HAND HYGIENE POLICY FOR STAFF WORKING IN CLINICAL ENVIRONMENTS

Policy Type	Clinical Infection prevention and control
Directorate	Corporate Nursing
Policy Owner	Chief Nurse including Midwifery and Allied Health Professionals
Policy Author	Infection Prevention and Control Team
Next Author Review Date	1st June 2022
Approving Body	Policy Management Sub-Committee 22nd November 2018
Version No.	8.0
Policy Valid from date	1st November 2018
Policy Valid to date:	30th November 2022

'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
3 Sep 12	6	Sep 12	Executive Director Nursing & Workforce		Approved at Executive Board
Aug 15	6.1		Executive Director of Nursing	Change to appendix B & C, minor updates	Ratified at IPCC
07 Aug 15	6.2		Executive Director of Nursing	For ratification	Ratified at Clinical Standards Group
18 Aug 15	7	18 Aug 15	Executive Director of Nursing	Requested amendments	Approved at Policy Management Group
14/09/18	7.1		Director of Nursing	Current Trust format with Minor updates	
26/10/18	7.1		Director of Nursing	Ratified at	Clinical Standards Group
22/11/18	8.0	22 Nov 18	Director of Nursing	Approved at	Policy Management Sub-Committee
29/01/21	8.0	22 Nov 18	Chief Nurse including Midwifery and Allied Health Professionals	12 month blanket policy extension due to covid 19 applied with author review date set 6 months prior to Valid to Date.	Quality & Performance Committee
14/05/21	8.0	22 Nov 18	Chief Nurse including Midwifery and Allied Health Professionals	Extended policy uploaded and linked back	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents **Page**

1 Executive Summary

This policy provides clear, evidence-based standards for hand hygiene practice in all healthcare settings. It includes:-

- The importance of the World Health Organisation's "5 moments for hand hygiene"
- Standards for standard hand hygiene (decontamination) and when to apply in the workplace with additional guidance for aseptic and surgical hand disinfection.
- Importance of and evidence-base for hand hygiene practice in routine clinical practice as part of the duty of care to patients to reduce healthcare associated infections (HCAI).
- Hand hygiene audit requirements, including responsibility for ensuring that compliance with hand hygiene policy is regularly monitored to ensure patient safety.
- Healthcare staff skills training, teaching and assessment processes to ensure all staff groups receive appropriate training and that there is evidence to provide the Trust with assurance that staff are appropriately trained.

2 Introduction

Hand hygiene is one of the most important factors in preventing transmission of infection. There is clear evidence that consistent and rigorous application of good hand hygiene practice will prevent HCAI. It is essential that hand hygiene practice standards are consistently high and complied with by all healthcare staff.

Effective hand hygiene is essential to protect patients from infection and reduce HCAI such as Meticillin Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile Infection (CDI).*

3 Definitions

HCAI – Healthcare Associated Infection

MRSA – Meticillin Resistant Staphylococcus Aureus

IPCT – Infection Prevention and Control Team

CDI – Clostridium *difficile* Infection

DIPC – Director of Infection Prevention and Control

4 Scope

This policy applies to all healthcare staff working in the Trust. The same standards should apply in all healthcare settings including those outside the Trust.

5 Purpose

To provide clear, evidence-based standards for hand hygiene practice for staff working in all clinical health care environments

6 Roles and Responsibilities

6.1 Director of Infection Prevention and Control (DIPC)

The DIPC oversees this policy and its implementation.

6.2 Infection Prevention and Control Team (IPCT)

The IPCT is responsible for producing and updating this policy and for training hand hygiene "Champions" to deliver practical hand hygiene training. The IPCT are also available to provide expert infection prevention and control advice.

6.3 Individual responsibility

Clinical healthcare staff of all grades must be competent in techniques for hand decontamination and consistently apply good hand hygiene in workplace practice. Failure to do so is a serious breach of policy and the duty of care to patients. All healthcare staff have a duty of care to comply with this and other Trust policies for prevention and control of HCAIs. This is clearly stated in job descriptions and will be asked about at appraisal.

6.4 Department Managers, Lead Clinicians, Ward Sisters, AHP Leads and Modern Matrons are responsible for:-

- Monitoring and overseeing standard infection control hand hygiene policies in their clinical area of responsibility, and for monitoring practical hand hygiene training attendance.
- Ensuring that where practically possible, regular audits of hand hygiene are undertaken within their area of responsibility and that effective processes are in place for review of audit findings, including monitoring at Directorate level.
- Monitoring and keeping evidence that staff have attended appropriate training in practical hand hygiene and that systems are in place for identifying and managing staff who have not attended training.

