

LTHT Infection Prevention and Control Policies

Policy No. 4(a)

HAND HYGIENE POLICY

Policy Title	Hand Hygiene Policy
Keywords	Hand Hygiene, Mandatory Training, Responsibility, Communication, Multidisciplinary.
Version:	2
Approved by:	Trust Board /SMT
Date of approval:	September 2007/Sept.2009
Name of originator/author:	Adele Dyche
Name of responsible committee/individual:	Director of Infection Prevention and Control
Date issued:	September 2009
Review date:	September 2010
Target audience:	All Trust Staff

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1 INTRODUCTION

Healthcare Associated Infections (HCAI) has both a financial and a human cost. Hand hygiene is universally considered to be the simplest, most effective measure for preventing nosocomial infection. Unfortunately it is also one of the most neglected practices.

Despite advances in Infection Prevention and Control and hospital epidemiology, Semmelweis's early message regarding the importance of hand decontamination in preventing infection is not consistently translated into clinical practice and healthcare workers adherence to recommended hand hygiene practices is unacceptably low. (Jarvis 1994)

Average compliance with hand hygiene recommendations varies between hospital, among professional categories of healthcare worker and according to working conditions. Compliance with this simple procedure remains unacceptably low with rates of adherence often reported as <50% (Pittet 2001)

Non compliance with hand hygiene is not just regarded as a national problem but is universally regarded as a trans-global one. (Pittet 2001) Promotion of hand hygiene remains a major challenge for infection control experts.

2 PURPOSE

The policy is intended to ensure that all members of clinical and non clinical staff including non permanent members of staff working within LTHT adhere to and practice good hand hygiene technique. To provide and maintain a safe environment for patients, other staff groups and visitors in the interests of preventing and controlling the spread of infection.

This policy covers the following principal topics:

- Duties within the Trust with regard to hand hygiene;
- The provision of hand hygiene training to relevant permanent staff groups;
- Failure by members of relevant permanent staff groups to attend hand hygiene training;
- The process for monitoring compliance with this policy and the effectiveness of the arrangements contained within it.

The key principles and aims of the policy are as follows:

- Prevention of Healthcare Associated Infection
- Providing assurance of compliance
- Improving and sustaining compliance with hand hygiene
- Ensuring a safe environment for patients, staff and visitors to LTHT
- Securing and ensuring hand hygiene as a high priority within the Trust from Trust board to grass roots.
- Ensuring the hand hygiene policy is the responsibility of all LTHT staff/students to implement and support.
- Ensuring that staff access and receive annual hand hygiene training.

The overall aim of the hand hygiene policy is to promote and sustain improved compliance with the practice of hand hygiene, thus in turn creating a safer environment for patients staff and visitors to the Trust by preventing and controlling infection.

This is a mandatory policy to be complied with by all clinical and non clinical staff within the Trust.

FAILURE OF ANY STAFF MEMBER TO FOLLOW THIS POLICY COULD RESULT IN THE INSTIGATION OF DISCIPLINARY PROCEDURES.

3 DEFINITIONS

Antimicrobial- Any compound that selectively destroys or inhibits the growth of micro organisms.

CCDC- Consultant for Communicable Disease Control- A doctor appointed by each health authority who has the responsibility for the surveillance and prevention and control of infections within a defined geographical area.

CYHC- Clean your Hands Campaign- National campaign that was instigated in 2004 by the National Patient Safety Agency (NPSA) in the interests of raising awareness with hand hygiene and improving compliance with hand hygiene practice in all NHS trusts across England.

DIPC - Director of Infection Prevention and Control - A named individual who is responsible for Infection Prevention and Control within an NHS organisation. This involves responsibility for the infection Prevention and Control team, overseeing local Infection Prevention policies and their implementation, reporting directly to the Chief Executive. The DIPC and their nominated deputy will possess the authority to challenge both inappropriate clinical hygiene and inappropriate antimicrobial prescribing.

DH - Department of Health- The government department that is responsible for all public health issues across the United Kingdom.

HCAI- Healthcare Associated Infection - An infection that was neither present nor incubating at the time of a patients admission to hospital (the definition used for the purposes of this policy is an infection that normally manifests itself more than 48 hours after a patients admission to hospital)

IPCC - Infection Prevention and Control Committee - The main hospital forum for routine consultation between the infection prevention and control team and the rest of the Trust. It is required to approve and lend support to the infection prevention and control team's programme

IPCN - Infection Prevention and Control Nurse- A registered general nurse with knowledge of all aspects of infection prevention and control.

