcohol hand rubs or soap and water on entering and leaving the ward/department. Posters to support this will be displayed in public areas.
- Patient and visitor awareness campaigns will be held at least annually on both hospital sites.

3. Training requirements

All clinical staff are required to undertake hand hygiene training updates every two years. See Appendix 3 for details of training programme.

Staff will be required to sign an attendance sheet for any training. This information will be entered onto the central training record.

Staff will be required to demonstrate that they have achieved the requirements for each year as part of their Knowledge and Skills Framework evidence.

4. Responsibilities

It is vital that all staff are aware of the reasons for hand hygiene and decontamination, and the consequences of non compliance in terms of adverse patient outcomes, registration with the Care Quality Commission and professional accountability.

Each individual has clinical and ethical responsibility to carry out hand hygiene appropriately and to carry personal gel dispensers as appropriate. Appendix 1 shows the correct technique to ensure complete skin coverage during any kind of hand decontamination. Every member of staff also has a responsibility to attend/complete the hand hygiene component of mandatory training annually.

Matrons/SCNs and ward/department managers have a responsibility to ensure that all staff have had mandatory hand hygiene training, and that the resources are available to allow staff to perform hand hygiene effectively.

The Facilities Managers and Domestic Service Managers have a responsibility to ensure that the equipment required for hand hygiene is functional and clean, including: wash hand basins with appropriate taps, soap and towel dispensers and foot operated waste bins.

The IPCT is responsible for ensuring that hand hygiene remains a priority for the Trust. This will be achieved by:

- Regular campaigns and initiatives.
- Working in partnership with link workers.
- Mandatory hand hygiene education programme for all staff.

5. References

1. Pratt et al (2006) *epic2* :National Evidence- based Guidelines for preventing Healthcare Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection.*65 (supplement)

2. BMA (2006) Healthcare associated infections. www.bma.org.uk/ap.nsf/Content/HealthcareAssocInfect

3. Department of Health (2003) Winning Ways: working together to reduce healthcare associated infection in England. London. Department of Health

4. North Tees and Hartlepool NHS Foundation Trust Uniform and Personal Appearance Policy

5. North Tees and Hartlepool NHS Foundation Trust Standard Precautions to Prevent the Spread of Infection Policy

6. North Tees and Hartlepool NHS Foundation Trust Effective Management of Mandatory Training Policy

7. The Health Act 2006.Code of Practice for the Prevention and Control of Healthcare Associated Infections. Department Of Health

6. Consultation

This Policy has been formulated in consultation with the multidisciplinary membership of the Trust Infection Control Committee, which includes patient representation.

7. Review and revision of the policy

The Hand Hygiene Policy will be reviewed annually in order to take account of changes in national guidance and the evolving training requirements in relation to hand hygiene.

8. Monitoring

8.1 Monitoring of hand hygiene training compliance (refer to HR45)

- Quarterly reports including achievement of hand hygiene traininng will be presented to Executive Directors by the Director of HR & OD via the HR Quarterly Report.
- Directorate reports will be sent to General Managers and equivalents every two months and include a Red Amber Green report for all staff.

- Actions plans will be developed by the Directorates where achievement of mandatory training is not being achieved. These action plans will be monitored by ETOG and Clinical Governance Committee
- A corporate action plan will be developed and monitored by the General Manager (EL&D) and will be discussed and monitored at the Education and Training Operational Group (ETOG) and Medical Education Executive Committee every two months. Progress made against the action plan will be monitored via these groups.
- Audits of the processes above will be monitored by the Quality Team within the Directorate of EL&D on an annual basis and be discussed at ETOG and Quality Group.

