Hand Hygiene Policy

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Version Control

Version Date	Version No.	Author/ Reviewer	Comments
July 2005, 2007, 2008		Infection Prevention and Control Team	
21/06/2010	6	Infection Prevention and Control Team	Change HH Technique from 6 step to 7. Revised HH Audit tool
04/05/2012	7	Infection Prevention and Control Team	Revised HH Audit Tool Update References
01/03/2014	8	Infection Prevention and Control Team	Revised HH Audit Tool
15/03/2016	9	Infection Prevention and Control Team	Minor changes
01/03/2018	10	Infection Prevention and Control Team	Minor changes
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1. Introduction

Hand hygiene is one important component in the battle against cross-infection. Minimising risks of infection to patients depends on a range of factors. However, just by increasing hand hygiene alone can dramatically reduce the risk of a patient acquiring an infection. Scientific evidence demonstrates that the bacteria that causes healthcare associated infections (HCAI) are most frequently spread from one patient to another on the hands of healthcare workers. Health Act 2006 (2008), The Health and Social Care Act 2008 (2015), Essential Steps to Safe, Clean Care (2007), Cleanyourhands (2008) Epic 3 (2014). Therefore hand hygiene carried out immediately before and after contact with patients i.e. at point of care, is the best way to prevent HCAIs.

Hand hygiene procedures do not only relate to clinical staff, all staff must wash their hands correctly and at the appropriate time, see WHO 'your 5 moments for hand hygiene'.

2. Purpose and scope

To ensure correct hand washing practice. This document applies to all staff either employed or contracted by East Coast Community Healthcare (ECCH). These staff may work within our premises, patients own homes, or care settings owned by other agencies.

3. Guidance Statement

This guidance will be implemented to ensure adherence to safe practice.

4. Responsibilities

It is the responsibility of all staff to ensure that they adhere to evidence based best practice. All staff must take responsibility for their own hand decontamination and should act as an advocate for all their clients and others to ensure that everyone decontaminates their hands appropriately.

5. Monitoring

It is the responsibility of all department heads/professional leads to ensure that staff they manage adhere to this guidance. All managers are required to ensure their teams complete the audit.

The target for correct and complete hand hygiene is set at 100% and should be monitored through monthly ward audits and quarterly departmental audits.

Should a ward area fall below 80% on 2 consecutive months the ward manager and the Infection Prevention & Control link nurse from the area will, using reflection, produce a written action plan using SMART objectives, (S-specific, M-measurable, A-achievable, R-realistic and T-timely). This will be submitted to Matrons and to the Infection Prevention & Control Team(IP&C) and will be taken to the Infection Prevention & Control Committee (IPACC).

The IP&C Team will set the number of hand hygiene audits to be carried out in each area depending on staff numbers and whole time equivalents. The audit should be carried out using the appropriate form found in this document. This should be returned monthly to the IP&C Team. These results are reported to IPACC on a quarterly basis. They are included in the Infection Control Quarterly and Annual reports which are submitted to the board and provide part of the assurance required by ECCH to the Care Quality Commission of adherence to the Health and Social Care Act 2008 (2015) (DH 2009).

The IP&C Team will carry out induction and yearly mandatory infection control training for clinical staff and 3 yearly for non-clinical staff. It is the responsibility of all ECCH staff to maintain their compliance with Infection Prevention and Control training. The IP&C Team will also observe hand hygiene technique and opportunities during regular community hospital visits and during audits for all ECCH areas.

6. Review

This guidance will be reviewed every two years by the Infection Prevention and Control Team, unless a substantive change occurs before this date.

7. The Importance of Hand Hygiene

Thorough hand washing is undoubtedly one of the simplest and most effective ways of preventing person-to-person transmission of infective agents in clinical practice.

Hand decontamination has a dual role in protecting both the patient and the healthcare worker. Hands readily pick up and transfer micro-organisms. Hands must be decontaminated between all activities that result in even superficial contact with patient surroundings.

There is no set frequency for hand decontamination as it is determined by clinical actions, but there are guidelines from the World Health Organisation (WHO) and the National Patient Safety Agency on 'your 5 moments for hand hygiene at the point of care' (see 14 & 15). A risk assessment of the activity intended to be performed, will determine the appropriate decontamination process and the choice of cleansing agent.