IPCT- Infection Prevention and Control Team - The Team within the Trust which has primary responsibility for and reports to the Chief Executive on all aspects of surveillance and prevention and control of infection. The members of this team are an Infection Prevention and Control Doctor, Consultant Medical Microbiologists and a number of Infection Prevention and Control Nurses.

Clinical Educator - Senior member of staff usually a Registered General Nurse whose remit is to provide education and training on aspects of patient care to all members of staff within their area of responsibility.

Keyworker - A Nominated individual who provides a link between the Infection Prevention and Control Team and their colleagues at ward level . Key workers act as roles models and champion best Infection Prevention practice. Key workers are expected to complete and pass the Level 3 Infection Prevention Module to accompany this role.

Non Clinical staff - Staff members within the Trust who have no direct contact with patients in the course of their duties but may nonetheless access the patient environment. This may include housekeepers, certain volunteers, secretaries, Ward Clerks or others.

Clinical staff - Staff such as Nurses, Doctors, Physiotherapists and others who will come into direct contact with patients in the course of their duties.

Nosocomial- Hospital associated

4 DUTIES WITHIN THE ORGANISATION

Chief Executive

The Chief Executive is responsible for the prevention and control of healthcare associated infection, and sustainable improved compliance with hand hygiene.

The Chief Executive delegates responsibility for the development and implementation of the policy to the Director of Infection Prevention and Control

Director of Infection Prevention and Control (DIPC)

DIPC has the delegated responsibility from the Chief Executive for the following:

- Commissioning the development and assuring implementation of the hand hygiene policy and the hand hygiene in practice policy (Policy 4b)
- Reporting directly to the Chief Executive and the Board on matters pertaining to hand hygiene, particularly hand hygiene compliance including any risks to compliance.
- Registering any risks to compliance and developing plans to mitigate risks
- Challenging inappropriate clinical practice within the Trust where hand hygiene is concerned.
- Assessing the impact of the existing hand hygiene policy and making recommendations for change where appropriate.
- Being an integral member of the organisation's clinical governance and patient safety teams and structure.
- Producing an annual report on the state of HCAI in the organisation, to include reference to hand hygiene policy and compliance.

DIPC role adapted from *DH (2006) The Health Act Code of practice for the prevention and control of health care associated infections. P9 annex 1*

Additional hand hygiene responsibilities of the DIPC include:

- Ensuring that hand hygiene features prominently on LTHT's clinical and strategic agenda;
- Ensuring the provision and implementation of hand hygiene performance standards and audit tool;
- Ensuring that all Trust staff at all levels complies with the LTHT hand hygiene policies.
- Ensuring that hand hygiene resources are available within the Trust for the use of staff, patients and visitors so that they may adhere to hand hygiene policy. This will include for example ensuring the adequate provision of alcohol hand rubs soaps and paper towels.
- Ensuring that high quality information is provided to patients, public and clinical teams so that the risks that are associated with the performance of certain procedures are transparent.
- Ensuring Trust participation with National /International initiatives such as the CYHC
- Ensuring that all staff, both clinical and non-clinical, has access to adequate annual hand hygiene training. The mechanisms for providing such training are set out at paragraph 5.0.
- Ensuring that all non permanent members of staff are aware of and adhere to LTHT hand hygiene policy

Divisional General Manager

The Divisional General Manager is responsible for the following:

- Ensure the successful delivery of the LTHT hand hygiene policy and compliance with this policy within their area of responsibility and ensure management arrangements are in place to achieve the following;
- Support both the Chief executive and DIPC in achieving the main objectives of Hand Hygiene policy;
- Registering any risks to compliance and developing plans to mitigate risks

- Ensure that each directorate under their responsibility is aware of the Hand Hygiene policy and has a robust multidisciplinary action plan in place to ensure continued and sustained compliance;
- Ensure that practice is regularly audited using the agreed LTHT hand hygiene audit tool and recorded.
- Ensures that the Division under their jurisdiction provides regular assurance to the IPCT and other relevant stakeholders of their compliance with LTHT hand hygiene policies.

