



Brent Community Services

Hand Hygiene Policy

To be read with:

Brent Community Services Policy for Standard/Universal Infection Control Precautions and the Use of Protective Equipment (ICC10)

Brent Community Services Dress Code Policy

Brent Community Services Infection Control Strategy (ICC 00)

The PCT incorporates and supports the human rights of the individual as set out in the European Convention on Human Rights and the Human Rights Act 1998

Document Reference Information:

Version	4
Status	Ratified
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Ratified By and Date	Version 3 - PEC 16th July 2008 (Approved by Infection Control Committee – June 2008) Version 4 – Changes approved by Infection Control Committee December 2009
Date Effective	10 th December 2009
Date of Next Formal Review	December 2011
Target audience:	All staff working within Brent Community Services

Version Control Record:

Version	Description of Change(s)	Reason for Change	Author	Date
3	<ul style="list-style-type: none"> •Syntax and grammar •Addition of training requirements •Hand washing as opposed to hand disinfection with alcohol when caring for patients with <i>C. difficile</i> •Addition of the concept of 'bare below the elbow' •Addition of appendix 4, photo of an appropriate hand washing station •Addition of appendices 4,5 and 6: audit tools for hand washing •Addition of appendix 8: Assurance form 	<ul style="list-style-type: none"> •To improve written presentation •To comply with the Health Act (2007) •To comply with DH guidance •To comply with DH guidance •To serve as a visual aid •To comply with BCS requirements for policy content •To comply with BCS requirements for policy content 	Lynn Leaver (LL) & Lazar Der Gregorian (LDG)	May 2008
4	<ul style="list-style-type: none"> •Principle of 5 moments of hand hygiene added •Addition of Appendix 2 (5 moments poster) •Updated Patient Survey Forms (Appendices 6 and 7) •Updated observational hand hygiene tool (Appendix 7) 	<ul style="list-style-type: none"> •To comply with DH guidance •To serve as a visual aid •To simplify and aid ease of use by patients •To aid ease of use and improve usefulness of information collected 	LDG	December 2009

HAND HYGIENE POLICY

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1. INTRODUCTION

Hand hygiene is the simplest, most effective measure for preventing health care associated infection (Pittet, 2001). The association between good hand hygiene and the prevention of cross-infection has been well established for many years, with a number of studies demonstrating a relationship between improved hand hygiene practices and reduced infection rates. However, despite this evidence, many studies show that adherence to recommended hand hygiene practice is unacceptably low in health care workers, presenting a risk to patients (Ward et al, 1997, Pittet et al, 1999). Hand hygiene is therefore an important component of risk management and clinical governance. The purpose of this policy is to identify the key elements of good hand hygiene practice for all BCS staff and to define responsibilities and actions required for compliance with good hand hygiene throughout the organisation.

2. COMPLIANCE WITH HAND HYGIENE

Most studies demonstrate that compliance with good hand hygiene practice is poor, estimated at less than 50% (Pittet, 2001). Reasons cited for poor compliance with good hand hygiene practice have included the following:

- Lack of knowledge/scepticism about the value of hand decontamination
- Perception of insufficient time or shortage of staff
- Belief that wearing gloves obviates the need for hand hygiene
- Shortage of conveniently located sinks
- Lack of mixer taps to control water temperature
- Poor facilities for effective hand hygiene (especially in community settings)
- Skin irritation caused by hand decontamination agents
- Lack of supplies
- Interference with worker-patient relationship/patient needs perceived as priority
- Lack of encouragement/role modelling from key staff

(Hand Hygiene Task Force, 2001)

However, factors that have been associated with improved compliance with hand hygiene practice include:

- Education – continuous and innovative
- Written guidelines and reminders in the workplace
- Routine observation and performance feedback
- Engineering controls, e.g. conveniently sited sinks, mixer taps
- Acceptable hand hygiene and skin care agents

- Making alcohol hand rubs available

- Patient education
- Active participation and support from all levels of the organisation
- Addressing understaffing issues

(Hand Hygiene Task Force, 2001)

Many interventions are associated with transient improvements in hand hygiene, but Larson and Kretzer (1995) found that no single intervention had consistently improved compliance. Therefore a strategy is required, which recognises the interdependence of factors associated with the individual, the environment as well as the organisation. Active participation by staff, managers and BCS as an organisation are therefore required to promote good hand hygiene practice as the expected norm. Staff awareness campaigns, such as the National Patient Safety Association's 'Clean Your Hands Campaign' should also be promoted.

Hand hygiene training is regularly provided by the BCS Infection Control Team, either as a part of general Infection Control training or as a subject in its own right. All staff are taught the hand decontamination technique on Infection Control induction and subsequently at annual refresher sessions. Compliance with hand decontamination among clinical staff is monitored periodically through suitable audit programmes.

