

Policy 1a

Hand hygiene

Key messages

1. Hand hygiene must be performed before and after every contact with the patient, the patient's equipment or environment.
2. Remove jewellery and watches, ensure you are bare below the elbow (see relevant section in the [Trust professional dress code and uniform policy](#)) and cover all cuts.
3. Effective hand hygiene technique is the key: coverage of all surfaces of the hands and wrists, rinsing and effective drying.
<http://www.cuh.org.uk/cms/addenbrookes-hospital/infection-control/video-together-we-can-fight-infection>
4. Alcohol gel should only be used on socially clean hands.
5. Hand washing is essential in case of:
 - known or suspected norovirus
 - *Clostridium difficile*
 - diarrhoea of unknown cause

1 Scope

Trust-wide.

2 Purpose

- To minimise the transmission of infection between patients.
- To ensure that all Trust staff perform hand hygiene at the appropriate time, using the correct product and method.

This policy is supported by the Trust's [mandatory training policy](#) and all associated documentation, including the [guide to mandatory training and refresher requirements](#).

3 Key recommendations

Hand hygiene must **always** be performed at the point of care **before and after each and every direct patient contact or care** ie if in contact with anything within the 'bed curtain area'.

Hands must be decontaminated immediately before **each and every** episode of direct patient contact/ care and after any activity or patient related contact that potentially results in hands becoming contaminated (see [table 1](#) for further examples). This is based on the WHO World Alliance for Patient Safety 2006 *Five moments for hand hygiene*. It will result in reduced risks to patients.

Hands that are visibly soiled or potentially grossly contaminated with dirt or organic material **must** be washed with liquid soap and water.

Apply an alcohol-based hand rub or wash hands with liquid soap and water to decontaminate hands between caring for different patients, or between different caring activities for the same patient.

Uniformed staff should remove all wrist and hand jewellery (excluding plain band rings) at the beginning of each clinical shift before regular hand decontamination begins. Cuts and abrasions must be covered with waterproof dressings (see bare below the elbow guidelines).

In addition it is expected that non-uniformed staff including medical staff, ward clerks, estates personnel, other clerical staff (eg coding) and any others entering and working in clinical areas conform to the bare below the elbow guidelines and the recommendations above.

Effective hand washing technique involves three stages:

1. the removal of wrist watches/ wrist jewellery in preparation
2. washing and rinsing
3. drying

When using alcohol gel, hands should be free of dirt. The gel must come into contact with all surfaces of the hand. One pump (approximately 3ml) should be an adequate dose. The hands must be rubbed together vigorously until the solution has evaporated and the hands are dry, paying particular attention to the:

- tips of the fingers
- thumbs
- areas between the fingers

After approximately five applications of alcohol gel, staff may experience a build-up. This is to be expected and acts as an emollient; it can be removed by washing with soap and water.

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Apply an emollient hand cream regularly to protect the skin from the drying effects of regular hand hygiene. If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation, seek advice from occupational health (OH).

If a member of staff has a history of or current atopic eczema they must seek advice from the Cambridge Centre for Occupational Health (CCOH) at the earliest opportunity.

Risk assessment should be performed with respect to ingestion and storage of hand hygiene products.

Table 1: Examples of identified hand hygiene opportunities

Alcohol gel or soap and water	Hand washing using a skin disinfectant (chlorhexidine/iodine)
Before entering ward	Contact with body fluids (gloves)
Before and after any direct patient care	Urinary catheters (gloves)
Contact with notes/ charts in bed curtain area	Bedpans, commodes (gloves)
Bed making	Suction, tracheostomy care (gloves)
Cleaning beds, equipment	Wound dressings (gloves)
Setting up O ₂ , nebulisers	Central venous catheter care [gloves or aseptic non-touch technique (ANTT)]
Before and after taking observations	Before and after cannulation (gloves)
Before and after giving IVIs, injections	Before and after phlebotomy (gloves)
Before and after glove use	In case of clostridium difficile and outbreak of viral diarrhoea and vomiting
Serving meals and feeding	
Drug rounds	
Ward rounds	
After touching anything within the bed curtain area	
Contact with telephone (inpatient areas)	
Contact with keyboards (inpatient areas)	

4 Responsibilities

All departments should ensure that adequate facilities are provided including sufficient numbers of:

- accessible hand wash basins
- soap and/or alcohol hand rubs
- soft disposable paper towels
- waste disposal receptacles

Every patient bed space must have an alcohol gel available, in areas where for patient safety reasons this is not achievable then every member of ward based clinical staff must have a personal tottle.

Regular annual audits of hand washing facilities will take place. These will be led by the infection control team, with results fed back to the control of infection committee and Trust board of directors.