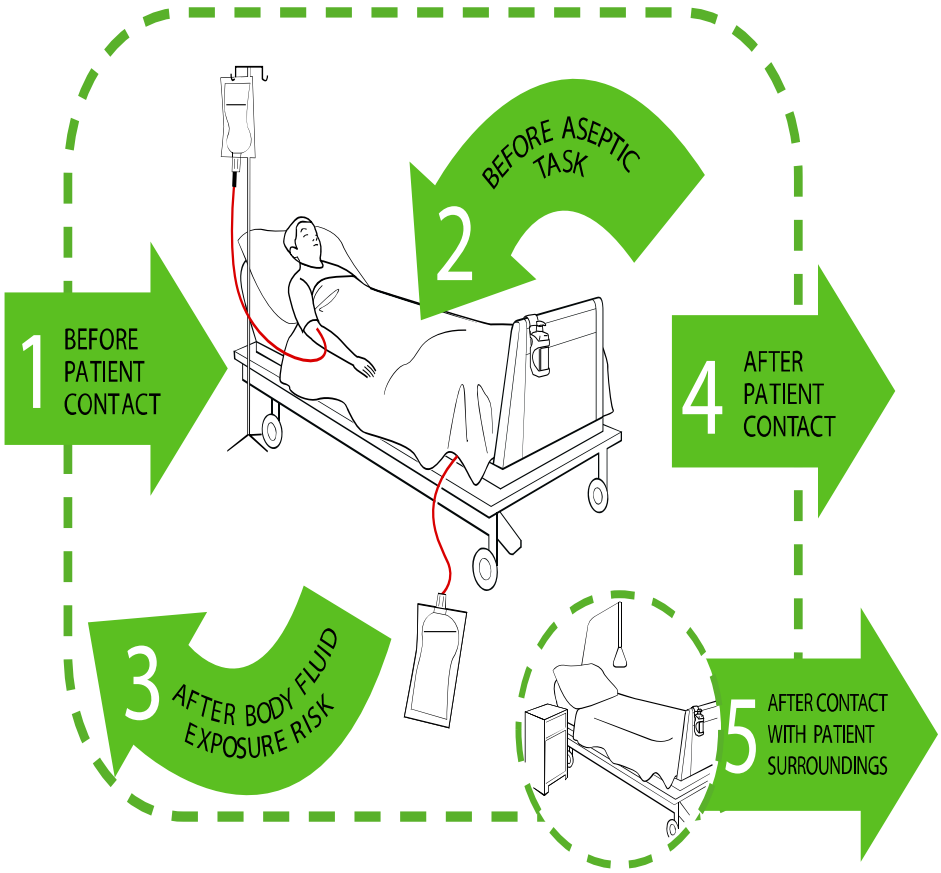
8.2 Monitoring of compliance with facilities and hand hygiene practices

- A hand hygiene audit will be carried out annually in all clinical areas (hospital only), by the Infection Prevention and Control Link Workers, with spot audits carried out randomly by the IPCT. Action plans must be produced in response to any shortfalls and all actions completed within the recorded timescale. A Trust wide audit report will be produced annually with feedback and results being presented to the Infection Control Committee. Appendix 4 shows the audit tool used to measure compliance with this policy.

- Monthly completion of 'Saving Lives' High Impact Intervention (HII) No 1 tool (hospital staff) or Essential Steps (community staff) by all clinical areas will also monitor compliance with optimal hand hygiene practices. Use of the tool and scores achieved will be received by the Healthcare Associated Infection (HCAI) Action Group monthly. Directorate scores will be displayed monthly on the strategic dashboard. Any area falling below 95% compliance must perform weekly audits until scores are above 95%. Community hand hygiene compliance will be reported two monthly to the Implementation Group

