

## Hand Hygiene Policy

*The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix B.*

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## Contents

<b>Paragraph</b>		<b>Page</b>
	Executive Summary	3
1	Introduction	4
2	Purpose	4
3	Definitions	4
4	Scope	4
5	Roles and responsibilities	5
6	Transient and Resident Flora	6
7	When to Perform Hand Hygiene	6
8	Choice of Agent for Hand Decontamination	7
9	Water Temperature	9
10	Hand Decontamination Technique	10
11	Hand Drying	11
12	Bare Below the Elbows	11
13	Use of Gloves	12
14	Skin Damage	12
15	Availability of Products and Facilities	12
16	Patients and Visitors Hand Hygiene	13
17	Replenishment	14
18	Clinical Handwash Basins	14
19	Training	15
20	Dissemination and Implementation	15
21	Monitoring compliance	15
22	Associated documents	17
23	References	17
<b>Appendices</b>		17
A	Equality Impact Assessment	18
B	Procedural Document Checklist	19
C	Hand Hygiene Audit Tool	21

## **Executive Summary**

Effective hand hygiene results in significant reductions in the carriage of potential pathogens on the hands and decreases the incidence of preventable Healthcare Associated Infections (HCAI), leading to a reduction in patient morbidity and mortality (epic2 2007). Effective hand hygiene also prevents staff from acquiring micro-organisms that may cause infection.

This policy applies to all staff including contractors and agency/ locum staff and volunteers that work in the Trust who provide care or treatment, accommodation, or related services to patients.

## 1. Introduction

Effective hand hygiene results in significant reductions in the carriage of potential pathogens on the hands and decreases the incidence of preventable Healthcare Associated Infections (HCAI), leading to a reduction in patient morbidity and mortality (epic2 2007).

It is also important in protecting the healthcare worker from acquiring organisms which may cause them harm.

Hands may become contaminated by;

- Direct contact with the patient
- Handling equipment
- Contact with the general environment

## 2. Purpose

The purpose of this policy is to inform and educate staff on the principles and practice required for effective hand hygiene in order to reduce the risk of healthcare associated infection to patients, staff and others.

## 3. Definitions

Hand hygiene refers to the process of hand decontamination during which there is physical removal of blood, body fluids and / or the removal or destruction of micro-organisms from the hands.

## 4. Scope

This policy applies to all staff (temporary or permanent) **working in all the locations registered by St George's Healthcare NHS Trust** with the Care Quality Commission, to provide its regulated activities.

This also includes volunteers, contractors, students and/or trainees.

## 5. Roles and Responsibilities

### 5.1 The Chief Executive

The Chief Executive as the accountable officer has overall responsibility for ensuring that there are adequate structures and effective control mechanisms / arrangements for infection control within the Trust and clear lines of accountability for infection control throughout the organisation.

This includes an appropriate assurance framework, infection control programme and infection control infrastructure, adequate resourcing of infection control services and subjection of their work to scrutiny.

### 5.2 Director of Infection Prevention and Control (DIPC)

The Director of Infection Prevention and Control (DIPC), is responsible for ensuring that this policy is adhered to together with the Infection Control Team, is a member of the Trust Executive and reports directly to the Chief Executive and the Board. The DIPC reports important matters relating to Infection Control such as serious untoward incidents to them and also gives executive force to the advice/recommendations emanating from the Infection Control Team.

The DIPC is responsible for the Infection Control Team; oversees infection control policies, their implementation and impact; is a member of the Risk, Assurance and Compliance

Committee and oversees the Infection Control annual report, ensuring that it is publicly released.

### **5.3 The Infection Control Committee**

The Infection Control Committee, chaired by the DIPC, meets bi-monthly, to oversee the work of the Infection Control Team. The Trust Infection Control Committee is responsible for infection control policy and guidance, annual infection control programme and monitoring progress and providing annual reports to the Patient Safety Committee and Trust Board.

The Infection Control Committee reports to the Patient Safety Committee, which reports in turn to the Executive Risk Committee.

### **5.4 Health Care Associated Infection Taskforce**

The HCAI Taskforce is chaired by the DIPC. The Taskforce meets fortnightly and is attended by clinicians and senior managers from each of the divisions and representatives from relevant departments such as Estates, Facilities, Pharmacy and Communications. The Taskforce works to ensure the Trust is meeting the requirements of the Hygiene Code.