Divisional Medical Manager/Divisional Nurse Manager (Infection Prevention Divisional lead)

Each Divisional Medical Manager/Divisional Nurse Manager/Infection Prevention Divisional lead) must ensure that the following occurs within their area of responsibility:

- The immediate and ongoing dissemination and implementation of hand hygiene policies at local level;
- Hand hygiene compliance audit will be undertaken weekly and the results fed back to the multidisciplinary team;
- Registering any risks to compliance and developing plans to mitigate risks
- Staff will be made continually aware of hand hygiene policy and each area will have a robust multidisciplinary action plan in place to ensure continued and sustained compliance;
- Staff will access and receive hand hygiene training annually;
- Hand hygiene audit results and training will be monitored through the divisional clinical governance forum
- Alongside other members of staff must take steps to ensure that the appropriate resources are available in their area of responsibility to allow patients, staff and visitors to comply with this policy, such as alcohol gel, soap, paper towels, an adequate number of wash basins and high quality information/educational resources.

Matrons/Senior Nurses and Clinical Directors

Matrons and Senior Nurses and Clinical Directors must:

- Support and ensure the implementation of the LTHT hand hygiene policy;
- Alongside other members of staff, take steps to ensure that the appropriate resources are available in their area of responsibility to allow patients staff and visitors to be able to comply with this policy such as the provision of alcohol gel, soap paper towels, an adequate number of hand wash basins to be able to perform hand hygiene and high quality information /educational resources.
- Alongside other members of staff, take steps to ensure and monitor that a hand hygiene audit is completed every week using the agreed LTHT hand hygiene tool and that a compliance figure is submitted to the LTHT hand hygiene compliance database.
- Registering any risks to compliance and developing plans to mitigate risks
- Co ordinate the delivery of the agreed hand hygiene action plan for each ward/department area.
- Alongside other members of staff, provide patients and visitors at the earliest opportunity (e.g. pre-assessment or as part of the admissions process) with copies of the Infection Prevention and Control leaflets 'Preventing infection during your hospital stay', 'Infection Prevention and Control Guidance for Relatives' and 'Hand Hygiene for Patients' and ensure they are available in prominent places for easy access.
- Monitor and review staff uptake of mandatory annual hand hygiene training.
- Participate in local/national hand hygiene initiatives such as CYHC.

Infection Prevention and Control Team

This department is responsible for the following:

- Support both the Chief Executive, DIPC and the Trust Divisions with the main objectives of the Hand Hygiene policy;
- Revise, update and review current guidance /legislation which will inform the LTHT hand hygiene policy and the LTHT e-learning package for hand hygiene
- Support LTHT with the implementation of the LTHT hand hygiene policy;
- Alongside other members of staff, take steps to ensure that the appropriate resources are available in their area of responsibility to allow patients staff and visitors to be able to comply with this policy such as the provision of alcohol gel, soap paper towels, an adequate number of hand wash basins to be able to perform hand hygiene and high quality information /educational resources.

- Provide training to all groups of Trust staff both clinical and non-clinical on all aspects of hand hygiene as indicated in the LTHT Mandatory Training Policy.
- Act and serve as a role model for both junior and senior colleagues of all disciplines
- Co-ordinate and participate in local /national hand hygiene initiatives such as CYHC
- As divisional IPCNs assist in the delivery of the Divisions agreed hand hygiene action plan at local level

Ward/Departmental Managers, Senior Sisters, Charge Nurses, Clinical Educators /Key workers

These members of staff must:

- Assist and support Matrons/Senior Nurses in the implementation of this policy;
- Ensure that staff are aware of and adhere to this policy and that it is implemented immediately;
- Ensure staff know how to access this policy;
- Ensure that staff are given adequate protected time to receive hand hygiene training;
- Monitor individual staff compliance with hand hygiene training
- Ensure the delivery of the Divisions agreed hand hygiene action plan at local level;
- Complete weekly hand hygiene audits using the agreed LTHT audit tool;
- Provide regular/immediate feed back to staff on hand hygiene performance following the departments audit;
- Alongside other members of staff, provide patients and visitors with copies of the Infection Prevention and Control leaflets 'Preventing Infection during your hospital stay', 'Infection control guidance for relatives' and 'hand hygiene' at the earliest opportunity, for example at pre-assessment or on admission, and ensure they are supplied in prominent places for easy access.
- Participate in local /national hand hygiene initiatives such as CYHC
- Act and serve as a role model for both junior and senior colleagues of all disciplines

- Where indicated as part of the LTHT Mandatory Training Policy, provide junior and senior colleagues with regular hand hygiene training.

