Title	Zero Tolerance Hand Hygiene Policy
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Developed by	Infection Control Team
Equality & Diversity Impact Assessed	Yes

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1.0 Intent

The aim of this policy is to ensure optimum patient and staff safety through effective hand hygiene.

2.0 Introduction

Patient Safety is the primary corporate objective for NHS Borders. Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HAI), when providing care.

This Zero Tolerance Hand Hygiene Policy should be read in conjunction with the Standard Infection Control Precautions Policy which provides full detail of the required hand hygiene practice and process.

3.0 Standards

This policy reflects current national guidance and mandatory requirements (including: CEL 5(2009); Model Policy: Hand Hygiene (HPS, Standard Infection Control Precautions, 2012).

As a condition of their contract with NHS Borders, staff are required to comply with, and are professionally accountable for, adherence to NHS Board policies that are in place to ensure the health and safety of patients, visitors and staff, including compliance with the hand hygiene policy.

If it can be demonstrated that an individual repeatedly fails to comply with this requirement, they can be found in breach of contract and as such, disciplinary action can be taken. The process is as detailed in flowchart below.

This Zero Tolerance policy applies to individual staff member's non-compliance with hand hygiene, it does not relate to departmental performance.
NHS Borders' Management of Employee Conduct Policy sets out the current arrangements for addressing and maintaining standards of conduct at work and will confirm the procedures to be applied where there is an alleged failure in meeting such standards; and as such will be used to support implementation of the zero tolerance approach to non-compliance with hand hygiene for healthcare workers at all levels.

Detailed information on Flowchart of activity to be undertaken in event of non compliance with hand hygiene

Monthly audits by every department to establish compliance	As required by the Scottish Government (CEL 5 2009) monthly local audits should be conducted in each ward/department.
1st Breach Staff member notified of non compliance by observer	When individual non compliance with hand hygiene is observed, the staff member must be notified by the observer and the cause must be ascertained. Staff member to be reminded of the National Standard Infection Control Precautions Policy and Dress Code/Uniform Policy. Incident recorded on template (page 4).
2nd Breach: mandatory 'one to one practical training' with line manager, Cleanliness Champion or member of the Infection Prevention and Control Team	If there is repeated noncompliance with the same member of staff, the line manager must be notified and documented. Practical training should be completed within 48 hours of the incidence of non compliance or as soon as the offender returns to duty (in case of shift patterns or leave). Line manager to remind staff member of the National Standard Infection Control Precautions Policy and Dress Code/Uniform Policy.
3rd breach: Undertake on-line stand alone hand hygiene course: www.nes-hai.info and produce completion certificate	Complete the on-line NES stand alone hand hygiene learning module within one month of the 3rd Breach of Hand Hygiene compliance. Incident recorded on template (page 4).
4th Breach: Conduct or Capability process to be initiated	It is the responsibility of the Department Manager to ensure that all stages of this flowchart have been implemented before Incident recording template completed (page 4).

Record of non compliance with Hand Hygiene

Name of Employee_____ **Designation**_____
Name of Manager_____ **Designation**_____

***5 moments for hand hygiene* - Incidence of non compliance** (please circle**)**
1 Before patient contact **2** Before aseptic technique **3** After body fluid exposure risk
4 After patient contact **5** After contact with patient surroundings

Not adhering to Hand Hygiene Policy or Dress Code/Uniform Policy (please circle)
Not bare elbows to wrist Wearing jewellery Wearing a wrist watch Other (Please state)

Observed By whom? (Please circle)

Manager **Colleague** **Auditor** **Patient** **Visitor** **Other** (Please state)

Reason for non compliance (Please circle reason and whether 1st, 2nd, 3rd or 4th Breach																							
Lack of Knowledge				**Poor Facilities**				**Omission**				**Emergency**				**Skin Irritation**				**Other**			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4

Action taken (Please outline e.g. broken hand hygiene dispenser fixed; 1 to 1 training undertaken, referred to Occupational Health)

1st Breach : Date of incidence:
Line Manager notified of non compliance
On:
Any other action taken:
Signed (employee) **Signed** (manager)
Date: **Date:**

2nd Breach: Date of Incidence:
Mandatory 'one to one practical training' with line manager, Cleanliness Champion or member of the Infection Prevention and Control Team
Expected completion date:
Any other action taken:
Signed (employee) **Signed** (manager)
Date: **Date:**

3rd Breach: Date of Incidence:
Undertake on-line stand alone hand hygiene course: www.nes-hai.info and produce completion certificate
Completion certificate to be attached to this form

Any other action taken:
Signed (employee) **Signed** (manager)
Date: **Date:**

4th Breach: Date of Incidence:
Disciplinary process to be initiated immediately
Disciplinary process initiated on:
Any other action taken:
Signed (employee) **Signed** (manager)
Date: **Date:**

References

1. CNO (2005) 1 – Alcohol base hand rubs and Infection Control, 9th February 2005

2. CEL 5 (2009) – Zero Tolerance to Hand Hygiene Compliance, 26th January 2009

3. Draft Model Infection Control Policies (hand hygiene) Health Protection Scotland (HPS), July 2011

4. CNO (2012) 1 – National Infection Prevention & Control Manual for NHS Scotland, 13th January 2012

Implementation Plan

1. **Professional responsibilities**
    a. **Professional Leads and Line Managers**
        - Disseminate this Policy

    b. **Clinical/Line Managers**
        - Implement the Policy into their area.
        - Supervise compliance with the Policy and organise audits
        - Respond to audit results and take corrective action as detailed in above.

    c. **Clinicians**
        - Ensure that their practice adheres to this Policy
        - Participate in regular audit and engage in training and development as necessary.

2. **Audit**
    Hand Hygiene compliance will be audited:
        - Minimum monthly
        - Each clinical area will audit compliance
        - The Clinical Audit Support Team will provide technical advice in relation to audit
        - The Clinical Audit Support Team will offer support with data analysis and report writing

3. **Review**
        - The Policy will be reviewed every three years after issue or following any change in National Standards.
        - Any revision to this Policy will be approved by the Infection Control Committee which includes the Policy.

Development/Review Group

Infection Control Manager
Senior Infection Control Nurse
Hand Hygiene Coordinator