### **5.5 The Infection Control Team**

The Infection Control Team is responsible for an annual infection control programme and report outlining its activities and HCAs. This is evaluated and discussed by the Infection Control Team and reported to the Trust Executive Group and Trust Board by the DIPC.

The Infection Control Team consists of staff with both nursing and consultant medical expertise who are responsible for providing advice and assistance to all Trust staff on aspects of infection control. They also provide, where appropriate, training, access to surveillance data and support in the management of incidents and outbreaks.

### **5.6 Senior Nurses / Managers / Consultants**

Senior Nurses/Managers/Consultants in their sphere of management receive appropriate training and understand the importance of infection prevention and control in clinical and non-clinical areas.

They identify infection prevention and control link nurses, liaise and communicate with the Infection Control Team when necessary and ensure that all infection incidents are reported in a timely and appropriate way in accordance with Trust policies.

All staff in positions of authority (including consultants, matrons, ward sisters, managers) should provide clinical leadership which includes operational management and risk assessments to ensure that they enforce strict compliance with all relevant policies and protocols by all other staff who are answerable to them, or who enter an area for which they are responsible. They must also act as role models of good infection control practice by proactively undertaking risk assessments on infection control /prevention in their everyday practice.

### **5.7 Estates & Facilities & Project Managers**

When there are new work, projects, construction or demolition are concerned, the Infection Control Team must be involved to provide advice and guidance on air movements/changes, methods, procedures and materials to undertake cleaning and decontamination.

There will be consultation between Estates & Facilities and Infection Control staff regarding the design and layout of new and refurbished wards departments or areas, so as to limit the spread of infection by good design. Consultation will also take place before commencing any building works that will create dust so control measures can be planned. For further details please refer to the relevant policies, Control of Infective Agents Associated with Building

## **5.8 All Staff**

All staff, including contractors and agency/locum staff must ensure effective prevention and control procedures are incorporated into their daily practice and report any problems to their line manager.

All staff have a duty not to harm their patients and to comply, as far as is reasonably practicable, to the Infection Control policy and clinical protocols. These standards may include other Trust policies, procedures or guidelines that pertain to aspects of Infection Control, as well as national guidelines and other expert sources (see Appendix B).

All healthcare workers must avoid working and attend Occupational Health, if appropriate, when they have reason to believe they may pose a significant infectious risk to patients or other staff. Healthcare workers also have a duty to cooperate with and follow the recommendations of the Occupational Health department with regard to the need to be screened for certain infections and health clearance to work.

## **6. Transient and Resident Hand Flora**

There are two categories of micro-organisms present on the skin; transient and resident flora.

### **6.1. Transient flora.**

These are organisms temporarily lodged on the skin and may be acquired through contact with patients, equipment or the environment; they do not routinely live on the skin. Procedures, such as lifting and washing of patients result in hand contamination with bacteria that are readily transferred by subsequent touch. The majority of these micro-organisms are easily removed mechanically by washing with soap and water for ten to fifteen seconds. A good technique is vital. Alcohol gel/rub will also remove transient flora. Removal of transient flora is sufficient for general social contact and most clinical care activities.

### **6.2. Resident flora.**

These are present in deep skin crevices and normally colonise the skin. They play an important role in protecting the skin from invasion by other harmful species, but are not readily transferred to other people or surfaces. Reduction is only necessary for highly invasive procedures involving normally sterile body sites e.g. during surgery. Resident flora are not easily reduced by washing with soap and water. Use of alcohol gel, aqueous chlorhexidine (*Hibiscrub*), and aqueous iodine (*Betadine*) will reduce the numbers of both transient and resident bacteria. Alcohol gel should not be used unless hands are visibly clean.

## **7. When to perform hand hygiene**

### **7.1. At the Point of Care**

Hand Hygiene should ideally be carried out at the point of care. The point of care represents the time and place at which there is the highest likelihood of transmission of infection via healthcare staff, whose hands act as mediators in the transfer of micro-organisms.

The point of care refers to the patient's immediate environment (zone) in which healthcare staff-to-patient contact or treatment is taking place. In the hospital environment it is usually at

the patient's bed, but in other contexts it could be in a treatment room, cot, chair, ambulance or a patient's home for example.

