Mersey and West Lancashire Teaching Hospitals NHS Trust

Hand Hygiene Policy

Version No: 1

Document Summary:
This policy aims to ensure that safe, effective hand hygiene is performed at appropriate times to minimise the risk of infection to patients and staff.

Document status	Approved	
Document type	Policy	**Trust wide**
Document number	PD0079	
Approving body	Patient Safety Council	
Date approved	12/06/2024	
Date implemented	26/07/2024	
Review date	***3 years from approval date** **30/06/2027**	
Accountable Director	Director of Nursing, Midwifery & Governance	
Policy Author	Infection Prevention Team	
Target audience	All staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information	
Title	Hand Hygiene Policy
Directorate	Corporate
Brief Description of amendments	
Version 1	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes
Data Protection Impact Analysis completed?	Yes

Section 2 – Consultation Information* *Please remember to consult with all services provided by the Trust, including Community & Primary Care			
Consultation Completed	☑ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	13/03/2024	**Consultation end date**	31/03/2024

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
1	12/06/2024	Policy now harmonised for use by MWL
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	

Section 4 – Approval *– To be completed by Document Control*			
Document approved	☑ Approved ☐ Approved with minor amendments		
Assurance provided by author & Chair	☒ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	12/06/2024	**Review date**	30/06/2027

Section 5 – Withdrawal *– To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval
Date Withdrawn:	Click here to enter a date.

1. Contents

2. Scope

This policy applies to all staff, patients, and visitors to the Trust. The policy details the correct protocols for hand hygiene, the responsibilities of specific staff groups in relation to hand hygiene, and the related training and audit requirements.

3. Introduction

Hand hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause Healthcare Associated Infections (HCAIs).

When hand hygiene is performed consistently, transmission of microorganisms and the likelihood of HCAI is reduced.

4. Statement of Intent

This policy aims to ensure that safe, effective hand hygiene is performed at appropriate times to minimise the risk of infection to patients and staff.

5. Definitions

Term/Abbreviation	Definition/meaning
HCAI	Health Care Associated Infection
DIPC	Director of Infection Prevention and Control
IPCT	Infection Prevention & Control Team
Bare Below the Elbow	A Department of Health initiative adopted by the Trust to ensure there are no physical barriers to effective hand hygiene
HCAI	Health Care Associated Infection
DIPC	Director of Infection Prevention and Control
IPCT	Infection Prevention & Control Team

6. Duties, Accountabilities and Responsibilities

6.1 Chief Executive – Director of Infection Prevention and Control (DIPC)

Provide organisational oversight and leadership for IPC, to ensure safe practice and a safe environment which protects patients, visitors, and staff from infections.

6.2 Infection Prevention Team

Provide training for staff and others attending Induction and Mandatory Training (e-learning) and contribute to other relevant training programmes both formal and informal.

Provide training for Infection Prevention Link Practitioners or other training leads.

Compliance with Hand Hygiene Policy will be measured formally during the Infection Prevention audit process and informally whilst visiting clinical areas and observing practice.

To report audit findings through the Trust governance structures.

6.3 Staff

All employees are responsible for adhering to this policy and for undertaking mandatory training as required, which includes hand hygiene.

Bring to the attention of the department manager or Infection Prevention Team any barriers to implementing this guidance.

6.4 Ward/Department Managers

That staff have access to the appropriate facilities and products to undertake effective hand hygiene.

To actively promote compliance with this policy in their areas of responsibility.

Compliance is monitored and actions taken to improve practice, where appropriate.

Staff receive appropriate Trust and local Training in accordance with this policy and the Trusts Induction and Mandatory Training Policies.

7. Process

7.1 Performing hand hygiene

Liquid soap and water should be used:-

- If hands are visibly soiled or dirty.
- Caring for a patients with vomiting or diarrhoeal illnesses (whether in direct contact with the patient or indirectly by contact with their immediate environment or equipment)
- Caring for a patient with a suspected or known organism such as *Clostridioides difficile* or norovirus, which are not susceptible to alcohol-based hand rubs.
- After using the toilet.

In all other circumstances, use alcohol based handrubs (ABHRs) for routine hand hygiene during care. ABHR is also the preferred product for general hand hygiene on entry to and when leaving wards and departments.

ABHRs must be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used.

7.2 Clinical hand-wash basins

Clinical hand-wash basins must:

- be used for that purpose only and not used for the disposal of other liquids.