3. ROLES AND RESPONSABILITIES

All staff

- Staff must observe stringent hand hygiene by decontaminating their hands on entry to and exit from any clinical area, and before and after every patient contact
- Staff members have a duty to attend infection control training provided for them by BCS.
- Staff members have a responsibility to report any obstacles to maintaining high standards of Infection Control and hand hygiene to their line manager or Infection Control Team

The above points are included within the job descriptions of all staff employed by BCS.

Service Leads

- Service leads must ensure that each member of their team has attended Infection Control training as stated within section 4 of this policy.

- Service Leads are responsible for ensuring that observational hand hygiene audits are carried out at least quarterly within their service.

Site Managers

- Site Managers must ensure that appropriate facilities are available for effective hand hygiene for staff during all clinical activity (see section 7)
- Where this is not available the appropriate Service Lead must be informed that clinical activity needs be discontinued until hand washing facilities can be re-instated. Advice may need to be sought from the Infection Control Team.

Infection Control Team

- The Infection Control Team will provide hand hygiene training as stated in section 4 of this policy, plus ad hoc sessions dedicated to hand hygiene as necessary.
- The Infection Control team will carry out hand hygiene awareness campaigns and provide educational materials to staff
- The ICT will provide advice and ensure that the hand hygiene policy is updated at east every 3 years according to best practice and current evidence.
- The Infection Control team will monitor compliance of this policy through collation of hand hygiene audit data.
- The Infection Control team will be responsible for carrying out patient surveys in regards to hand hygiene at least every 6 months (see appendices 4 and 5)

Director of Infection Prevention and Control (DIPC)

- The DIPC has corporate responsibility for infection, prevention and control (including hand hygiene) throughout the Trust as delegated by the Chief Executive.

4. TRAINING

Hand hygiene training will be provided as part of the mandatory training programme as laid described in the BCS Infection Control Strategy (ICC 00) and training needs analysis. This is provided to all staff working in clinical areas or having patient contact. It includes the following :

Clinical Staff : Induction – 4 hours
Annual update – 2 hours

Non-clinical staff : Induction – 3 hours
Annual update – 2 hours

Training sessions will be advertised via e-mail and via the BCS intranet and records of attendance will be maintained.

Feedback regarding individual attendance will be provided to the senior management team on a 6 monthly basis for distribution to Service Leads. This process will ensure that staff not attending Infection Control training will be identified and approached by their manager. The BCS Electronic Staff Record (ESR) will be used to check that all relevant staff groups, as identified above, complete hand hygiene training. If staff fail to attend, the relevant Service Lead will be notified via e-mail.

In order to address the difficulties experienced by staff leaving clinical areas for training, the Infection Control Team also provide site based Infection Control training for teams of clinical and non-clinical staff.

Additional hand hygiene training and audit will be provided as necessary by the Infection Control Team i.e. through the use of ultraviolet dyes as well as ATP and microbiological swabbing.

5. MICROBIOLOGY OF THE HANDS

Skin flora on the hands can be divided into two categories: transient and resident micro-organisms.

Transient micro-organisms:

- Not usually part of the normal flora on the hands.
- Easily picked up during contact with patients, equipment or the environment and readily transferred to the next person or surface touched.
- Often responsible for cross-infection.
- Easily removed with good hand washing.

Resident micro-organisms:

- Normal bacterial flora that live deep in the epidermis of the skin, in crevices and hair follicles, and beneath fingernails.
- Part of the body's natural defence mechanism.
- During invasive procedures such as minor surgery there is a risk that a patient's resident skin flora may enter their tissues and cause an infection.
- Not readily transferred to other people.
- Difficult to remove from hands by hand washing.

6. WHEN TO WASH HANDS

Routine Hand Decontamination

- Routine hand washing using liquid soap and water removes most transient micro-organisms from hands.
- If hands are potentially contaminated but visibly clean, they can be decontaminated using an alcohol-based preparation.
- Hands must be decontaminated immediately :
 - Before and after **every** episode of direct patient care
 - Before handling food
 - After any activity that potentially results in the hands becoming contaminated i.e. bed making, handling bedpans / urinals etc
 - After gloves and / or aprons are removed
 - On arrival and before departure from the clients' home.
 - When hands are visibly dirty
 - After using the toilet
 - After contact with any body fluid
- It is advised that the 'Five Moments' for hand hygiene developed by The World Health Organization (WHO) and the National Patient Safety Agency (NPSA) is put into practice. The 'Five Moments' model simply defines the key points for healthcare workers to clean their hands. These are presented in a poster provided in appendix 2, which can be printed (preferably enlarged to A3 size), laminated and displayed in all clinical environments.