## 7.2. The Five Moments for Hand Hygiene at the Point of Care

The 5 moments include;

- **before patient contact**
- **before an aseptic task**, handling an invasive device, even if gloves are worn.
- **after body fluid exposure risk** including excretions, mucous membranes, non-intact skin or wound dressings. For example after any procedure that may have caused faecal contamination such as assisting patient to toilet; handling commode or bedpan; assisting a patient to bathe/bed bath.
- **after patient contact**
- **after contact with patient surroundings**, includes contact with inanimate objects e.g. medical equipment.

The 5 moments for hand hygiene are illustrated in figures 1 and 2.

Other times at which hands should be decontaminated are;

- Before and after leaving the ward or clinical area.
- If moving from a contaminated body site to a clean body site during patient care.
- After removing gloves.
- Before handling food.
- Before handling medicine.

## 8.0 Choice of Agent for Hand Decontamination

### 8.1. Alcohol Gel/Rub

Alcohol handrub is recommended for **routine** hand decontamination because it is;

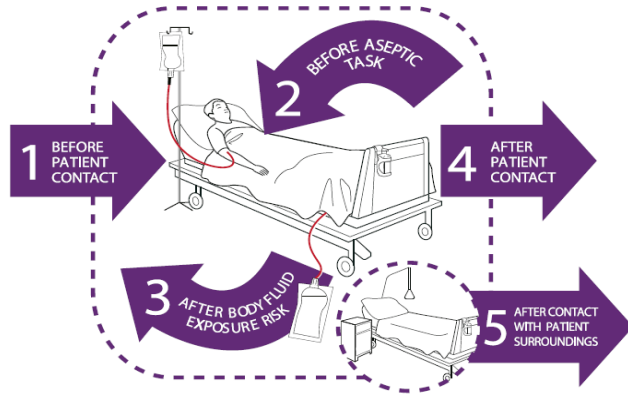
- more effective,
- quicker and easier to use,
- better tolerated by the hands
- can be provided at the point of care.

However alcohol gel/rub will **not** remove dirt or organic material and is not effective against *Clostridium difficile* and Norovirus.

Hands *must* be decontaminated with alcohol gel/rub before invasive tasks such as dressings or giving intravenous injections. (Wash hands first with soap and water if visibly soiled).

Alcohol gel/rub is flammable and must be correctly stored.

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



1	<b>BEFORE PATIENT CONTACT</b>	<b>WHEN?</b> Clean your hands before touching a patient when approaching him/her <b>WHY?</b> To protect the patient against harmful germs carried on your hands
2	<b>BEFORE AN ASEPTIC TASK</b>	<b>WHEN?</b> Clean your hands immediately before any aseptic task <b>WHY?</b> To protect the patient against harmful germs, including the patient's own, from entering his/her body
3	<b>AFTER BODY FLUID EXPOSURE RISK</b>	<b>WHEN?</b> Clean your hands immediately after an exposure risk to body fluids (and after glove removal) <b>WHY?</b> To protect yourself and the healthcare environment from harmful patient germs
4	<b>AFTER PATIENT CONTACT</b>	<b>WHEN?</b> Clean your hands after touching a patient and her/his immediate surroundings when leaving the patient's side <b>WHY?</b> To protect yourself and the healthcare environment from harmful patient germs
5	<b>AFTER CONTACT WITH PATIENT SURROUNDINGS</b>	<b>WHEN?</b> 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 <b>WHY?</b> To protect yourself and the healthcare environment from harmful patient germs

Adapted from WHO World Alliance for Patient Safety 2006



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



Figures 1 and 2.



## 8.2. Liquid Soap and Water.

Handwashing with liquid soap and water removes dirt, organic matter and transient flora by mechanical action and should be used;

- following direct hand contact with body fluids when gloves should have been worn
- when hands are visibly dirty or visibly soiled with body fluids and other organic matter.
- when caring for patients with undiagnosed diarrhoea and/or vomiting, patients with *Clostridium difficile* or Norovirus and during outbreaks of these organisms on wards or in bays.
- after several consecutive applications of alcohol gel/rub.

Liquid soap alone does not provide sufficient hand disinfection before invasive procedures and surgery.

## 8.3. Aqueous Chlorhexidine (*Hibiscrub*)

Before procedures involving the insertion of devices such as central lines, chest drain, epidural or in operating theatres; either wash with aqueous chlorhexidine (*Hibiscrub*) and dry thoroughly. **Aqueous Iodine (*Betadine*)** may be used as an alternative agent, *in theatres only*.

