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1. **Introduction**
	1. Hand hygiene is widely acknowledged to be the single most important activity for reducing the spread of disease1. Patients are put at risk of developing a Healthcare Associated Infection (HCAI) when informal carers or healthcare workers caring for them have contaminated hands. Hands must be decontaminated before and after every episode of care that involves direct contact with the following:
* patient’s skin
* invasive devices or dressings.
* The patient’s environment

 The body of evidence confirming the need to decontaminate hands as a first line measure against HCAI is substantial1,2,3,4.

* 1. The Board of Science for the BMA in its document “Healthcare Associated Infections: A guide for healthcare professionals” states ‘There is considerable evidence that patient contact results in contamination of healthcare professionals hands by pathogens that cause HCAIs including microbial resistant microbes3.
	2. Epic3: Guidelines for preventing Healthcare Associated Infections in NHS Hospitals has hand hygiene as it first standard principle. Although the recommendations are primarily for hospital setting the standard principles provide guidance on infection control precautions that should be applied to all healthcare personnel to the care of patients in community and primary care settings4.
	3. WHO published their guidelines for hand hygiene in the healthcare setting in 2009 2. These guidelines advise on best practice in hand decontamination, soaps, alcohol products and gloves following a systematic review of all of the available evidence.
1. **Policy statement**

It is the policy of the **(name of practice)** that all staff will decontaminate their hands before and after every episode of direct patient care contact, either with liquid/foam soap or alcohol hand rub depending on the risk assessment of which type of hand hygiene is required.

1. **Scope:**

This Policy applies to all *insert practice name* staff (including those managed by a third party e.g. agency staff or contracted domestic staff) and premises where they work. This policy compliments Health & Safety Policies.

1. **Monitoring Compliance to this policy**
	1. Compliance to the hand hygiene policy will be monitored in the following ways:-
* Infection Control Audits on an annual basis (as a minimum)
* Compliance with Hand hygiene training
* Reports of hand hygiene audits, bare below the elbows compliance and training records will be reviewed by the practice during their practice meetings.
1. **Microbiology of the skin**

 Skin flora can be divided into two categories: Resident and transient.

* 1. **Transient** organisms are those that are **not** usually part of the normal flora and acquired by touch e.g. from the patient laundry, equipment. They are located superficially on the skin, readily transmitted to the next thing touched, and are responsible for the majority of healthcare associated infections. They are easily removed by hand decontamination.
	2. **Resident** organisms are normal flora forming part of the body’s normal defence mechanisms, and protecting the skin from invasion by more harmful micro-organisms. They rarely cause disease and are of minor significance in routine clinical situations. Resident organisms may enter deep tissues and establish infections and these can be removed by the surgical scrub technique.
1. **Decontamination of hands**
	1. Decontamination refers to the process of the physical removal of blood, body fluids and transient micro-organisms from the hands by cleaning with both soap and water or an alcohol based hand rub.

 Published literature demonstrates that contaminated hands are one of the major contributing factors in the spread of infection and that effective hand decontamination can result in a significant reduction in the incidence of hospital acquired infections1,2,3,4,5,6,7.

* 1. **Bare below the Elbows**
		1. The Department of Health issued guidance in 2007 that hand hygiene is not performed effectively if sleeves and cuffs are close to wrists, this is echoed in the WHO 2009 guidelines. Cuffs also become contaminated during clinical activity. The DoH recommended that all health care organisations adopt a Bare Below the Elbows policy13 ,14.

 Bare Below the Elbows means:

 No shirt sleeves

 No wrist watches

 No bracelets or wrist bands

 No rings except one plain band (no stones)

 Nail Care:

 Do not wear artificial fingernails, extenders or nail varnish when having direct contact with patients.

 Natural nails should be kept short no more than 1/8 inch/ 4mm and neat.

Bare below the elbows should be adhered to when providing direct clinical care in general practice.

* 1. **When to decontaminate**
		1. Before clinical work begins all wrist and hand jewellery should be removed. It is essential to remove rings (other than a plain wedding band) bracelet and wrist watch and have no sleeves below the elbow. Jewellery inhibits good hand washing and dirt and bacteria can remain beneath jewellery after hand washing. Long sleeves prevent effective washing of wrists and cuffs become heavily contaminated and are more likely to come into contact with patients13.
		2. Hands must be decontaminated immediately before and after every episode of direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated. Adherence to the ‘five moments of hand hygiene’ as defined by WHO in 20092 ensures hand decontamination occurs when necessary.
		3. WHO ‘five moments of hand hygiene’



* + 1. Rationale for each of the ‘five moments’:
1. **Before patient contact**

To protect the patient against colonization and, in some cases, against exogenous infection, by harmful germs carried on your hands

1. **Before clean/aseptic procedure**

To protect the patient against infection with harmful germs,including his/her own germs, entering his/her body

1. **After body fluid exposure risk**

To protect you from colonization or infection with patient’s harmful germs and to protect the health-care environment from germ spread

1. **After patient contact**

To protect you from colonization with patient germs and to protect the health-care environment from germ spread

1. **After contact with patient surroundings**

To protect you from colonization with patient germs that may be present on surfaces / objects in patient surroundings and to protect the health-care environment against germ spread

* 1. **Adherence with Hand Hygiene**
		1. Research into hand hygiene compliance amongst healthcare staff has shown that compliance is inconsistent. Observation of practice regularly reveals a mismatch between what staff say they are doing and what they actually do6.
		2. All clinical areas must have measures in place to improve the adherence with

Hand Hygiene. Hand Hygiene must be included on all staff’s induction programme.

