### Hand Hygiene Policy

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Developed in response to: Health and Social Care Act 2008
Contributes CQC Outcome: Outcome 8

#### Consulted With

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<td>Sue Breitsamiter</td>
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<tr>
<td>Zaheera Hassanali</td>
<td>May 2017</td>
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<td>Lyn Hinton</td>
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<td>Robert Ghosh</td>
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<td>Carin Charlton</td>
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<tr>
<td>Hilary Bowring</td>
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<td>Infection Prevention Group</td>
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#### Professionally Approved By

| Dr Louise Teare | May 2017 |

#### Version Number

| 8.0 |

#### Issuing Directorate

| Infection Prevention |

#### Ratified by

| DRAG Chairmans Action |

#### Ratified on

10th July 2017

#### Trust Executive Sign Off Date

July/August 2017

#### Next Review Date

June 2020

#### Author/Contact for Information

Nicola Gibson / Amanda Kirkham

#### Policy to be followed by (target staff)

All Trust staff

#### Distribution Method

Intranet and Website

#### Related Trust Policies (to be read in conjunction with)

- Standard Infection Prevention Precautions
- ANTT Policy
- Dress Code/Uniform Policy
- Mandatory Training Policy

#### Document Review History

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1. **Purpose**

1.1 The purpose of this policy is to provide detailed guidance on how to perform hand hygiene effectively in order to prevent and control the spread of infection.

1.2 The hands of healthcare workers are the most common cause of transmission of microorganisms between patients and are frequently implicated as the route of transmission in outbreaks of infection.

1.3 To describe the correct hand hygiene technique and the different hand cleansing agents.

1.4 To identify the 5 Moments of hand hygiene.

1.5 To comply with the Health and Social Care Act 2008 Code of Practice on the control and prevention of infections and related guidance.

2.0 **Scope**

2.1 This policy applies to all healthcare staff & employed by the Trust on a substantive and temporary basis.

2.2 This policy also applies to all volunteers and contractors.

3.0 **Equality and Diversity**

3.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

4. **Responsibilities**

4.1 **Chief Executive**

4.1.1 The Chief Executive has overall responsibility for ensuring that the Trust has the necessary management systems in place to enable the effective implementation of this policy and overall responsibility for the health and safety of staff, patients and visitors.

4.2 **Chief Medical Officer**

4.2.1 The Chief Medical Officer has strategic responsibility for ensuring that systems are in place to facilitate awareness of policy amongst medical staff and to provide support to enable staff in delivering practice as outlined in this policy.

4.3 **Chief Nurse**

4.3.1 The Chief Nurse has strategic responsibility for ensuring systems are in place to facilitate the nursing staff’s awareness of this policy and appropriate support is given to enable staff in delivering practice as outlined in this policy.

4.4 **Director of Infection Prevention and Control (DIPC)**

4.4.1 The DIPC will have operational responsibility for the effective implementation of this policy.
4.4.2 The DIPC will give expert advice regarding the spectrum of activity for hand hygiene products

4.4.3 To include as part of the divisional scorecards the hand hygiene audit results in the monthly DIPC report

4.5 Infection Prevention and Control Team (IPT)

4.5.1 To ensure all staff are made aware of this policy

4.5.2 To provide hand hygiene education and training for all staff on induction, during mandatory training and as required in bespoke sessions

4.5.3 Work in collaboration with procurement and occupational health to evaluate hand hygiene products and advise the Trust on the most appropriate alcohol hand rub/liquid soap to use in clinical practice

4.5.4 To support Occupational Health in advising staff (who encounter skin problems on their hands) on the correct hand wash technique and on ways to promote the integrity of their skin

4.5.5 To promote and assist in the education of hand hygiene for patients and visitors

4.5.6 To facilitate the Trust monthly hand hygiene audits

4.6 All staff

4.6.1 To comply with this policy

4.6.2 All staff have a responsibility to ensure that hand hygiene is part of their everyday clinical practice; cleaning their hands at the right time and in the right way thereby preventing infection and improving patient’s safety