These preparations exert a residual effect on skin flora that can be useful in situations where prolonged reduction in microbial flora on the skin is required. They are not normally necessary for everyday clinical practice.

## 9. Water Temperature

Contact time and friction appear to be more important than temperature of water, though for staff comfort, water should be warm.

## **10. Hand Decontamination Technique**

- A good technique is important to ensure all surfaces of the hand are clean.
- A poster describing the recommended hand washing technique should be displayed at all clinical handwash basins, see Figure 3.
- Jewellery must not be worn on wrists or fingers (with the exception of a wedding ring) and wrist watches must be removed.
- In high risk settings such as operating theatres ALL jewellery including wedding rings must be removed.
- Cuts and abrasions must be covered with a water-proof dressing .
- Fingernails must be short, clean and free from nail polish. False nails and extensions must not be worn.
- Do not wash or use alcohol gel/rub on gloved hands.

### **10.1. Using Alcohol gel/rub**

- Hands must be free from dirt and organic matter; if not, wash first.
- Avoid using excessive amounts of alcohol gel/rub to minimise skin damage, apply one shot (approx 5 ml) of alcohol hand rub.
- The hand rub must come into contact with all surfaces of the hands, so hands must be rubbed together vigorously and systemically to include wrists, tips of fingers, backs of hands, palms, thumbs and webs of fingers, for ten to fifteen seconds until the solution has evaporated.
- Duration of procedure: 20-30 seconds.

### **10.2. Using Liquid Soap and Water**

- Prepare hands by wetting under tepid running water before applying liquid soap.
- Avoid using excessive amounts of liquid soap to minimise skin damage; one shot (approx 9 ml) is sufficient to cover all hand surfaces.
- Use running water
- The soap solution must come into contact with all surfaces of the hands, so hands must be rubbed together vigorously and systemically to include wrists, tips of fingers, backs of hands, palms, thumbs and webs of fingers, see figure 3.
- Thoroughly rinse hands to flush organisms away and to prevent skin damage.
- Hands must be thoroughly dried with paper towels after washing. This removes further bacteria and prevents cracking of skin.
- Hot air hand dryers should be avoided since users do not generally dry hands adequately. Bacteria will multiply in moist conditions.

- Turn taps off with elbows or using paper towel; do not use hands.
- Do not touch bin lid when disposing of paper towels.
- Duration of procedure, including drying: 40-60 seconds.