There should be an appropriate use of 'single use non sterile gloves' and 'sterile gloves' within ECCH. Hands should be washed before and after the use of gloves. Gloves should not be cleaned with hand sanitizer/rub they must be changed between each patient contact or episode of care.

The principles of hand decontamination apply equally to healthcare provided in hospitals as they do to care provided in the community, but these may need to be adapted to suit local circumstances.

8. The Microbiology of the hand

There are two populations of microbes present on the hands.

Transient micro-organisms – these superficially present on the skin and are:

- Easily removed by routine hand washing
- Easily acquired by touch
- Readily transferred to the next person or surface touched
- The usual source of cross infection

Resident micro-organisms – these are deep seated within the skin:

- They are difficult to remove
- Are not readily transferred to other people or surfaces
- Can enter tissues and establish infection during highly invasive procedures such as surgery
- Play an important part in protecting skin from other harmful organisms

9. Routine hand decontamination

The aim of this is to remove transient micro-organisms before they can be transferred. Hands that are visibly soiled with dirt or organic material, or potentially contaminated with micro-organisms should be washed using liquid soap and water using the seven step technique taking 15-30 seconds, then rinsed and dried thoroughly. Antibacterial hand cleansing solutions/soap

are not routinely recommended as they kill off the resident micro-organisms, (the ones which help protect the skin), as well as the transient ones.

If hands are potentially contaminated, but visibly clean they may be decontaminated at point of care, using an alcohol based preparation, and the seven step technique taking 15-30 seconds, until both hands are dry. There are three makes of hand sanitizer which are approved for use within ECCH, they are Gojo Purell, Braun Softalind or Ecolab Spirigel.

9.1. Requirements

Estates and Facilities.

Sinks specifically designated to facilitate effective hand decontamination should be provided in all clinical areas, with elbow or non-touch taps and which conform to current recommendations, a supply of warm water, liquid soap and disposable paper towels in wall mounted dispensers, and a foot operated, closed lidded disposal bin for household waste. It is preferable to use products available via the approved supply chain when purchasing soap/paper towels/hand cream/hand rub/hand gel.

Hand sanitizer should be available at the point of care, preferably wall or bed/locker mounted at strategic points within clinical areas e.g. on notes trolley for during ward rounds. It is the responsibility of members of staff who finish the end of a bottle/container to replenish with fresh stock. Hotel Services will be responsible for daily cleaning, maintenance and reporting faulty hand hygiene products/stations. It is the responsibility of the ward to keep check list of cleaning and maintenance.

Hand sanitizer does not replace the need for conveniently located and dedicated facilities for hand washing in clinical areas, and where possible extra sinks will be fitted which conform to current recommendations.

Single use patient hand wipes must be available for those patients who are unable to access liquid soap and water for hand washing e.g. before meals, after using the toilet.

There should be hand sanitizer/bottles of liquid soap/hand wipes carried as individual dispensers for specialist areas or special circumstances e.g. community, paediatrics, domiciliary visits. Dispensers must not be refilled.

In areas where it is considered unsafe to have hand sanitizer easily available, a risk assessment must be carried out and submitted.

At the entrance to all in patient healthcare facilities there should be signs explaining the importance of hand hygiene and the ECCH's commitment to improving hand hygiene. All hand hygiene stations whether sinks or hand sanitzer, should have easily visible, clear signage which should encourage staff, patients and visitors to comply with hand hygiene measures.

9.2 Preparation of hands:

Intact skin is an effective barrier to prevent micro-organisms entering the body. Thus all cuts, abrasions and other skin lesions on the hands (and other exposed areas of skin) of health care workers should be covered with an occlusive waterproof dressing.

Best practice in hand hygiene consists of keeping fingernails short and clean, (when holding hands up, palm facing you, you should not be able to see the white of the nails). Best practice requires removal of all jewellery, except one plain ring band (please also refer to the Uniform Policy, and Bare Below the Elbows in Clean, Safe Care. DH (2008) Epic 3 (2014)) including nail jewellery, nail polish and artificial finger nails.

Hand creams should be regularly applied to hands to protect the skin from the drying effects of regular hand decontamination. Communal jars of hand cream are not advisable as the contents

may themselves become contaminated and therefore become a source of cross infection. Wall mounted pump dispensers and hand cream are available through stores.

Nail brushes are not recommended for routine use as they can damage the skin. Where nail brushes are used they should be sterile and single use only.