Staff must adhere to the *standard principles for preventing hospital-acquired infections* [Department of Health (DH), 2001] and the guidance contained within the National Institute for health and Care Excellence (NICE) *infection control; prevention of healthcare-associated infection in primary and community care* (see [key recommendations](#)).

All staff must follow and show evidence of attendance at the infection control hand hygiene training as set out in the training needs analysis documentation (please refer to [appendix 2](#)). As a minimum, this should take place at induction for all new staff, and as part of the mandatory update. Training should be appropriate to each staff member's role.

Attendance at the training sessions will be recorded on oracle learning management (OLM). The names of non-attenders will be emailed to managers to follow up. Where there is persistent non-attendance in a particular area this information will be sent to assistant directors of operations to address.

Staff including ward clerks, estates personnel, other clerical staff (eg coding) and any others entering and/or working in clinical areas conform to the bare below the elbow guidelines.

Health and safety of patients is of primary concern for the Trust and in accordance with equality legislation, health and safety overrides religious customs and beliefs in the workplace.

All staff should be informed of the bare below the elbow guidelines and [Trust professional dress code and uniform policy](#) at the recruitment stage and again on induction.

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Revised DH guidance (March 2010) states that where exposure of forearms is not acceptable for religious reasons the following recommendations should be followed:

- uniforms can have three-quarter length sleeves provided these are not loose or dangling. They must be able to be rolled or pulled back and kept securely in place during hand hygiene and direct patient care activity
- disposable over-sleeves, elasticated at the elbow and wrist, may be used but must be put on and discarded in exactly the same way as disposable gloves
- strict procedures for washing of hands and wrists must still be observed

4.1 Infection control team (ICT)

The ICT will be responsible for:

- the formulation of up to date, evidence-based hand hygiene guidelines which will form part of the hand hygiene policy
- updating the hand hygiene policy two-yearly or more frequently in the light of new guidelines, mandatory requirements, or new research evidence
- advising the hospital on the most appropriate liquid soap/ antiseptic soap/ alcohol hand rub product for use in clinical practice chosen from the range available on the national contract
- advising on the most appropriate methods for auditing knowledge of and compliance with the policy

The ICT will:

- have overall responsibility for providing hand hygiene education/ training for all staff as appropriate to their role
- support the occupational health department with appropriate advice based on their specialist knowledge of hand hygiene products and their use in case of staff allergy
- be involved in risk assessments relating to the placement of alcohol hand gel

4.2 Ward/ department manager

Ward/ department managers are responsible for ensuring there are adequate hand washing/ hand rub facilities in their areas. This includes availability of adequate supplies of:

- liquid soap
- disposable hand towels
- pedal operated waste bins

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All hand washing sinks in clinical practice should be supplied with mixer taps.

Each ward/ department manager, in conjunction with Medirest, should identify who is responsible for:

- replacement
- maintenance
- cleaning

of all hand hygiene products.

Alcohol hand rub must be available at the end of every bed, or every locker, and also at:

- all ward/ department entrances and
- outside isolation rooms

There **must** be designated members of staff who ensure alcohol hand rub containers are:

- checked **at least daily**
- replaced as necessary

Ward/ department managers are responsible for ensuring that:

- there are sufficient notices displayed which indicate that hand hygiene is required
- the hand hygiene guidelines are implemented in their areas
- a culture of challenge is promoted

Ward/ department managers must ensure that clinical staff:

- attend the mandatory infection control session on joining the Trust
- complete the mandatory infection control training (which includes education on hand hygiene) on an annual basis

It is the ward/ department manager's responsibility to ensure that the infection control link nurses have dedicated time, as agreed in the infection control link nurse standard, to carry out the hand hygiene assessments of all clinical staff within their work area.

Ward/ department managers should:

- encourage their staff to participate in the practical hand hygiene sessions using the ultraviolet glow and tell machine facilities undertaken by the ICT
- act as a role model in the demonstration of best practice in hand hygiene

Ward/ department managers will be responsible for ensuring that two weekly hand hygiene audits are completed and fed back to individuals at the time of audit and discussed at regular ward/ departmental meetings.

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4.3 Infection control link nurses (ICLNs)

ICLNs should actively participate in all events promoting the importance of hand hygiene.

ICLNs will undertake assessment of hand decontamination technique of staff members in their own ward/ department, including:

- technique for hand washing
- the application of alcohol hand rub

4.4 Occupational health team

The occupational health team is responsible for advising staff who develop allergies to specific hand hygiene products on the alternatives which are available.

4.5 Medical consultants/ staff grades

Medical consultants/ staff grades will act as role models in the execution of best practice regarding hand hygiene.

Medical consultants will be responsible for ensuring that junior medical staff within their team complete the mandatory infection control training and apply best hand hygiene practice.