4.7 Ward Managers

4.7.1 To ensure that patients have the opportunity to decontaminate their hands if unable to get to a hand wash basin.

4.7.2 To ensure that monthly hand hygiene audits are undertaken and submitted to the Infection Prevention team in a timely manner. To give feedback to staff and to organise any actions required following the audit

4.7.3 To ensure the availability of alcohol gel at the point of care or a risk assessment in place if this is not appropriate

4.7.4 To promote and assist in the education of hand hygiene for patients and visitors

4.7.5 To refer staff who encounter skin problems on their hands to occupational health

4.7.6 To support and ensure engagement with the infection prevention link practitioners for the ward / department.
4.8 Occupational Health

4.8.1 To advise staff (who encounter skin problems on their hands) on ways to promote the integrity of their skin and the appropriate skin emollients

4.9 Procurement

4.9.1 To work with the Infection Prevention Team when evaluating hand hygiene products

5.0 The Microbiology of the Hands

5.1 There are two groups of micro-organisms on the hands: Resident micro-organisms that colonise (or live on) the skin and transient micro-organisms that are carried temporarily on the surface of the skin.

5.2 Resident skin flora

5.2.1 Resident skin flora are present in deep skin crevices and normally colonise skin.

5.2.2 They play an important role in protecting the skin from invasion by other harmful species, and are not readily transferred to other people or surfaces.

5.2.3 Resident organisms are not easily removed but will be significantly reduced by the use of a bactericide such as chlorhexidine.

5.3 Transient skin flora

5.3.1 These are micro-organisms acquired on the hands through contact with the environment or other people.

5.3.2 Easily acquired by touch and readily transferred to the next person or surface touched, and so thought to be largely responsible for the transmission of microorganisms such as Meticillin resistant \textit{Staphylococcus aureus} (MRSA).

5.3.3 Removal of transient organisms from hands is essential in preventing cross-infection, and is easily achieved by washing with soap and water. The use of alcohol gel will also destroy the majority of transient microorganisms on hands if used appropriately.

6.0 Reasons for hand hygiene

6.1 Patients and hospital staff will be colonised with micro-organisms, some of which are potentially harmful. Additionally there will be a number of inpatients who are admitted with infections. Hand hygiene, correctly carried out and at the appropriate time will help to prevent transmission of micro-organisms from staff to patients and from patient to patient.

6.2 Hospitalised patients shed their skin squames and associated micro-organisms into the immediate environment and onto equipment i.e. bed linen, bedside furniture. Hands must therefore be decontaminated after contact with the patient’s surroundings.

6.3 Healthcare workers’ hands have been shown to be vectors of healthcare associated microorganisms picked up from contact with patients or the healthcare environment. Patients’ hands can also become contaminated as a result of contact with the environment.

6.4 Transient carriage of potential pathogenic micro-organisms can lead to serious infection if
they are deposited onto vulnerable sites such as surgical wounds or sites of invasive devices.

6.5 During hand hygiene, the removal and/or destruction of transient micro-organisms and reduction of resident micro-organisms will help to reduce cross-contamination of pathogenic micro-organisms.

7.0 **Indications for hand hygiene**

7.1 It is important to perform hand hygiene at the point of care.

7.2 The WHO 5 moments of hand hygiene (*Appendix 1*) defines the key moments when healthcare workers should perform hand hygiene. This evidence based, user-centred approach is designed to be easy to learn, logical and applicable in a wide range of settings.

7.2.1 This approach recommends health-care workers decontaminate their hands:

- Before touching a patient
- Before clean/aseptic procedures
- After body fluid risk/ exposure
- After touching a patient
- After touching patients surrounding

7.2.2 Hand hygiene must also be performed in the following situations;

5. After using the toilet
6. Before handling food and drink
7. Before and after a shift or span of duty
8. Entering and leaving clinical areas or wards
9. After cleaning equipment or environment
10. After sneezing or blowing your nose
11. After handling notes

7.3 Patients must be encouraged to wash their hands after using the toilet. Those patients unable to mobilise must be provided with a bowl of water and soap or moist hand wipe at the bedside and assisted as necessary. Patients must be requested to clean their hands before meals with an approved disposable moist hand wipe or soap and water.

