Hand Hygiene Policy

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What is in this policy?

This Policy sets out hand decontamination guidance for use in University Hospitals Bristol and Weston (UHBW) NHS Foundation Trust. It is directed at all employees of the Trust, and non-Trust staff working on Trust premises, including all students, volunteers, temporary staff and visiting contractors. It includes actions that patients and visitors should be encouraged to practice. It is recognised that effective hand hygiene technique prevents transmission of pathogenic (disease-causing) organisms.

The Policy is based on national and international guidance and meets the requirements of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection and related guidance (Department of Health 2015).

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
August 2011	05	[redacted]	New format	Updated and new format
January 2014	06	[redacted]	New format	Updated and new format
July 2016	07	[redacted]	Minor updates	Minor updates
July 2018	08	Infection Prevention & Control Nurses	Minor updates	Minor updates
April 2021	09	Infection Prevention & Control Team	Minor updates	Alignment of UH Bristol and Weston Policies

Sign off Process and Dates	
Groups consulted	**Date agreed**
Infection Control Group	22/07/2021
Clinical Quality Group	10/03/2022
Policy Assurance Group	26/07/2018

- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.
- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

Table of Contents

Do I need to read this Policy?

All Trust Staff
Must read this Policy

1. Introduction

Hand hygiene is an essential element of infection prevention and control (IP&C) activity. It is the most simple and effective way to help prevent healthcare-associated infections (HCAIs).

This Policy defines the standard for hand hygiene practice across the Trust and the arrangements for ensuring staff are trained and comply with requirements.

The Policy is based on national and international guidance and meets the requirements of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection and related guidance (Department of Health 2015).

2. Purpose

The aims of this Policy are to:

- Help reduce the risks of infection to patients, visitors and staff.
- Set standards for hand hygiene across the Trust.
- To encourage consistency of hand hygiene practice.
- To promote compliance.

3. Scope

This Policy applies to all employees of the Trust and non-Trust staff working on Trust premises, including all students, volunteers, temporary staff and visiting contractors.

4. Definitions

4.1 Hand hygiene

The removal of blood, body fluids and transient microorganisms from the hands by decontaminating them with appropriate hand cleansing preparations using a systematic technique. In this Policy the term is interchangeable with 'hand decontamination'.

4.2 Social hand wash

Washing hands using un-medicated soap and water to remove dirt and loose transient microorganisms in order to prevent cross-infection. This is the most common way that staff, patients and visitors should use to clean their hands.

Alcohol hand gel can be used if hands are visibly clean.

4.3 Alcohol hand sanitiser

A hand cleaning product containing 70% alcohol designed to be used on visibly clean hands. It
reduces the number of microorganisms on the hands. To be effective the product must be applied systematically and left to dry.

If a patient is experiencing diarrhoea and/or vomiting the Trust recommendation for staff is that alcohol gel is not used when giving personal care or having significant contact with that patient. Alcohol gel can be less effective than liquid soap and water with some microorganisms (e.g., Norovirus).

Alcohol hand sanitiser is highly flammable. It needs to be carefully sited so that any risks to patients, visitors and staff are minimised.

4.4 Aseptic hand wash

Hand washing using an antiseptic solution, e.g., 4% chlorhexidine gluconate. This is advised prior to carrying out aseptic procedures where sterile gloves need to be worn. However, liquid soap can be used if an antiseptic is not immediately available.

Critical care areas and areas where there are immunocompromised patients are advised to keep a pump dispenser containing antiseptic by hand wash basins. General ward areas should keep a pump dispenser somewhere it can be easily accessed by medical/nursing staff.

4.5 Surgical scrub

Prolonged and thorough hand washing using an antiseptic solution. This is carried out prior to gowning and gloving in ultra clean environments (e.g., Theatres/Day Case).

4.6 Emollient hand cream

A water-based emollient (skin softening) hand cream should be applied to hands to protect from the drying effects of regular hand washing. If a Trust approved hand cream is not available staff can use their own product. It must be dispensed via a pump action bottle or from a tube, never from a tub. It must not be shared between staff.

5. Duties, Roles and Responsibilities

5.1 Trust Board of Directors

(a) Ensure there are effective and adequately resourced arrangements for Infection Prevention and Control (IP&C) within the Trust.

(b) Identify a board-level lead for IP&C.

5.2 Chief Executive

(a) Has overall responsibility for ensuring that there are effective arrangements for hand hygiene throughout the Trust. In practice this responsibility is delegated to the Chief Nurse, Medical Director, Chief Operating Officer and Director of Infection Prevention & Control (DIPC).