4.6 Contract cleaners

The contract cleaning site manager will be responsible for ensuring that:

- all staff complete an infection prevention and control induction session
- all contract cleaning staff are assessed on their hand hygiene technique as well as alcohol hand rub knowledge and indications for use. Training should be recorded.

Contractors' job descriptions should identify who is responsible for:

- replacement
- maintenance
- cleaning

of all hand hygiene products.

4.7 Infection control divisional leads

The infection control divisional leads will be responsible for ensuring that clinical staff support the current hand hygiene initiatives and implement the hand hygiene guidelines.

The infection control divisional leads will promote the implementation of hand hygiene audits using the 'Cleanyourhands' audit tool to achieve hand hygiene compliance of 95% within clinical directorates. Results should be discussed at

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clinical governance directorate meetings as well as reported to the Trust board of directors.

4.8 Public and patient involvement forum (PPIF)

The PPIF will audit hand hygiene compliance on wards and departments in conjunction with the ICT.

5 Gross breaches of the hand hygiene policy

Effective and timely hand hygiene is an integral part of every staff member's role at Addenbrooke's Hospital. Each staff member is expected to be familiar with and adhere to the content of the hand hygiene policy and the bare below the elbow guidelines.

Staff found to be committing gross breaches of the hand hygiene policy may be subject to the Trust's [disciplinary procedure](#).

Please refer to [appendix 1](#) for further information.

6 Why wash your hands?

The spread of infection via hands is well-established. Hands are the principle route by which cross-infection occurs. Hand hygiene is an infection control (IC) practice with a clearly demonstrated efficacy, and remains the cornerstone of efforts to control infection.

Studies have found hand washing frequency to be much lower than claimed, and that techniques used often miss areas of the hands, particularly fingertips.

The current emergence and spread of antibiotic-resistant organisms can be attributed, at least in part, to a failure by health care workers (HCWs) to perform hand hygiene either as often, or as efficiently as the situation requires.

Risks to patients are greatly reduced if staff disinfect or wash their hands between every patient contact.

7 Which products should be used?

Three types of agent may be used to remove microorganisms from the hands:

- soap
- antiseptic skin cleansers
- alcohol hand rubs

7.1 Soap and water

Hands that are visibly soiled or grossly contaminated with dirt or organic matter must be washed with liquid soap and water.

Skin is not sterile. The flora found there can be divided into two categories: resident and transient organisms.

- **Resident organisms** are commonly termed normal commensals. They live deeply seated in the epidermis – in skin crevices, hair follicles, sweat glands and beneath fingernails. These organisms do not readily cause infections and are not easily removed. However, during surgery or other invasive procedures they may enter deep tissues and establish an infection. Therefore it is considered desirable that they are removed prior to procedures in which the patient's body defences are breached.

Normal skin flora include coagulase-negative staphylococci (mainly *Staphylococcus epidermidis*, but also other Staphylococcal species) and aerobic and anaerobic diphtheroids.

- **Transient organisms** are located on the surface of the skin and beneath the superficial cells of the stratum corneum. They are termed 'transient' because direct contact with other people, equipment and body sites all result in the transfer of these microorganisms to and from the hands. Any damaged skin, moisture or ring-wearing will increase the possibility of colonisation. Carriage of bacteria and viruses have been found on the hands of HCWs.

The ability of transient organisms to transfer to and from the hands with ease results in hands being extremely efficient vectors of infection. However, unlike resident flora, these microorganisms can easily be removed with careful hand hygiene thus reducing the risk of cross-infection.

Transient organisms which may be picked up in the course of everyday activities include:

- *Escherichia coli*
- *Staphylococcus aureus*
- Pseudomonas
- Klebsiella

Washing with **soap and water** removes transient microorganisms mechanically, but has little effect on the resident population. However, in most situations hand washing with soap and water is all that is necessary to prevent cross-infection and protect patients and staff from acquiring infection.

The use of bar soap in clinical areas should be discouraged.

Liquid soap should be supplied in containers which cannot be topped up. Liquid soap dispensers should be wall-mounted and operated by elbow, wrist or foot wherever possible. Disposable cartridges should be used as these will reduce the risk of contamination. Cleaning of liquid soap dispensers should be part of the domestic cleaning schedule.

7.2 Antibiotic skin cleansers

These agents which are also used for surgical scrubs, contain a microbicide. They are designed to remove transient and reduce resident microorganisms, and have a cumulative effect which helps to prevent the regrowth of resident flora. Chlorhexidine (eg Hibiscrub) solutions may be slightly more effective than iodine-based ones (eg Povidone Iodine, Betadine), but there is little significant difference in practice. If used frequently they may cause skin damage in some individuals, with coincidental increased levels of bacteria on the skin.