- have mixer taps, no overflow or plug and be in a good state of repair.
- have wall mounted liquid soap and paper towel dispensers.

Hand hygiene facilities should include instructional posters or signage on dispensers.

7.3 Bare below the elbow

All staff working in the Trust when entering, or working in a clinical area are required to be bare below elbow to facilitate effective hand hygiene. This includes;

- No long sleeved tops, coats etc.
- Removal of all hand and wrist jewellery. The wearing of a single, plain metal finger ring, eg a wedding band, is permitted but should be removed (or moved up) during hand hygiene. If a religious bangle is worn, it should be moved up the forearm during hand hygiene and secured during patient care activities.
- Fingernails should be kept clean and short. Do not wear artificial nails or nail products (See Trust Uniform Policy for further information).
- Cover all cuts or abrasions with a waterproof dressing.

7.4 When to perform hand hygiene

'Your 5 Moments for Hand Hygiene' identifies key moments for hand hygiene at the point of patient care. The 'point of care' indicates the most critical moments for hand hygiene where the risk of transmission of infection for the patient is greatest. This is primarily via the hands of healthcare workers.

<u>The 5 key moments are:</u>

- before touching a patient.
- before clean or aseptic procedures.
- after body fluid exposure risk
- after touching a patient; and
- after touching a patient's immediate surroundings.

<u>Additional examples of when hands must be cleaned includes:</u>

- before donning of PPE.
- after removal of gloves regardless of the task undertaken.
- before entering and on leaving a clinical area.
- before preparing or handling food.
- between different activities for the same patient e.g. bathing, mouthcare, invasive device care.

Figure 1. Your 5 Moments for Hand Hygiene

7.5 Disposable gloves and hand cleaning

Gloves are not a substitute for hand washing or hand decontamination. Glove usage should be appropriate for the task in hand and be removed as soon as necessary. The World Health Organisation (2009) guidelines and the National IPC Manual emphasise that the use of gloves does not replace the need for hand cleaning by either hand rub or hand washing, and that gloves should be removed after caring for a patient.

7.6 Hand hygiene technique

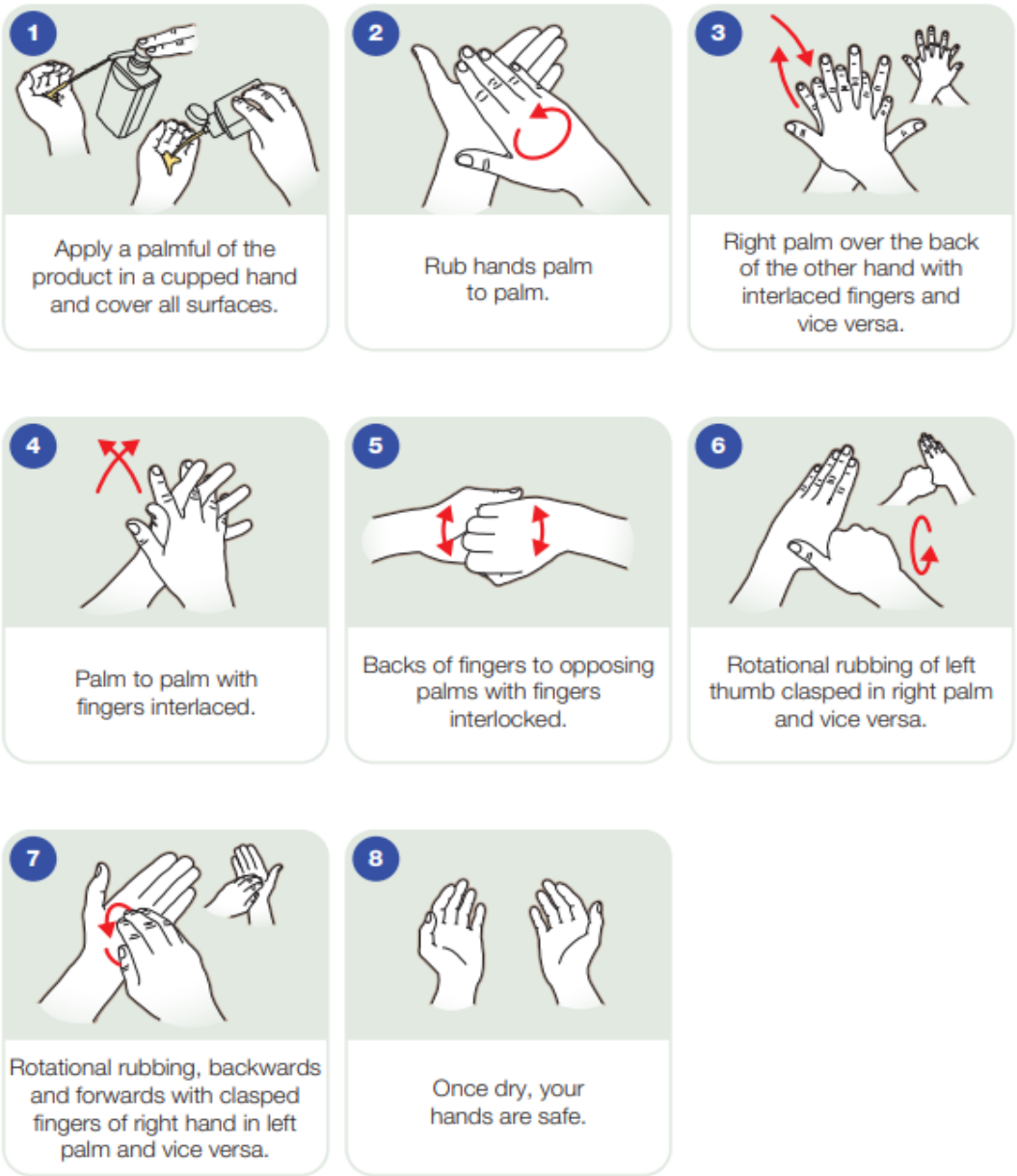
For how to wash hands and how to use hand wash and hand rub (both using the Ayliffe technique) see the step-by-step guides below.