Surgical Hand Decontamination

- Surgical hand washing using an antiseptic solution (or alcohol if hands are visibly clean) aims to substantially reduce resident micro-organisms and to remove transient micro-organisms.
- Surgical hand decontamination must be carried out prior to invasive procedures, where extra care must be taken to prevent micro-organisms on hands from being introduced into the patient's tissues if gloves are damaged.
- Hands must therefore be surgically decontaminated :
 - Before putting on sterile gloves prior to minor surgery, insertion of indwelling urinary catheters or any other sterile procedure.
 - Before caring for a severely immuno-suppressed patient.

7. FACILITIES REQUIRED FOR EFFECTIVE HAND WASHING IN THE CLINICAL AREA

- Sinks specifically allocated for hand washing (not to be used for other purposes such as cleaning of equipment).
- Wrist or elbow operated mixer taps.
- Wall mounted liquid soap (individual pre-packed containers only).
- Wall mounted paper towels.
- Foot operated domestic waste bin with lid.
- Where indicated wall mounted skin antiseptics must be made available (hand held alcohol dispensers should also be available for clinical staff in some clinical areas but not as a part of the hand washing station).

Please refer to Appendix 4 for a photograph of an appropriate hand washing station.

The responsibility for daily checking and replenishment of liquid soap dispensers must be clearly defined in each clinical area, e.g. written into cleaning schedules and monitored by site managers.

Facilities for hand hygiene must be considered at the design stage of all development of health care premises and refurbishments.

Where such facilities are not available, such as within a clients own home, staff should carry liquid soap, paper towels and alcohol rub to facilitate good hand hygiene.

8. CHOICE OF HAND HYGIENE AGENT / SOLUTION

Liquid Soap

Liquid soap aids mechanical removal of transient micro-organisms. It is therefore suitable for **all routine** hand decontamination. Bar soap or decanted liquid soap must never be used, due to possible contamination and therefore increased risk of cross-infection.

Skin Antiseptic

The use of aqueous antiseptic solutions will both remove and destroy transient micro-organisms, and reduce levels of resident organisms on the hands. They must therefore be used for **all surgical** hand decontamination. Chlorhexidine based products (eg "Hibiscrub") are only recommended.

Alcohol Rub

All clinical areas must have adequate hand washing facilities in order for staff to decontaminate their hands effectively before and after the relevant activities listed above. However, the facilities in clients' homes may not always be suitable. Alcohol rub must therefore be taken on all home visits as this is an acceptable alternative to soap and water where the correct hand hygiene facilities are not available, provided that the hands are not visibly contaminated.

Alcohol-based hand rubs are more easily accessible and less time consuming than using soap and water, and are often less irritant as well. They have been found to increase compliance with hand hygiene practice by up to 25% (Bissett, 2002). For this reason, wall mounted alcohol rub must be available in all bedded areas of BCS. Portable containers of alcohol rub should also be made available to all community staff with any clinical activity.

Alcohol hand rubs should **not** be used when caring for patients suffering with infections caused by *Clostridium difficile* or *Norovirus* as they may not be effective against these organisms. In this case hand washing with soap and water is the preferred method of hand decontamination.

Hands will need to be washed with soap and water after several applications of alcohol hand gel to prevent the build-up of emollients on the skin.

Alcohol hand rubs may also be used when surgical hand decontamination is required. They are immediately active against a wide range of micro-organisms but do not have any residual activity.

Any plans to change products used for hand hygiene must first be discussed with the Infection Control Team.

9. HAND DECONTAMINATION TECHNIQUE

General points

- It is essential that **no** wrist watches or jewellery with ridges or stones are worn by clinical staff. They can increase bacterial counts and harbour pathogenic organisms which can be a source of cross-infection.
- Any cuts or abrasions on hands or forearms must be covered with a waterproof dressing or plaster.
- Clinical staff must be bare below elbows to facilitate effective hand washing (see BCS Dress Code policy). This means :
 - Long sleeves must be rolled up
 - No wrist watches
 - No bracelets or wrist bands
 - No rings except one plain band (no stones)

- No false nails
- All wrist and hand jewellery should be removed (apart from plain band). It is essential to remove rings, bracelet and wrist watch and roll up long sleeves. Jewellery inhibits good hand washing and dirt and bacteria can remain beneath jewellery after hand washing, whilst long sleeves prevent washing of wrists. Please note: the hand wash solution must come into contact with all surfaces of the hand (see BCS Hand Hygiene Policy, ICC01).
- Cardigans or jumpers may be worn over work clothing . However they must always be removed before giving clinical care.