7.3 Alcohol-based handrub

Alcohol-based hand rubs and hand gels (eg Hibisol, Spirigel):

- have a rapid microbicidal action
- can be applied quickly without access to water
- reduce bacteria at a greater rate than soap and water

However, alcohol-based hand rub will not penetrate organic material and should only be used on visibly clean hands. The hand rub should come into contact with all surfaces of the hands. One pump (approximately 3ml) is an adequate dose.

Hands must be rubbed vigorously until the solution evaporates and hands are dry, paying attention to:

- fingertips
- thumbs
- between the fingers

After approximately five applications of alcohol gel, staff may experience a build-up which can be removed by washing with soap and water. This build-up is to be expected and acts as an emollient.

If alcohol is combined with an antiseptic the solution appears to prevent the regrowth of resident microflora for several hours after application and may be of value for use prior to minor surgical procedures performed at ward level eg insertion of central lines.

The newer hand rubs and gels now have emollients in them to help preserve the integrity of the skin. This is of great benefit to the skin with the increasing use of the alcohol based hand gels.

However alcohol may not be effective against some viruses (eg enteroviruses, small round structured viruses) and some spores (eg *Clostridium difficile*) due to the relatively short exposure time of the agent on the hands. Therefore in these situations washing with soap and water is recommended.

Soft disposable paper towels with good drying properties should be available for use. These should be disposed of into a pedal-operated bin to prevent possible recontamination of hands on lifting lids.

8 How to wash your hands?

8.1 Hand washing technique

Hand washing with a good technique, covering all surfaces of the hands at the right time, is more important than the agent used or the time taken in the procedure.

An effective hand washing technique involves three principles:

1. preparation
2. washing and rinsing
3. drying

8.1.1 Preparation

Any damaged skin, particularly on hands or forearms, should be protected with a waterproof dressing.

Preparation involves removing rings and wrist-watches, then wetting hands under running water **before** applying liquid soap or an antimicrobial preparation.

8.1.2 Washing and rinsing

Hands must be wet before applying the recommended amount of soap or hand wash solution.

The hand wash solution must come into contact with **all** surfaces of the hands.

The hands must be **rubbed** vigorously for a minimum of 10-15 seconds, paying particular attention to the:

- tips of the fingers
- thumbs
- areas between the fingers

Hands should be rinsed thoroughly before drying. If hands are not rinsed and dried adequately, there is potential for skin damage to occur.

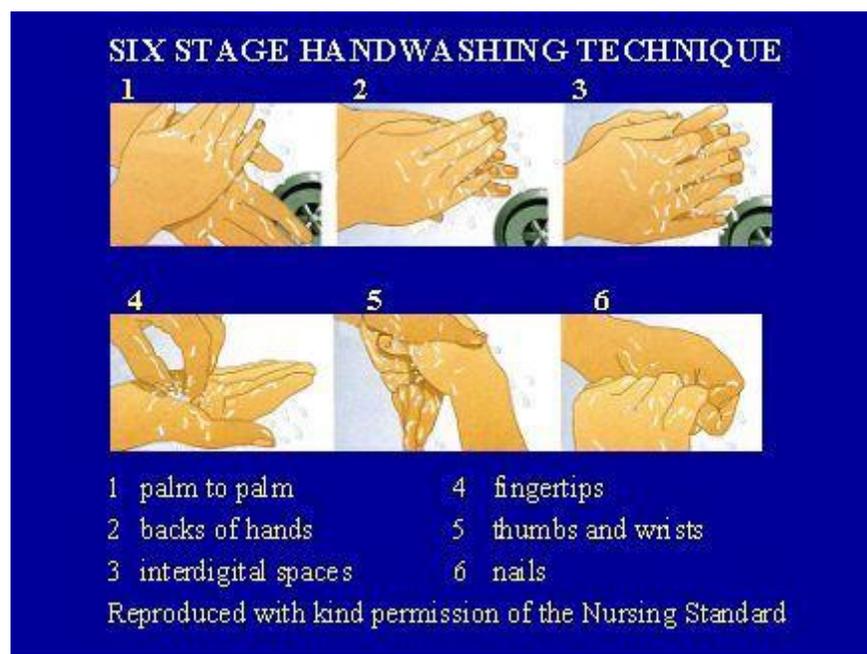
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8.1.3 Drying

It is important that hands are dried well as wet surfaces transfer microorganisms more effectively than dry ones. Drying should be performed by the use of paper towels.

Frequent hand washing removes natural skin emollients. This may result in dry, sore hands, compromising the integrity of the skin. If skin integrity is not maintained, transient flora may become resident and difficult to remove.



The six-stage hand washing technique.

This need only take 10-20 seconds (the exception to this is the surgical scrub, which should last for at least two minutes).