6.5 Hand Hygiene Champions

All areas should ensure a hand hygiene "Champion" is in place. The Hand Hygiene "Champion" will act as a hand hygiene information resource for the area and will be trained to deliver practical hand hygiene training to clinical staff of all grades and disciplines.

7 Policy detail/Course of Action

7.1 Standard hand hygiene (decontamination)

In all clinical healthcare settings:

The World Health Organisation's "5 moments for hand hygiene" (see Appendix A) indicates standard (routine) hand hygiene is necessary:

- Before contact with patients; the patient should be able to see staff decontaminate their hands.
- Before any clean or aseptic procedure (e.g., cannula care, catheter care, aseptic technique, taking observations)
- After contact with body fluids or secretions, dressings etc.
- After patient contact (e.g. when leaving the patient's space)
- After contact with the patient environment (e.g., Curtains, table, bedside record).

When decontaminating the hands, remember the following points:

- Hand decontamination can be carried out by using a hand sanitiser gel at the point of care or by washing hands with liquid soap and water.
- If hands are visibly dirty, soiled or contaminated with blood or body fluids OR if the patient has diarrhoea, it is **essential** to wash hands using liquid soap and water.
- When cleaning hands (using hand sanitiser gel or soap and water) ensure no parts of the hands are missed and use the correct technique. Include wrists as well as hands.

Bare below the elbows:

Watchstraps, rings, cuffs, bracelets, false fingernails and other items on hands, wrists or forearms compromise hand hygiene by preventing thorough decontamination of those areas. For this reason, **all** staff involved in direct patient care or in uniform are required to be "bare below the elbows" when in the patient care environment. For further information and guidance on bare below the elbows, please refer to the Dress Code and Uniform Policy.

7.2 Standard Hand hygiene (decontamination) - TECHNIQUE

Using liquid soap and water

- Wet hands and wrists under tepid running water *before* applying liquid soap.
- Apply one dose of liquid soap.
- Rub all surfaces of the lathered hands vigorously for 10 - 15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers.
- Rinse well under running water until all soap has been removed.
- Turn off taps using elbows or paper towels.
- Dry hands and wrists thoroughly using disposable paper towels (use a patting action to prevent skin damage).
- Place used towel in a foot-operated bin (do not touch the top of bin with hands).

Using hand sanitiser gel

- Dispense a measure of hand sanitiser gel onto dry hands.
- Do not add water.
- The hand sanitiser gel must come into contact with all surfaces of the hand: rub hands together vigorously and use the same technique as for hand washing (see illustration). Pay particular attention to the tips of the fingers, the thumbs and the areas between the fingers.

- Rub hands with gel until solution has evaporated and the hands are completely dry.

Aseptic hand disinfection - TECHNIQUE

Aseptic hand decontamination aims to reduce resident microorganisms as well as destroying or removing transient microorganisms. Perform before undertaking an invasive or aseptic procedure (see also 'Aseptic Non Touch Technique Policy').

- Use the technique outlined above for washing hands with soap and water then, when hands are dry, apply hand sanitiser gel using the technique above, rubbing into all surfaces of the hands and wrists until completely dry.

Surgical hand disinfection (Scrub) -technique

Surgical hand disinfection is a prolonged version of the 'aseptic' hand-washing procedure that removes all transient microorganisms and suppresses resident flora, providing a higher level of decontamination. Perform before any invasive surgical procedure (e.g. surgical operations).

8 Consultation

This policy has been consulted on via the members of the Infection Prevention and Control Committee.

9 Training

"This Hand Hygiene Policy has a mandatory training requirement which is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis"

9.1 All clinical staff (those who work in a clinical environment) must:

- Undertake annual mandatory infection control training.
- Undertake annual practical hand hygiene training provided by hand hygiene "Champions" in their working environment (or by the IPCT or Practice Development Facilitators by prior agreement).

9.2 Hand hygiene champions must ensure that records of attendance at training events are forwarded to the Education and Training Department who will enter the information on to the appropriate training record. Failure to do so will result in incorrect central recording of training for which the area may be penalised.

9.3 The IPCT will provide notices, posters and instructions for use in clinical areas in relation to good hand hygiene practice.

9.4 At appraisal staff should provide evidence of competency in hand hygiene and attendance at relevant teaching sessions; demonstrate understanding of hand hygiene as a key patient safety measure and expect to be asked about compliance with hand hygiene.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 Compliance monitoring of hand hygiene practice in wards and clinical areas must take place through a regular audit programme.