”Bare below the elbows” applies only at the time of carrying out a clinical activity (see definition above) and during hand hygiene.

Soap and Water (See appendix 1)

- Turn on the taps, preferably using elbows, and set the water to warm and wet hands.
- Apply **one** shot of liquid soap or disinfectant (depending on circumstances), to the hands, and build up a lather.
- Make sure that all of the areas of the hands are rubbed. Pay special attention to thumbs, finger webs and finger tips (see appendix 3).
- Thoroughly rinse off soap under running water.
- Turn off the taps with elbows. If elbow taps are not provided, they can be turned off using a disposable paper towel.
- Dry hands thoroughly with disposable paper towels. Damp skin encourages microbial growth and transfer of micro-organisms between hands and other objects.
- Dispose of paper towels in a foot-operated pedal bin for domestic waste. The lid of the bin must **not** be lifted manually, as hands can easily become re-contaminated.

Alcohol Hand Rub

Approximately 1ml of hand Rub must be applied to the hands (refer to manufacturer’s guidance). Hands and wrists must then be rubbed together until dry, using the same technique as for hand washing, ensuring that all areas of the hands are covered, and adequate contact time has been achieved.

10. HAND DRYING

Effective drying of the hands is important as wet skin surfaces transfer micro-organisms more readily than dry ones. The method of hand drying is important in maintaining hygiene. Hands can become re-contaminated by drying methods such as fabric towels. Hands must therefore only be dried using good quality paper towels from wall-mounted dispensers close to each sink. There is conflicting evidence regarding the efficacy of hot air dryers, but they must be avoided in clinical areas due to noise, the time taken to use them, and their potential for re-circulating contaminated air.

11. HAND CARE

Intact skin forms an effective barrier against many pathogenic micro-organisms. The skins' secretions also have some anti-bacterial properties. However, **poor** hand hygiene carried out on a frequent basis, removes natural skin emollients, and can result in dry and sore hands. Risks of cross-infection can therefore be increased. Good hand care is therefore essential.

- All cuts and abrasions on hands must be covered with a waterproof plaster or an occlusive waterproof dressing.
- Hand creams may be used as frequently as needed. However, communal multi-use pots must never be used, as they can easily become contaminated, and act as a source of cross-infection. Personal individual tubes of hand cream, or creams with a pump dispenser are acceptable.
- Staff with damaged skin e.g. eczema or dermatitis must consult the Occupational Health Department.
- Nails must be kept clean and short. Artificial nails are not permitted for clinical staff.
- Nail brushes must not be used for routine hand washing. Continual use of nail-brushes damages the skin which will then harbour more bacteria. Nail-brushes also become contaminated, and therefore act as a source of cross-infection. If used in specific circumstances, i.e. prior to minor surgery, they must be single use and sterile and discarded after use.
- The wearing of jewellery by clinical staff must be kept to a minimum. Only wedding bands are permitted for clinical staff.

NB. Staff are responsible for protecting their hands. If they are using a product that appears to be having a detrimental effect on their skin, or develop damaged broken skin, they must attend the Occupational Health Department. The relevant manager may need to be informed of the outcome of the Occupational Health Department assessment where changes in work practice or alternative hand hygiene products are required.

12. MONITORING & REVIEW

- Hand washing audits should be carried out quarterly by the Infection Control Team and/ or Service Leads using the Policy Audit Tools on at least a quarterly basis (see Appendices 4, 5 and 6). Service Leads will locally manage and monitor the embedding of this policy, and will put action plans into place where required.
- The Infection Control Team will audit compliance with this policy annually covering the following NHSLA minimum requirements :
 1. Duties as outlined in this policy
 2. Relevant staff groups complete hand hygiene training
 3. Process for following up staff that fail to attend hand hygiene training
- The outcome of the audit will be shared with the senior management team and Service Leads
- Service Leads will use the Assurance Form (appendix 8) to locally manage and document the embedding of this policy and will put action plans into place where required.

13. REFERENCES

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APPENDICES

APPENDIX 1

Hand Washing Technique (Ayliffe et al, 1978)

Wet hands, apply soap and use the following procedure

1. Rub palm to palm



2. Rub back of both hands

3. Rub palm to palm with fingers interlaced



4. Rub backs of fingers (interlocked)



5. Rub all parts of both hands



6. Rub both palms with finger tips

7. Rinse hands under running water and dry thoroughly on a clean towel.

APPENDIX 2

Five moments of hand hygiene

This poster can be printed (preferably enlarged to A3 size), laminated and displayed in all appropriate areas, especially where clinical activity takes place.

