Leicestershire Partnership NHS Trust

Hand Hygiene Policy

Including Bare Below the Elbows

This policy describes the Processes and Procedures for Hand Hygiene for all staff working within Leicestershire Partnership NHS Trust.

Key Words:	Hand Hygiene	
Version:	7	
Adopted by:	Quality Assurance Committee	
Date Adopted:	18 June 2019	
Name of Author:	Mel Hutchings Infection Prevention and Control Nurse	
Name of responsible Committee:	Infection Prevention and Control Committee	
Date issued for publication:	June 2019	
Review date:	September 2021	
Expiry date:	1 March 2022	
Target audience:	All LPT staff	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?		

Contents

Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Version 1.0	August 2007	Review of national guidelines relevant to policy
Version 2	September 2009	Replaces K027 V1 and K028 Version 1
Version 3	October 2009	Reviewed by A. Howell. Changed from guidelines to policy and incorporated associated CQC requirement changes and requirements from the NHS LA standards
Version 4	August 2011	Harmonised in line with LCRCHS, LCCHS, LPT (Historical organisations)
Version 5	December 2014	Reviewed in line with policy review date.
Version 6	June 2015	Review of policy against current legislation
Version 7	October 2017	Further review of policy by Antonia Garfoot encompassing Bare Below the Elbows Flow chart, standards and rationale
Version 8	January 2019	Reviewed in line with current practice and guidelines Clarity made with regards to the requirements for staff to adhere to national hand hygiene policy The flowchart and accompanying rationale for BBE has been modified to remove the allowance to attend a shift not BBE but to remove when delivering direct patient care. This was removed to eliminate any ambiguity in practice.

For further information contact:

Infection Prevention and Control Team

Definitions that apply to this policy

Disinfection	A process used to remove harmful organisms with alcohol/or other chemical
Decontamination	Process of cleaning to remove contamination
Hand hygiene	The act of cleaning hands for the purpose of removing soil, dirt and microorganisms
Infections	An organism which is present at a site and causes an inflammatory response or where the organism is present in a normally sterile site
Organisms	Defined as any living thing, in medical terms we refer to bacteria and viruses as organisms

1.0 Purpose of the policy

There are many different forms of hand hygiene WHO (2009). However, within this policy, hand hygiene refers to the decontamination of hands by methods including routine hand washing and the use of alcohol hand sanitisers.

Another method of washing hands is a surgical scrub. However within LPT we would not routinely use this method and therefore it is not covered in this policy. Should a surgical scrub be indicated please take advise from the specialist practitioner who has recommended it.

This policy has been developed to give clear guidance to staff in relation to the procedures for hand hygiene set by LPT.

Direction is given on:

- Indications for hand hygiene
- Types of cleansing agents and indications for use
- Hand hygiene technique
- Promoting hand hygiene
- Healthcare workers with patient contact
- Bare Below the Elbows
- Failure in regard to formally assessed hand hygiene (Appendix 2)

2.0 Summary and key points

Hand Hygiene is considered the single most important factor in the control of infection (Weston, 2013). It is an essential practice for patient safety, carried out by staff, visitors and patients.

Healthcare associated infections (HAI) are the most frequent adverse event during care delivery and are a global problem for patient safety. The prevention and management of the risk of HAI's is an essential part of maintaining patient safety and fundamental in any healthcare setting (WHO 2011).

Staff compliance with guidance for hand hygiene is often poor (Boscart et al 2012). The reasons why staff do not wash their hands include lack of available hand hygiene products, lack of time and the personal belief that they will not spread infection. The National Patient Safety Agency chose hand hygiene as their first national priority for action and implemented a national programme to improve staff hand hygiene compliance in 2004, 2008 (NPSA 2008)

The transfer of organisms between humans can occur directly via hand, or indirectly via an environment source (eg, clinical equipment, furniture, toys, or sinks). Loveday et al (2014).

World Health Organisation (WHO) First global Patient Safety Challenge “Clean Care is Safer Care” has expanded on the tools originally developed for this strategy and the concept of “MY five moments for hand hygiene” was developed (Sax et al 2007)

3.0. Introduction

The purpose of this policy is to provide all staff employed by LPT with a clear and robust process for hand hygiene. This policy applies to all permanent employees including medical staff who work for LPT including those on bank, agency or honorary contracts within LPT. All health professionals should ensure they work within the scope of their professional code of conduct.

Hand hygiene is one of the simplest, most cost efficient ways of reducing healthcare acquired infections and reducing the risk of cross infection from person to person. It is a mandatory requirement that all staff are aware of the hand hygiene policy and adhere to correct management of hand hygiene at all times. Hand hygiene forms part of the mandatory training requirements for all clinical staff and should be updated every two years. This policy supports that training.