- A regular schedule for hand hygiene audits must be performed in all wards and clinical areas (where it is possible to do so – for example lone workers may be unable to carry out successful audits).
- The audits should be performed using the standardised audit tool approved by the Infection Prevention and Control Committee, IPCC (see Appendix C).
- The Infection Prevention and Control Nursing Team (IPCNT) will provide training where necessary re hand hygiene audits.
- Frequency of audits will depend on the clinical area and the level of compliance previously observed and should be to an agreed annual schedule set by the IPCC and monitored via the Care Group quality meetings and IPCC monthly meeting.
- Modern Matrons (or equivalent) should oversee implementation of an effective audit programme and ensure results are routinely reported within their Care Group/Division.

10.2 Compliance with mandatory practical hand hygiene training will be monitored using the Nursing Dashboard at the Nursing Dashboard Meeting and should be routinely monitored and reviewed at ward, Care Group and Divisional level.

- Training records will be maintained by the Development and Training department. Periodic compliance reports will be made available to wards/care groups/divisions and for use in the nursing dashboards.
- Wards/departments will be considered to be compliant with staff training if an 90% attendance rate is maintained (this will be recorded as green on the nursing dashboard).
- Ward and department Sisters/Charge Nurses are required to maintain evidence that individuals who have not attended trainign are followed up appropriately abd trained in a timely manner.
- Corrective actions where necessary will be taken.

This should include:

- Audits planned to be undertaken
- Frequency and detail of monitoring
- Who will be responsible for monitoring
- Where the results will be presented / reported?
- Where failings have been identified, what the procedure should be, who will draw up the action plans and make changes made to reduce the risks

Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

11. LINKS TO OTHER ORGANISATION POLICIES/DOCUMENTS

Infection Prevention and Control - Aseptic Non-Touch Technique (ANTT) Policy

http://www.iow.nhs.uk/Downloads/Policies/IPC_Aseptic%20Non%20Touch%20Technique%20ANTT%20policy.pdf

Infection Prevention and Control – Standard precautions: use of personal protective equipment equipment for direct patient care.

http://www.iow.nhs.uk/Downloads/Policies/Use%20of%20Personal%20Protective%20Equipment%20PPE%20Policy.pdf

Dress Code and Uniform Policy

http://www.iow.nhs.uk/Downloads/Policies/Dress%20Code%20and%20Uniform%20Policy.pdf