7.4 Visitors within the hospital will be requested to decontaminate their hands on entry to and exit of the ward area. Alcohol based gel hand sanitisers are wall-mounted in departments and clinical areas for the use of staff, patients and visitors.

8.0 **Preparation for effective hand hygiene by health care workers**

8.1 The Trust expects all clinical staff to adhere to specific standards in order to improve hand washing technique and efficacy;

8.2 All staff must be bare below the elbow at the point of care. This is a **mandatory** standard in all clinical environments and patient areas.

- Nails must be short and unvarnished i.e. not visible beyond the finger tip when viewed from palm side and attention must be paid to them when washing hands.
Staff must not wear false/acrylic/gel nails or nail extensions as these impede thorough, effective hand decontamination and are likely to be harbouring gram-negative organisms.

A plain metal wedding ring may be worn, but no other hand or wrist jewellery.

Staff whose religion requires them to wear a religious symbol may do so provided that they are discreet and comply with infection control and health and safety policies and guidance, e.g. staff that are required to wear a Kara (steel bangle) may do so provided that it is pushed up the arm securely to enable effective clinical hand washing/decontamination.

Wrist watches impair efficient hand washing practice and must not be worn by clinical staff.

Long sleeves MUST be rolled up when entering a clinical area

Cuts and abrasions must be covered with a waterproof plaster.

Food handlers must use blue waterproof dressing plasters to cover cuts

9.0 Hand Hygiene Techniques

9.1 There are 2 recognised techniques for performing hand hygiene, hand washing with soap and water and hand rubbing with alcohol gel

9.2 Staff are required to ensure that they use the appropriate technique for their intended task

9.3 Hand hygiene with soap and water is suitable for all health care activities, including following the removal of gloves where hands are moist and perspiring

- Washing hands with soap and water is appropriate when hands are visibility dirty, soiled with blood or other body fluids or after using the toilet.

- Hand washing with soap and water must be performed after contact with patients with diarrhoea, including suspected or confirmed spore-forming organisms, e.g. Clostridium difficile disease, regardless of whether gloves have been worn.

- The hand washing technique consists of a vigorous rubbing together of all surfaces of lathered hands followed by rinsing under running water and thorough drying. The hand hygiene technique can be seen in Appendix 2.

- During hand washing, particular attention should be paid to those areas of hands which are most frequently missed. (See Appendix 3)

- Hands should be rinsed thoroughly under running water at the end of the process, ensuring all soap residue is removed.

- Dry thoroughly with single-use paper towels. Gently pat skin rather than rubbing to protect hands from cracking.

- Hand drying is an essential part of hand hygiene and healthcare workers must ensure that hands are dried thoroughly. In clinical settings disposable paper towels are the method of choice.
- Used disposable paper towels should be disposed of into a waste, foot-operated bin. Do not use hands to lift the lid or they will become re-contaminated.

- Duration for the entire procedure is appropriately 40 - 60 seconds.

9.4 Alcohol gel may be used for many clinical situations as described in section 7.0. It provides a quick alternative method of hand hygiene that has the benefit of being able to be performed directly in front of the patient thereby affording some reassurance that hand hygiene has been carried out.

- One measure of alcohol gel is applied to visibly clean hands and rubbed onto the hands using the same six steps as for hand washing (Appendix 2). Rub hands until the alcohol gel has evaporated and the hands are dry.

- Hand rubbing with alcohol gel is not recommended when hands are visibly dirty or when having cared for a patient with diarrhoea.

- Duration for the entire procedure is appropriately 20 - 30 seconds

9.5 **Activities when hands can be decontaminated using alcohol-based gel hand sanitiser** (hands must be dry and visibly clean);

- Before and after having direct contact with patients (where there is no exposure to body fluids)

- Before handling an invasive device for patient care, regardless of whether or not gloves are used

- Between different activities for the same patient

- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient

10.0 **Surgical Hand Antisepsis**

10.1 The aim of surgical hand antisepsis is to remove and destroy transient microorganisms and substantially reduce resident microorganisms on the hands of the surgical team for the duration of the invasive procedure. Surgical hand antisepsis should help to inhibit the growth of resident microorganism under gloved hands, and to reduce the release of microorganisms into open wounds if surgical gloves are damaged.