5.3 Chief Nurse, Medical Director, Chief Operating Officer

(a) To ensure that this Policy is adhered to by all staff and that appropriate hand hygiene resources are available to ensure effective implementation.

(b) Ensure mechanisms are in place to inform staff, patients, visitors and others of this Policy.

5.4 DIPC, Infection Control Doctor (ICD), Deputy DIPC

(a) Provide expert and professional advice on practice and hand hygiene products required to facilitate effective hand hygiene Trust-wide.

5.5 Infection Prevention & Control Team (IP&CT)

(a) Work closely with the DIPC, ICD and Deputy DIPC.

(b) Implement and contribute to Trust-wide IP&C training programmes promoting hand hygiene.

(c) Advise the Trust on current best practice in planning construction or refurbishment work to ensure compliance with hand hygiene.

(d) Involvement in Link Practitioner programmes to strengthen hand hygiene compliance in clinical areas.

(e) Monitoring compliance with the Policy through infection prevention and control audit and routine observation of practice. This includes monthly audit ('Perfect Ward') that is carried out by ward staff in relation to hand hygiene.

(f) Ensure the implementation of effective national campaigns and innovations e.g., World Health Organization 'Your 5 moments for Hand Hygiene' and World Hand Hygiene Day.

(g) Promote patient empowerment in respect to hand hygiene practice through appropriate forums.

5.6 Matrons, Ward Sisters/Charge Nurses/Department Heads

(a) To ensure that 'Perfect Ward' hand hygiene audits are conducted monthly.
(b) To ensure that any additional monitoring of hand hygiene is carried out as requested by the DIPC/Deputy DIPC or IP&CT.
(c) To act as a 'role model' for good hand hygiene practice in clinical areas.
(d) To implement action plans to improve hand hygiene compliance where necessary.
(e) To ensure Trust approved hand hygiene posters are displayed above, or close to all hand wash basins.
(f) To ensure hand wash basins are always easily accessible and dedicated to hand washing only (e.g., they should never be used for disposal of used wash water, emptying fluid bags).

5.7 Heads of Nursing/Midwifery and Allied Healthcare Professional Leads

(a) To support the Matrons in delivering on the hand hygiene audits.
(b) To report to the Infection Control Group (ICG) bi-monthly on behalf of their Divisions.
(c) Report to Divisional Management Boards on compliance and practice issues.
(d) To implement action plans to improve compliance where necessary.

5.8 All Medical staff

(a) Act as 'role models' for good hand hygiene practice and encourage compliance to hand hygiene by example.

5.9 Divisional Management Boards

(a) Ensure recommended actions by the ICG are carried out.
(b) Monitor compliance within the Divisions to this Policy.

5.10 Infection Control Group (ICG)

(a) Recommend actions to correct any adverse trends in monthly hand hygiene audit results.
(b) Monitor the implementation and effectiveness of this Policy.

5.11 All Staff

(a) To follow the guidance set out in this Policy.

(b) To remind any member of staff seen not to be complying with the Hand Hygiene Policy of its requirements. If that person refuses to comply, to inform their Line Manager or, if the line manager is not known, refer to ward sister/charge nurse or Matron. See Section 9.1.

(c) To complete UHBW Induction training and Essential Training updates as designated by the Learning & Development Department. These include IP&C sessions which have a hand hygiene component.

(d) If a staff member experiences problems with their hands (e.g., persistent soreness, allergic reaction), it is the individual's responsibility to report this to their line manager/supervisor.

5.12 Avon Partnership Occupational Health Service (APOHS)

(a) Provide specialist advice in relation to any staff member experiencing problems adhering to practical hand hygiene guidance in this Policy.

(b) Report any specific trends/adverse issues relating to hand hygiene to ICG.

5.13 Patients and Visitors

(a) Are requested to follow any hand hygiene advice that is implemented to help keep other patients, visitors and staff safe within the Trust.

6. Policy Statement and Provisions

6.1 Hand decontamination: When?

Hands must be decontaminated in all the following circumstances:

(a) When entering a UHBW hospital/department/clinic.

(b) When entering/exiting clinical areas. This includes outpatient areas.

(c) Immediately before every episode of direct patient contact or care, including Aseptic Non-Touch Technique (ANTT) procedures.

(d) Between each, and every episode of patient care or contact (a contact is defined as contact with both the patient and their direct care environment).

(e) Between dirty and clean tasks on the same patient.

(f) Immediately after every episode of direct patient contact or care.