8.2 Rings, wrist watches and long-sleeved clothing

Avoid wearing rings with ridges or stones:

- total bacterial counts are higher when rings are worn, and
- rings interfere with thorough hand washing and the donning of gloves

Wrist watches and long-sleeved clothing should **not** be worn as these may prevent the wrists from being included in the procedure.

Where exposure of forearms is not acceptable for religious reasons the following recommendations should be followed:

- uniforms may include provision for sleeves that can be full length when staff are not involved in direct patient care activities
- uniforms can have three-quarter length sleeves provided these are not loose or dangling. They must be able to be rolled or pulled back and kept securely in place during hand hygiene and direct patient care activity
- disposable over-sleeves, elasticated at the elbow and wrist, may be used but must be put on and discarded in exactly the same way as disposable gloves.
- strict procedures for washing of hands and wrists must still be observed

8.3 Fingernails and nail brushes

Nails should be kept short and attention paid to them during hand washing as most microbes on the hands come from beneath fingernails.

Nail brushes, however, must **not** be used for routine hand hygiene as they damage the skin and encourage shedding of skin squames. Nail brushes, if used, must be sterile and used once only.

8.4 Gloves

The use of gloves is **not** a substitute for hand hygiene: there is increased bacterial multiplication in the warm moist conditions beneath them.

Gloves should be changed between tasks.

Gloves do not always provide an impermeable barrier; hands should always be washed following their removal.

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Gloved hands should not be washed, nor cleaned with alcohol hand rubs as this renders them more adherent to microbes.

8.5 Hand cream

Hands may further be protected by the use of good quality hand cream. However:

- hand cream should only be applied **after** hand hygiene has been performed, and
- communal dispensers should be **avoided** due to the risk of contamination

9 Hand washing facilities

Each clinical area should have:

- a sufficient number of appropriately positioned and provisioned facilities
- dedicated basins for hand washing
- elbow/ knee operated mixer or thermostatically controlled taps
- a wall-mounted liquid soap dispenser for each basin
- liquid soap provided in a collapsible cartridge with a non-return valve
- readily available alcohol hand rub at each bed space including personal dispensers (tottles) where hand rub cannot be placed at each bedside
- soft disposable paper towels
- foot-operated waste bins for disposal of paper towels
- hand washing poster

10 When to perform hand hygiene?

Hand hygiene must be performed:

- immediately before every patient contact
- after touching anything in the bed space area (ie within the bed curtain area)

This should be based on the World Health Organisation (WHO) information *Five moments for hand hygiene* from the National Patient Safety Agency (NPSA) adapted from the WHO *World Alliance for Patient Safety* (2006) leaflet – see below.

The decision to perform hand hygiene should be based on an assessment of the risk that microorganisms may have been acquired or may be transmitted.

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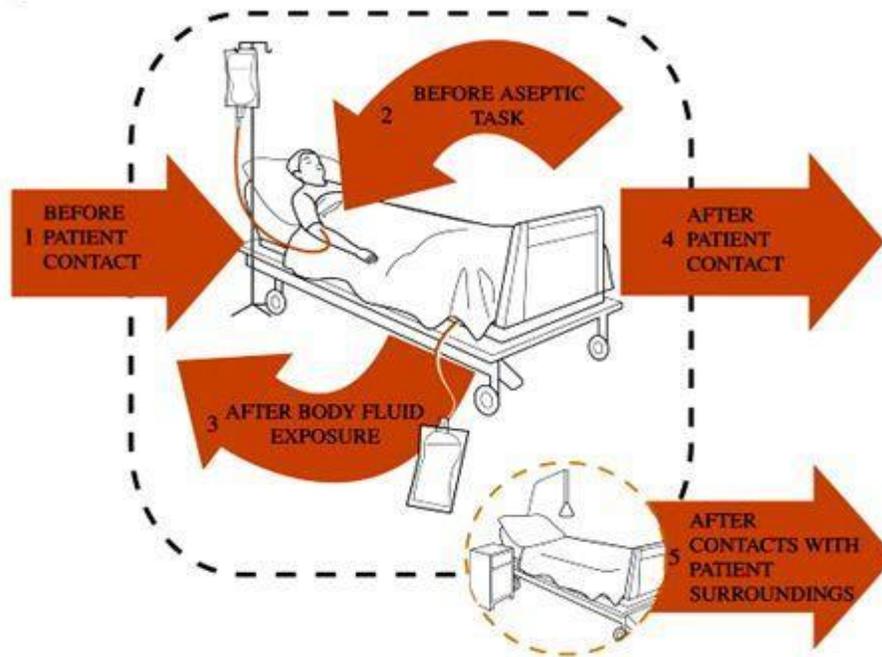
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Hands should be washed **before**:

- food preparation
- patient contact
- any clinical procedure

Hands should be washed **after**:

- any activity that involves contaminated skin
- glove removal



WHO / NPSA 645/K

11 Skin

Skin is a harsh environment. It is arid and acidic, has limited nutrients and is constantly worn away and renewed.