10.2 Types of solution used for surgical hand antisepsis;

- Chlorhexidine 4% in surfactant solution or providone-iodine 7.5% in aqueous solution

- Alcohol-based hand rub available in preparation of 70% to 80% strength

10.3 Surgical hand antisepsis should include the following key principles:

- If nails are visibly dirty use single use nail picks to remove debris from under nails on the first scrub of the day. Nail brushes are not recommended.

- The level of the hands should always remain above the elbows.
• Always use elbow operated taps.

• Apply an appropriate amount of surgical scrub solution and follow the local theatre hand scrub technique as in Appendix 4

• One sterile towel should be used to blot dry the first hand and arm and another sterile towel for the second hand and arm.

• When using alcohol-based hand rub for surgical hand antisepsis, follow the local theatre protocol for hand scrub technique

11.0 Hand Drying

11.1 Effective drying of hands after washing is important because wet surfaces transfer microorganisms more effectively than dry ones and inadequately dried hands are prone to skin damage. In clinical settings, disposable paper towels are the method of choice because communal towels are a source of cross contamination.

11.2 It has been suggested that paper towels not only dry the skin but also remove transient micro-organisms and dead skin cells loosely attached to the surface of the hands. Paper towels should be conveniently placed in relation to hand washing facilities, preferably in a wall-mounted dispenser, where they will not be contaminated by splashing water. Used disposable towels should be disposed of as domestic waste in foot operated bins. Do not use hands to lift the lid or they will become re-contaminated.

11.3 There is conflicting evidence regarding the efficiency of hot air dryers, but they should be avoided in clinical areas due to noise, the time taken to use them and their potential for re-circulating contaminated air.

11.4 Hand drying after surgical hand decontamination must be undertaken using sterile towels whilst maintaining strict asepsis.

12.0 The appropriate use of gloves

12.1 The use of gloves does not replace the need for hand cleansing by either hand washing or alcohol based gel hand sanitiser.

12.2 Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur.

12.3 Remove gloves immediately after caring for a patient.

12.4 Do not use the same pair of gloves for the care of more than one patient.

12.5 Wearing gloves does not replace the need for hand hygiene.

12.6 Gloves will need to be changed when caring for an individual patient if moving from a contaminated body site to either another body site or to a medical device.

12.7 Gloves must be worn as single-use items and must not be washed or decontaminated with alcohol gel.

12.8 Always decontaminate hands after removing gloves.
13.0 Religious issues

13.1 All religions accept the use of alcohol as a medical agent and recognise the unique value of using alcohol-based hand rub in healthcare settings.

14.0 Trust Hand Hygiene Facilities

14.1 Conveniently placed hand wash basins, should be available in all clinical areas. Hand wash basins must be kept clean and free from lime scale and be maintained in good working order. The cleanliness of hand wash basins will be inspected during the 49 steps audits (NPSA April 2007) and during executive walkabouts.

14.2 To ensure staff compliance with the Trust Hand Decontamination Policy, there must be sufficient numbers of hand wash basins located conveniently to where clinical procedures are carried out.

14.3 Clinical hand wash basins are required in the following areas:

- Isolation rooms.
- Clinical treatment rooms.
- Patient assessment / examination suites and consulting rooms.
- Assisted bathrooms.
- Dirty utility rooms.
- Kitchens.

14.4 Clinical Hand Wash Basin Standards

14.4.1 Clinical basins must be used for hand washing only.

14.4.2 Clinical hand hygiene basins must not be used for other purposes e.g. cleaning equipment (HBN 00-10, 2013)

14.4.3 In augmented care units (e.g. ITU, Renal Unit, Neonatal Unit), it is recommended that hand washing is followed by the use of alcohol gel.

14.4.4 Clinical basins must be located appropriately to avoid contamination e.g. away from slop hoppers, bed pan washers or dirty equipment.

14.4.5 Hand washing basins must be easily accessible by healthcare workers, patients and visitors and not used for any other purpose. There must be sufficient basins to encourage hand hygiene compliance.