(g) Immediately after any exposure to body fluids.

(h) Immediately after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated.

(i) Immediately after removal of gloves; non-sterile and sterile.

(j) The World Health Organization 'Your 5 moments for Hand Hygiene' provides a simple pictorial guide. See Section 9.2.

6.2 Hand decontamination: What with?

In most instances you can use either Trust approved alcohol hand gel, or Trust approved liquid soap and water. However:

(a) Alcohol hand gel should only be used when hands are visibly clean.
(b) Soap and water should be used when entering clinical areas closed with diagnosed/undiagnosed diarrhoea and/or vomiting. This includes areas closed with norovirus.
(c) Soap and water should be used when caring for any patient colonised or infected with *Clostridium difficile*. This principle should also be applied when caring for patients in side rooms with diagnosed/undiagnosed diarrhoea and vomiting.
(d) In patient food preparation areas, an antibacterial liquid soap should be available in wall-mounted soap dispensers.
(e) The Trust approved alcohol hand gel has properties that kill viruses, but IP&C advise that clinical staff hand wash with soap and water when working in areas, and with patients, where there is undiagnosed/diagnosed diarrhoea and/or vomiting.
(f) Using an antiseptic solution, e.g., 4% chlorhexidine gluconate, is advised prior to carrying out aseptic procedures where sterile gloves need to be worn. However, liquid soap can be used if an antiseptic is not immediately available.
(g) Critical care areas and areas where there are immunocompromised patients are advised to keep a pump dispenser containing antiseptic solution by hand wash basins.
(h) General ward areas should keep an antiseptic solution pump dispenser somewhere it can be easily accessed by medical/nursing staff.
(i) Never use non-Trust approved products or products you would use in a domestic environment (e.g., Carex) or bar soap.
(j) The IP&CT can provide you with the names of current approved hand hygiene products.

6.3 Hand decontamination: Essentials

(a) All staff must be 'bare below the elbows' when delivering direct patient care other than wearing a plain finger ring. If a ring is worn this must be moved on the finger to ensure the area under it is washed and dried thoroughly.
(b) Rings with stones should not be worn as microorganisms can be harboured in ring settings.

(c) Staff must remain bare below the elbows for the duration of contact with a patient and the patient surroundings or environment. This is to ensure that there is effective decontamination of the hands extending to mid forearm. This also helps to promote patient and public confidence.

(d) Any wrist or hand jewellery worn for religious/cultural/health reasons must be agreed with line managers/supervisors and if on the wrist must be able to be pushed up the arm to facilitate thorough hand decontamination extending to mid forearm. Refer to UHBW Uniform Policy.

(e) Fingernails should be short, clean and free of nail polish.

(f) Nail varnish, false fingernails or nail jewellery must not be worn when carrying out clinical care or when preparing food.

(g) All cuts and abrasions should be covered with waterproof dressings.

(h) If non-clinical staff go into clinical areas (e.g., medical records staff, chaplain, pharmacy porters) they must follow the hand hygiene requirements demanded of clinical staff; minimal jewellery, be able to wash hands to mid forearm.

(i) A Trust Hand Hygiene leaflet is available on the Document Management System (DMS) aimed at staff, patients and visitors.

(j) It is strongly recommended that all clinicians and staff in uniform are bare from the elbow down whenever they are in a clinical environment, to promote patient and public confidence.

6.4 Hand decontamination process using Trust approved liquid soap and water, or antiseptic (not a surgical scrub)

An effective hand wash technique involves three stages:

(a) Preparation:

- Remove wrist and hand jewellery.
- Cover cuts and abrasions with waterproof dressings.
- Wet hands under tepid running water before applying liquid soap or an antiseptic as this helps create a good lather.

(b) Washing and rinsing:

- The hand wash solution must come into contact with all surfaces of the hand.
- The hands must be rubbed together vigorously for a minimum of 10 – 15 seconds, paying particular attention to the tips of the fingers, the thumbs, the areas between the fingers and the wrists.

Use a systematic technique:

- Rub hands palm to palm.
- Rub back of each hand with the palm of other hand with fingers interlaced.
- Rub palm to palm with fingers interlaced.
- Rub with backs of fingers to opposing palms with fingers interlocked.
- Rub each thumb clasped in opposite hand using rotational movement.
- Rub tips of fingers in opposite palm in a circular motion.
- Rub each wrist with opposite hand.
- Pay particular attention to the tips of the fingers, the thumbs and the areas between the fingers.
- Hands should be rinsed thoroughly under running water before drying.
- Avoid re-contaminating hands on taps – use elbow to turn off tap or a paper towel.