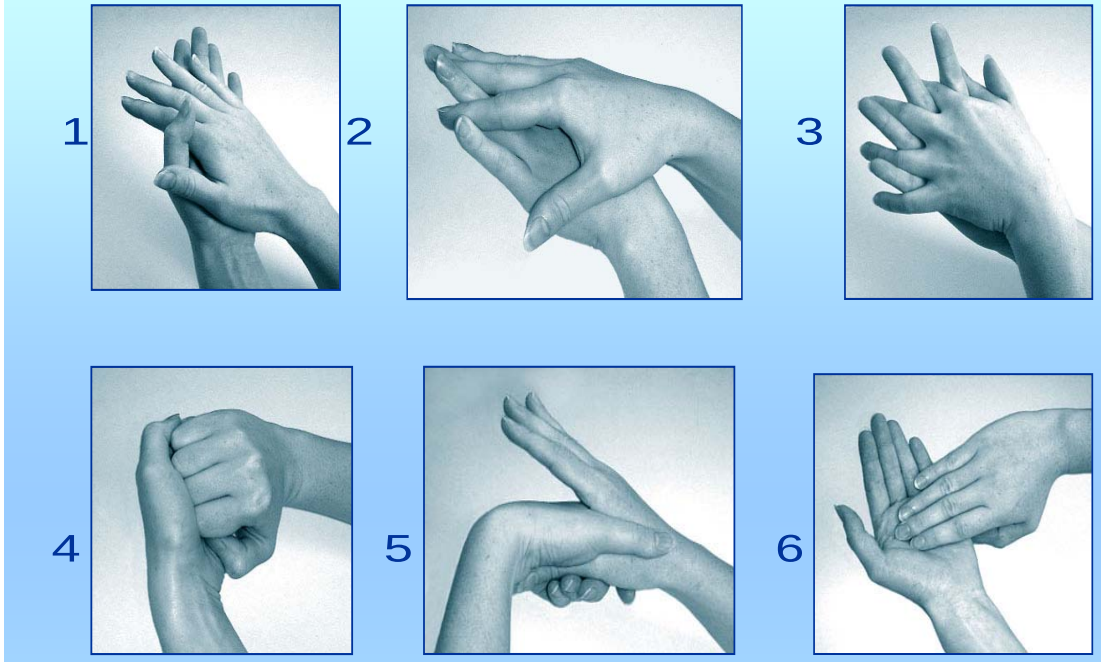
APPENDIX1

Your 5 moments for hand hygiene at the point of care*



APPENDIX 2

6 step hand hygiene technique



•Use liquid soap with thorough rinsing and drying if hands soiled

•Alcohol gel after every contact, unless patient has diarrhoea

- ✓ *Before handling food*
- ✓ *After bed making*
- ✓ *Before and after any direct care*
- ✓ *After toileting*
- ✓ *Before and after wearing gloves*
- ✓ *After handling bedding or waste*
- ✓ *Before leaving isolation room*
- ✓ *Before entering isolation room*
- ✓ *Before leaving work area*
- ✓ *Presence of visible dirt*
- ✓ *Before and after handling wounds, catheters, IV line, PEGs, etc*

APPENDIX 3

Infection Prevention and Control Hand Hygiene Training Programme

1. At commencement of employment as part of Trust Induction programme held monthly. To include the members of and roles of the Infection Prevention and Control Team (IPCT), reasons why hand hygiene is so important, adverse outcomes if hand hygiene is not carried out effectively, costs of HCAI to NHS, Trust and patient, individual responsibility for hand hygiene, practical hand hygiene training, overview of standard precautions.

2. Full Risk management training programme - as part of an in-depth training programme for all grades of staff. Dates available in "Training Times". To include reasons why hand hygiene is so important, adverse outcomes if hand hygiene is not carried out effectively, costs of HCAI to NHS, Trust and patient, individual responsibility for hand hygiene, practical hand hygiene training, and overview of standard precautions.

3. Drop in sessions – 30 minute sessions held twice each month on alternate sites. No nominations required. To include reasons why hand hygiene is so important, adverse outcomes if hand hygiene is not carried out effectively, costs of HCAI to NHS, Trust and patient, individual responsibility for hand hygiene, practical hand hygiene training, overview of standard precautions. Dates circulated regularly via email.

4. Ward/department based sessions – 30 minutes arranged by individual wards and departments as convenient. Training carried out either by IPCT member or by competent link worker/key trainer using training pack produced by IPCT.

5. Electronic learning via NHS Online Infection Control Training at www.infectioncontrol.nhs.uk

APPENDIX 4

Hand Hygiene Audit

Ward/Dept	Site: UHNT or UHH	Auditors
Calculation: __yes__ x 100% yes + no *(do not include N/A responses)*	Audit score %	Audit date

		Yes	No	N/A
1	There are posters displayed at clinical hand wash sinks showing correct method of hand decontamination.			
2	Liquid soap is available at all hand wash sinks.			
3	Alcohol gel is available at the entrance/exits to ward/dept and patient areas.			
4	Dispensers are clean and filled, and drip trays are clean.			
5	All staff carry individual tottles of alcohol gel.			
6	Staff decontaminate their hands before serving meals to the patients (question/observe two staff).			
7	A poster is displayed to make visitors aware of the importance of hand hygiene before entering and leaving the ward/dept.			
8	'clean**your**hands' information is displayed.			
9	'5 moments for hand hygiene' awareness posters are displayed.			
10	An approved, wall mounted hand cream dispenser is available in at least one clinical area.			
11	All hand wash sinks are accessible, clean, free from plugs, overflows, equipment, and patient's property.			
12	Elbow operated or automated taps are available at clinical hand wash sinks.			
13	Dispensers are labelled correctly (gel/handcream/soap).			
14	Hand towel dispensers are filled and staff are aware of where supplies are kept (question two staff).			
15	Staff are aware of the Trust Hand Hygiene Policy and its location (question two staff).			
16	All staff comply with Uniform Policy and bare below the elbows guidance.			
17	Staff have received hand hygiene training in the last year (question two staff).			
18	Staff are aware when it is not appropriate to use alcohol gel (question two staff).			
19	Patients are offered the opportunity for hand hygiene after going to the toilet and before meals (question two patients).			

Hand Hygiene Audit Action Plan

Action plan required? **YES** **NO** **Ward/Dept/Site:**

Problem/issue	Actions	Nominated responsibility	Date for completion	Date for review

COMMENTS

Copies within two weeks to:
Auditors, Ward Matron, Infection Prevention and Control Department, General Manager, SCN