Appraisal Policy

http://www.iow.nhs.uk/Downloads/Policies/Appraisal%20policy.pdf

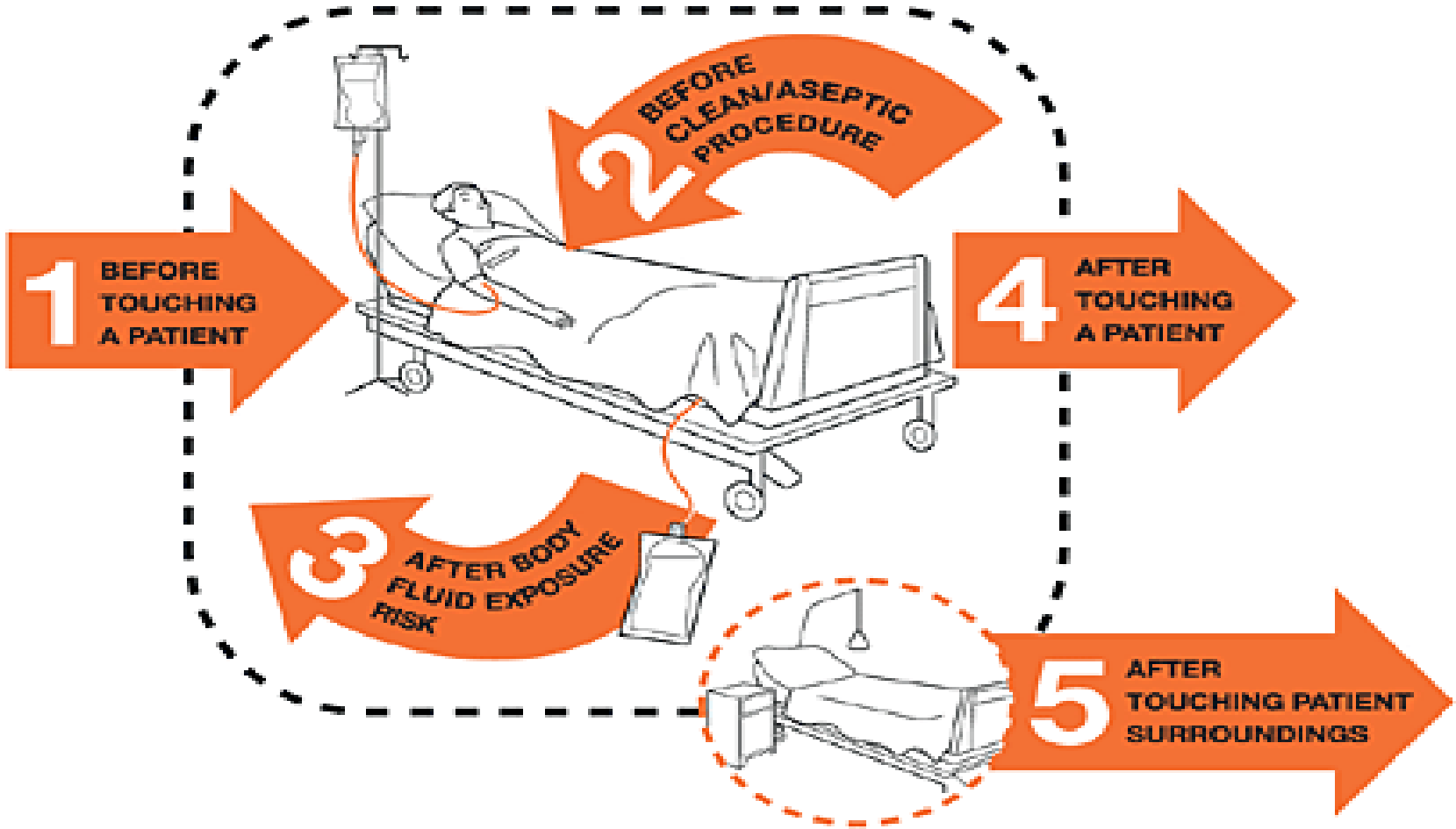
12. References

Epic3: National Evidence-Based Guidelines for Preevnting Healthcare-Associated infections in NHS Hospitals in England. H. P. Loveday et al. Journal of Hospital Infection 86S1 (2014) S1-S70
https://improvement.nhs.uk/documents/847/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

WHO Tools for Training and Education
http://www.who.int/gpsc/5may/tools/training_education/en/

14. Appendices

Your 5 moments for Hand Hygiene at the point of care. **Appendix A**



World Health Organisation (WHO)

Hand washing technique

Appendix B

Hand Hygiene Audit Tool **Appendix C**

HAND HYGIENE (5 MOMENTS + BARE BELOW ELBOWS)		Nurses/Students/HCA		Medical Staff /Students		Therapists /other		WARD TOTAL (Automatically calculated)	
	Criteria to be met	Opportunities Occuring	Opportunities Taken	Opportunities Occuring	Opportunities Taken	Opportunities Occuring	Opportunities Taken	Opportunities Occuring	Opportunities Taken
1	Hand cleansing before patient contact							0	0
2	Hand cleansing before an aseptic task							0	0
3	Hand cleansing after body fluid exposure							0	0
4	Hand cleansing after patient contact							0	0
5	Hand cleansing after contact with patient environment							0	0
6	Bare below the elbows when in a patient environment. No wrist watches, long sleeves or rings other than wedding band							0	0
	Overall score in % for hand hygiene (Automatically calculated)	**n/a**		**n/a**		**n/a**		**n/a**	
	Action Plan required (Is score is less 90%?)	**no**		**no**		**no**		**no**	

Appendix D

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**HAND HYGIENE POLICY FOR STAFF WORKING IN CLINICAL ENVIRONMENTS**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs			
Training Staff			
Equipment & Provision of resources			

Summary of Impact: Resources already deployed.

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**

Totals:		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix E

Equality Impact Assessment (EIA) Screening Tool

Document Title:	HAND HYGIENE POLICY FOR STAFF WORKING IN CLINICAL ENVIRONMENTS
Purpose of document	To provide clear, evidence-based standards for hand hygiene practice for staff working in all clinical health care environments
Target Audience	All staff working in clinical environments
Person or Committee undertaken the Equality Impact Assessment	Head of Infection Prevention and Control

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

No – This policy is concerned solely with best practice and best outcomes for all patients and staff working in a clinical environment.

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	no	no	
	Women	no	no	
Race	Asian or Asian British People	no	no	
	Black or Black British People	no	no	
	Chinese people	no	no	
	People of Mixed Race	no	no	

	White people (including Irish people)	no	no	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	no	no	
Sexual Orientation	Transgender	no	no	
	Lesbian, Gay men and bisexual	no	no	
Age	Children	no	no	
	Older People (60+)	no	no	
	Younger People (17 to 25 yrs)	no	no	
Faith Group		no	no	
Pregnancy & Maternity		no	no	
Equal Opportunities and/or improved relations		no	no	

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	Karen Robinson. Head of Infection Prevention and Control
Date Initial Screening completed	14/09/2018