* + 1. Alcohol hand rub must be readily available in all clinical areas and especially at the point of care8.
		2. Staff who have clinical contact with patients should be issued with an individual pocket sized alcohol hand rub dispenser as this has been shown to be effective at improving hand hygiene adherence.

Diagram 1: Areas of hands most frequently missed when decontaminating hands:

Most frequently missed

Less frequently missed

Not missed



1. **Hand washing using Soap and Water**
	1. Washing with soap and water relies on using a **good technique,** which is more important than the product used or the length of time in use.
	2. Hand washing with soap and water involves three stages: preparation, washing and rinsing, then drying: See page 14 for diagram.
	3. The key components of the process are described below
	4. Sinks should have elbow or wrist operated taps to prevent recontamination of hands when turning off the taps. If there are no elbow operated taps use a hand towel at the end of the procedure to turn off the tap.
	5. Hands require wetting under tepid water **before** applying liquid soap. This reduces the likelihood of the product causing adverse skin reactions, including dryness and irritation. **n.b** bars of soap become contaminated easily and contribute to the risks of infection, therefore should not be used.
	6. The soap must come into contact with all the surfaces of the hand.
	7. The hands must be rubbed together vigorously for a minimum of 20 seconds.
	8. Particular attention must be paid to the tips of the fingers, thumbs and the areas between the fingers.
	9. Hands should be rinsed thoroughly under running water.
	10. Drying with a good quality paper towel is essential. This completes the process of mechanical removal of micro-organisms as well as reducing the likelihood of drying and chapping skin. In addition, wet surfaces transfer micro-organisms more effectively than dry ones.
	11. Communal towels promote cross-infection do not dry effectively and must not be used.
	12. Hand driers can circulate air loaded with bacteria and therefore not recommended in clinical rooms.
2. **Hand hygiene using Alcohol based preparations**
	1. Alcohol hand rubs are an effective mechanism for decontaminating hands and in reducing the number of transient micro-organisms.
	2. The key components of the process are described below (see page 13 for diagram)
	3. Ensure hands are physically clean: if they are not, wash with soap and water. If hand washing facilities are not available alcohol rub can be used to decontaminate hands to some extent but they must be washed at the earliest opportunity.
	4. Squirt about 3ml of hand rub into the palm of one hand
	5. Rub the hand rub over all of both hands and wrists as in the diagram, paying particular attention to the fingertips and thumbs.
	6. Allow to dry (about 10-20 seconds)
	7. Alcohol hand rubs contain emollients and skin moisturisers that help maintain the integrity of healthcare workers skin. .
	8. Alcohol based hand rubs have been shown to be less effective in reducing levels of bacterial spores, as the spore’s outer coat which makes it more difficult for the active ingredients to penetrate. For this reason, alcohol hand rub is **NOT** the product of choice to use when patients are known to have ***Clostridium difficile***diarrhoea. Hands should be decontaminated using soap and water, utilising a good hand washing technique – **as described in section 8- Soap and Water**
	9. Alcohol based hand rubs have been shown to be less effective in destroying the Norovirus, which is commonly responsible for outbreaks of diarrhoea and vomiting. Therefore when caring for a patient with unexplained causes of diarrhoea staff should use soap and water to decontaminate their hands.
3. **Gloves**
	1. Gloves should be worn in compliance with standard precautions (refer to OCCG core policy 2) when in contact or potential contact with blood or bodily fluids
	2. Hands must be thoroughly decontaminated **prior** to use and **following removal** of gloves.
	3. Glove use should **never** be seen as a substitute for adequate and appropriate hand decontamination.
	4. Gloves should not be washed or cleaned with alcohol rub.
	5. Gloves must not be powdered.
4. **Skin Care / Conditioning**
	1. Hands should be kept in the best condition possible: hands with dry or damaged skin can be uncomfortable or painful, are much harder to clean than hands with intact skin, and are therefore more likely to pass on potentially infectious organisms.
	2. Apply a hand cream regularly to protect the skin from the drying effects ofregular hand decontamination.
	3. Skin care products should be used with caution when wearing gloves asthey can degrade the integrity of the product.
	4. If a member of staff develops sore or dry cracked hands they should be referred to Occupational Health for assessment.
	5. Skin damage is generally associated with the detergent base of the preparation and/or poor hand washing technique e.g. not drying hands thoroughly.
	6. All cuts and abrasions (especially on hands and forearms) must be covered with a waterproof dressing before starting work and replaced as necessary.
	7. Caution should be used when applying alcohol based products to hands with cuts / abrasions as the product may sting. Replace waterproof dressings regularly as they are a potential source of micro-organisms and difficult to decontaminate effectively.
5. **Hand Hygiene Facilities**
	1. Good hand washing practice is encouraged by the provision of appropriate facilities. Each clinical area should have sufficient clinical hand washbasins of an appropriate design which are known to increase compliance with hand hygiene.
	2. The criteria for clinical hand wash basins include the following:
* The dimensions must be large enough to contain splashes and therefore enable the correct technique to be performed.
* Single standing wall mounted clinical hand wash basins are preferable
* Waterproof splash backs
* Recessed waste with no plug
* No overflow
* Wall mounted elbow, knee or sensor operated mixer taps.
	1. Each clinical wash hand basin should be equipped with wall-mounted soap and paper towel dispensers.
	2. Any modernisation, upgrading or designing of new builds should be discussed with the infection control lead to ensure all these components are considered.
	3. Further details can be found in Health Technical memorandum 00-10C, Infection Control in the Built Environment (NHS Estates, 2002) and Health Technical Memorandum 11-01 and can be sought from the OCCG infection control lead
1. **Distribution of Dispensers/near patient bottles or staff carried hand rub**
	1. It is the responsibility of the practice (often the cleaning staff) to ensure all soap and hand towel dispensers are topped up, clean and well maintained.
2. **Training**
	1. Training is an essential component in improving practice and increasing awareness of risks. All health care staff must be taught the basics of hand hygiene and be familiar with local protocols at the time of their local induction.
	2. All health care professionals must have biannual updates and attend awareness raising activities to help improve adherence with hand hygiene initiatives.
	3. All areas are encouraged to identify hand hygiene champions who are strong role models for staff to encourage best practice.
	4. Staff must have their hand hygiene competency assessed and recorded.
3. **Patient Partnership / Empowerment**
	1. Encouraging patients and their families to remind health care professionals to decontaminate their hands has been found to be effective at improving compliance with hand hygiene
	2. Patients, relatives and their carers should be informed of the importance of hand hygiene as part of their admission procedure to hospital. Patients should be encouraged to remind staff to clean their hands if necessary.
	3. Hand hygiene materials such as posters, leaflets and the hand rub itself can influence compliance, thus must be prominent in all clinical areas.
4. **Audit**
	1. This policy will be audited annually alongside the other infection control policies.