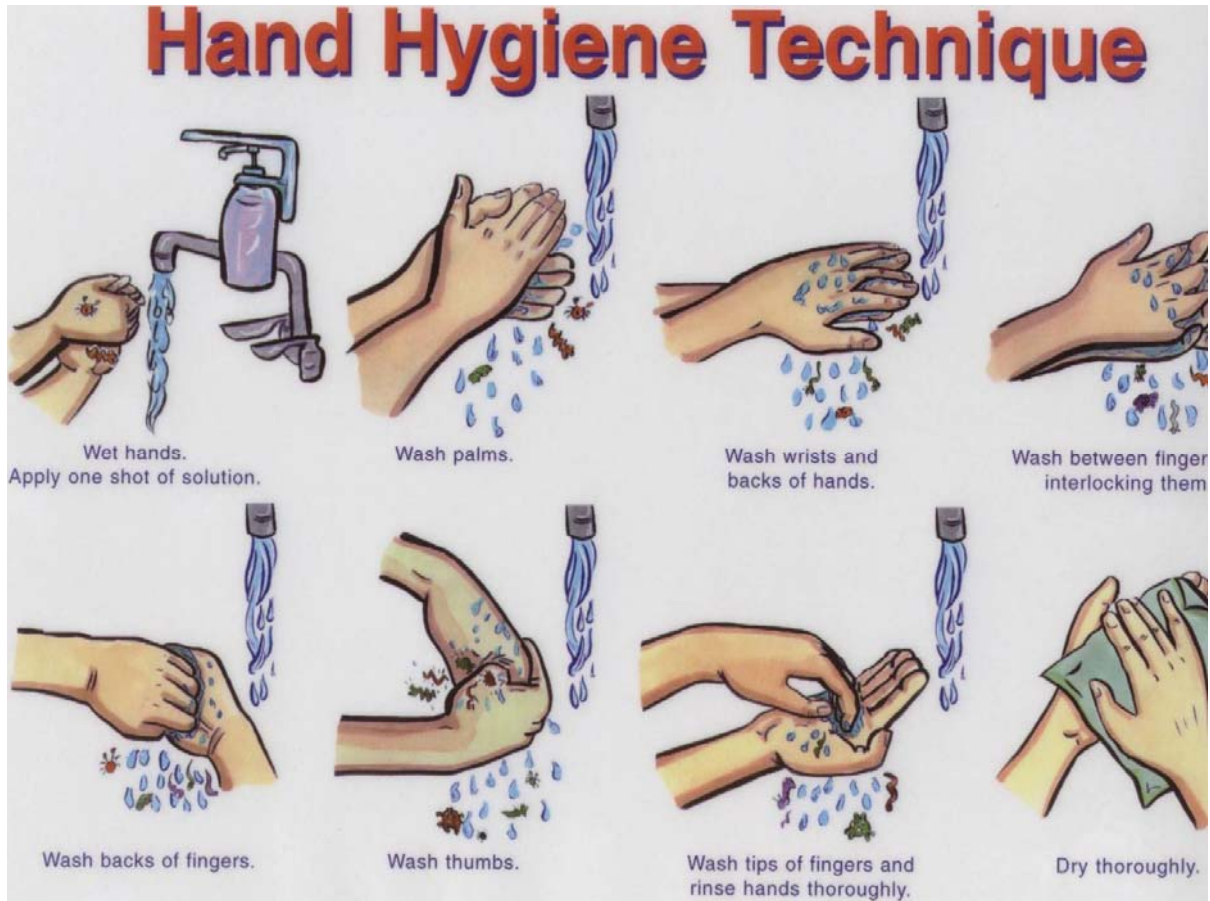


Figure 3

### 10.3. Using Aqueous Chlorhexidine (*Hibiscrub*) or Aqueous Iodine (*Betadine*)

Follow local theatre policy for scrub procedure.

### 11. Hand Drying

Hand drying is an essential step in hand hygiene. Drying of hands in the clinical area must be done using disposable, singly dispensed paper towels.

Hot-air dryers may only be used in public toilets and non-clinical areas.

### 12. Bare Below the Elbows

In November 2007 the Department of health announced that all Trusts should adopt a 'Bare below the Elbows' policy whilst providing / undertaking clinical care procedures. This has been implemented by the Trust, see Dress Code Policy.

A 'Bare Below the Elbows' dress code will apply to;

- Anyone undertaking direct delivery of care to any patients in any area of the Trust, including outpatients.
- All staff on all ward rounds who may come into contact with patients
- Any member of staff interacting with a patient
- Ties, wrist watches or jewellery may not be worn other than that stipulated in the Trust policy during patient contact
- This applies to all staff which includes medical, nursing, clerical, managers, and allied healthcare professionals.

### **13. Use of Gloves**

The use of gloves does not replace the need for hand hygiene. See Glove Policy 2008. Gloved hands must not be washed or cleaned with alcohol handrub. Hands must be washed after removal of gloves.

### **14. Skin Damage**

Skin damage may be associated with poor hand washing technique but also the frequent use of hand hygiene agents. Excoriated hands are associated with increased colonisation of potentially pathogenic organisms and increase the risk of infection. Irritant and hand drying effects of hand preparations are one of the reasons why staff fail to adhere to hand hygiene guidelines.

- Clinical staff to be aware of potentially damaging effects of hand hygiene products.
- Avoid donning gloves while hands are still wet from washing or applying alcohol rub.
- Avoid rubbing hands with paper towels; skin should be patted dry.
- Avoid over-use of gloves.
- Use emollient hand cream regularly e.g. after washing hands, before break, when going off duty and when off duty.
- If irritation occurs review compliance with hand decontamination technique above before consulting Occupational Health department.
- Avoid communal 'pots' of moisturiser as they can become a potential source of infection. Hand cream dispensers or individual tubes may be used provided care is taken not to contaminate the nozzle.

### **15. Availability of Products and Facilities**

#### **15.1. Alcohol gel/rub**

**It is most beneficial to patient safety to place alcohol gel/rub at the point of care.**

This can be at the **foot of the bed**, on the bedside locker, or in other care settings the dispenser can be attached to the internal wall of an ambulance, patient's chair or carried by the healthcare worker (NPSA, 2007).