Clinical areas

- It is the responsibility of Ward Sisters and/or similar team leaders to assess the capabilities of their patients in performing good hand hygiene. This should be evaluated on admission and recorded in a care plan. The care plan must contain measures to reduce the likelihood of a HCAI and strategies in place to assist the individual in effective hand decontamination.

All clinical and non clinical staff/students practicing within LTHT

These members of staff must:

- Encourage colleagues, patients and visitors to perform hand hygiene when appropriate and to comply with this policy in all respects;
- Challenge and report poor practice and non-adherence to this policy;
- Promote good hand hygiene within their sphere of work;
- Be aware of and strictly adhere to the Trust hand hygiene policy at all times;
- Behave in a safe and responsible manner taking all appropriate steps to minimise the risks of HCAI;
- Provide patients and visitors with the copies of the infection control leaflets 'Preventing Infection during your hospital stay', 'Infection control guidance for relatives' and 'hand hygiene for patients' at the earliest opportunity and ensure the leaflets are supplied in prominent places for easy access
- Assist patients to adequately decontaminate their hands.
- Attend and provide evidence of having attended mandatory annual hand hygiene training.

FAILURE TO FOLLOW THIS POLICY COULD RESULT IN THE INSTIGATION OF DISCIPLINARY PROCEEDINGS.

5 TRAINING IN HAND HYGIENE

5.1 Provision of hand hygiene training

Section 5.1 of this policy runs in conjunction with LTHT Mandatory Training policy

All staff are required to undertake training in hand hygiene on an annual basis. Therefore the Trust has categorised this as mandatory for all clinical and non clinical staff working in LTHT. *Please refer to the LTHT Mandatory Training Policy. Appendix 1 Training needs analysis - Hand Hygiene.*

Training in hand hygiene will be provided as follows:

- First day generic awareness information (delivered at corporate induction) for all staff, both clinical and non clinical;
- First 4 weeks role-specific training for all clinical staff. This will be delivered at local induction and may delivered in person by either a clinical educator or Infection prevention key worker, or otherwise by completion by the member of staff of the Trust's hand hygiene e-learning package;
- Annual refresher for all Trust staff, both clinical and non-clinical. This annual refresher training will be delivered in one of the 3 ways set out below. Clinical staff will receive annual specialist refresher training which is specific to their role. Non-clinical staff will receive annual generic refresher training.

Staff may access hand hygiene training in a number of different ways within the Trust. These are outlined below. No matter how that training is accessed, staff are personally responsible for providing evidence to their line manager of having received that training on at least the mandatory annual basis. Line managers are responsible for monitoring completion by staff of mandatory hand hygiene training at local level.

There are 3 methods of Hand hygiene training available in LTHT :

- By accessing and completing the LTHT E-learning programme on hand hygiene. (N.B there is an expectation that all clinical staff alongside any refresher training must complete the hand hygiene e-learning package annually)
- By attendance at any of the LTHT hand hygiene drop in sessions run by the Infection Prevention and Control Team;
- By attendance at training given by a key trainer, such as a key worker or Clinical Educator, within the individual's division

Staff are given protected time to attend a classroom-taught session or to complete the e-learning package for hand hygiene. Staff are also able to access the e-learning package for hand hygiene from home should they wish to. Please refer to LTHT Mandatory Training Policy.

5.2 Failure to attend hand hygiene training

Staff must provide evidence of attendance/completion of training annually at appraisal.

Staff who fail to attend hand hygiene training or to provide evidence of attendance at hand hygiene training when required will be followed up by their line manager and instructed to access training as per the process outlined in the mandatory training policy. Continued failure to attend training will result in disciplinary action at local level by Matron, Clinical Director or other responsible person where necessary.

Persistent failure will result in escalation to the Divisional Nurse/ Divisional /Medical Manager (Director of Estates and Facilities for Estates and facilities staff) and possible suspension from work until training is completed.

6 PRIORITISATION OF WORK

Hand hygiene is the single most effective measure in the prevention of HCAI. (Rotter 1997) However compliance with this simple procedure remains unacceptably low with rates of adherence often reported as <50% (Boyle et al 2001)

Non compliance with hand hygiene is not just regarded as a national problem but is universally regarded as a trans-global one. (Pittet 2001)

In 1999 the Department of Health and the National Service Executive (NHSE1999) demanded chief executives of hospital trusts improve hand hygiene standards in hospitals.