Your 5 moments for hand hygiene at the point of care

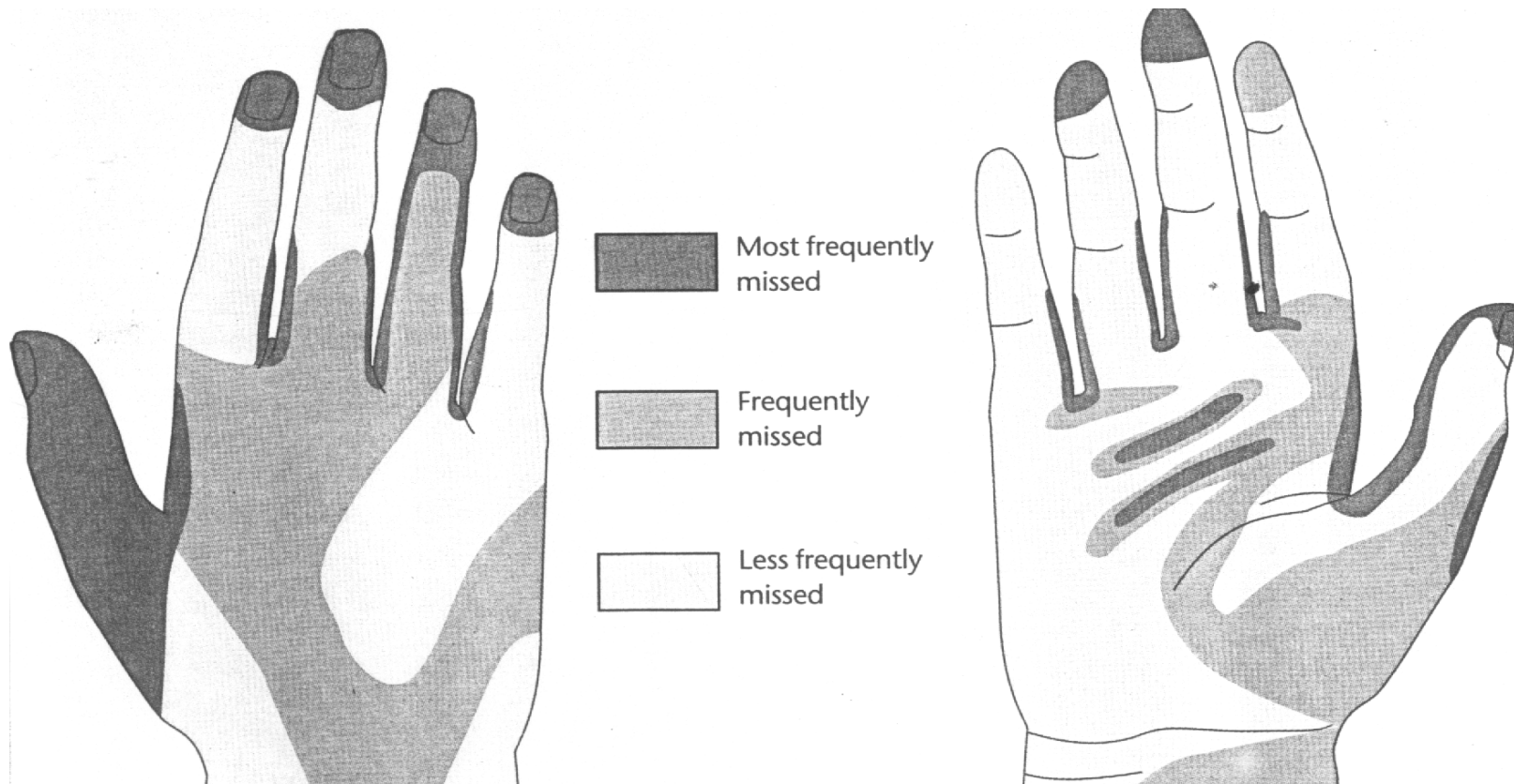


1	BEFORE PATIENT CONTACT	WHEN? Clean your hands before touching a patient when approaching him/her WHY? To protect the patient against harmful germs carried on your hands
2	BEFORE AN ASEPTIC TASK	WHEN? Clean your hands immediately before any aseptic task WHY? To protect the patient against harmful germs, 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 healthcare environment from harmful patient germs
4	AFTER PATIENT CONTACT	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 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 if the patient has not been touched WHY? To protect yourself and the healthcare environment from harmful patient germs

Adapted from WHO World Alliance for Patient Safety 2006

APPENDIX 3

Areas Most Frequently Missed During Hand Washing (Ayliffe et al, 1992)



APPENDIX 4

An example of an appropriately equipped hand washing station



APPENDIX 5

Patient survey form as an audit tool for hand washing by community healthcare staff (used as a part of the clean~~your~~**our**hands campaign):

WITHIN PATIENTS' HOMES

Dear Patient/Guardian,

We take healthcare infections and their prevention very seriously at Brent Community Services and want you to feel safe in our hands. One way we can do this is to ensure our staff clean their hands when they touch or treat you. We are confident that they are very good at this but we would like to check it **for your assurance** from time to time.