**16 Quick Reference Guide to Key Recommendations**

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| **Hand hygiene is important in the prevention of cross infection.****All staff have a duty to clean their hands before and after every episode of direct patient care or contact with the patient’s immediate environment.** **This will ensure the safety of patients and staff.** |
| **ALCOHOL HAND RUB OR SOAP AND WATER HAND WASH**: In most routine clinical situations decontaminating hands with an alcohol hand rub or a soap and water hand wash is sufficient. A good technique that covers all areas of the hands is vital. |
| **Alcohol hand rubs**: Are the most effective way to decontaminate hands (unless they are visibly soiled) and must be used at the point of care. The rub should be applied to one palm and the hands rubbed together ensuring all surfaces of hands and fingers are covered until dry.Alcohol hand rub **does not**  kill spores of *Clostridium difficile* and is known to be ineffective against norovirus. |
| **SOAP AND WATER HAND WASH:** Washing with soap and water relies on a good technique. Particular attention must be paid to the tips of the fingers, thumbs and the areas between the fingers. Hands should be rinsed thoroughly. Drying thoroughly with a good quality paper towel is essential. |
| **BARE BELOW ELBOWS:** Wear short sleeved shirts and blouses and uniforms and avoid wearing white coats when providing patient care |
| **JEWELLERY AND WRIST WATCHES**: All wrist and hand jewellery should be removed. Exceptions can only be made for plain wedding rings. |
| **ARTIFICIAL NAILS:** Artificial fingernails, nail extensions or nail varnish should not be worn when having direct contact with patients. Natural nails should be kept short, neat and clean. |
| **GLOVES**: Gloves should be worn in line with Standard Precautions when in contact or potential contact with blood or bodily fluids. (See Standard Precautions policy). Hands must be thoroughly decontaminated prior to application and following removal of gloves. |
| **SKIN CARE**: Hand cream should be available and applied regularly to protect the skin from the drying effects of regular hand decontamination. If a staff member develops sore or dry cracked hands they should be referred to the Occupational Health Department. |
| **AUDIT:** Hand hygiene adherence should be audited and training provided for staff where technique or compliance with the five moments is not of an acceptable standard. Tools are available to enable compliance rates to be measured. |
| **TRAINING**: All staff must have hand hygiene included on their induction and attend biannual updates. |
| **Patient Partnership**: Encouraging patients and their families to remind healthcare professionals to decontaminate the hands contributes to improved compliance. |

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