14.4.6 Taps must be non-touch i.e. elbow or sensor operated.

14.4.7 The IPCT must be consulted with regard to the placement of clinical hand washing basins, particularly with regard to new builds or refurbishments.

14.5 Advantages of soap and water

- Cheap and readily available
- Effectively removes transient micro-organisms
14.6 **Disadvantages of soap and water**
- Time consuming
- Requires facilities for washing and drying
- Can damage skin

14.7 **Alcohol-based preparation**
Alcohol hand rubs and gels offer a practical and acceptable alternative to hand washing in most situations, provided hands are *not dirty*. Alcohol is not a cleansing agent and visible contaminants must be removed with soap and water. In addition, repeated applications of the alcoholic hand rub will produce a build-up of emollient on the skin, which produces a tacky feeling and at this stage, hands should be washed with soap and water.

14.8 **Advantages of alcohol**
- Active immediately against a wide range of micro-organisms
- Requires no facilities
- Kinder to the skin due to added emollients
- Can be packaged into bag/pocket sized containers
- Useful for rapid bedside hand decontamination between patients or procedures
- Useful for community-based Health Care Workers where access to adequate hand washing facilities may be lacking

14.9 **Disadvantages of alcohol**
- Not a cleansing agent
- Astringent, making hands sting if minor skin abrasions are present
- Flammable – requires correct storage
- Emollients build up on the skin after several applications
- Limited activity against bacterial spores and some viruses i.e. Clostridium *difficile* and Norovirus (in these cases soap and water must be used to decontaminate hands)
- Does not have any residual activity.

15.0 **Skin care**

15.1 Bacterial counts increase when the skin is damaged therefore care must be taken to maintain skin integrity. The following will help to maintain the integrity of skin:
- Always wet hands thoroughly prior to application of liquid soap
- Rinse hands thoroughly to remove soap
- Dry hands thoroughly
- Continue to rub in alcohol gel until it is dry as this is when the emollient is released
- Apply good quality hand cream (preferably non-perfumed) at the end of the shift
• Any member of staff who develops eczema, dermatitis or any other skin condition must seek advice from the Occupational Health Department.

• Cuts and abrasions must be covered with a waterproof dressing

• Always wash hands after removal of gloves

16.0 Audit and Monitoring

16.1 The Infection Prevention and Control Group reviews the Infection Prevention and Control policies.

16.2 Compliance with this policy will be monitored as part of the Infection Prevention and Control audit programme and results are reported as a key performance indicator and are monitored at Divisional Governance meetings and by the Infection Prevention and Control Group. Divisions are required to develop localised action plans when hand hygiene does not meet the required standard.

16.3 It is the responsibility of the ward/departmental manager to ensure that monthly hand hygiene audits (Appendix 5) are undertaken and submitted to the Infection Prevention Team. If audit results fall below 95% it is the responsibility of the manager to develop an action plan for improvement. The IPT will provide support where necessary.

16.4 The process to monitor compliance with mandatory hand hygiene training is described in the Mandatory Training Policy.

17.0 Implementation & Communication

17.1 This policy will be issued to the following staff groups to disseminate. These individuals will ensure their staff are made aware of the policy:

• Ward Managers – issue to all nursing staff within their ward
• Matrons- issue to all nursing staff within their department
• Bed Management Team / Service Co-ordinators
• Estate and Hotel Service managers –to issue to all staff within their department
• General Department Managers – HR, IT, Medical Secretaries, Finance, Governance
• Clinical Directors - to issue to relevant medical staff

17.2 The guideline will also be issued via the Staff Focus and made available on the Intranet and a hard copy available in the Ward/Department Infection Prevention Policy folder.

18.0 Training

18.1 The Infection Prevention Team will provide hand hygiene education and training for all staff on induction and during mandatory training as outlined in the Mandatory training policy. Hand hygiene education will be included in the Infection Prevention e-training and delivered as required in bespoke sessions.