This technique can be seen on Trust approved hand hygiene posters which should be displayed above, or close to clinical hand wash basins.
Hand hygiene posters are available from the IP&CT. They should be on Trust approved wipeable paper securely fixed to the wall (do not secure with sticky tape or any sort of clinical tape), and not be stained or damaged in any way.

(c) Drying:

- In clinical areas good quality paper towels should be available from sealed hand towel dispensers.
- The friction action of using paper hand towels assists in removing transient microorganisms from skin surfaces.
- If staff are prone to skin problems the advice is to pat the skin dry rather than using a rubbing action.
- Hands must be dried thoroughly and used paper towels disposed of in the appropriate waste stream using a foot operated bin.
- Hot air driers or fabric hand towels should never be used in a clinical hospital setting.

6.5 Hand decontamination process using Trust-approved alcohol hand gel

When decontaminating hands using an alcohol hand gel:

- Hands should be free from dirt and organic material as well as visibly clean.
- Apply a small amount (about 3ml) of alcohol hand gel into a cupped hand.
- The hand gel must come into contact with all surfaces of the hand.

- Rub hands palm to palm.
- Rub back of each hand with the palm of other hand with fingers interlaced.
- Rub palm to palm with fingers interlaced.
- Rub with backs of fingers to opposing palms with fingers interlocked.
- Rub each thumb clasped in opposite hand using rotational movement.
- Rub tips of fingers in opposite palm in a circular motion.
- Rub each wrist with opposite hand.
- Allow hands to dry – it's the drying action of the gel that renders microorganisms inactive.
- After using alcohol hand gel after 3 to 4 times it is advisable to wash your hands with liquid soap and water.

6.6 Taking care of hands

(a) A Trust approved emollient hand cream is available on EROS; Ecolab Silonda at Bristol and GOJO Hand Medic at Weston. It should be applied regularly to protect skin from the drying effects of regular hand decontamination. Clinical areas are advised to site this product appropriately within their areas. Estates have the correct holders which need to be attached to the wall.

(b) There is some evidence to suggest that normal hand flora can be altered if skin is damaged which may lead to hands carrying increased pathogens which could be responsible for healthcare-associated infections (Larson 1999). The provision of hand emollient assists in the maintenance of skin integrity and hydration (Loveday *et.al.* 2014).

(c) If a particular Trust-approved soap, antiseptic hand wash, alcohol hand gel, hand cream product causes skin irritation this should be reported to the line manager/supervisor. A referral to APOHS should be discussed.

(d) If staff are prone to skin problems the advice is to pat the skin dry with paper hand towels after hand washing rather than using a rubbing action.

(e) Staff with active skin lesions or any sort of rash on the hands or forearms must seek advice from APOHS in order that suitability to work can be assessed.

(f) The use of Dermol 500 may be advised by APOHS. In this instance it must only be used by that staff member and it should be labelled accordingly. It must never be shared between staff.

(g) Dermol 500 should not be used unless agreed with APOHS. It should be ordered by the line manager.

(h) Dermol 500 cannot be used to carry out a surgical scrub in place of an antiseptic.

6.7 Hand hygiene environment

(a) Hand wash basins should be designated for hand hygiene only - they must never be used for disposal of used wash water or emptying fluid bags.
(b) All hand wash basins must be sited appropriately and be easily accessible.
(c) Clinical hand wash basins must be kept free from any extraneous items and kept clean.
(d) All liquid soap dispensers should be clean and nozzles free from soap build-up.
(e) All alcohol hand gel dispensers should be clean and nozzles free from gel build-up and should not be positioned over a hand wash basin.
(f) All paper towel dispensers should be intact and clean.
(g) All foot operated waste bins should be clean, in good condition and fully operational.
(h) Antiseptic hand wash should be kept available in all clinical areas but in general areas should not be kept by every hand wash basin.
(i) It is the responsibility of the clinical area and their staff (including domestic staff and housekeepers) to ensure that there are good supplies of liquid soap, alcohol hand gel and paper towels.
(j) There should be an alcohol hand gel pump dispenser by every bed space/or attached to the bed in all areas except where it would be deemed unsafe (e.g., some paediatric areas, if a patient is confused).
(k) Staff in specific areas (e.g., Emergency Department, Day Case Unit) may carry personal issue alcohol hand gel as patient trolleys cannot always be fitted with hand gel dispensers.
(l) Alcohol hand gel should be safely sited close to entrances/exits of clinical areas.
(m) Alcohol hand gel should not be decanted from large containers to smaller ones.
(n) Used alcohol hand gel containers must be disposed of in line with the UHBW Waste Management Policy.
(o) In the event of failed/broken soap or paper towel dispensers, leaking taps, hand wash basins/taps which have lime scale build up it is the responsibility of the area to report this promptly via the Agility help desk in Estates at Bristol or raise an Estates ticket at Weston and to ensure problems are fixed with a minimum time delay.