Despite this inhospitable environment microbes have adapted to it and can be found in high numbers. This stable microbial flora is called the 'resident flora' (see figure 1):

	Resident	Transient
Comprise	Coagulase negative staphylococci Micrococci Diphtheroids	Microbes acquired by contact. Do not live long term on the skin.

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Nature	Permanent inhabitants, present throughout the skin thickness.	Temporary and sporadic; superficially located.
Infection potential	Low, may be important if gain access to manipulated sites.	Likely to be high in hospital, common means of transmission of pathogenic organisms.
Removal	Complete removal impossible, cumulative effect using chlorhexidine antiseptic cleanser.	Soap and water, antiseptic cleanser, alcoholic hand rub.

Figure 1 Types of microbes found on hands.

More importantly from the point of view of hospital infection, other bacteria can be isolated from the hands. These can originate from the inanimate or animate environment, and are called 'transient flora.' Transient flora can be acquired by touch; they will be superficially located on the skin and readily transferred to the next thing touched – eg a susceptible site on a patient.

Contamination can occur from a variety of activities such as:

- bed-making
- dressing wounds
- washing patients

12 Hand care to minimise dermatitis

Dermatitis in HCWs may place patients at risk because hand hygiene will not decrease bacterial counts on dermatitic skin, which contains high numbers of microorganisms.

HCWs may also be at increased risk of exposure to blood-borne pathogens and during contact with other bodily fluids.

Damaged skin should always be protected by a waterproof dressing while at work.

Increases in glove use to protect the HCW against blood-borne pathogens have resulted in an increase in cases of latex-related allergy amongst HCWs. Starch powder combined with allergens in the rubber may cause hypersensitivity of the skin or lungs if released into the air or inhaled. Please refer to the [glove use matrix](#).

See the [latex allergy: prevention and management policy and procedure](#). For latex-sensitive individuals an alternative glove product (eg Nitrile) should be available.

If signs of irritation develop after glove use, CCOH should be contacted for advice and assessment.

13 Patient provision for hand hygiene

Single use patient wipes must be available for those patients who are unable to access soap and water for hand washing before meals.

Patient wipes must be available for patients after using the toilet if they are unable to access a hand washing facility.

14 Management of risk

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

Use of personal dispensers (tottles) is best practice when caring for children, mental health patients or other patients for whom permanently sited dispensers may pose a risk.

Placement at other sites is based on a risk assessment of cross-infection and risk of unintended use and a management plan should be put in place.

If significant ingestion by a patient occurs the National Poisons Information Service may be contacted. There is 24 hour cover if necessary.

Accidental splashes in the eye should be managed with irrigation.

Current guidance advocates that minimum quantities should be stored at ward level (no more than five litres) when not in use. If more than this quantity is stored this should be in a locked, secure area.

15 Rationale for hand hygiene

	Social hand wash	Hygienic hand disinfection	Surgical scrub	
Why?	To achieve socially clean hands. To remove transient microorganisms.	To remove or destroy all transient microorganisms. Product used may have a prolonged effect.	To remove/ destroy transient microorganisms. To substantially reduce resident microorganisms. A prolonged effect is required.	
What?	Soap and water.	Skin disinfectants: chlorhexidine eg Hibiscrub, Povidone Iodine eg Betadine alcohol hand rub.	Skin disinfectants: chlorhexidine eg Hibiscrub, Povidone Iodine eg Betadine or alcohol hand rub.	
How?	A thorough wash with cosmetically acceptable soap.	A thorough wash using the six-step technique for 10-20 seconds, or use alcohol hand rub following the same technique.	Apply antiseptic soap to hands and forearms using a defined technique for a minimum of two minutes. Dry hands on sterile towel.	Alternatively: Clean hands and forearms with soap and water. Apply two applications of an alcohol hand rub.
When?	Before and after performing routine tasks in all clinical areas.	During outbreaks of infection. In high risk areas. After contact with body fluids/ infectious material.	Prior to surgery or invasive procedures.	

16 Monitoring compliance with and the effectiveness of this policy

16.1 Monitoring of NHSLA Risk Management Standards

Standard 2.8 of the NHSLA Risk Management Standards sets out the minimum requirements for a policy on hand hygiene training. The standards to be monitored at level 3 are:

- a) the process for checking that all permanent staff groups complete relevant hand hygiene training
- b) the process for following up those who fail to attend relevant hand hygiene training

The process for monitoring the above standards is set out in the monitoring section of the [mandatory training policy](#).