Hand hygiene and infection control have remained high on both the NHS and governmental agendas for some time with infection control being a performance indicator for Trusts in England.

In February 2004 the Department of Health released the Standards for Better Health document which superseded the controls assurance framework.

Section C4 a) clearly states 'that healthcare organisations must have systems in place to ensure that the risk of infection to patients staff and visitors is minimised'. Hand hygiene remains the most important means of preventing HCAI and must remain a priority amongst all staff within LTHT.

Thus LTHT have

- Developed a hand hygiene policy and hand hygiene in practice policy (4b) which applies to and must be adhered to by all staff (clinical and non-clinical).

This is a stand-alone policy which does not duplicate any other policy either locally or nationally.

- LTHT complies with national/international guidance/initiatives in the interests of improving compliance with hand hygiene, such as the NPSA “Clean Your Hands” campaign and adopting the World Health Organisation guidelines on hand hygiene

7 IDENTIFICATION OF STAKEHOLDERS

The stakeholders of this policy are

- Chief Executive and Trust Board
- Chief Nurse and their nominated Deputy
- DIPC and their nominated Deputy
- Senior Management Structures at Divisional Level (Divisional General Managers .Divisional Medical Managers, Divisional Nurse managers Clinical Directors and Matrons
- Director of Estates and Facilities and their nominated Infection Prevention Lead
- Membership of the IPCC (see Appendix 1)
- All staff groups both clinical and non clinical working within LTHT

Externally

- Consultant for Communicable Disease (Health Protection Agency), as a member of the IPCC
- Department of Health

All staff groups, clinical and non-clinical, and the individuals listed above are invited to comment on this policy.

8 RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

The Chief Executive has ultimate responsibility and is held accountable for the hand hygiene policy and its development.

The Chief Executive has delegated responsibility for the development and implementation of this policy to the Director of Infection Prevention and Control.

9 EQUALITY IMPACT ASSESSMENT

The Leeds Teaching Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

1. Screening			
How relevant is this policy and its associated procedures to promoting equality and eliminating discrimination? (indicate in boxes below)			
	Not relevant	Partly relevant (say which parts)	Very relevant
Race/ethnic group:	Not Relevant		
Disability ¹ :	Not Relevant		
Gender:	Not Relevant		
Age:	Not Relevant		
Sexual Orientation:	Not Relevant		
Religion:	Not Relevant		
Other (please state)	Not Relevant		
2. Assessing Impact (To be completed where the policy and associated procedures			

¹ Disability covers physical, sensory and mental impairments which include mental illness and learning disability. Long term conditions such as cancer, HIV and Multiple Sclerosis are included and any other condition at the point at which it begins to have an impact on a persons capacity to carry out normal day to day activities.

has been determined as relevant in the screening process)	
Please specify, in the rows below, anything that you have included in this policy and its associated procedures to ensure that equality is promoted and that no one will be unlawfully disadvantaged (discriminated against) as a result of this policy	
Race/ethnic group:	Not applicable
Disability:	Not applicable
Gender:	Not applicable
Age:	Not applicable
Sexual Orientation:	Not applicable
Religion:	Not applicable
Other (please state):	Not applicable

10 CONSULTATION PROCESS

A nominated individual within the infection control team 10 weeks before the policy is due for renewal is asked to commence review of this policy. All members of the multidisciplinary team within the trust will be invited to attend (should they wish) an initial consultation group to discuss the current policy. Comments will be gathered.

A first draft will be completed within 4 weeks of the consultation meeting and circulated to attendees of the consultation group, members of the Infection Prevention Team and the IPCC with a deadline of 2 weeks comments are to be received back to the relevant author/named individual.

A second draft is then circulated to the above stakeholders within 2 weeks of the previous deadline for further comment with a final 2 week deadline for final comments back to the relevant author/named individual.

The final draft is submitted to the Trust board and SMT for approval /ratification.

It is the IPTs responsibility to ensure that all persons who have returned comments are acknowledged within the policy and a record of comments received kept.

11 POLICY APPROVAL/RATIFICATION

All LTHT policies are ratified and approved by the Trust Board and SMT.

12 REVIEW/REVISION

The policy is reviewed every 2 years or sooner in light of new guidance. This is reviewed by the (DIPC) or nominated member of staff from the IPCT.