9.3 When to decontaminate hands:

Hands should always be cleaned:

- Before starting and at the end of each work period.
- Before and after each 'hands on' patient contact at point of care.
- Before and after carrying out each aseptic procedure.
- After any contact with body fluids or secretions.
- After handling soiled or contaminated equipment or linen.
- Before and after administering drugs.
- Whenever skin is visibly soiled.
- Before and after use of gloves.
- Before performing or assisting at operative procedures, a surgical scrub for hand decontamination should be performed.
- After using the lavatory.
- Before eating, drinking or handling food.
- After contact with patient surroundings.

This list is not exhaustive and we expect all staff to use the 5 moments for hand hygiene charts and their clinical judgement to decide appropriateness.

9.4 Cleansing agents

- Plain liquid soap and water is sufficient for most routine daily activities. The seven step procedure for cleaning hands should be used. Hand washing with liquid soap and water suspends the micro-organisms in solution and allows them to be rinsed off – this is referred to as *mechanical removal* of micro-organisms. Liquid soap is preferred for clinical settings, with enough soap applied to ensure that hands are well lathered all over. The dispenser should be wall mounted and regularly maintained, with individual replacement cartridges that are discarded when empty. There should be nominated staff to be responsible for this.
- Hand sanitizers are a practical and acceptable alternative to hand washing, provided that hands are not visibly soiled or dirty. It is not a cleansing agent and visible contaminants must be removed with liquid soap and water. It should be applied using an evidence based technique, we recommend the seven step procedure for cleaning hands, and about a 3ml dose dispensed (1metered doses of a 800 or 1000ml pump container) should be used until both hands are dry. **Hand sanitizer should not be used when there is diarrhoea or vomiting as it is less effective against some organisms than washing with liquid soap and water.** Hand sanitiser can be used consecutively until the hands start to feel tacky when they should be washed with liquid soap and water.
- Staff experiencing problems with skin irritation or with concerns should contact the relevant Occupational Health Department – Ingage Wellbeing Services 07580719899.

10. Surgical hand decontamination

The aim of this is to substantially reduce resident micro-organisms and remove or destroy transient micro-organisms.

Used prior to surgical or other highly invasive procedures where extra care must be taken to prevent micro-organisms on hands being introduced into tissues should gloves become damaged.

This process is achieved by using an antiseptic hand cleansing preparation.

- Antiseptic hand washing solutions used with water will remove and destroy micro-organisms by the *chemical removal* of micro-organisms.
- Hand disinfection carried out in this way will reduce counts of colonising resident flora as well as removing or destroying transient micro-organisms. Some have a residual activity providing continued anti-microbial activity, which is of benefit during surgical procedures. Examples of aqueous antiseptic solutions are: chlorhexidine, iodophors and triclosan.

11. Patients and Visitors

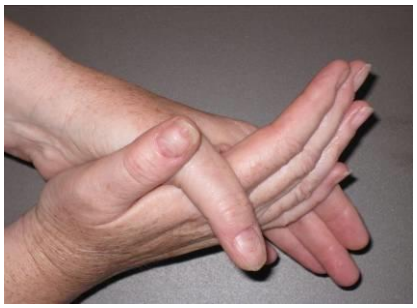
Staff should educate and encourage patients to decontaminate their hands after toileting, before consumption of food or drink and before caring for invasive lines or dressings.

Visitors should be encouraged to decontaminate their hands when entering or leaving wards/departments and before and after contact with patients.

12. Hand washing technique

Research has shown that the technique is as important as the time taken and the agent used

Hand Hygiene Technique

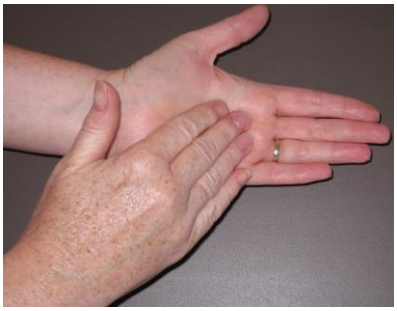


Rub hands palm to palm

Rub back of each hand with the palm of the other

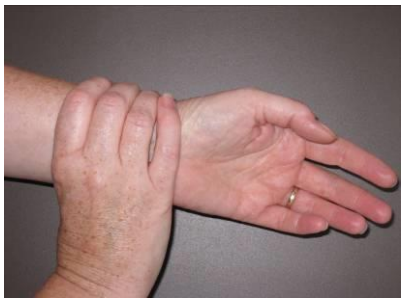
Rub palm to palm with fingers interlaced

Rub with back of fingers to opposing palms with fingers interlocked



Rub tips of fingers in opposite palm in circular motion

Rub each thumb clasped in opposite hand using rotational movement



Rub each wrist with opposite hand

Each step should be repeated 5 times.