Use of **personal dispensers** e.g. “Tottles” is best practice when caring for children, mental health patients or other patients/clients for whom permanently-sited dispensers may pose a risk e.g. visiting children and community.

It is recommended that **porters** and **therapists**, for example, carry personal dispensers as well as other relevant groups.

Other locations where alcohol gel/rub should be located include;

- at the entrance/exit to each ward or department, according to risk assessment.
- at each clinical hand-wash sink
- outside isolation rooms
- at other locations, as required

In public areas where ingestion is a risk, alcohol foam should be used.

## 15.2 Soap

**Liquid soap**, to be located at all clinical hand-wash sinks

**Liquid soap**, to be located at all patient only sinks, at an appropriate level in “accessible” toilets.

**Liquid soap**, liquid soap is recommended for community nursing staff providing care in patients’ homes or community settings. If liquid soap is unavailable staff should wash their hand under running water followed by an application of alcohol hand rub / gel. The need to wash hands is particularly important when providing care for patients with *C.difficile* and Norovirus (section 10.2 page 10).

**Bar soap** must *not* be located in communal areas and must *not* be used by clinical staff in clinical areas. It may be used on an individual patient basis, kept in the patient’s locker and discarded after patient discharge/transfer. In the community setting if liquid soap is unavailable staff may use bar soap followed by an application of alcohol hand rub / gel.

**15.3. Aqueous chlorhexidine (*Hibiscrub*) or aqueous iodine (*Betadine*)** must be located at scrub sinks in theatres and kept in treatment rooms on wards and departments for use, when required.

**15.4. Paper Towels** must be available in a wall-mounted dispenser at each hand-washbasin. These must be dispensed singly, not paper towel on a roll.

**15.5. Bins** with hands free operation must be located at each clinical hand-wash sink.

## 16. Patient and Visitor Hand Hygiene

Patients must be offered facilities to wash their hands following use of a commode/bedpan and before meals. Either a bowl of hot water and soap or hand-wipes should be used. Liquid soap should be available in all patient/visitor only areas. In “accessible” toilets, bins should be hand-operated, liquid soap and paper towels should be at an appropriate level. If patients or visitors are reluctant to use alcohol gel they should wash their hands instead. Signs should be clear and simple.

## **17. Replenishment**

Soap, paper towel and alcohol dispensers are refilled by domestic services. Staff should report empty dispensers to the domestic, reception or helpdesk or record on the action chart where available.

## **18. Clinical Handwash Basins**

Compliance with hand hygiene guidelines is often poor and a contributory factor is the absence of conveniently placed sinks. Good ward /department design, with appropriately placed hand-wash basins can increase hand washing compliance.

It is important that hand hygiene facilities are looked at when planning new healthcare premises and refurbishing existing premises.

A minimum of one hand-wash sink in each single room is required.

The use of hand-wash sinks for purposes other than hand-washing must be discouraged.

### **18.1 Provision of Clinical Handwash Basins**

En-suite single rooms should have a hand-wash basin in the en-suite facility in addition to a clinical hand-wash basin in the patient's room.

Isolation rooms should have a hand-wash sink in the ante-room, isolation room and en-suite facilities.

Ideally, in intensive care and high dependency units (critical care areas), consideration should be given to providing one hand-wash basin at the front of each bed space (see NHS Estates' HBN 57, 'Critical care facilities').

In acute, elderly and long-term care settings, consideration should be given to providing one sink between four patients.

In low-dependency settings, for example mental health units and learning disability units, consideration should be given to providing one sink between six patients.

In out-patient areas and primary care settings, a hand-wash basin must be close to where clinical procedures are carried out.

Hand-wash sinks must be accessible and must not be situated behind curtain rails.

All toilet facilities must have a hand-wash sink.

Dedicated clinical handwash basins must be provided in areas such as clean utility rooms, treatment rooms, sluices and cleaners cupboards. Other sinks in these areas will have a designated use e.g. decontamination of equipment and if used for hand washing could lead to contamination of clean hands.

Wall-mounted cartridge soap/antibacterial agent dispensers and paper towels must be available at each hand-wash sink.