6.8 Hand hygiene opportunities for patients and visitors

(a) Patients and visitors are advised to carry out hand hygiene when entering/exiting hospitals/departments/clinics, entering/exiting clinical areas, before and after eating, before and after using toilet facilities.
(b) Alcohol hand gel is widely available for patients and visitors.
(c) Staff are expected to offer hand hygiene opportunities to patients after using the toilet and before eating and should assist patients where they are not able to carry

this out without help. If a hand wash basin is not accessible patients should be offered patient hand wipes or alcohol hand gel.

(d) The Trust supports patients' and visitors' rights to challenge staff as to whether they have decontaminated their hands.

(e) Staff have a responsibility to remind visitors to wash/gel their hands.

(f) There is a Trust Hand Hygiene leaflet available for patients and visitors.

6.9 National standards for hand hygiene facilities

(a) The document below details the requirements and guidance for hand hygiene facilities:
Department of Health (2013) Health Building Note 00-09: Infection Control in the built environment. https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment Accessed: March 25th 2021.

(b) In all clinical refurbishments and new buildings, the IP&CT must approve provision and locations of hand wash basins/scrub sinks.

(c) No hand wash basins/scrub sinks will be removed/re-sited without consultation with the IP&CT.

(d) Any taps installed in clinical areas should be mixer taps (water is mixed in the tap - or blended water (water is blended before reaching tap). Taps must be elbow or knee-operated or sensor controlled. The IP&CT must be consulted on the appropriate choice of taps being considered for use in the Trust.

(e) Sinks in clinical areas must be suitable for that purpose (not of a domestic design or hotel-style).

(f) The dimensions of a clinical sink must be large enough to contain splashes and therefore enable the correct hand-wash technique to be performed.

(g) Clinical sinks must not have a plug or a recess capable of taking a plug.

7. Standards and Key Performance Indicators

7.1 Applicable Standards

(a) This Policy is based on national and international guidance and meets the requirements of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection and related guidance (Department of Health 2015).

(b) Section 5 highlights responsibilities and actions required for implementation of this Policy Trust-wide and at a local level.

(c) The ICG meet bi-monthly and are the core Trust Group with IP&C responsibility.

(d) External to the Trust, the Clinical Commissioning Group (CCG) require assurance that this Policy is being adhered to.
(e) Announced and unannounced visits by the Care Quality Commission (CQC) will require similar assurance.

7.2 Measurement and Key Performance Indicators

Audit

(a) A monthly hand hygiene audit is carried out Trust-wide in every ward area as part of the 'Perfect Ward' audit process. The frequency of hand hygiene audits is determined by the DIPC but at a minimum of 20 observations per month; a minimum compliance level of 95% is required.
(b) Results should be displayed in a prominent area in each clinical area. Results are also monitored by Division at the ICG.
(c) Infection rates will be monitored and seen as key performance indicators for this Policy.

Training

(a) All Trust IP&C training is aimed at reducing the risks of HCAIs. The importance of effective hand hygiene is a core component of this training.
(b) All Trust-employed staff receive IP&C training within their induction programme.
(c) Contractors, Bank and Agency staff should be made aware of their responsibilities to IP&C prior to commencing work. A leaflet outlining Trust policy and practice is available for this purpose and includes hand hygiene.
(d) All Trust-employed staff undertake approved IP&C training as directed by the Education Learning & Development Department and detailed in individual training programmes. Clinical staff are required to have annual updates and non-clinical staff, updates three yearly.
(e) ICG is responsible for monitoring Divisional compliance to statutory IP&C training.
(f) All Divisions have access to hand hygiene training including Glo-Boxes.
(g) Infection Control Link Practitioners are encouraged to carry out hand hygiene training in their areas with support from the IP&CT.
(h) Ad hoc hand hygiene training will be delivered by the IP&CT as requested.
(i) Trust IP&C training data will indicate staff who have received hand hygiene basic training at Induction and at Essential Updates.