18.2 Infection Prevention Link Practitioners will receive hand hygiene “train the trainer” training in order that they are able to cascade train colleagues in their own area and submit training records to the training and development team for updating of personal records.
19.0 References

- Department of Health (2013) Health Building Note 00-10 Part C; Sanitary Assemblies
- Department of Health (2013) Health Technical Memorandum 04-01; The control of Legionella, hygiene, “safe” hot water, cold water and drinking water systems.
- NPSA (April 2007) National Specification for Cleanliness in the NHS
- WHO Guidelines on hand Hygiene in health care, First Global Patient Safety challenge; Clean Care is Safer care (2009), WHO
Your 5 moments for **HAND HYGIENE**

1. **BEFORE PATIENT CONTACT**
   - **WHEN:** Clean your hands before touching a patient when approaching him or her.
   - **WHY??** To protect the patient against harmful germs carried on your hands.

2. **BEFORE ASEPTIC TASK**
   - **WHEN:** Clean your hands immediately before any aseptic task.
   - **WHY??** To protect the patient against harmful germs, including the patient’s own germs, entering his or 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 healthcare environment from harmful patient germs.

4. **AFTER PATIENT CONTACT**
   - **WHEN:** Clean your hands after touching a patient and his or her immediate surroundings when leaving.
   - **WHY??** To protect yourself and the healthcare environment from harmful patient germs.

5. **AFTER CONTACT WITH PATIENT SURROUNDINGS**
   - **WHEN:** Clean your hands after touching any object or furniture in the patient’s immediate surroundings, when leaving even without touching the patient.
   - **WHY??** To protect yourself and the healthcare environment from harmful patient germs.

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**WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.**

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**Appendix 2**

14
Hand Washing Technique

- Wet hands
- Disperse soap
- Palm to palm
- Back of hands
- Inter-digital spaces
- Nails
- Fingertips
- Thumbs and wrists
- Rinse hands
- Dry hands

Alcohol Gel Application

HANDS SHOULD BE VISIBLY CLEAN

- Press front of the dispenser
- Massage into hands as follows:
- Palm to palm
- Back of hands
- Inter-digital spaces
- Nails
- Fingertips
- Thumbs and wrists
Appendix 3

AREAS MISSED DURING HANDWASHING (Taylor, L. 1978)
Surgical Hand Antisepsis – using surgical scrub solution

- Wash hand and arms under running water and a surgical scrub solution
- Remove debris under nails with a nail pick
- Rinse arm and arms
- During each of the following steps, keep hands above elbow, allowing water to drain away

**Step 1 (pre-scrub)**

**Step 2**
Apply an amount surgical scrub into palm, working palm to palm

**Step 3**
Continue rotating action working down the just above elbow

**Step 4**
Right hand over left hand & visa versa, fingers interlaced

**Step 5**
Rub palm to palm, fingers interlaced

**Step 6**
Rotational rubbing of Rt. Thumb clasped in left hand, visa versa

**Step 7**
Rub Lt. palm with clasped hand of right hand, visa versa

**Step 8**
Rotate down the arm just above elbow. Repeat 2-8

**Step 9**
Rinse hand under running water

**Step 10**
Dry thoroughly using one cloth for each hand
INFECTION PREVENTION AND CONTROL DEPARTMENT

HAND HYGIENE OBSERVATION TOOL

Background

Approximately 8% of hospitalised patients acquire an infection during their hospital stay.

It is estimated that the additional costs for each patient ranges from £1300 - £5300 and that patients remain in hospital for a further 10 days on average.

The cost to the NHS is approximately £1 billion per year.

It is estimated that healthcare associated infections (HCAI) cause more than 5000 deaths each year.

It is recognised that HCAI could be significantly reduced if Healthcare workers complied with hand hygiene guidance.

# Hand Hygiene Observation Audit Tool

**Guidance Notes:**
A total of 10 people must be observed. At least 25 individual Hand Hygiene Moments must be observed over the month.

**Hand Hygiene Observation Audit Tool**

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Auditor

Y/tick - good hand hygiene OBSERVED
N/cross - good hand hygiene NOT OBSERVED
Leave the box BLANK if hand hygiene NOT WITNESSED

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**Feedback Given:**

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