### **18.2 Design**

Elbow-operated or non-touch mixer taps are required for all clinical hand-wash sinks.

Hand-wash sinks must be designed for that purpose.

Hand-wash sinks must not have a plug or overflow or be capable of taking a sink plug.

The taps must not be aligned to run directly into the drain aperture.

Waterproof splash backs should be used for all sinks.

Space must be allowed at the design stage for the placement of waste bins next to the hand wash basin.

Detailed guidance on the provision, design and assembly of clinical handwash basins is available from the following documents:-

Infection Control in the Built Environment

Health Technical Manual (HTM) 4

Health Technical Manual (HTM) 64

## **19. Training**

All staff will receive Hand Hygiene training at Corporate Induction as per the Trust's Training Needs Analysis (TNA). Contractors and volunteers receive hand hygiene training as part of the corporate or Member of the Team (MOT) induction.

Monitoring of attendance and follow up of non attendance please see the Corporate Induction Policy.

## **20. Dissemination and implementation**

### **20.1 Dissemination:**

Once authorised the policy will be published on the intranet and publicised in the eG weekly bulletin. The previous version of the policy will be removed from the Intranet.

### **20.2. Implementation**

The Infection Control Team will support Senior Managers to bring the policy to the attention of their staff and oversee its implementation in their areas. This process will be supported by the Infection Control Link Personnel.

The policy will be included in all education and training sessions as identified in the Training Needs Analysis including Trust and Nurse Induction and all bespoke training.

## **21. Monitoring compliance**

The table below outlines the process for monitoring compliance with this document.  
*Populate table.*

**Monitoring compliance and effectiveness table**

<b>Element/ Activity being monitored</b>	<b>Lead/role</b>	<b>Methodology to be used for monitoring</b>	<b>Frequency of monitoring and Reporting arrangements</b>	<b>Acting on recommendations and Leads</b>	<b>Change in practice and lessons to be shared</b>
NPSA hand hygiene facilities and Hand hygiene audit	Matrons, all clinical areas with support from Infection Control Team  Infection Control Department	On going monthly hand Hygiene audits using the hand hygiene performance indicators  Monitored via: - Monthly Corporate Performance Report. - Quarterly Composite Infection Control Scorecard: - Quarterly Care Group Scorecard - Annual Infection Control Report	Bi-monthly reports on audit findings /trend analysis to the Infection Control Committee (ICC)  The ICC committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them. This will be documented in the meeting minutes.	Required actions will be identified and completed in a specified timeframe.	The Infection Control Management committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.  This will be documented in the meeting minutes.



## 22. Associated documentation

Infection Control Policy  
Dress Code and Uniform Policy for All Employees  
Glove Policy  
Corporate Induction Policy  
MAST Policy  
Local Induction Policy

## 23. References

Department of Health (2006) *The Health Act 2006, Code of practice for the Prevention and Control of healthcare Associated Infections* London, DH.

National Institute for Health and Clinical Excellence (2003) *Infection control: prevention of healthcare-associated infections in primary and community care*. London: NICE.

Available from: [www.nice.org.uk/nicemedia/pdf/Infection\\_control\\_fullguideline.pdf](http://www.nice.org.uk/nicemedia/pdf/Infection_control_fullguideline.pdf)

NHS Estates (2002) *Infection Control in the Built Environment*. London. HMSO. Available from: [www.publications.spaceforhealth.nhs.uk](http://www.publications.spaceforhealth.nhs.uk)

NHS Estates (1997) HBN 4: *In-patient accommodation – options for choice*. HMSO. Available from: [www.publications.spaceforhealth.nhs.uk](http://www.publications.spaceforhealth.nhs.uk)

NHS Estates (1995) HTM 64: *Sanitary assemblies*. HMSO. Available from: [www.publications.spaceforhealth.nhs.uk](http://www.publications.spaceforhealth.nhs.uk)

NPSA (2008) Patient Safety Alert, *Clean Hands Save Lives* 2<sup>nd</sup> edition. London. NPSA

Pittet D, Hugonnet S et al (2000). *Effectiveness of a hospital-wide programme to improve compliance with hand hygiene*. The Lancet, 356: 1307-1312.

Pratt et al. (2007) Epic2: *National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England*. Journal of Hospital Infection. Vol. 65 supplement 1 S15 Feb 2007.