Figure 2. Hand wash technique

Figure 3. Hand rub technique

UK Health Security Agency

Best Practice: How to handrub step by step images



Adapted from the World Health Organization/Health Protection Scotland

7.7 Surgical hand antisepsis

The purpose of surgical hand hygiene is to remove or destroy all transient organisms and to substantially reduce the burden of colonisation with resident organisms. For this reason a surgical hand wash should be undertaken for a longer period – at least 2 but no more than 5 minutes – using an antiseptic hand wash e.g. Videne, Hibiscrub. The use of an antiseptic handwash will also have a residual effect (the agent will remain on the hands for a period of time after the hand wash procedure and reduce the re-colonisation of the hands). It is critical to dry hands thoroughly with sterile towels after washing hands.

Surgical scrubbing/rubbing (this applies to those undertaking surgical and some invasive procedures):

- perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, eg before inserting central vascular access devices.
- remove all hand and wrist jewellery (including wedding band).
- nail brushes should not be used for surgical hand antisepsis.
- nail picks (single-use) can be used if nails are visibly dirty.
- use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label).
- ABHR can be used between surgical procedures if licensed for this use or between glove changes if hands are not visibly soiled.

For how to perform surgical hand antisepsis using antimicrobial soap see the step-by-step guide below.

Figure 4. Surgical hand antisepsis using antimicrobial soap

7.8 Skin care

- dry hands thoroughly after hand washing, using disposable paper towels.
- use an emollient hand cream regularly eg during breaks and when off duty.
- do not use, or provide, communal tubs of hand cream in the care setting.
- staff with skin problems should seek advice from Health, Work and Wellbeing or their GP and depending on their skin condition, and the severity, may require additional interventions or reporting.

7.9 Patient and visitor hand hygiene

Patients should be supported and encouraged to perform hand hygiene; particularly after using the toilet and before meals. Patients who are not able to sit/stand at a sink should be provided with hand cleansing wipes and assisted in the use of these if necessary.

Hand hygiene amongst visitors should be promoted by ward staff. Visitors should be encouraged to use the alcohol gel available at the entrances to wards/clinical areas on entering and leaving; and, to decontaminate hands on entering and leaving isolation rooms.

Bar soap: Bar soap may only be used for individual patient use. Patients should be advised to keep soap in a dry soap container or stored dry and unwrapped in the patients' locker. Bar soap must not be left in toilets/bathrooms as this may promote communal usage leading to cross contamination of hands.