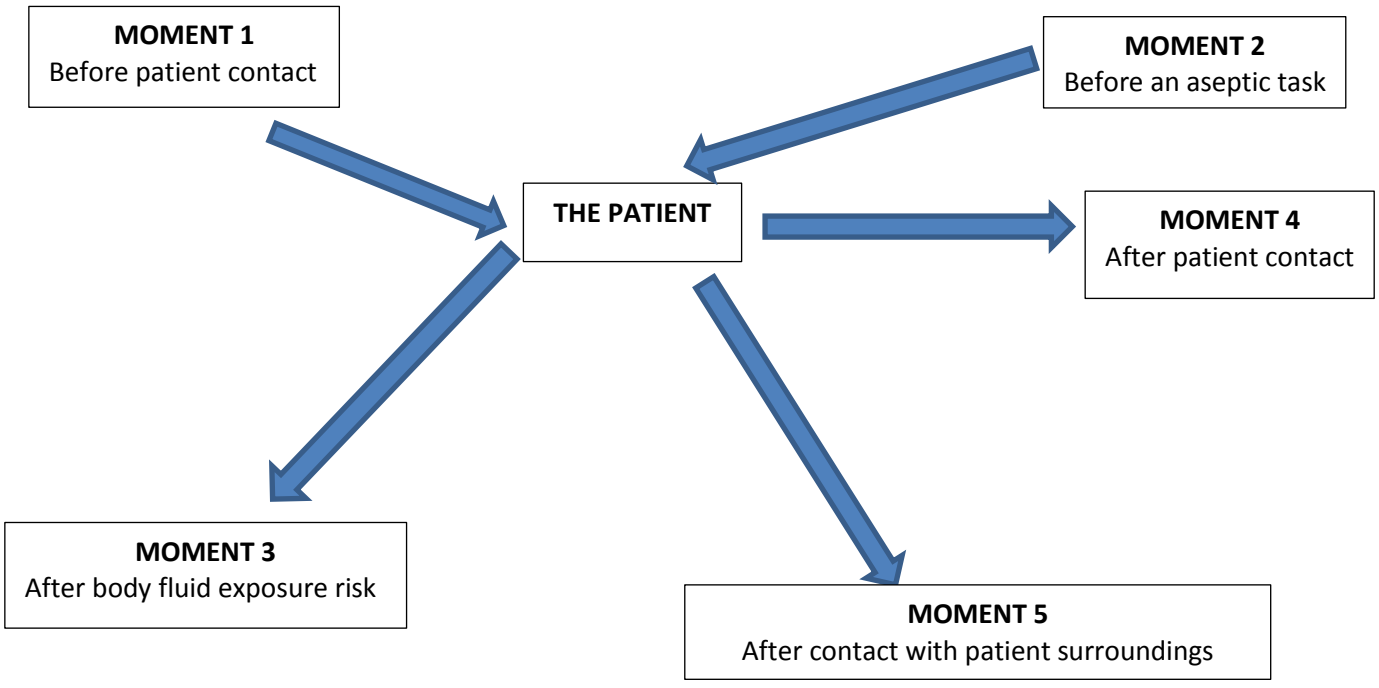
4.0 Hand hygiene

4.1 Indications for hand hygiene

Good hand hygiene at the point of care has been shown to reduce the spread of healthcare associated infections. Hands must be decontaminated immediately before each and every episode of patient contact or care and after any activity or contact that potentially results in hands being contaminated.

The World Health Organisation developed evidence-based recommendations for when hand decontamination should be carried out. This is known as the "five moments for hand hygiene" (WHO 2012), and are numbered according to a natural sequence of workflow:

YOUR 5 MOMENTS OF HAND HYGIENE



Where there is contact with a patient who is receiving source isolation precautions hands must be decontaminated first with liquid soap and water followed by alcohol sanitiser.

Alcohol sanitiser is not effective against viruses or protons such as clostridium difficile spores which can cause diarrhoea.

Resident flora

This type of flora forms part of the body's normal defence mechanism and has 2 main functions. The normal microbiota maintained an environment that inhibits colonisation with potentially pathogenic organisms and it also helps in the provision of nutrients for the skin.

Resident flora is rarely associated with infections, however it can cause infections in sterile body cavities, the eyes or on non-intact skin.

Transient flora

This microbiota colonises on the superficial layers of the skin and is more easily removed by routine hand hygiene. The microorganisms do not multiply on the skin surface, but they can survive and sporadically multiply on skin surface and thus can be a key factor in causing cross-infection.

Transient flora is often acquired by HCW's during direct contact with patients or their environment and is the organism that is frequently associated with HCAIs.

4.2 Healthcare workers with direct patient care contact

The Department of Health has confirmed its commitment to the implementation of "Bare Below the Elbows" (BBE) by all NHS Trusts (Johnson 2007). This is based on research that hand and wrists jewellery can harbour microorganisms and reduce compliance with hand hygiene.

All staff must comply with BBE when entering the patient environment. Therefore staff must be BBE whenever they are in a clinical area (a clinical area is any location in LPT premises or off site which includes the patient's own home, where face to face consultations take place and/or direct hands on care is undertaken by staff.