World Health Organisation (2006) *World Alliance for Patient Safety. WHO Guidelines on Hand Hygiene in Healthcare (Advanced Draft): A Summary*. Geneva, Switzerland, WHO.

Appendix A:

**1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING**

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
<p><b>1.1 Who is responsible for this service / function / policy?</b> Ruth Law and Selma Mehdi; Lead Nurses Infection Control  Richard Holliman: Infection Control Doctor</p>				
<p><b>1.2 Describe the purpose of the service / function / policy?</b> The purpose of this policy is to inform and educate staff on the principles and practice required for effective hand hygiene in order to reduce the risk of healthcare associated infections to patients, staff and others.</p>				
<p><b>1.3 Are there any associated objectives</b> The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare Associated Infections and related guidance.  NHSLA Standards</p>				
<p><b>1.4 What factors contribute or detract from achieving intended outcomes?</b> Hand hygiene signs and posters have diagrams showing the hand decontamination technique. Patient information leaflets, signs and posters are only available in printed format in English.</p>				
<p><b>1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?</b> Persons who cannot read English and those with sight problems will need assistance to access the printed information</p>				
<p><b>1.6 If yes, please describe current or planned activities to address the impact.</b> Interpreter Service should be used to provide accessible information to persons for whom English is not their first language.  Nursing staff should be able to assist persons with poor literacy skills to access the information in the leaflet.  Accessible information for persons with sight problems could be provided in large print or audio format.</p>				
<p><b>1.7 Is there any scope for new measures which would promote equality?</b> Yes, if a need for additional accessible information is identified.</p>				
<p><b>1.8 What are your monitoring arrangements for this policy/ service</b>All requests for information in accessible formats will be reported to and monitored by the Infection Control Committee.</p>				
<p><b>1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above</b>  Low</p>				
<p><b>2.0. Please give you reasons for this rating</b>  To date there have been no resource implications as there have been no requests for accessible information. An action plan will be developed for each request for accessible information.</p>				

**Appendix B:**

**Checklist for the Review and Approval of Procedural Documents**

To be completed and attached to any document submitted to the Policy Approval Group for ratification.

Title of document being reviewed		Yes/No/Unsure	Comments
<b>1.</b>	<b>Title</b>		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
<b>2.</b>	<b>Rationale</b>		
	Are reasons for development of the document stated?	Yes	
<b>3.</b>	<b>Development Process</b>		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
<b>4.</b>	<b>Content</b>		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
<b>5.</b>	<b>Evidence Base</b>		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
<b>6.</b>	<b>Approval</b>		
	Does the document identify which committee/group will approve it?	Yes	

Title of document being reviewed		Yes/No/ Unsure	Comments
	If appropriate, have human resources/staff side committees (or equivalent) approved the document?	N/a	

<b>7.</b>	<b>Dissemination and Implementation</b>		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
<b>8.</b>	<b>Document Control</b>		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
<b>9.</b>	<b>Process for Monitoring Compliance</b>		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
<b>10.</b>	<b>Review Date</b>		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
<b>11.</b>	<b>Overall Responsibility for the Document</b>		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

## Appendix C – Hand Hygiene Audit Tool

### Instructions

Mark a **cross** when an opportunity to decontaminate hands is missed. Mark a **tick** when there is an opportunity **and** compliance with hand hygiene. Please ensure that at least 20 – 30 opportunities are observed or the data have limited value; however you do *not* need to wait to observe *all* activities. You *must* feedback to staff you have observed at the end of the audit., or immediately if necessary.

Date: \_\_\_\_\_ Time: from: \_\_\_\_\_ to \_\_\_\_\_ WARD

Observer (Name & Position – printed): \_\_\_\_\_

Activity	Nurses incl. students	Consultant	Other Medical staff incl. students	HCA	Physios	Occ. Therapists	Speech Therapists	Dieticians	Phlebotomists	Porters	Domestics	Others (NOT visitors)
<b>Practice</b>												
Before patient contact	1.1											
After patient contact												
Before putting on gloves.												
After removal of gloves.												
Before an aseptic task												
Before handling food												
After body fluid exposure												
After contact with patient surroundings												
<b>Policy and Procedure</b>												
Correct procedure for decontaminating hands is used.												
Nails are short, clean and free of nail varnish.												
Hands & wrists are free of watches, stoned rings & other wrist jewellery.												