You can help us with this by completing the questionnaire overleaf

How to use the questionnaire

- Please read through the questions overleaf beforehand to familiarise yourself with them
- Between and, every time you come into any physical contact* with one of our health care staff please complete one of these forms (one form per visit or as many as you feel able to complete if you are visited on several occasions during this period)
- After you have received your treatment, etc. tick the appropriate boxes overleaf (or ask a relative or carer to do it for you)

DO NOT WRITE YOUR NAME ON THE FORM

- Put the completed form(s) in the pre-paid envelope provided and post it back to us (ask a relative or carer to post it for you if you can't get out yourself)

*Examples of physical contact are:

- Changing a wound dressing
- Giving an injection
- Taking blood
- Physiotherapy
- Cutting toe nails
- Physical examination, etc.

We would like to thank you in advance for your cooperation

IMPORTANT: Participation in this survey is entirely voluntary and will not affect your care. All information collected during this campaign will be kept strictly confidential, and your anonymity will be maintained at all times.

If you would like to find out more about what we are doing about controlling infections please ask one of our staff for a copy of the leaflet 'Together We Can Control Healthcare Infection in Brent'.

Please answer all the questions

Today's date:.....

1. Please tick the staff group you had contact with

- | | |
|---|---|
| <input type="checkbox"/> Community Children's Nurse | <input type="checkbox"/> Phlebotomist |
| <input type="checkbox"/> Dentist/ Dental Nurse | <input type="checkbox"/> Physiotherapist |
| <input type="checkbox"/> District Nurse | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Dietician | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> GP | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> Health Care Assistant | _____ |
| <input type="checkbox"/> Health Visitor | _____ |

If you are seeing more than one member of staff please complete a new form for each staff member

2. Immediately before a procedure or touching you did she/he:

- a. Wash her/his hands
 YES NO Not sure
- b. Clean her/his hands with alcohol hand rub
 YES NO Not sure

3. After finishing a procedure or touching you, did she/he:

- a. Wash her/his hands
 YES NO Not sure
- b. Clean her/his hands with alcohol hand rub
 YES NO Not sure

4. Did she/he wear gloves during the procedure? YES NO (go to 5)

If YES,

- a. Did she/he put on a new pair before touching you? YES NO Not sure
- b. Did she/he wash her/his hands or clean them with alcohol hand rub after removing them? YES NO Not sure

5. If you have any comments please add them below:

APPENDIX 6

Patient survey form as an audit tool for hand washing by healthcare staff in BCS clinics (used as a part of the **cleanyourhands** campaign):

WITHIN BCS CLINICS/ HEALTH CENTRES

**If you need help with reading this document
please ask a member of staff**

Dear Patient/Parent,

We take healthcare infections and their prevention very seriously at Brent Community Services and want you to feel safe in our hands. One way we can do this is to ensure our staff clean their hands when they touch or treat you. We are confident that they are very good at this but we would like to check it **for your assurance** from time to time.

You can help us with this by completing this questionnaire

How to use the questionnaire

- Please read through the questions overleaf beforehand to familiarise yourself with them
- Please complete one questionnaire every time you come into any physical contact* with one of our health care staff
- After you have received your treatment, etc. tick the appropriate boxes

DO NOT WRITE YOUR NAME ON THE FORM

- Put the completed form in the labelled box at the reception desk before you leave

*Examples of physical contact are:

- Changing a wound dressing
- Giving an injection
- Taking blood
- Physiotherapy
- Cutting toe nails
- Physical examination, etc.

We would like to thank you in advance for your cooperation

IMPORTANT: Participation in this survey is entirely voluntary and will not affect your care. All information collected during this campaign will be kept strictly confidential, and your anonymity will be maintained at all times.

If you would like to find out more about what we are doing about controlling infections please pick up a copy of the leaflet 'Together We Can Control Healthcare Infection in Brent' from the health centre you are visiting.

P.T.O.

Please answer all the questions

Today's date:.....