Sleeves can easily become contaminated and are likely to come into contact with patients. Wrist watches must not be worn in clinical areas as they hinder the thorough and effective washing of hands.

Finger nails

Finger nails must be kept clean, short, smooth and natural. When hands are viewed from palm side, no nail should be visible beyond the fingertip. Nail varnish, false nails, gel or infills should **never** be worn.

False nails encourage the growth of bacteria and fungi around the nail bed. This is because they can limit the effectiveness of hand washing. The nail bed is often scuffed to facilitate attachment of the false nail and the fixative can sometimes give rise to nail bed damage. These issues may result in infection, particularly fungal infection, for the wearer and will certainly present a risk of cross infection for the patient (Walasek et al, 2018).

Hand and wrist Jewellery

Stoned rings, (including engagement rings and stoned wedding and eternity rings), wristwatches, bangles, friendship bands, Fitness trackers, and charity bracelets must not be worn when working in the clinical environment or undertaking clinical activity. One wedding ring or steel Kara bracelet is permitted. Staff who need to wear an “alert bracelet “should ensure their manager is aware as is Occupational Health and a non-fabric bracelet (or necklace) is worn. (WHO 2009)

For religious requirements some staff may wish to cover their forearms, in this instance disposable sleeves from elbow to wrist must be available. These are single use only and should be treated as any other PPE. (LPT PPE policy 2018)

Skin care

Hands should be maintained in good condition to discourage the accumulation of micro-organisms. This includes the regular application of hand moisturiser, which should be perfume free, preferably water-based and contain an effective preservative and provided by the organisation. Staff should not provide their own moisturisers. Moisturisers should be dispensed from sealed units, and should not be re-filled. If hand moisturiser is supplied via occupational health for a particular member of staff and therefore is not dispensed from a sealed unit it should be clearly identified for individual staff use.
Any member of staff who is unable to use the available hand hygiene products due to the development of, or existing skin condition / allergy, must seek advice from Occupational Health and/or their general practitioner and report to their line manager. Staff can be referred to Occupational Health by their manager or can self-refer.

Cuts and abrasions must be covered with an occlusive, waterproof dressing which should be changed as frequently as necessary (soiled or damaged)

Hand hygiene audits are carried out within LPT to monitor staffs adherence to the hand hygiene policy. The audits are reviewed by the Infection Prevention and Control Committee and there is a formal process to be followed should anyone fail the audit (Appendix 2).

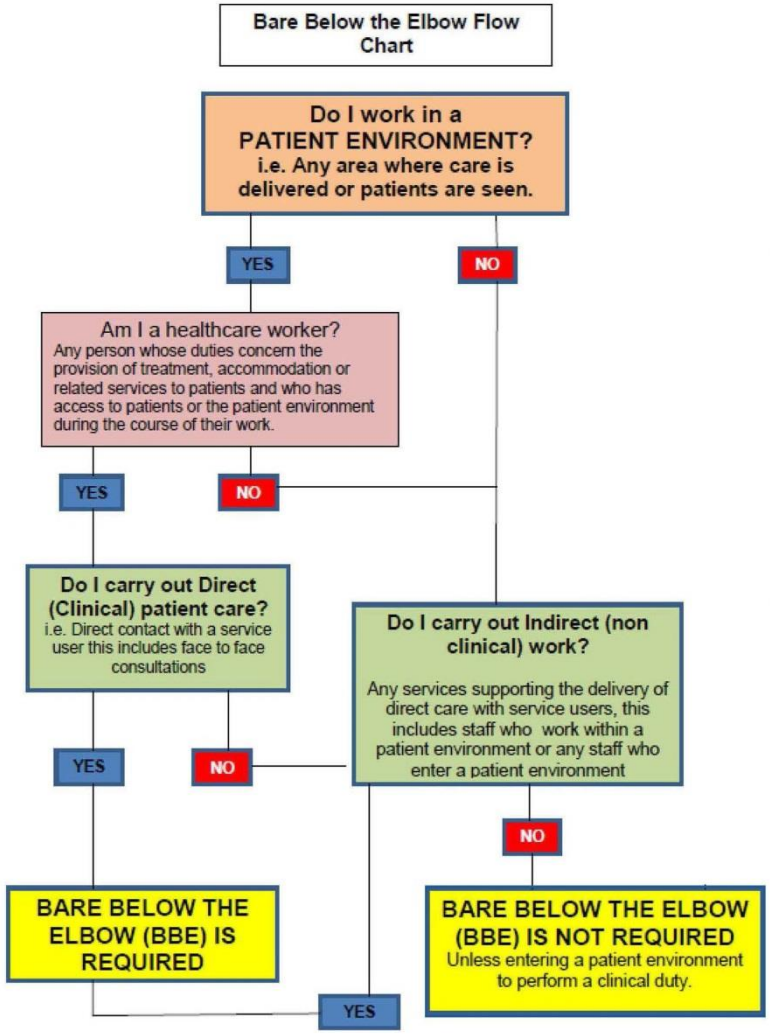
Hands must be decontaminated immediately before each and every episode of patient contact/care and after any activity or contact that potentially results in hands becoming contaminated.