This same seven step technique should be used when using soap and water or hand sanitiser.

Infection Prevention and Control Team

East Coast Community Healthcare

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Hand Hygiene Audit Tool mk 5 Site; Date;

Obs	Designation of staff	Description of Task (Why you are washing your hands. dressings, feeding, personal care)	Hand Hygiene please state opportunity	7 Step hand hygiene technique										Hand Care			Personal Protective Equipment	Signature
				wetting hands/correct amount of gel	palm to palm	palm to back of hands	palm to palm fingers interlaced	back of fingers to palm	thumbs	rotational rubbing fingertips	wrists	rinsing	drying	Minimal Jewellery (1 plain band/no wrist watch)	Skin Condition hands (intact/cuts covered)	Finger nails clean, short, no varnish		
			See Key	Yes/No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No/ N/A	Yes/ No/ N/A	Yes/No	Yes/No	Yes/No	Yes/No/ N/A	
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8																		
9																		
10																		
11																		
12																		
Total																		
% Compliance																		

Return to Research & Audit Team, ECCH HQ by end of the month

Designation of staff - N-Nurse, Dr- Doctor, P-Physio, OT-OT, B/A- Bank/Agency

Adapted from NHS Leeds ESSCC Hand Hygiene Audit Tool

Infection Prevention Team

ECCH 24/04/2012

Key

1 - Before contact

2 - After contact

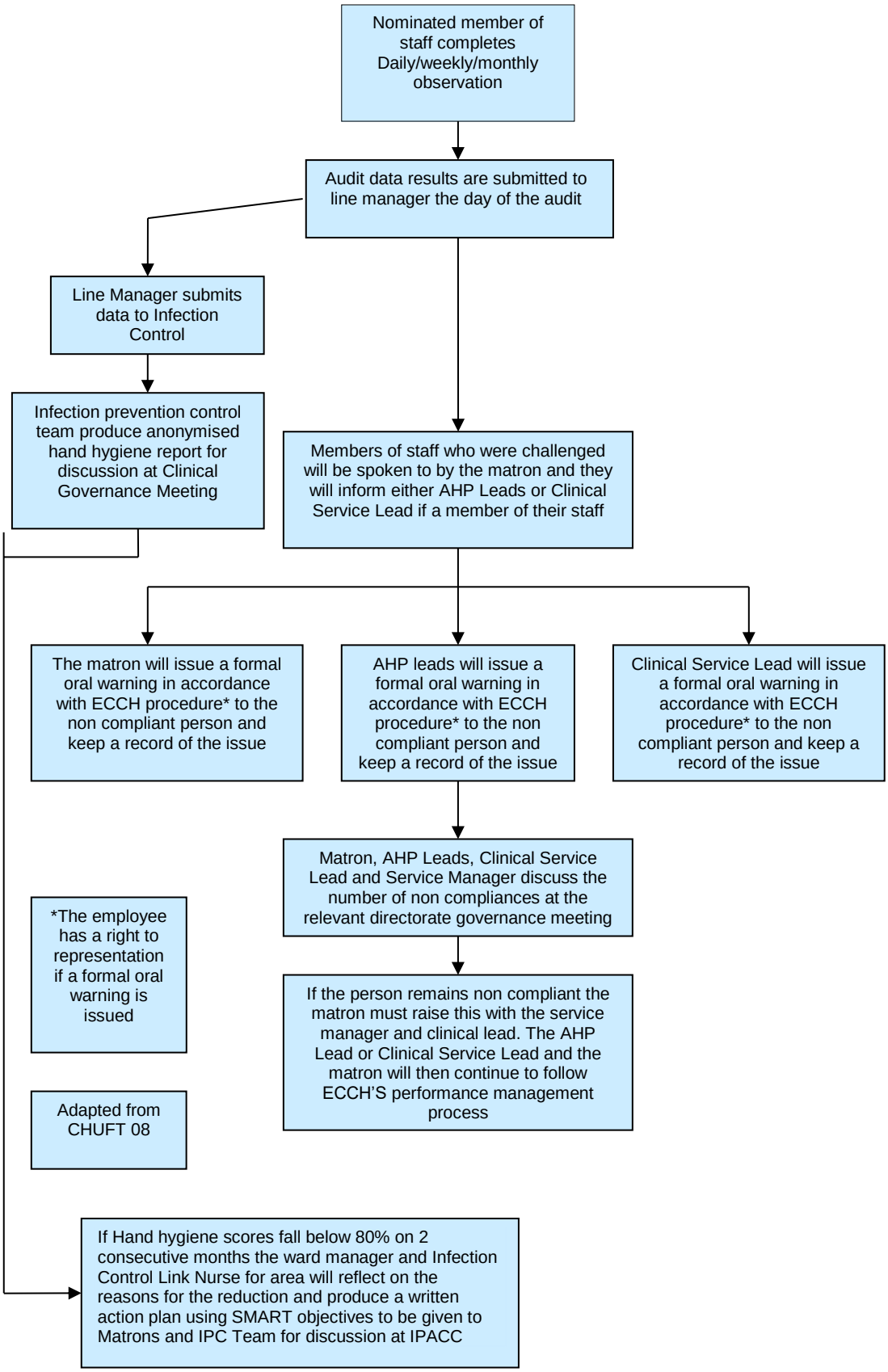
3 - Before Aseptic Technique

4 After Body Fluid Exposure Risk

5 - After contact with patient Surroundings

6 - Missed opportunity

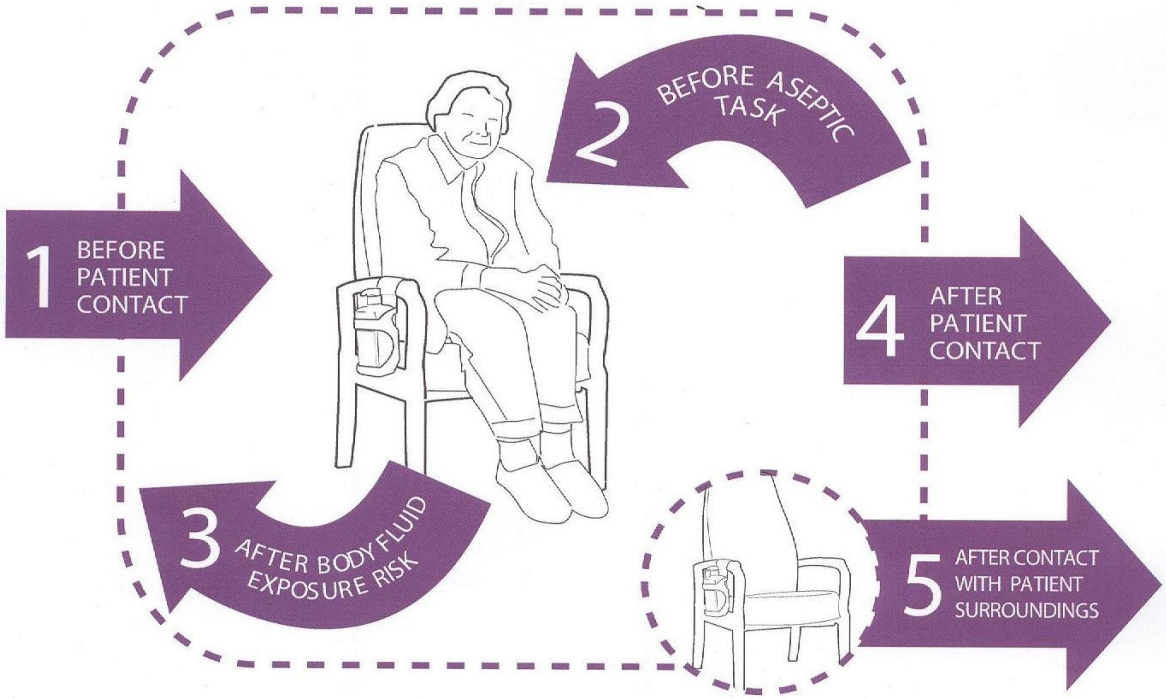
13. Hand Hygiene Disciplinary Framework



14.