16.2 Additional monitoring

- **Nursing quality metrics:**

Hand hygiene compliance is monitored two weekly by ward/ departmental auditors using the hand hygiene audit tool included in the *Saving Lives* initiative. The key performance indicator (KPI) is 100% compliance. The results are fed back to the monthly senior clinical nurse meeting chaired by the chief nurse and operating officer.

Wards/ departments where compliance is below 95% are required to produce an action plan within two weeks and send it to the chief nurse and operating officer. Remedial action will include additional education, reminders and re-audit. Individual areas are responsible for monitoring their infection control compliance data through local departmental meetings, clinical governance and divisional meetings.

- **Monthly infection control performance report:**

This includes a summary of compliance data with hand hygiene performance broken down on a monthly basis. This data is available to all staff on a ward, divisional and Trust level via the Cambridge hospitals evaluation quality system (CHEQS) business intelligence system on Connect.

The results of the above monitoring (ie in 16.2) will be summarised in the annual infection control report. This report is presented to the control of infection committee and to the board of directors who are responsible for identifying and monitoring any actions required.

17 References

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18 Associated documents

- [aseptic non touch technique \(ANTT\) for administration of intravascular drugs and fluids procedure](#)
- [disciplinary procedure](#)
- [dressing changes for non tunnelled central venous catheters procedure](#)
- [dressing changes for tunnelled central venous catheters procedure](#)
- [dressing changes for peripherally inserted central venous catheters procedure](#)
- [glove use matrix](#)
- [guide to mandatory training and refresher requirements](#)
- [latex allergy: prevention and management policy and procedure](#)
- [mandatory training policy](#)
- [strategy for the management of risks associated with infection prevention and control](#)
- [Trust professional dress code and uniform policy](#)

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Disclaimer

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Document management

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Appendix 1: Gross breaches of the hand hygiene policy

Effective and timely hand hygiene is an integral part of every staff member's role at Addenbrooke's Hospital. You are expected to familiarise yourself with and adhere to the content of the hand hygiene policy.

The following are considered gross breaches of the hand hygiene policy. Failure to comply will result in disciplinary action in accordance with the Trust's [disciplinary procedure](#). Breaches of hand hygiene by a member of staff should be reported to the appropriate line manager.

Gross breaches of hand hygiene policy

1. Not performing hand hygiene before and after touching a patient or anything in the curtained area around the patient.
2. Leaving a bed-space/ side-room without removing contaminated apron/gloves and without performing hand hygiene. The **only exception** to this is going to the sluice to dispose of bedpan or body fluids. In this case keep the apron and gloves on, go straight to the sluice, after disposal immediately remove gloves and apron and wash your hands.
3. Not performing hand hygiene before, during and after aseptic procedures including drug administration, connection of infusions and wound dressings.
[aseptic non touch technique \(ANTT\) for administration of intravascular drugs and fluids](#)
[dressing changes for tunnelled central venous catheters](#)
[dressing changes for non tunnelled central venous catheters](#)
[dressing changes for peripherally inserted central venous catheters](#)

You are reminded that all staff are expected to carry out hand hygiene:

- before entering and on leaving a ward
- before and after glove use
- before and after bed making
- after cleaning equipment
- after touching patient nursing and medical notes.

This is by no means an exhaustive list; further information is available in the hand hygiene policy, which you are expected to be familiar with.

Definitions

Performing hand hygiene:

Use of hand wash or alcohol hand rub according to the hand hygiene policy.

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Appendix 2: Hand hygiene training needs analysis

The hand hygiene training needs analysis tool, as laid out below, describes the processes in place for ensuring effective delivery of hand hygiene training. Please see:

- [strategy for the management of risks associated with infection prevention and control](#)
- [guide to mandatory training and refresher requirements](#)

	Subject	When?	Mandatory Yes/No	Who?	How?	Process for recording and monitoring
1	Information on hand hygiene including hand washing technique	On induction (including medical staff)	Yes	Newly appointed clinical and non clinical staff, including domestic and portering staff	20 minute PowerPoint presentation plus demonstration on hand hygiene technique and practical participation by attendees	Monitored by education and training, who provide assurance that induction training has been completed Hand hygiene leaflet to be included in Induction package Practical application of alcohol gel.
2	The principles of infection control including hand hygiene and use of personal protective equipment (PPE)	On induction.	Yes	All clinical staff, (not including medical staff).	Presentation by the infection control nurse specialists/trainees.	Records kept on OLM 45 minute session with PowerPoint presentation.