This includes when entering a clinical area. A clinical area is anywhere a patient is receiving care and so includes inpatient areas, clinics and outpatient areas and patient's homes where a HCW is entering as part of their duties whilst employed by LPT. The HCW does not actually have to be delivering hands on care for for the area to be classed as a clinical area.

Where there is contact with a patient who is receiving source isolation precautions hands must be decontaminated first with liquid soap and water followed by alcohol sanitiser.

Alcohol sanitizer is not effective against clostridium difficile spores and viruses, for example, norovirus.

FLOW CHART AND RATIONALE FOR BARE BELOW THE ELBOWS



Adapted from Central and Northwest London NHS Trust Hand Hygiene Policy (2017)

NHS
Leicestershire Partnership
NHS Trust

Bare Below the Elbow Standards & Rationale	
Standard	**Rationale**
Keep finger nails short and clean	Microbes can thrive beneath finger nails
Do not wear false nails or nail polish	False nails and nail polish discourage thorough hand washing Micro-organisms thrive in nail glue and in cracked nail polish
Do not wear wrist watches, bracelets and rings with stones and ridges. One plain band is permitted.	
Sleeves must be short or rolled up to facilitate effective hand decontamination.	High numbers of bacteria can be found on skin under rings, wrist watches and bracelets. Wearing these discourages effective hand washing.
Cardigans may be worn outside, but not in the clinical area or during any care activity that involves direct patient contact.	Hand decontamination cannot effectively take place, putting patients at risk
Any breached skin - cuts, dermatitis or abrasions - must be covered with a waterproof dressing.	To reduce the risk of cross contamination
Permissible Jewellery	**Unacceptable Jewellery**
Plain wedding band	Rings other than a plain band • Engagement rings • Eternity rings Ridges, stones or grooves harbour higher levels of micro-organisms & could potentially damage the integrity of a patient's skin
Kara bracelet A steel bracelet (usually worn on the right wrist) by members of the Sikh faith	Bracelets other than a Kara • Charity bracelets • Friendship bands • Silks loosely tied around the wrists by Hindus are not acceptable and must be removed. • Woven silk or cotton bracelets such as the Rakhis worn by Hindus and Jains for the festival of Raksha Bandhan will need to be removed for compliance with this policy.
Medic-Alert Bracelets- May be worn after consultation with Occupational Health. These must be non-fabric.	Wrist watches/ Fitness Trackers

4.3 Types of cleansing agents and indications for use

Liquid soap and water

For hand washing, liquid soap and running water must be used. Soaps must not be decanted from one container to another.

- Before and after contact with a patient.
- When hands are visibly soiled.
- After dealing with a patient who has a known or suspected infection.

Alcohol sanitiser

Alcohol sanitiser will not remove dirt and organic matter and can therefore only be used on hands that are visibly clean.

It should not be used prior to handling medical gas cylinders due to the risk of ignition.

Alcohol sanitiser is useful in situations where hand washing and drying facilities are unavailable or inadequate, or where there is a frequent need for hands to be cleaned i.e. in-between bed making, during the drug round, in patient's own homes.

Staff who experience skin problems when using any hand hygiene products should be assessed by Occupational Health. They can be referred by their manager or via self-referral.

4.4 Hand hygiene technique

A good technique which is performed at the correct time, which covers all surfaces of the hands, is as important as the cleanser used or the length of time of hand washing (see Appendix 3). However research suggests that hands need to be washed for at least 15-30 seconds (Jensen et al, 2012), and many countries and global organisations recommend the optimal time for washing hands to be 20 seconds, with an additional 20-30 seconds added for drying hands effectively. (WHO, 2009).

However, the duration of washing needs to be as long as required to ensure all areas of hands have been covered. Hands should be systemically rubbed, ensuring all part of the hands and wrists are included, taking particular care to include the areas of the hand which are most frequently missed.

Hands must be washed using a sink with elbow or wrist operated taps, or alternatively automatic taps. If elbow or wrist operated taps are not available then the taps must be turned off with a clean paper towel which is then disposed of.