NHS
National Patient Safety Agency

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 AN ASEPTIC TASK	**WHEN?** Clean your hands immediately before any aseptic task **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 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

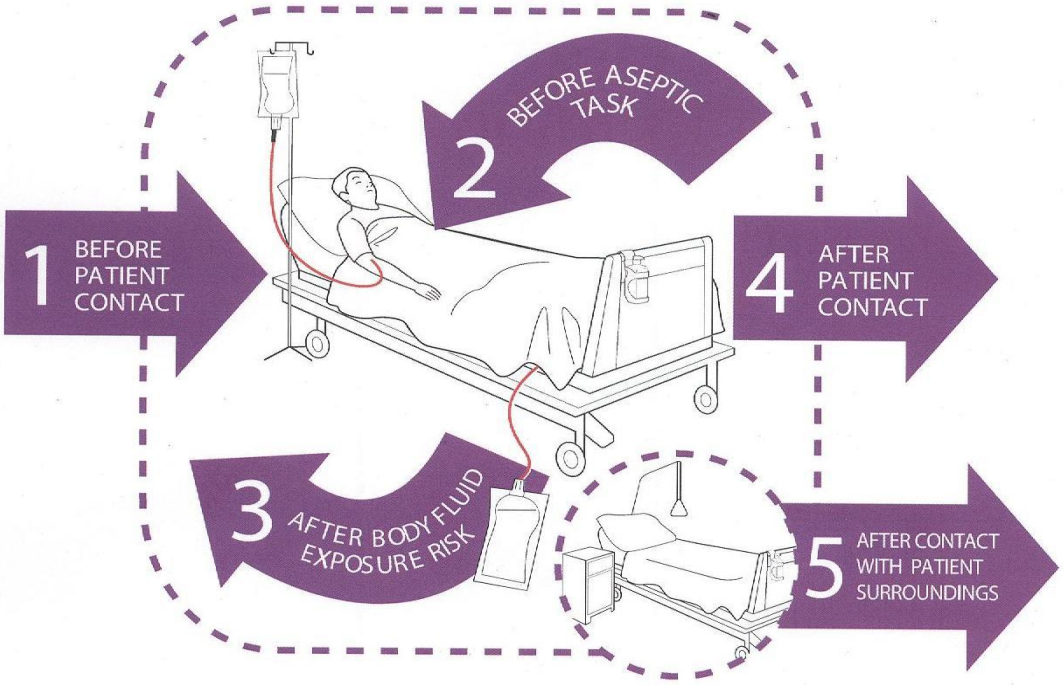
Adapted from WHO World Alliance for Patient Safety 2006

cleanyourhands® campaign

15.

NHS
National Patient Safety Agency

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 AN ASEPTIC TASK**	**WHEN?** Clean your hands immediately before any aseptic task **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 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
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Adapted from WHO World Alliance for Patient Safety 2006

cleanyourhands® campaign

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17. Author

Infection Prevention and Control Team,
East Coast Community Healthcare

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

- **All ECCH policies, procedures, protocols and guidelines (clinical and non-clinical)**
- **Service developments**
- **Estates and facilities developments**

Name of Policy / Procedure / Service	**Hand Hygiene Policy**
Manager Leading the Assessment	**Teresa Lewis**
Date of Assessment	**March 2016**

STAGE ONE – INITIAL ASSESSMENT

Q1. Is this a new or existing policy / procedure / service?

☐ **New**

√ **Existing**

Q2. Who is the policy / procedure / service aimed at?

☐ **Patients**

√ **Staff**

☐ **Visitors**

Q3. Could the policy / procedure / service affect different groups (age, disability, gender, race, ethnic origin, religion or belief, sexual orientation) adversely?

☐ **Yes**

√ **No**

If the answer to this question is NO please sign the form as the assessment is complete, if YES, proceed to Stage Two.

Analysis and Decision-Making

Using all of the information recorded above, please show below those groups for whom an adverse impact has been identified.

	Adverse Impact Identified?
Age	No
Disability	No
Gender	No
Race/Ethnic Origin	No
Religion/Belief	No
Sexual Orientation	No

- Can this adverse impact be justified?
- Can the policy/procedure be changed to remove the adverse impact?

If your assessment is likely to have an adverse impact, is there an alternative way of achieving the organisation's aim, objective or outcome
What changes, if any, need to be made in order to minimise unjustifiable adverse impact?