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	Subject	When?	Mandatory Yes/No	Who?	How?	Process for recording and monitoring
3	Infection prevention and control – current issues/ challenges, including hand hygiene/ use of alcohol hand rub	On induction.	Yes	Junior doctors	15 minute presentation by an infection control nurse specialist.	Monitored by the post graduate department, Addenbrooke's NHS Trust. Session is 15 minutes PowerPoint presentation. Important points for the use of alcohol hand rub. Important points for the safe use/ disposal of sharps and management of needle stick/ sharps injury or exposure to blood or body fluids. Important points for the care of peripheral IV cannulae. Prudent antibiotic prescribing.
4	Infection prevention and control – hand hygiene/ use of alcohol hand rub	Twice yearly on Trust induction, with 'mop-up sessions' as required	Yes	During the FY1 / FY2 Programme This also includes SpRs and consultants, as necessary.	Presentation by induction team	Recorded by medical staffing.
5	Infection prevention and control – hand hygiene/ use of alcohol hand rub	On induction.	Yes	New medical students	In groups of 10.	Recorded by the post graduate department 20 minute Powerpoint presentation and use of 'Glow & Tell' to test hand washing technique. Different levels of hand hygiene. Copy of session in medical student handbook

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	Subject	When?	Mandatory Yes/No	Who?	How?	Process for recording and monitoring
6	Infection prevention and control – including hand washing/ use of alcohol hand rub education and training	On induction.	Yes	All domestic, Estates and portering staff.	Presentation time – one hour.	Recorded on OLM. Includes practical hand washing session, as well as practical application of alcohol hand rub.
7	The principles of infection control and standard precautions (based on the EPIC and NPSA Guidelines)	Corporate mandatory update delivered two yearly	Yes	For all staff who have day to day contact with patients, including nurses, healthcare assistants, doctors, AHPs, support staff and volunteers.	Twenty minute PowerPoint presentation plus demonstration on hand hygiene technique and practical participation by attendees. Promotion of NHSLU E-Learning via Trust intranet.	E-Learning package includes as assessment tool requiring 80% to achieve a pass.
8	Hand washing and use of alcohol hand rub education and training	Annually.	Yes	All clinical staff (Annual Programme) including volunteers	Undertaken by link workers and volunteer leads within their own ward/ department.	Recorded by the link worker and collated by the ICT. Also directorate key performance indicator target. Link workers competency in hand washing/ use of alcohol rub is assessed by the infection control nurse specialists, prior to the assessment of clinical staff. Handout example given to staff for use in training.

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	Subject	When?	Mandatory Yes/No	Who?	How?	Process for recording and monitoring
9	Hand washing and use of alcohol hand rub education and training	Part of four day induction training	Yes	All domestic staff.	Undertaken by domestic education officer	Recorded by the assessor. Two practical assessments at ward level included in the process plus questionnaire on completion of four day training. Domestic education officer competency in hand washing/ use of alcohol rub is assessed by the infection control nurse specialist, prior to the assessment of clinical staff. Glow and Tell used to test technique of all staff.
10	Hand hygiene	N/A	No	All clinical ward/ department staff.	Section 1A in the infection control manual, available in all clinical departments (hard copy) and on Connect.	Ward/ department manager responsibility. Saving Lives monthly audits, monthly hand hygiene audits as part of KPI reporting. Guidelines are based on the EPIC and NPSA guidelines.
11	Clean your hands campaign	Ongoing	No	Trust-wide.	As directed by the NPSA in the campaign pack.	Ward/ department manager responsibility.
12	Hand hygiene	On induction to work areas.	Yes	All new staff in critical care areas	Leaflet and presentation by critical care infection control nurse and ICN	All staff receive a hand hygiene leaflet outlining responsibilities.
13	Practical hand hygiene sessions	As requested	No	All staff	Infection control study days organised for different staff groups.	Recorded by infection control team on Excel database. Use of healthcare scenarios as training.

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Additional information

Target Group	How	Aim
Patients	Notices at the bedside stating 'Point of Care: please clean your hands here, now' alternating with 'It's OK to ask' based on NPSA literature Information on hand hygiene compliance audit results on all ward boards	To encourage patients to use the alcohol rub provided on each locker.
Visitors	Framed notices displayed outside each ward/ department stating 'In the interest of hygiene would all visitors and staff entering and leaving the department please use the hand rub provided' Ward boards provide infection control information	To encourage all visitors and staff to use the alcohol rub on entering and leaving wards and departments. To inform staff, patients and visitors of IC messages and progress
All Trust staff	Posters displayed at ward entrances and in strategic points in all wards/ departments. Short video promoting appropriate hand hygiene http://www.cuh.org.uk/cms/addenbrookes-hospital/infection-control/video-together-we-can-fight-infection	To communicate important infection control messages to as many Trust staff as possible.
All potential users of alcohol hand rub	Mini notices displayed above/ near to alcohol hand rub dispensers based on NPSA wording. Some desktop wallpaper available in individual areas	To promote the use of hand rub.
Visitors	Notices are displayed in entrance halls and reception areas alerting visitors to the campaign 'Together we can fight infection'.	To notify visitors on first entering the hospitals that alcohol rub is available for use.