Other indicators

(a) Trust Risk Register.
(b) Complaints linked to hand hygiene practice/hand hygiene environment.
(c) Patient-Led Assessments of the Care Environment (PLACE) - annual Assessments – observation of hand hygiene environment.
(d) National Patient Surveys.
(e) Patient Safety Walk rounds.
(f) Unannounced/announced inspections by the Care Quality Commission (CQC).

7.3 Patient and Public Information

(a) The Trust annual IP&C report detailing IP&C structures and processes will be publicly available.
(b) The Trust internet site will include key information for patients and visitors
(c) IP&C related posters and information aimed at patients and visitors will be clear and prominently displayed (e.g., posters with information relating to outbreaks).

8. References

Department of Health (2013) Health Building Note 00-09: Infection Control in the built environment. https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment Accessed: April 10th 2021.

Department of Health (2015) 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. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Accessed: April 10th 2021.

Larson, E. (1999) Skin Hygiene and Infection Prevention: More of the same or Different Approaches? Clinical Infectious Diseases. Vol. 29, 1287-1294.

Loveday, H.P. Wilson, J.A. Pratt, R.J. et.al. (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection. Vol. 86, Supplement 1, S1–S70. epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England - ScienceDirect Accessed: April 10th 2021.

National Institute for Health and Care Excellence (2014) Infection prevention and control. Quality standard. Quality Statement 3 – Hand decontamination. Infection prevention and control (nice.org.uk) Accessed: April 10th 2021.

NHS England/NHS Improvement (2019) Standard infection control precautions: national hand hygiene and personal protective equipment policy. national-policy-on-hand-hygiene-and-ppe.pdf (england.nhs.uk) Accessed: April 10th 2021.

NHS (2020) How to wash your hands (includes video). How to wash your hands - NHS (www.nhs.uk) Accessed: April 10th 2021.

NHS National Services Scotland/Health Protection Scotland (2012) National Infection Prevention and Control Manual (NIPCM). National Infection Prevention and Control Manual: About the Manual (scot.nhs.uk) Accessed: April 10th 2021.

Perry, C. (2007) Infection Prevention and Control. Oxford: Blackwell Publishing.

World Health Organization (2009) 5 Moments for Hand Hygiene. http://www.who.int/gpsc/tools/Five_moments/en/ Accessed: April 10th 2021.

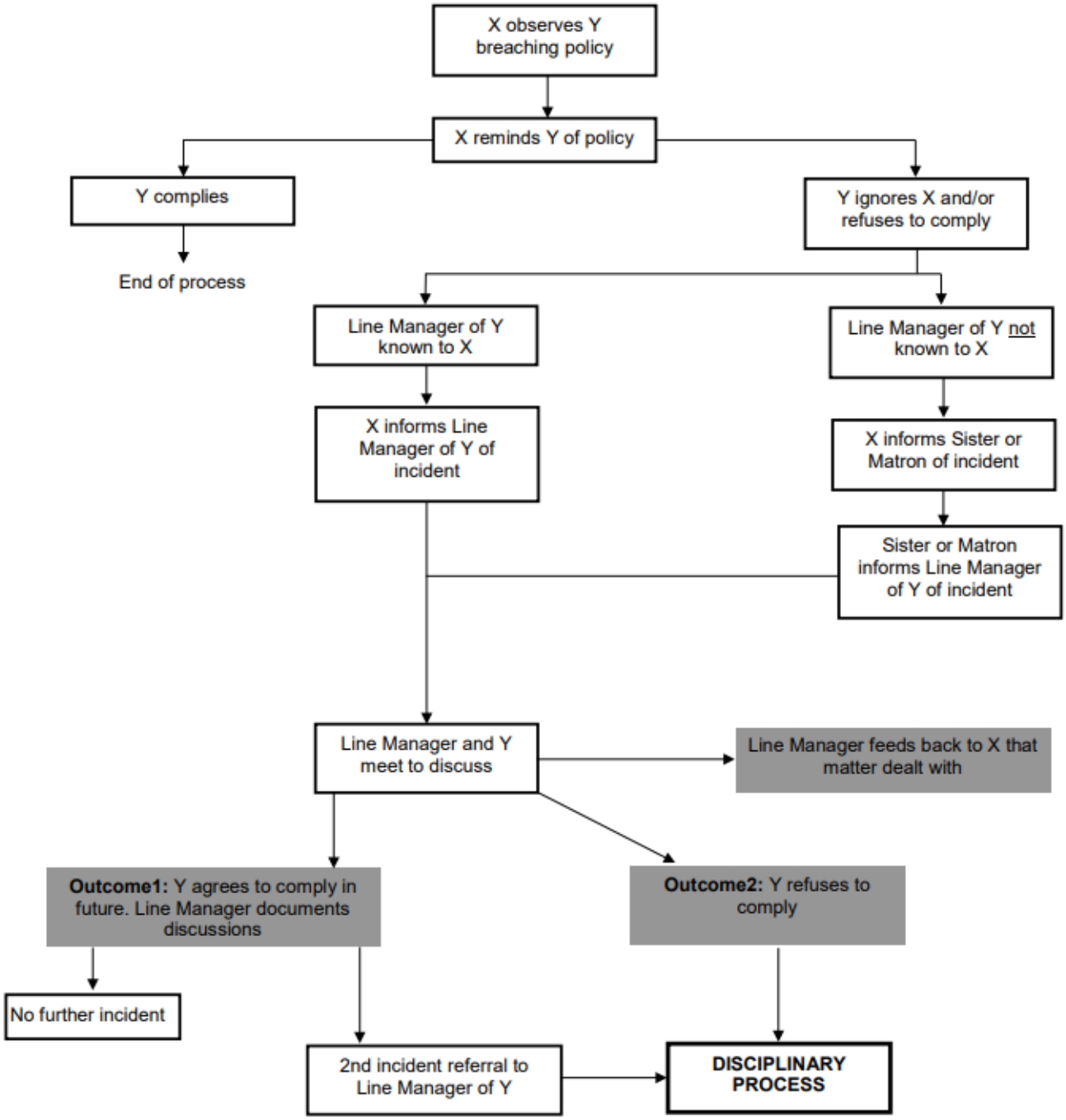
World Health Organization (2020) Hand Hygiene for All Initiative. Improving access and behaviour in health care facilities. 9789240011618-eng.pdf Accessed: April 10th 2021.