8. Training

What aspect/s of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Statutory & Mandatory Training Policy?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
All aspects require staff training	Clinical staff	Yes – Level 2 IPC Mandatory Training for all staff	N/A	e-learning	Every year	Divisional leads
All aspects require staff training	Non-clinical staff	Yes – Level 1 IPC Mandatory Training for all staff	N/A	e-learning	Every two years	Divisional leads

9. Monitoring Compliance

9.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	Hand hygiene compliance to be monitored through regular audit by the IPC Team, with feedback to clinical/divisional teams, and reported via the Trust governance processes.
2.	Audit of hand hygiene facility appropriateness and accessibility is included in routine IPCT audit.
3.	Audit of hand hygiene compliance completed monthly in clinical areas and results reported via Trust governance processes.

9.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Audit of at least 3 procedural documents	Assistant Director of Governance / Policy Governance Group	Random review of procedural documents to be agreed by the Policy Governance Group	Monthly review of sample of 3 procedural documents	Policy Governance Group and Quality Committee	Author(s) Policy Governance Group Members
95% of procedural documents on the intranet are within review date	Quality and Risk Office Manager / Assistant Director of Governance	Monthly report to be submitted to Policy Governance Group showing compliance	Monthly	Policy Governance Group and Quality Committee (annually)	Author(s) Policy Governance Group Members Lead Executive Director(s)

10. References/Bibliography/Relevant Legislation/National Guidelines

No	Reference
1.	Health and Social Care Act 2008: code of practice on the prevention and control of infections. Updated 13th December 2022 Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)
2.	National Infection Prevention and Control Manual for England. Updated 25th October 2023. NHS England » Chapter 1: Standard infection control precautions (SICPs)
3.	World Health Organisation (2009) WHO Guidelines on hand hygiene in healthcare. WHO guidelines on hand hygiene in health care

11. Related Trust Documents

No	Related Document
1.	IPC policy
2.	Transmission-based precautions Policy
3.	Isolation Policy
4.	Uniform and Dress Code Policy

12. Equality Analysis Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Head of Patient Inclusion and Experience for monitoring purposes via the following email, cheryl.farmer@sthk.nhs.uk. If the assessment is related to workforce a copy should be sent to the workforce Head of Equality, Diversity and Inclusion for workforce equality&diversity@sthk.nhs.uk.
If this screening assessment indicates that discrimination could potentially be introduced then seek advice from either the Head of Patient Inclusion and Experience or Head of Equality, Diversity (Workforce) and Inclusion.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Hand Hygiene Policy
Brief description of function to be assessed	No change to policy and no impact on cost, patients or staff.
Date of assessment	18.05.24
Lead Executive Director	Sue Redfern, DIPC
Name of assessor	Fionnuala Browne
Job title of assessor	Consultant Nurse IPC

Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to or will in practice, discriminate against equality groups
2) Promote equality of opportunity, or foster good relations between equality groups?
3) Where there is potential unlawful discrimination, is this justifiable?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Age	No	No	

	Negative Impact	Positive Impact	Justification/ evidence and data source
Disability	No	No	
Gender reassignment	No	No	
Pregnancy or maternity	No	No	
Race	No	No	
Religion or belief	No	No	
Sex	No	No	
Sexual orientation	No	No	

Human Rights

Is the policy/proposal infringing on the Human Rights of individuals or groups?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Right to life	No	No	
Right to be free from inhumane or degrading treatment	No	No	
Right to Liberty/security	No	No	
Right to privacy/family life, home and correspondence	No	No	
Right to freedom of Thought/conscience	No	No	
Right to Freedom of expression	No	No	
Right to a fair trial	No	No	

Health Inequalities

Is the policy/proposal addressing health inequalities and are there potential or actual negative impact on health inequality groups, or positive impacts? Where there is potential unlawful impacts is this justifiable.

	Negative Impact	Positive Impact	Justification/ evidence and data source
Deprived Populations	No	No	
Inclusion health groups	No	No	
5 child clinical areas	No	No	
5 adult clinical areas	No	No	

Outcome

After completing all of the above sections, please review the responses and consider the outcome.

Is a full EIA required?	Yes ☐ No ☒ Please include rationale: No change to policy and no impact on cost, patients or staff.

Sign off

Name of approving manager	Brendan Prescott
Job title of approving manager	Deputy Director Governance
Date approved	13/06/24

13. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		✓		
Will the procedural document lead to the collection of new information about individuals?		✓		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		✓		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		✓		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		✓		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		✓		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		✓		
Will the implementation of the procedural document compel individuals to provide information about themselves?		✓		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author: Fionnuala Browne **Date 13/03/2024**