Hand Hygiene FAQ 2021

- **Where should Hand Hygiene posters be displayed?**

  6 steps posters highlighting technique should be displayed at all CWHBs and ABHR stations situated at entrances to wards/departments and in public areas.

  5 moments posters should be displayed in 2-3 prominent positions throughout the ward/department.

- **When should dispensers be cleaned?**

  Dispensers and nozzles should be kept clean and free from residue on a daily basis, with cleaning schedules reflecting this.

- **How should hands be dried after washing?**

  Hands should be dried thoroughly following hand washing by drying with a soft, absorbent, disposable paper towel from a dispenser which is located close to the sink but beyond the risk of splash contamination.

  Cloth towels – either roll or hanging type – pose a contamination risk and therefore should not be used in the clinical/hospital setting and other care settings.

  Air-dryers, including high speed air-dryers, should not be used in the clinical setting or other health and care settings because they are noisy and may disperse microorganisms via the airborne (aerosol) route.

- **Do I need to clean my hands twice between patients?**

  If HCWs have cleaned their hands using ABHR or a hand wash when leaving a patient and are going directly to the next patient, e.g. ward rounds or patient care, then they are not required to repeat this again, unless they have touch contact with anything else in that period.

- **Is the use of ABHR suitable for individuals who abstain from alcohol for religious reasons?**

  The use of ABHR by persons with religious beliefs that forbid the consumption of alcohol is permissible as external application of the synthetic alcohol in these solutions is not considered intoxicating.

- **Which products are suitable for surgical scrubbing/surgical rubbing?**

  Surgical rubbing with ABHR is a suitable alternative to surgical scrubbing with an antimicrobial scrub agent if the ABHR is licensed for this use. Surgical rubbing should be performed with an agent that has immediate and sustained antimicrobial effect.

  Surgical scrubbing should be performed with an agent that has immediate and sustained antimicrobial effect (e.g. chlorhexidine gluconate, povidone-iodine).

- **How should hands be cleaned after surgical procedures?**

  Once all surgical procedures are finished, general hand hygiene (i.e. non-antimicrobial liquid soap and water or ABHR (if hands are not visibly soiled)) should be performed after surgical gloves are removed and before any other activities are undertaken.

- **How long should hand hygiene take place for?**

  For ABHR use, hand rubbing should be performed until the hands are dry, typically for a minimum of 20-30 seconds.

  For a hand wash, after applying soap, hands should be rubbed together for at least 15 seconds, ensuring all surfaces of the hands are covered with lather.

  For Surgical Rubbing, Manufacturer's guidance should be followed to ensure effectiveness of the product used.

  For Surgical Scrubbing, the process should take a minimum of 4 minutes to complete, however, manufacturer's guidance for the minimum specific time that is deemed effective for their product should be adhered to and the process lengthened if required.

- **Should nail brushes/sponges be used when performing surgical hand antisepsis?**

  Nail brushes should not be used for surgical hand antisepsis. Nail cleaners (e.g. nail picks (single-use)) can be used if nails are visibly dirty. Soft, non-abrasive, sterile (single-use) sponges may be used to apply antimicrobial liquid soap to the skin if licensed for this purpose.

- **What is the evidence relating to finger nails to enable effective hand hygiene?**

  When providing patient care, nails should be kept short and clean and staff should not wear false nails. Finger nails should not exceed ¼ inch (approx. 0.5 cm) beyond the end of the fingertip to prevent the accumulation of debris under nails and to facilitate effective hand hygiene.

  Artificial nails should not be worn as they inhibit hand hygiene and pose an infection risk.

  Nail products should not be worn as chips may harbour bacteria and thus represent an infection risk.

- **What is the evidence regarding being bare below the elbows, including jewellery worn for religious reasons?**

  The Scottish Government in line with the Department of Health recommendation, and as part of the development of a national NHSScotland uniform policy, have recommended that staff providing care in NHSScotland should be "bare below the elbows". Jewellery, including wrist watches, wrist worn technology devices, bracelets and rings (excluding a plain metal finger ring), should not be worn when providing care or during hand hygiene because they can inhibit effective hand washing, may increase bacterial load on the hands and thus pose an infection risk. Jewellery also interferes with the provision of care.

  Bracelets or bangles such as the Kara which are worn for religious reasons should be able to be pushed higher onto the arm and secured in place for all patient care activities. This is to enable effective hand hygiene (which includes the wrists).

  In Surgical settings, all hand and wrist jewellery must be removed.

  These are mandatory requirements.

- **I have irritated skin, how are hand hygiene products chosen for use?**

  NHSGGC are required to provide products that meet requirements on decontamination of hands and these products are also required to contain emollients that help minimise the risk of irritation to hands. ABHRs contain emollients in their formulation. Emollient hand creams as supplied by NHSGGC should be used to maintain skin integrity and minimise the development of contact dermatitis. Emollient hand creams used in the health and care setting must not affect the efficacy of the hand hygiene products or gloves used (oil-based products are known to have a potentially damaging effect on gloves).

- **What are the requirements for sink design, provision and types of tap for clinical hand wash?**

  Hand washing facilities should: Only be used for the purpose of hand washing and not be used for disposal of any body fluids.

  Sinks located in the clinical area need to be fit for purpose (e.g. designed to prevent splashing, enable effective cleaning, designed not to have a plug or overflow, include a splash-back). Sinks should be large enough to contain most splashes and enable the correct hand washing technique to be performed without excessive splashing of the user and the surrounding area. The use of a shallow sink should therefore be avoided.

  In healthcare settings mixer taps should be used as high water temperatures are used to control Legionella spp. The operation of the mixer tap should allow them to be easily turned on and off without recontamination on the operator's hands (the elbow, wrist or knee should be used). The mixer tap should be placed in such a way that they do not point directly into the sink outlet.

  In high risk units and low-use situations, the use of sensor operated, automated 'non-touch' taps is not recommended as the complexity of the internal mechanisms can result in a greater risk of contamination by microorganisms and biofilms.

  For new installation and planned replacements or refurbishments in intensive care units, taps should be removable and easily dismantled for cleaning and disinfection.

  Strainers and anti-splash devices for sink outlets should not be used as they can become easily contaminated.

  In areas where clinical procedures or examinations are undertaken (e.g. outpatient departments), the hand washing basins should be located close to the procedure.

  In low dependency settings, one sink between six patients is recommended.

  Acute, elderly and long-term care settings, one sink between four patients is recommended.

  Infrequently used water outlets should be identified and assessed as per the local Water Safety Plan and incorporated into a flushing regime or removed from use.