1. Which health centre were you attending?

2. Please tick the staff group you had contact with

- | | | |
|--|--|---|
| <input type="checkbox"/> District nurse | <input type="checkbox"/> Health visitor | <input type="checkbox"/> Health Care Assistant |
| <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Dietician | <input type="checkbox"/> Community children's nurse |
| <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Dentist/ Dental Nurse |
| <input type="checkbox"/> GP | <input type="checkbox"/> Retinal screener | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Practice Nurse | <input type="checkbox"/> Other, please specify _____ | |

If you are seeing more than one member of staff please complete a new questionnaire for each staff member

4. Immediately before a procedure or touching you did she/he:

- a. Wash her/his hands
 YES NO Not sure
- b. Clean her/his hands with alcohol hand rub
 YES NO Not sure

5. After finishing a procedure or touching you, did she/he:

- c. Wash her/his hands
 YES NO Not sure
- d. Clean her/his hands with alcohol hand rub
 YES NO Not sure

6. Did she/he wear gloves during the procedure? YES NO (go to 6)

If YES,

- a. Did she/he put on a new pair before touching you? YES NO Not sure
- b. Did she/he wash her/his hands or clean them with alcohol hand rub after removing them? YES NO Not sure

7. If you have any comments please add them below:

APPENDIX 7

Observational audit tool

(Adapted from a Hand Hygiene Observational Tool as used at Bradford Teaching Hospitals NHS Foundation Trust)

Hand Hygiene Compliance Observational Audit Tool

Ward/Department: _____

Date: _____

Name and position of observer: _____

Nurse	HCA	Student nurse	Doctor	Physio	OT	Other

Instruction:

Record each hand hygiene opportunity based on the '5 moments of hand hygiene' model by inserting an 'O'. The '5 moments' are: Before touching a patient; Before an aseptic task; After body fluid exposure risk (and removing gloves); After touching a patient; After touching the patient's environment.

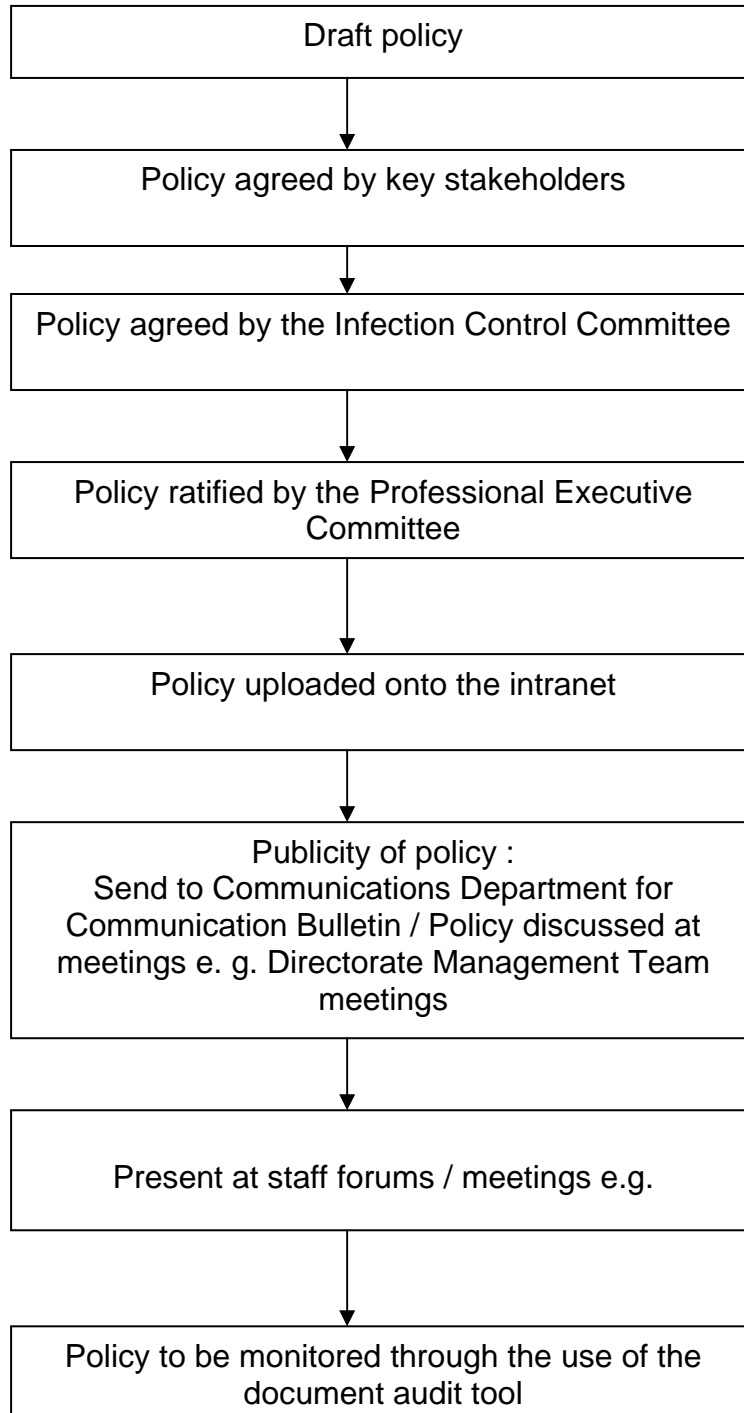
Record each hand hygiene activity by inserting an 'H'. If hand hygiene doesn't take place don't record anything else; if it does, insert an 'O'. If compliance is 100%, for each 'O' there would be a corresponding 'H', which is unlikely (although, of course desirable). Therefore compliance is calculated as a percentage: $\text{Total H} / \text{Total O} \times 100$.

Record observations for a given period of time, for example **1 hour**.

Use one sheet per given period.

APPENDIX 9

Policy Ratification and Publication Flowchart



APPENDIX 10 - Equality Impact Assessment Tool

DOCUMENT AUTHOR: Lazar Der Gregorian Lynn Leaver	DIRECTORATE: Brent Community Services
NAME OF DOCUMENT/POLICY/STRATEGY/PROCEDURE Hand Hygiene Policy	EXISTING ASSOCIATED POLICIES, STRATEGIES OR PROCEDURES Brent Community Services Policy for Standard/Universal Infection Control Precautions and the Use of Protective Equipment (ICC10) Brent Community Services Dress Code Policy Brent Community Services Infection Control Strategy (ICC 00)
DATE : December 2009	

Aim/Status

[a] What is the aim/purpose of the policy/strategy/procedure? The purpose of this policy is to identify the key elements of good hand hygiene practice for all BCS staff and to define responsibilities and actions required for compliance with good hand hygiene throughout the organisation.
[b] Who is intended to benefit from this policy/strategy/procedure and in what way? Patients – receiving safe care from healthcare workers in direct contact with them Staff – not becoming unduly infected by harmful microorganisms in the course of their work
[c] How have they been involved in the development of this policy/strategy/procedure? The policy was discussed in the Infection Control Committee meetings and representatives from various services were given the opportunity to discuss it within their services. There was no patient involvement with the development of this policy.
[d] How does it fit into the broader corporate aims? This policy supports achievement of the following Corporate objectives: Corporate Objective 4 Increase the quality and safety of services commissioned from providers <ul style="list-style-type: none"> • By reducing the risk of cross infection an HCAI Corporate Objective 5. Increase patient satisfaction rates and patient experience for all commissioned services <ul style="list-style-type: none"> • Through overall decrease in HCAs
[e] What outcomes are intended from this policy/strategy/procedure? Transmission of infections to patients through direct contact by healthcare workers and vice versa will be prevented.
[f] What resource implications are linked to this policy/strategy/procedure? None of significance

Impacts

[a] what is the likely impact [whether intended or unintended, positive or negative] of the initiative on individual users or on the public at large? The public will be reassured that Brent Community Services healthcare staff do their utmost to prevent the spread of infection to their patients/clients through direct contact.
[b] Is there likely to be differential impact on any group? If yes, please state if this impact may be adverse and give further details [e.g. which specific groups are affected, in what way, and why you believe this to be the case] No

[i] Grounds of race, ethnicity, colour, nationality or national origin	Please tick Box No	Please tick box Adverse? <input type="checkbox"/> Please give further details
[ii] Grounds of sex or marital Status Women and Men	No	Adverse? <input type="checkbox"/> Please give further details
[iii] Grounds of gender: Transgender or Transsexual People	No	Adverse? <input type="checkbox"/> Please give further details
[iv] Grounds of religion or belief: Religious /faith or other Groups with a recognised belief system	No	Adverse? <input type="checkbox"/> Please give further details
[v] Grounds of disability	No	Adverse? <input type="checkbox"/> Please give further details
[vi] Grounds of age: Older people, children and Young people	No	Adverse? <input type="checkbox"/> Please give further details
[vii] Grounds of sexual orientation: Lesbian, gay, bisexual	No	Adverse? <input type="checkbox"/> Please give further details
[viii] Grounds of carers: Older relatives, children	No	Adverse? <input type="checkbox"/> Please give further details
[ix] Grounds of human rights	No	Adverse? <input type="checkbox"/> Please give further details
Is the policy directly discriminatory? No	Is the policy indirectly discriminatory? No	Is the policy intended to increase equality of opportunity by permitting positive action or action to redress disadvantage No
If the policy is unlawfully discriminatory it must go to a full impact assessment (please Contact the Equality, Diversity & Human Rights Advisor – Human Resources Directorate)		
Persons conducting EqIA	Nolan Victory, Sharon Lam, Kanta Kerai	
Signed: Nolan Victory	Date: 10 December 2009	