World Health Organization (2021) Evidence for Hand Hygiene Guidelines.

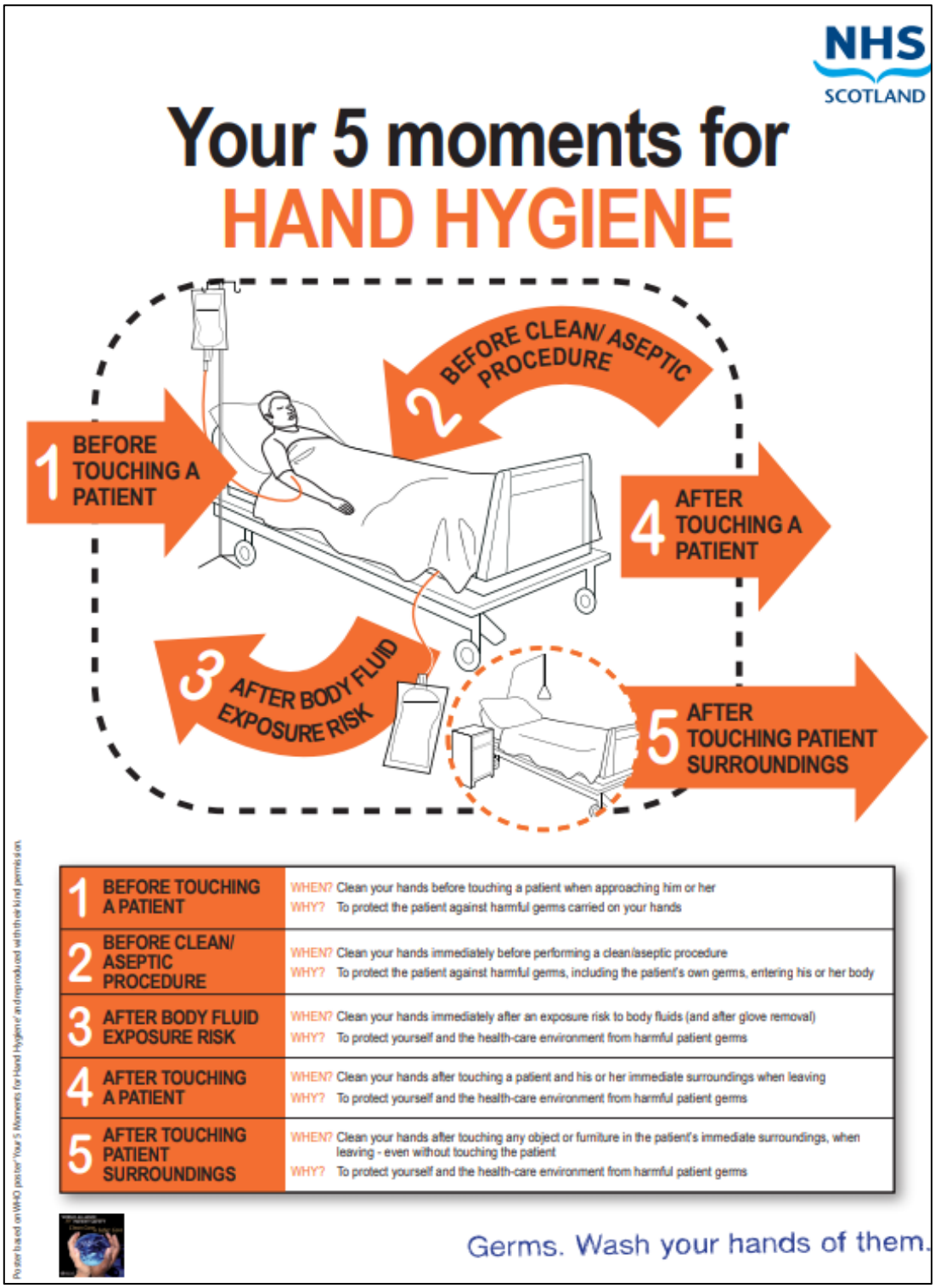
http://www.who.int/gpsc/tools/faqs/evidence_hand_hygiene/en/ Accessed: April 10th 2021.