13 COMMUNICATION AND DISSEMINATION

The policy once approved and ratified by SMT is then disseminated immediately by the IPCT electronically. The policy is disseminated to Matrons, Chief Nurses Team, Consultants, Divisional General Managers, Divisional Nurse Managers, Medical Directors, Clinical Directors and Trust-wide. It is the above individuals' responsibility to ensure that all staff under their jurisdiction is aware of and have ready access to the policy.

This policy is placed on the Infection control intranet site and clinical areas are asked to print the new policy, discard the old one and store the new policy in the Infection control manual at local level for future reference.

14 IMPLEMENTATION

Once ratified by the appropriate body within the Trust this policy will be implemented within 4 weeks of the final version being disseminated via email.

15 MONITORING COMPLIANCE AND EFFECTIVENESS

A weekly hand hygiene compliance audit is conducted in each clinical area which is the responsibility of the ward/departmental manager. The results are recorded and entered onto the Trust hand hygiene database which is accessible via the infection prevention and control intranet page. A failure to achieve the standard of 95% compliance will lead to the production of a multidisciplinary action plan on improving compliance with both hand hygiene technique and policy. This is monitored and reviewed at local level by the matron/ clinical director.

Action plans are monitored and reviewed on a regular basis at divisional level through established infection prevention and control meetings; this is the responsibility of the Divisional Medical Manager.

Divisional compliance is further reviewed at organisational level through the performance management framework, led by the Chief Executive; outstanding items from divisional action plans are placed on the divisional risk registers.

The Infection Prevention & Control Committee will review risks across the organisation associated with hand hygiene compliance, led by the DIPC and based on the hand hygiene audit compliance data and divisional action plans.

Compliance with and the effectiveness of staff training requirements will be monitored by means of the arrangements set out in paragraph 5.2.

16 KEY PERFORMANCE INDICATORS

All clinical areas that have direct patient contact are required to complete and submit a weekly compliance figure to the LTHT hand hygiene database using the universally agreed audit tool.

Action plans to improve compliance for hand hygiene which show multidisciplinary involvement are submitted to the data base, monitored and evaluated by the Divisional General Manager/ Divisional Nurse Clinical Director/ Matron/Senior Nurse.

The Divisions must all embrace and are part of the NPSA clean your hands campaign. Participation in the National Saving Lives Programme where key standards are adopted is also required.

17 REFERENCES/ASSOCIATED DOCUMENTATION

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Rotter M L (1997) 150 years of hand disinfection- Semmelweis's heritage. Journal of medicine and hygiene 22,332-9

World Health Organisation (2005) Guidelines on hand hygiene in Health Care (Advanced Draft)

Appendix 1

Infection Control Committee Representation

Mr Brian Godfrey - Divisional General Manager Diagnostic and Therapeutic Services

Mr Craig Brigg- Director of Quality

Dawn Marshall- Divisional Nurse Manager, Oncology and Surgery Division

Dr Emer McAteer-Divisional Medical Manager Diagnostic and Therapeutic services

Dr Fiona Campbell- Divisional Medical Manager, Women's and Children's Head, Neck and Dental

Dr Graham Johnson- Divisional Medical Manager Medicine Division

Dr Peter Belfield- Interim Medical Director

Professor Ian Lewis - Divisional Medical Manager Specialist Surgery

Dr Mark Baker - Divisional Medical Manager Oncology and Surgery Division

Dr Phil Ayres Deputy Medical Director

Dr Philip Howard - Consultant Pharmacist (antimicrobials)

MS Clare Ashby - matron Infection Prevention and Control

Ms Juliette Cosgrove, Lead Nurse for patient safety /Interim Deputy DIPC

Prof Liz Kay, Head of CMT, Pharmacy

Mr Darryn Kerr, Director of Estates and Facilities

Dr Jane Minton, Consultant in Infectious Diseases

Dr John Shepherd, Occupational Health Consultant

Dr Mike Gent, CCDU, HPA

Ms Ruth Holt, Chief Nurse , Director of Infection Prevention and Control

Mr Nigel Lumb, Head of Health & Safety

Professor Mark Wilcox, Head of Microbiology

Dr Richard Hobson, Infection Prevention and Control Doctor

Ms Gillian Hodgson, Nurse Consultant, Infection Prevention and Control