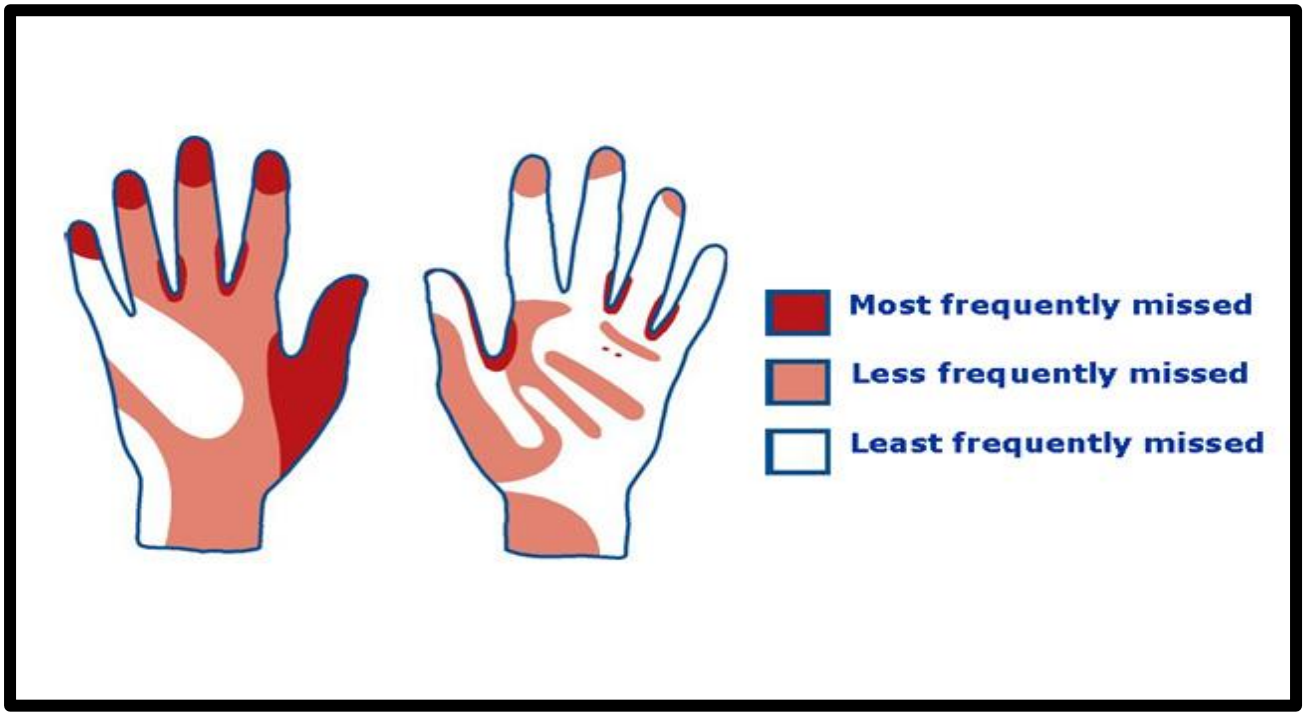
Contact time and friction appear to be more important than the temperature of water, though for staff comfort, water should be warm. Clean running water should be used as hands can become recontaminated if a basin of standing water is used. (Palit A et al 2012). The surfactants in soap remove dirt and micro-organisms from the skin and it has been shown that people will scrub their hands more thoroughly when using soap than when using water alone (Burton et al, 2011).

Hands should be rubbed together, ensuring all areas of the hands and wrists are covered, including underneath the plain wedding band, if worn. Lathering and scrubbing hands has been shown to create friction, which helps in the removal of dirt and microbes which are present on all areas of the hands including under the nails, which is why they must be short. (Gordin et al 2007).

Dry hands thoroughly with single use paper towels – discard after use (wet hands are more likely to become damaged and also harbour more micro-organisms)

Bar soap **must not** be used as it poses a cross infection risk. Only liquid soap must be used.

Areas frequently missed during hand washing



Taylor L (1978)

4.5 Promoting hand hygiene

Adequate facilities should be provided in a healthcare environment complying to HTM 64 (2014), to encourage staff to clean their hands appropriately when indicated. This includes:

- Dedicated hand wash basins that are clean and accessible
- Liquid soap in wall mounted easy to sue and easy to clean holder systems that contain single use disposable cartridge sets
- Wall mounted disposable paper towel dispensers containing soft absorbent disposable paper towels
- Plugs must not be used in hand wash basins
- Nail brushes must not be used
- All hand wash basins in healthcare settings, wherever possible, should be fitted with elbow operated or hands free mixer taps
- Foot operated lidded pedal bins if use, must also be positioned near the wash basin. (Note: it may not be appropriate for foot operated lidded pedal bins to be used in some healthcare areas within LPT).

In areas where facilities are either unavailable or do not fit LPT standards? (such as patients own home) then alternative provisions should be made/sought. Healthcare professionals working within the primary care environment should be provided by the organisation with a personal supply of liquid soap, alcohol hand sanitiser, and hand cream. A supply of disposable paper towels/kitchen towels for hand drying will also need to be provided.

4.6 Responsibility for ensuring compliance

All staff have a duty of care to adhere to the hand hygiene policy.

The person who has overall responsibility for the ward, team or department is accountable for ensuring that the hand hygiene policy, which includes BBE is adhered. This person is responsible for audit, observation and the reporting of compliance to the policy. They must also personally demonstrate and promote adherence to the policy.

The person with overall responsibility for the ward, team or department is expected to challenge and correct poor practice when observed by them or reported to them. This can be achieved through appraisal and or training.

5.0. Training needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as mandatory.

All staff attend Trust induction delivered by the Learning and Development team in line with the Mandatory Training Register and hand hygiene is included within the Infection Prevention and Control section of this training.

Furthermore, any additional training required due to an individual's role will be undertaken as required.

6.0. References and associated documents

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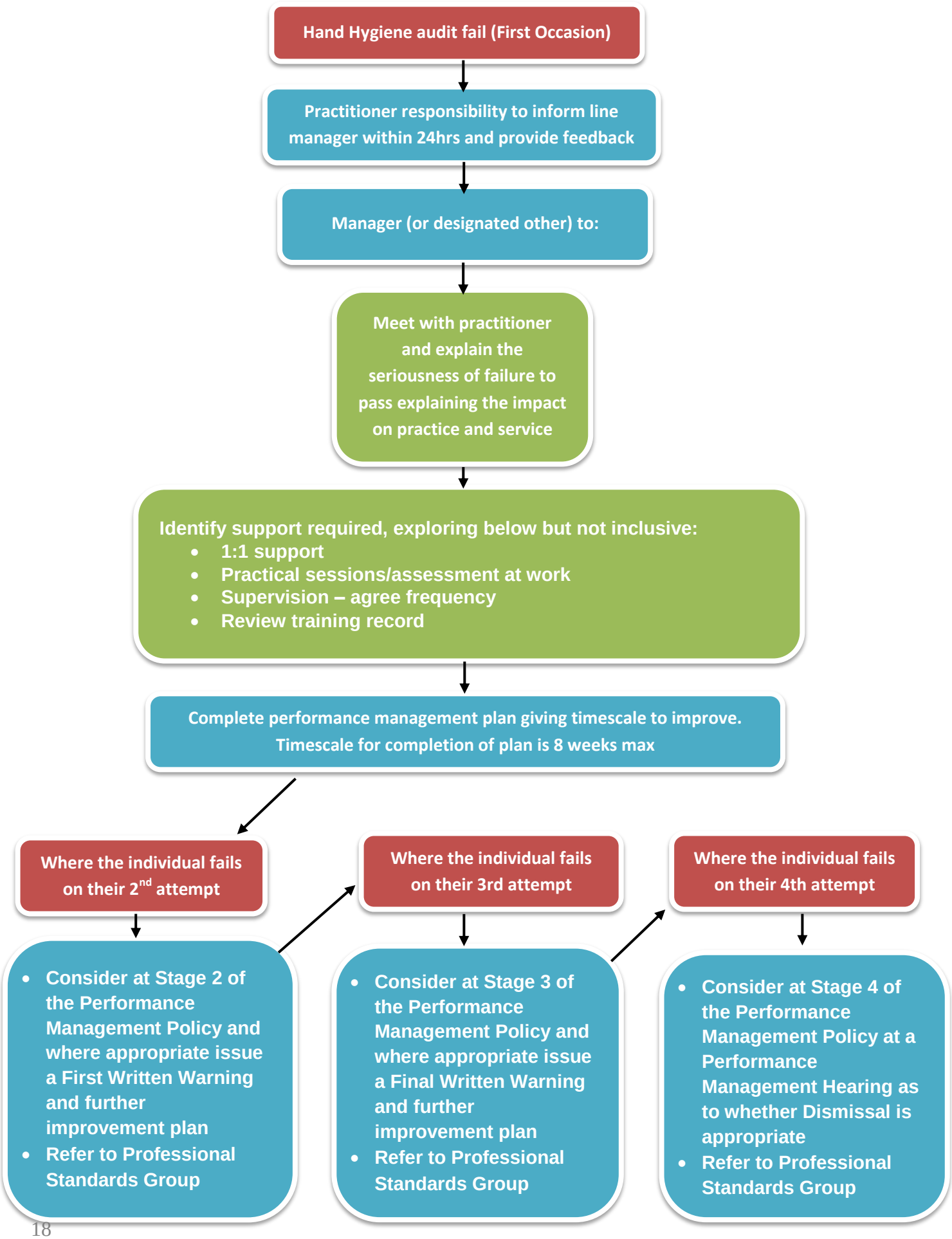
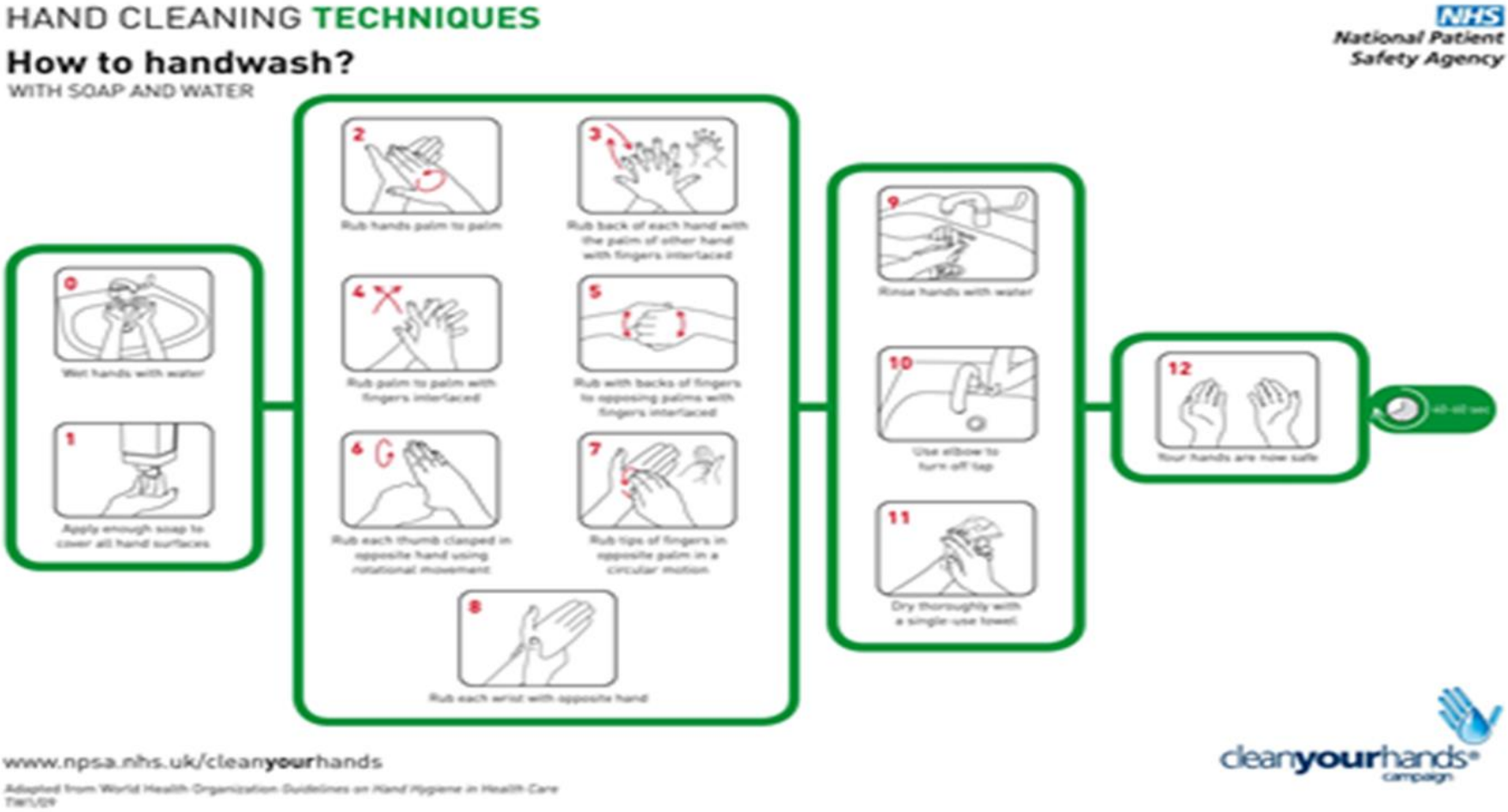
Appendix 1