9. Associated Internal Documentation

9.1 Management of staff non-compliant with UHBW Hand Hygiene Policy



9.2 Your 5 moments for Hand Hygiene



9.3 Staff hand decontamination: Products to use

Situations	Comments	Process
General	Hands are visibly clean	Alcohol hand gel
General	Hands are visibly soiled	Liquid soap and water
Working with patients with *Clostridium difficile*		Liquid soap and water
Norovirus closed Bays/Wards		Liquid soap and water
Undiagnosed diarrhoea and/or vomiting		Liquid soap and water
Prior to donning non-sterile gloves	Assess whether patient has diagnosed/ undiagnosed diarrhoea and/or vomiting before using alcohol hand gel	Liquid soap and water or alcohol hand gel
After removing non-sterile gloves		Liquid soap and water or alcohol hand gel
Prior to donning sterile gloves		Antiseptic*
After removing sterile gloves		Antiseptic* or liquid soap or alcohol hand gel
Critical care areas		Antiseptic* or liquid soap or alcohol hand gel
Working with immunocompromised patients		Antiseptic* or liquid soap or alcohol hand gel
Areas where patient food is prepared		Antibacterial liquid soap

* Antiseptic solutions (e.g., 4% chlorhexidine gluconate) can be harsh on the skin. It is advised that they are primarily used prior to aseptic procedures; where sterile gloves need to be worn, when working with immunocompromised patients and in critical care areas.

10. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table.

Objective	Evidence	Method	Frequency	Responsible	Committee
Monitoring Hand hygiene compliance to this policy	Hand hygiene audits	Data extraction from hand hygiene monitoring systems	Weekly Quarterly Annually	Divisional leads	Infection Control group
Monitoring the impact of hand hygiene on the health of staff hands	Datix reported incidences of hand hygiene related skin damage	Data extraction from incident reporting system-Datix	Quarterly	Occupational Health	Infection Control Group

11. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	[DITP - Dissemination Lead Job Title]
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	A
If answer above is B: Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	[DITP - Document to be disseminated to]
Method of dissemination:	[DITP – Method of Dissemination]
Is Training required:	No
The Training Lead is:	[DITP - Training Lead Job Title]

Additional Comments
[DITP - Additional Comments]

12. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:
http://nww.avon.nhs.uk/dms/download.aspx?did=17833

Query	Response
What is the main purpose of the document?	
Who is the target audience of the document? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ **Staff Patients Visitors Carers Others**

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		X	
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	
Gender reassignment		X	
Pregnancy and maternity		X	
Race (includes ethnicity as well as gypsy travelers)		X	
Religion and belief (includes non-belief)		X	
Sex (male and female)		X	
Sexual Orientation (lesbian, gay, bisexual, other)		X	
Groups at risk of stigma or social exclusion (e.g., offenders, homeless people)		X	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?			NA
Will it help to get rid of discrimination?			NA
Will it help to get rid of harassment?			NA

Will it promote good relations between people from all groups?			NA
Will it promote and protect human rights?			NA

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
Significant	Some	Very Little	NONE	Very Little	Some	Significant

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Is a full equality impact assessment required? NO

Date assessment completed:

Person completing the assessment: