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 (LPT)

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Policy on a page

Summary and aim

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

The purpose of this policy is to provide all staff that are employed by LPT with a clear and robust process for hand hygiene.

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-person.

It is a mandatory requirement that all staff are aware of the hand hygiene policy and adhere to the correct procedures for 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.

Target audience

This policy applies to all permanent employees working within LPT including medical staff and members of staff working on the bank, Agency, or honorary contract.

Training

Infection Prevention & Control Level 1 E-Learning 3 Yearly

Infection Prevention & Control Level 2 E-Learning 2 Yearly.

Hand hygiene Practical assessment Yearly

Key requirements

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

The direction for staff is given on the following aspects.

- Indications for hand hygiene practice
- Types of cleansing agents and indications for use
- Hand hygiene technique
- Promotion of hand hygiene

- Healthcare workers with patient contact
- Bare Below the Elbows (BBE) guidance
- Failure in regard to formally assessed hand hygiene practice (Auditing)

Introduction and Purpose

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

The purpose of this policy is to provide all staff employed by LPT with a clear and robust process for hand hygiene practice.

Hand hygiene is considered to be the single most important factor in the control of infection (Weston, 2013). It is an essential practice for maintaining patient safety and should be carried out by all staff, visitors, and patients within our healthcare setting.

Healthcare associated infections (HAI) are the most frequent adverse events ha occurs during care delivery and continues to be 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 is fundamental in any healthcare setting (WHO 2011).

Staff compliance with guidance for hand hygiene has been recognised as often being poor (Boscart et al 2012) and the reasons why staff do not wash their hands include:

- Lack of available hand hygiene products
- Lack of time
- 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 program to improve staff hygiene compliance in 2004 & 2008 (NPSA 2008), this focus still remains ever present.

All staff should have training on hand hygiene, and it is best practice that this is provided at least annually.

This practice should minimise the risk of poor hand hygiene and ensure that process is in place to prevent this from re-occurring.

It is essential that everyone takes responsibility to ensure that the care provided is carried out in a safe manner.

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

The World Health Organisation (WHO) first global patient safety challenge 'Clean Care is Safer Care' expanded on the tools originally developed for this strategy and the concept of 'My 5 moments for hand hygiene' was developed (Sax et al, 2007).

Policy Requirements and Objectives

Process

1.1 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 (WHO) developed evidence-based recommendations for when hand decontamination should be carried out, this is known as the five moments for hand hygiene which are numbered accordingly to a natural sequence of workflow (WHO, 2012) (See appendix 1).

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 and therefore hands should only be decontaminated with soap & water

1.2 Microbiology of the hands

The skin on our hands harbour two types of microorganisms:

- Transient microorganisms (Transient Flora)
- Resident Microorganisms (Resident Flora)

Transient Microorganisms-

This includes bacteria & fungi which are located on the superficial layers of the skin and can be moved more easily by routine hand hygiene.

They are termed 'Transient' as they do not stay long, however they are easily transferred to other people for example through contact with a patient, wound, care equipment and the environment.

Transient Microorganisms can be easily transmitted from the hands of staff to vulnerable patient sites.

Transient flora is often acquired by Health care Workers (HCW) during direct contact with patients or their environment and is an organism that is frequently associated with HCAI'S.

Resident Microorganisms

This type of flora forms part of the bodies normal defence mechanisms and has two functions:

- Marinating an environment that inhibits colonisation with potential pathogenic organisms.
- Helping the provision of nutrients for the skin

Resident microorganisms are rarely associated with infections; however, it can cause infections if they enter the body through the broken skin or the person is immunocompromised.

Unlike transient microorganisms they are not easily removed with routine handwashing alone and handwashing should be followed by an application of alcohol handrub.

1.3 Skin care

Hands should be maintained in a good condition to discourage the accumulation of microorganisms.

This includes regular application of hand moisturiser which should be perfume free, preferably water based and contain an effective preservative and be one that is provided by the organisation.

Moisturisers should only be dispensed from sealed units and should not be re-filled. (Moisturisers used should only be trust approved products which can be found in the

green wall mounted dispensers near to hand wash sinks within our healthcare premises).

If the hand moisturiser supplied via occupational health is for a particular member of staff and therefore is not dispensed from a sealed unit then it should be clearly identified as for individual staff use.

Staff should not provide their own moisturisers

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 the occupational health team and/or their general Practitioner (GP) and report to their line manager-

Staff can be referred to occupational health by their manager or they can also self-refer

Cuts and abrasions must be covered with an occlusive waterproof dressing which should be changed as frequently as it is necessary i.e., if it becomes soiled or damaged.

Hands must be decontaminated immediately before and after each and every episode of contact/ care and after any activity or contact that may potentially result in hands becoming contaminated, this includes when entering a clinical area.

A clinical area is **'Anywhere a patient is receiving care and so would include inpatient areas, clinics, outpatient areas and also patients' homes where an 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 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 hand sanitiser.

Alcohol sanitiser is not effective against viruses or protons such as clostridium difficile spores which can cause diarrhoea and therefore hands should only be decontaminated with soap and water

Hand hygiene audits are carried out within LPT to monitor staff's adherence to the hand hygiene policy.

These audits are recorded on the Audit Management & Tracking (AMAT) system and are reviewed by the Infection Prevention & Control (IPC) group.

***Should any staff member fail the hand hygiene audit being undertaken then there is a formal process that should be followed (See appendix 2) *.**

Hand hygiene audit expectations for inpatient settings are decided from bed base and staffing levels within the ward/area.

If you are unsure of the audit expectations within your area, then please contact your ward manager or the IPC team:

IPC team contact details are as follows:

Telephone-01162952320 (This is an answerphone service)

Email-lpt-ipcteam@nhs.net

The current expectation is that each member of staff in the community are audited on their hand hygiene practice at least once per year.

It is the responsibility of the line manager to ensure that all team members are audited within the year.

Community teams should spread their audits out across the year they should not be completed in bulk at the end of the year.

If for any reason, an inpatient or community ward/team are unable to input their hand hygiene audits they should record this as 'no submission' with reason on AMAT so that it does not affect compliance scores.

Audit Expectations for inpatient community settings will be reviewed annually with directorate leads and the IPC team.

1.4 Types of cleansing agents & indications for use

Liquid soap

For hand washing, liquid soap and running water must be used, soap **must not be** decanted from one container to another and must be carried out:

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

Hands must then be thoroughly dried with paper towels (If this is not achievable e.g. community staff when visiting a patient's home may not have access to paper towel then a clean, dry towel can be considered for use)

Liquid soap used should only be dispensed from a sealed unit & should not be re-filled. (Liquid soaps used should only be trust approved products which can be found in the blue wall mounted dispensers within our healthcare premises).

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 when handwashing and drying facilities are unavailable or inadequate, or where there is frequent need for hands to be cleaned ie in between bed making, during a drug round or in patients own homes.

Staff who experience skin problems when using any hand hygiene products should be assessed by occupational health.

Referrals to occupational health can be made by the staff members manager or via the self-referral route.

One of the most common skin problems reported is skin dermatitis, early signs of skin dermatitis can include:

- Dryness
- Itching
- Reddening of the skin

If left untreated this can then develop into:

- Flaking
- Scaling
- Cracks
- Swelling
- Blistering of the skin

If staff experience any skin problems as listed above then this must be escalated to their line manager and a referral to the occupational health should be made

(Please see appendix 3 HSE skin checks for dermatitis poster)

1.5 Hand hygiene techniques

A good technique which is performed at the correct time which covers all the surfaces of the hands is as important as the cleanser used or the length of time of the hand-washing practice.

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 that 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 that all areas of the hands have been covered.

Hands should be systematically rubbed ensuring that all areas 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 taps must be turned off with a clean paper towel which is then disposed of. (If this is not achievable e.g. community staff when visiting a patient's home may not have access to paper towel then a clean, dry towel can be considered for use for this purpose).

Contact time and friction appear to be more important than the temperature of the water, though for staff comfort water should be warm.

Clean running water should be used as hands can become re-contaminated if a basin of standing water is used (Palit a et al 20012).

The surfactants in soap remove dirt and microorganisms from the skin and I 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 that all areas of the hand and wrist 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 nails, which is why they must be kept 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 microorganisms (If this is not achievable e.g. community staff when visiting a patient's home may not have access to paper towel then a clean, dry towel can be considered for use)

Bar soap **Must not be used** as it poses a cross-infection risk; only liquid soap must be used.

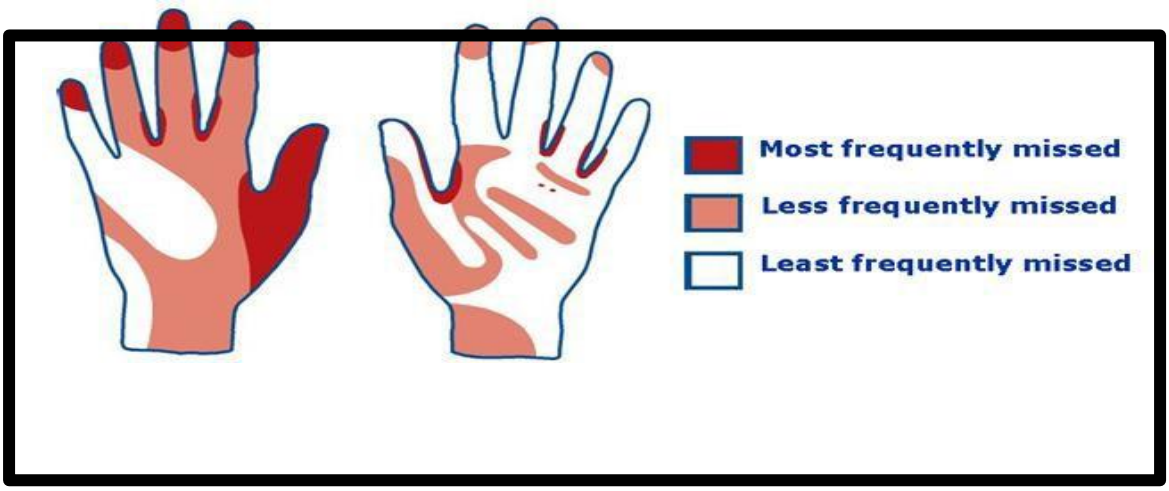

Diagram 1-Areas most frequently missed during hand hygiene.

1.6 Promoting hand hygiene.

Adequate facilities should be provided in a healthcare environment complying to HTM 64 (A guide to medical tap and basins regulations) to encourage staff to clean their hands appropriately when indicated and includes:

- Dedicated hand wash basins that are clean and accessible
- Liquid soap in wall mounted easy to use and easy to clean holder systems that contain single use disposable cartridge sets.
- Wall mounted disposable paper towels containing soft absorbent disposable towels.
- Plugs Must not be used in handwash 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 used must also positioned near to the hand 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 patient homes) then alternative provisions should be made/sought.

Healthcare professionals working within primary care environments should be provided by the organisation with a personal supply of liquid soap, alcohol sanitiser, and hand cream.

A supply of disposable towel/kitchen towel for hand drying will also need to be provided.

Healthcare workers with direct patient care contact and Bare Below the Elbows

The department of health has confirmed that its commitment to the implementation of ‘’Bare Below the Elbows’ (BBE) to be carried out by all NHS trusts (Johnson 2007).

This is based on research that hand and wrist 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 area/location within LPT premises or off site which includes the patient’s own home **when face to face consultation takes place and/or direct hands-on care is undertaken by staff ***

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

Fingernails

Fingernails must be kept:

- Clean
- Short
- Smooth
- Natural

When nails are viewed from palm side no nails should be visible beyond the fingertip and the following should never be worn:

- Nail varnish
- False nails
- Gel nails or infills.

False nails encourage the growth of bacteria and fungi around the nail bed; this is because they can limit the effectiveness of handwashing.

The nail bed is often scuffed to facilitate the 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 & wrist Jewellery

The following must not be worn by staff when working in the clinical environment or undertaking clinical activity:

*A clinical area is any area/location within LPT premises or off site which includes the patient's own home **when face to face consultation takes place and/or direct hands-on care is undertaken by staff ***

- Stoned rings (Including engagement rings, stoned wedding rings, and stoned eternity rings),
- wrist watches.
- Bangles
- Friendship bands
- Fitness trackers
- Charity bracelets

One wedding ring or steel Kara Bracelet is permitted, staff who need to wear an 'Alert bracelet' Should ensure that their manager is notified and also the occupational health team.

The alert bracelet will also need to be a non-fabric bracelet or necklace and will need to be moveable to ensure that effective hand hygiene practice can be carried out, it should also be regularly cleaned to remove any potential microorganisms.

Wedding band/civil Partnership band

Single Wedding band/civil partnership bands worn should be:

- Plain in design (Not decorated or elaborated) simple and basic in design.
- Should be smooth-having regular surfaces and be free from perceptible projections, lumps, grooves, or indentation.
- Must be able to be moved up the finger to allow cleaning underneath.
- Must NOT contain any stones.

Religious Bracelet (Kara)

Religious bracelets (Kara) should be:

- Plain (Not decorated or elaborated) simple and basic in design.
- Smooth-having even regular surfaces and be free from perceptible projections, lumps, grooves, or indentations.
- Be able to be moved up the arm to allow for cleaning underneath.
- Must be made of steel.

No fabric or other religious bracelets are permitted to be worn on the wrist as these can prevent effective hand hygiene being carried out

Any member of staff wearing such items which do not meet the above standards will be failed on the hand hygiene audits which are carried out.

Please refer to appendix 6 for the flow chart & rationale for Bare Below the Elbows

Please refer to the LPT workwear & uniform policy for further guidance on BBE & workwear/uniform.

BBE adjustment guidance

There may be some circumstances such as disability or religious & cultural grounds where staff may be unable to follow BBE requirements. Managers will be expected to take each case on individual merit, by undertaking a risk assessment and equality impact assessment. It is important that mangers seek advice and guidance from the HR advisory or the Equality Diversity and Inclusion team for clarification.

In this instance a risk assessment must be carried out by the staff members line manager, there is no specific risk assessment for this, and a generic HR risk assessment can be used.

The risk assessment should demonstrate why BBE is not able to be followed and measures that have been put into place to ensure that safe and effective hand hygiene can continue, Consideration should be given to the following:

- The wearing of ¾ sleeves which can be rolled up (It may be that a special uniform needs to be purchased for the staff member)

- The use of oversleeves (Oversleeves should be used only as a last resort)

Please refer to appendix 4 for BBE adjustment guidance further guidance

Disposable oversleeves should be elasticated at the wrist and elbow to cover forearms during patient care activity.

Oversleeves must be removed to facilitate effective hand washing and a new set of oversleeves applied.

Strict adherence to washing of hands and wrists must be observed before and after each use.

Oversleeves if worn **Must be changed** immediately after each patient and/or after completing a procedure/task even on the same patient, and hand hygiene performed.

Oversleeves **must be removed** and disposed of if they are visibly damaged, contaminated, or soiled.

Oversleeves are classed as healthcare waste and once removed they **must be discarded** into the appropriate waste streams in exactly the same way as disposable gloves.

Oversleeves are single use and should be treated as any other PPE (Please refer to the LPT Personal Protective Equipment (PPE) for use in healthcare policy)

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Roles and Responsibilities

Roles and responsibilities including duties of relevant individuals and groups.

Lead Executive Director

Responsible for ensuring that this policy is carried out effectively and that hand hygiene is manged effectively across the organisation.

Will communicate, disseminate, and ensure that directorates commence implementation of this policy and provide assurance through the trusts quality governance Framework.

Executive Management Board

Responsible for ensuring that this policy is carried out effectively and that hand hygiene is addressed and manged effectively across the organisation.

Will communicate, disseminate, and ensure that directorates implement the policy and provide assurance through the trust quality governance framework.

Governance Group level 1 and 2

Responsible for ensuring that all relevant staff are aware of the hand hygiene policy and adhere to the principles and guidance that is contained within it.

Policy Team

Responsible for ensuring that the Hand hygiene policy is reviewed in accordance with identified timescales and implementation of monitoring and effectiveness has been planned, is reviewed by directorates, and appropriate governance groups.

Policy Authors

Responsible for ensuring that the Infection, Prevention & Control team identify best learning and practice to inform this policy and update accordingly.

To ensure that this policy is reviewed in accordance with identified timescales and implementation of monitoring and effectiveness has been planned and is reviewed by by the directorate and appropriate governance group.

Operational leads

Responsible for ensuring the policy is implemented within their area and for ensuring that all staff who work within the area adhere to the principles of this policy at all times.

Staff

Each individual member of staff, substantive and temporary worker within the trust is responsible for complying with this policy.

Clinical staff involved in the care of patients will ensure that they familiarise themselves with the content of the policy and work in accordance with this.

Staff will also ensure that they provide support and education to the patient, carer, and family where appropriate.

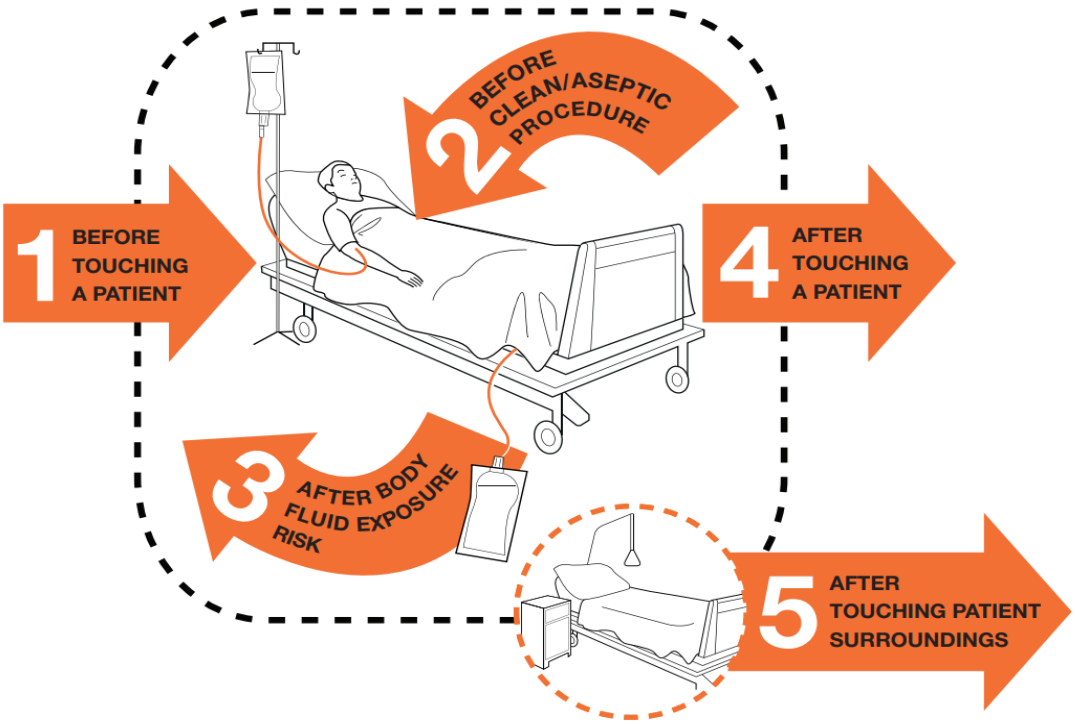
They will also be a source of knowledge and skill for colleagues where appropriate as well as ensure that they remain up to date with training in line with competencies of their job roles.

Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered.

Appendix One Your 5 Moments of Hand hygiene

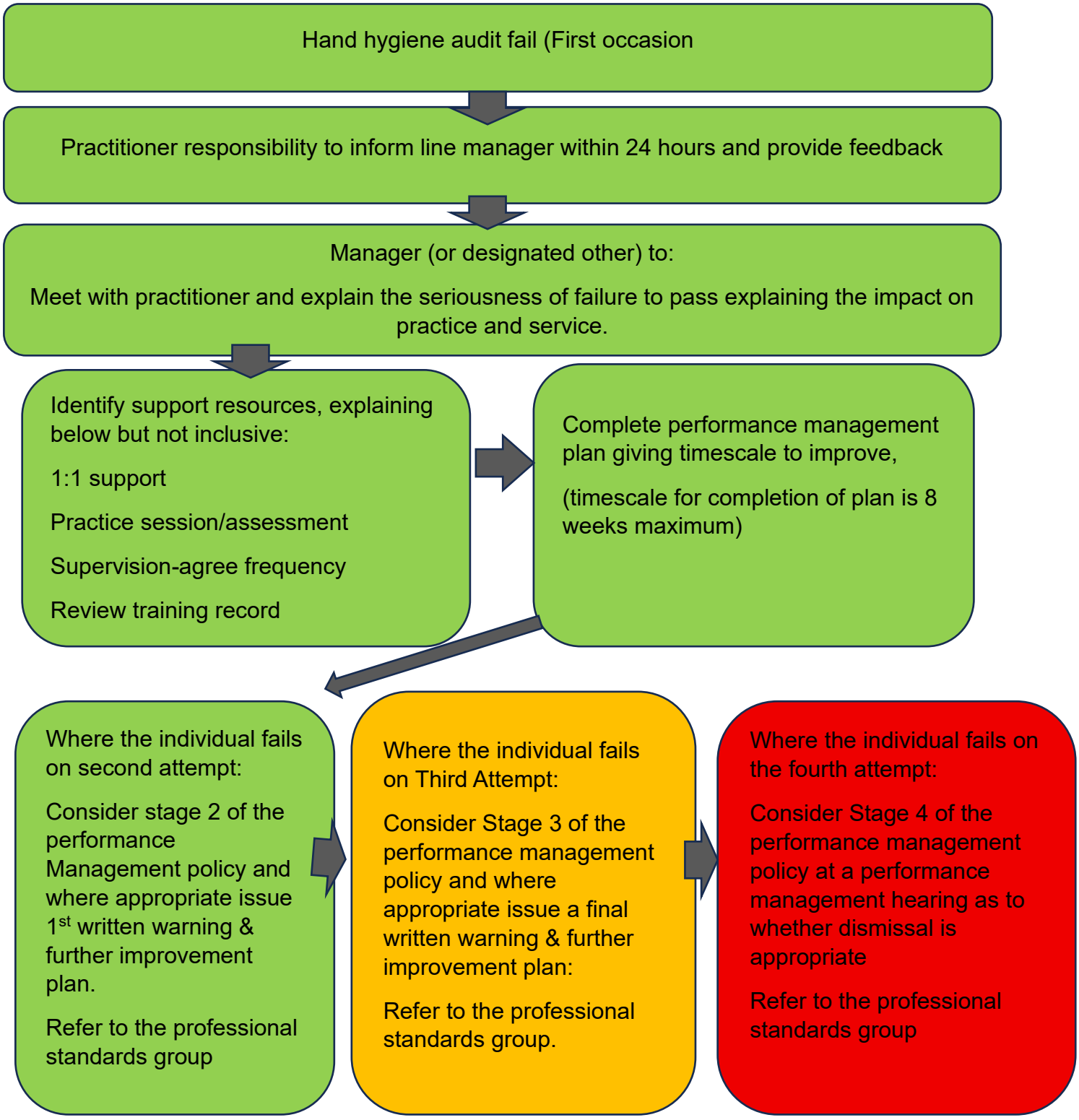
Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

Appendix 2 Process for failure of formally assessed hand hygiene audit

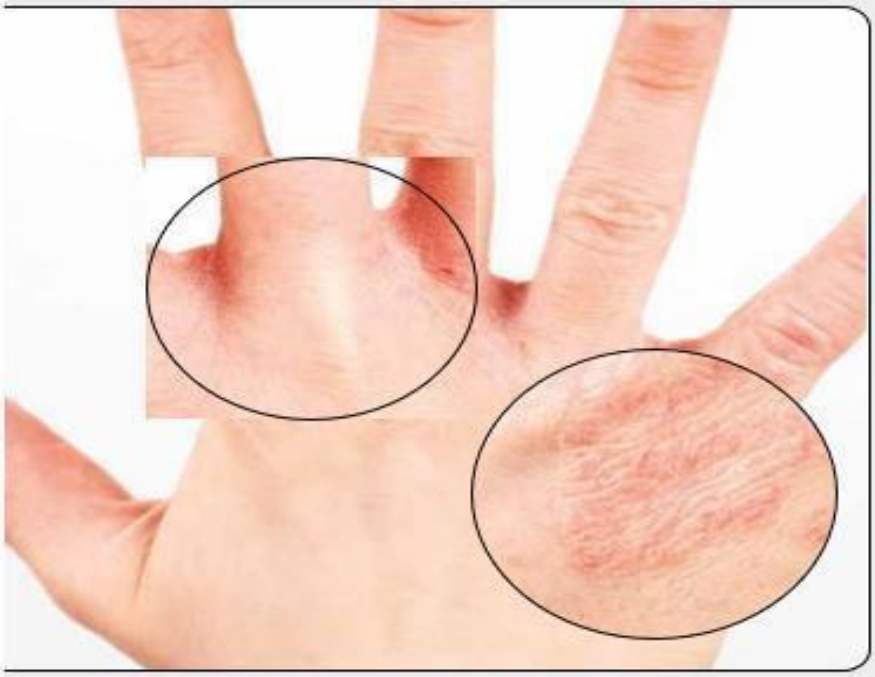


Appendix three Skin checks for dermatitis

HSE
Health and Safety Executive

Skin checks for dermatitis

Regularly check your skin for early signs of dermatitis



Look for...

Dryness
Itching
Redness

...which can develop into
flaking, **scaling**
cracks, **swelling**
and **blisters**

If you think you may have dermatitis, report it to your employer
Contact name
Your employer may need to refer you to an Occupational Health Doctor or Nurse

www.hse.gov.uk

Appendix four BBE Adjustment guidance: Risk assessment process

There may be some circumstances such as disability or religious & cultural grounds where staff may be unable to follow BBE requirements. In this instance the following must be carried out:

A risk assessment must be carried out by the staff members line manger with the member of staff, there is no specific risk assessment for this, and a generic HR risk assessment tool can be used.

The risk assessment must demonstrate why BBE can not be followed and include the measures that have been put into place to ensure that safe and effective hand hygiene practice can continue with the proposed adaptations in place.

The line manager will need to identify appropriate actions and process to be put into place to support the staff member.

The line manager will also need to liaise with the head/deputy head of nursing during the process to ensure that they are aware and supportive of the staff member continuing to work within their area.

The risk assessment should identify the wearing of ¾ sleeves in the first instance which can be rolled up to allow for safe and effective hand washing to be carried out by the member of staff.

The line manager will also need to liaise with the head/deputy head of nursing during the process to ensure that they are aware and supportive of the staff member continuing to work within their area.

If the wearing of ¾ is not achievable then consideration for purchase of a special uniform will be required

*LPT do not stock ¾ length sleeve uniform these would need to be ordered specifically if required

¾ sleeves will need to be able to be rolled up to facilitate effective handwashing.

If the above adjustments are not achievable for the staff member, then as a **last resort** the use of an oversleeve should be considered. These are available from NHS supply chain (Supplied in large packs of 200)

https://mysupplychain,nhs/catalogue/search-oversleeve

On completion of the risk assessment the head/deputy head of nursing for the directorate in which the staff member works will need to be contacted and they will need to agree the outcome/recommendation of the risk assessment that has been completed for the adjustment to BBE requirements to be implemented for the staff member in their area of work.

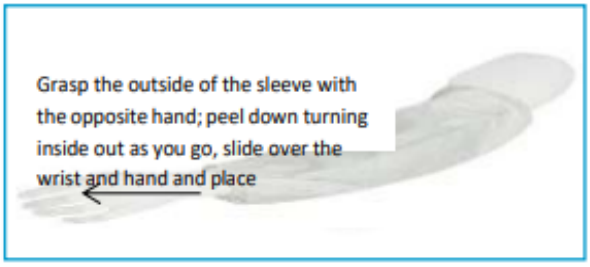
Oversleeves are a single use product and should be treated as any other PPE (Please refer to the LPT Personal Protective Equipment (PPE) for use in healthcare policy)

Oversleeves must be removed to facilitate effective hand washing and a new set of oversleeves applied.

Oversleeves must be made of a latex free material

Donning

Doffing



Appendix 5 Student supply of disposable single use arm oversleeves/gauntlets.

Student supply of disposable single use arm oversleeves/gauntlets

Hand Hygiene and Bare Below the Elbow (BBE) Policy

Health and Safety Personal Protective Equipment (PPE) Policy

All students must adhere to the Trusts policy for BBE and follow the correct rationale. Where students for religious requirements may wish to keep their forearms covered, they will be able to wear disposable oversleeves/gauntlets from elbow to wrist.

A personal supply of oversleeves will be made available from Learning and Development (L&D) for the sole use of students who require them whilst on placement. Students can request them as per process chart below.

Students must be aware and agree to working in accordance with above policies and the guidance of clinicians and supervisors in practice regarding the use of oversleeves. This includes removing oversleeves after each episode of care, rolling full-length sleeves up to complete the necessary hand washing.

University assessment of students confirms requirement for oversleeves.

⇓

University informs students of process to access stock of sleeves from L&D contact 0116 2958976.

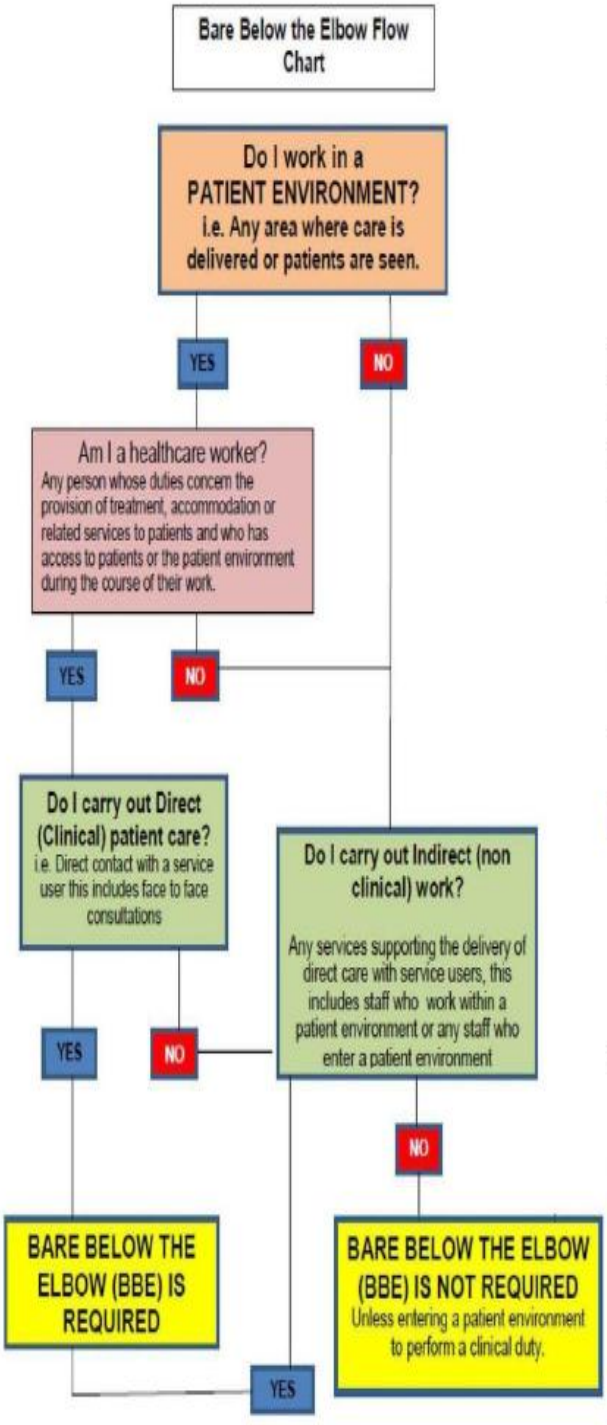
⇓

Student checks with their placement area if oversleeves are available in their practice area. If not, student can contact L&D and request a personal supply. They will agree number required, date and time of collection.

⇓

Collection point:
Glenfield Education and Training Centre, LE3 9EJ

L&D will purchase and order in stock as and when required. Delivery will usually be within 2 days of order. Stock will be stored until expiry date and then re-ordered when next required. Having central stock reduces risk of waste not being used before expiry date due to small amounts currently being required, supporting the Trusts Green Plan.

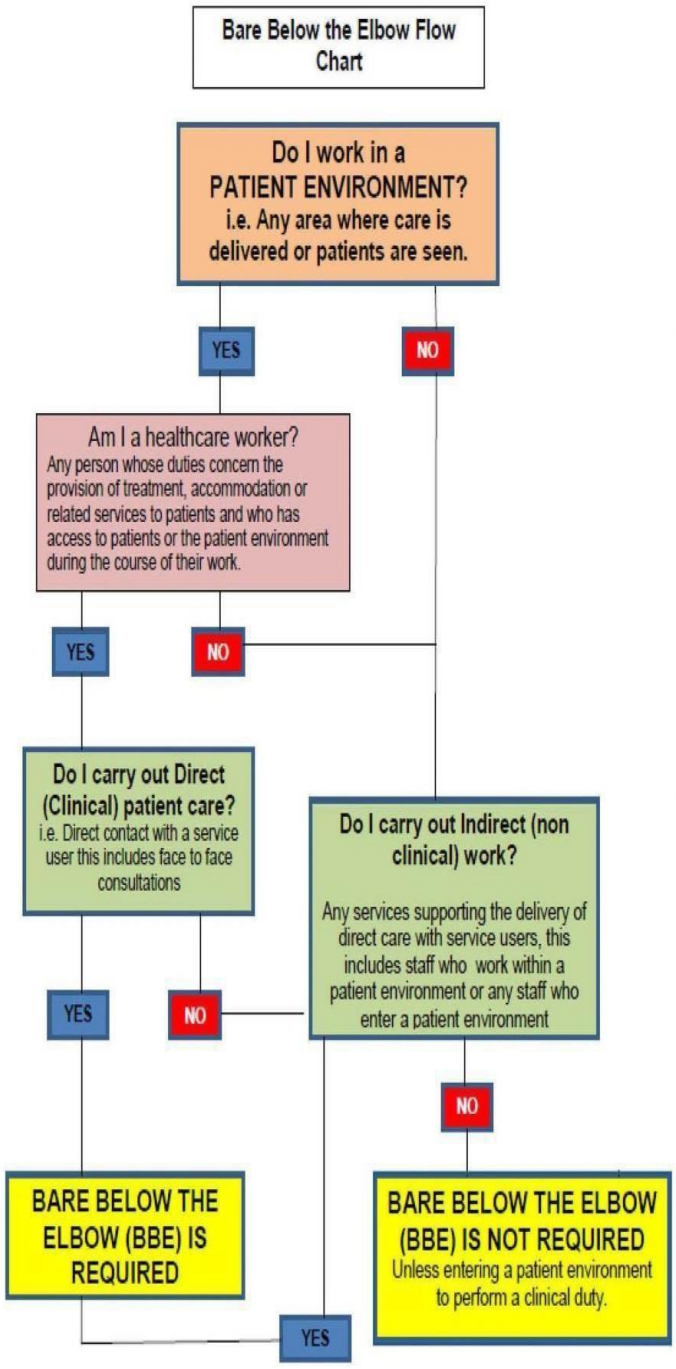


Adapted from Central and Northwest London NHS Trust Hand Hygiene Policy (2017)

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. Cardigans may be worn outside, but not in the clinical area or during any care activity that involves direct patient contact.	High numbers of bacteria can be found on skin under rings, wrist watches and bracelets. Wearing these discourages effective hand washing. 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

Appendix six: Flow chart and Rationale for Bare Below the Elbows



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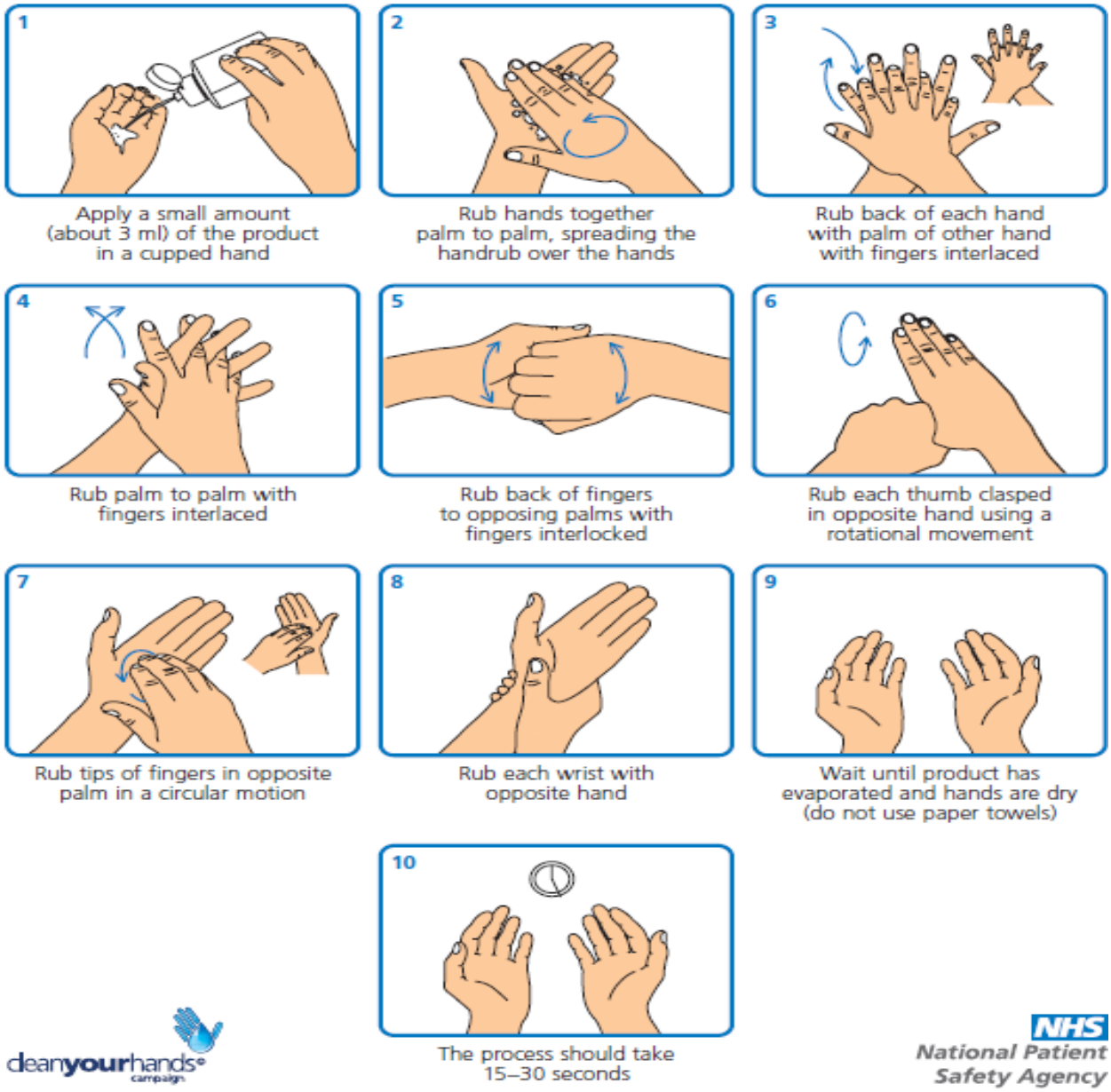
Appendix Seven Handwashing technique with soap and water.

Appendix eight Alcohol handrub hand hygiene technique for visibly clean hands

NHS

Alcohol handrub hand hygiene technique – for visibly clean hands



cleanyourhands campaign

NHS
National Patient Safety Agency

Appendix Nine: Governance

Version control and summary of changes

Version number	Date	Description of key change
Version 1.0	August 2007	Reviewed national guidelines relevant to policy
Version 2.0	September 2009	Replaces K027 V1 & K028 Version 1
Version 3.0	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 4.0	August 2011	Harmonised in line with LCRCHS, LCCHS.LPT (Historical organisations)
Version 5.0	December 2014	Reviewed in line with policy review date
Version 6.0	June 2015	Review of policy against current legislation
Version 7.0	October 2017	Further review of policy by Antonia Garfoot encompassing Bare Below the Elbows flow chart, standards, and rationale.
Version 8.0	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 flow chart for Bare Below the Elbows 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.
Version 9.0	April 2022	Reviewed in line with current practice and guidelines. Clarity added in relation to definitions of plain rings/Kara bracelet.
Version 10.	April 2024	Reviewed in line with current practice and guidelines.
Version 11	April 2026	Reviewed in line with current practice and guidelines-BBE adherence updated to reflect current guidance in relation to religious & disability BBE adjustment.

Responsibilities

Responsibility	Title
Executive Lead	*Group Chief Nurse*
Policy Author	*Head of Infection Prevention & Control*
Advisors	
Policy Expert Group	*Infection Prevention & Control Assurance Group.*

Governance

Governance Level	Name
Level 1 Assurance Oversight	*Quality & Safety committee*
Level 2 Delivery Group for policy approval and compliance monitoring	*Infection Prevention & Control Assurance Group.*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Should describe how you are monitoring what you say you will do in the policy e.g., 100% of nurses will be on the NMC register	Where will this information be reported, what format and how often?
Monitoring will be conducted through Hand hygiene auditing tool on AMAT. Monitoring of compliance will be based on percentage of staff audited for each individual service.	Reported through IPC assurance Group Monthly.

Training Requirements

Infection Prevention & Control Level 1 E-Learning (Non-Clinical staff)

Infection Prevention & Control Level 2 E-Learning (Clinical staff will need to have completed level 1 & level 2 Training)

Hand Hygiene Practical assessment