Process for failure of formally assessed hand hygiene audits



Appendix 2

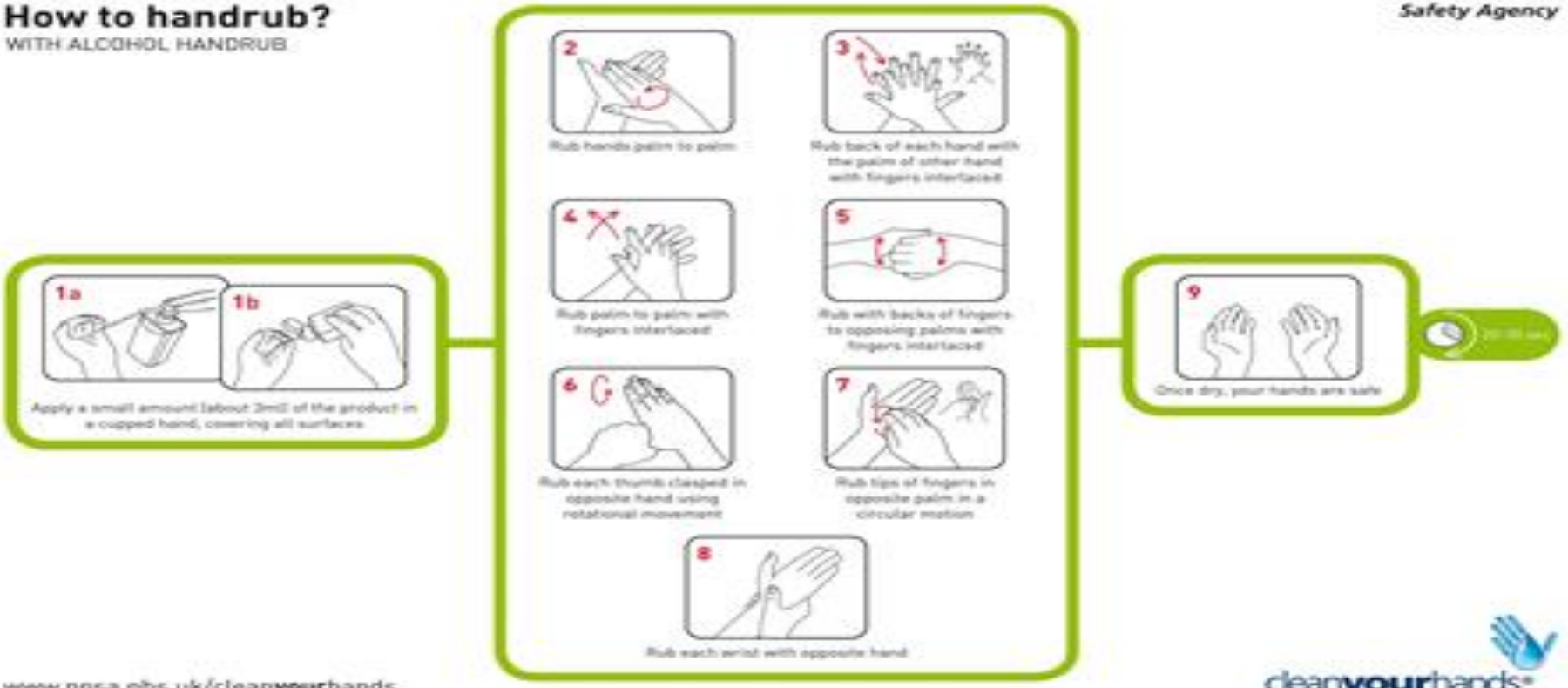

HAND CLEANING TECHNIQUES
How to handwash?
WITH SOAP AND WATER
NHS
National Patient
Safety Agency
0
Wet hands with water
1
Apply enough soap to cover all hand surfaces
2
Rub hands palm to palm
3
Rub back of each hand with the palm of other hand with fingers interlaced
4
Rub palm to palm with fingers interlaced
5
Rub with backs of fingers to opposing palms with fingers interlaced
6
Rub each thumb clasped in opposite hand using rotational movement
7
Rub tips of fingers in opposite palm in a circular motion
8
Rub each wrist with opposite hand
9
Rinse hands with water
10
Use elbow to turn off tap
11
Dry thoroughly with a single-use towel
12
Your hands are now safe
www.npsa.nhs.uk/cleanyourhands
Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
cleanyourhands campaign

HAND CLEANING TECHNIQUES

How to handrub?

WITH ALCOHOL HANDRUB

NHS National Patient Safety Agency



www.npsa.nhs.uk/cleanyourhands

Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
THEO/09

cleanyourhands campaign

Appendix 3

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment. **The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Hand Hygiene Policy, including bare below the elbows**		
Completed by:	**Mel Hutchings**		
Job title	**Infection Prevention and Control Nurse**	**Date**	**20/12/18**

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**no**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	
Date of approval	

Acknowledgement: Princess Alexandra Hospital NHS Trust

Appendix 4

Contribution List

Key individuals involved in developing the document

Name	Designation
Mel Hutchings	Infection Prevention and Control Nurse
Amanda Hemsley, Antonia Garfoot, Andy Knock Annette Powell	Infection Prevention and Control Team
Helen Thuraisingham	Clinical Nurse Manager – TB Service, Leicester, Leicestershire and Rutland TB Nursing Service

Circulated to the following individuals for consultation

Name	Designation
De Anne Scott	Deputy Chief Nurse
Amin Pabani	Service Manager, Podiatry
Bernadette Keavney	Head of Trust Health and Safety Compliance
Claire Armitage	Lead Nurse AMH&LD Community Services
Donna Bottrill	Community Services Matron
Dr Lauren Ahyrow	CCDC Consultant, Public Health England
Elizabeth Compton	Senior Matron AMH
Emma Wallis	Associate Directors of Nursing and Professional Practice
Helen Walton	Property Manager, Estates and Facilities
Jane Martin	Matron LD Services
Kam Palin	Senior Occupational Health Nurse
Katie Willetts	Senior Nurse FYPC
Laura Belshaw	Lead Nurse MHSOP
Michelle Churchard	Lead Nurse AMH&LD Inpatient Services
Pauline Blake	Acting Training Delivery Manager, Learning Development Team
Sally Smith	Facilities Manager, Non Acute Hospitals Soft FM
Sarah Latham	Lead Nurse, Community Hospitals, ICS CHS
Steph Marlow	Community Team Leader, CHS Division
Tejas Khatau	Lead Pharmacist, FYPC Services
Tracy Yole	Lead Nurse CHS Community Services