Aide-memoire: respiratory and hand hygiene
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Actions to ensure reliable improvements in infection prevention and control (IPC) practices.

_Respiratory and hand hygiene are part of standard and transmission-based precautions (droplet, contact and airborne)._ 

**HOW SHOULD I USE THIS AIDE-MEMOIRE?**

1. **Familiarize yourself with the content** of each of the five colour-coded sections.
2. **Consider each of the action checks to make a plan**, and outline them in discussions with others on the improvements to be made, **when preparing to implement WHO guidance, or at any time when aiming to improve adherence to IPC guideline recommendations.**
3. **Take action to make improvements** where needed, using the action checks (some web links are also provided to help if you do not know where to start). Note, this process will likely be cyclical/ongoing until all practices are reliably improved and sustained.

All action checks are for IPC focal points but also describe actions necessary by other professionals with important IPC input (where this is the case, the term IPC input is used acknowledging that individual groups of professionals alone cannot necessarily achieve the action but should combine to influence it to happen).

Monitor your overall progress – using the action checks will help you improve over time and will make you better prepared to meet the WHO core components of IPC programmes, when using the WHO infection prevention and control assessment framework.

The multiple actions presented, when used in combination, will contribute to influencing the behaviour of the target audience; those who should perform IPC practices. Focusing on only one aspect, such as a focus on delivering training only, will not achieve sustainable improvement in practices.
Read and use the statements below to ensure that a range of proven improvement actions have been taken.

**Your action checks**

- Systems to **reliably procure and distribute** tissues, medical masks, alcohol-based handrub (ABHR), soap and towels, as well as associated environmental cleaning and waste disposal products, have been put in place and included **IPC input** and the associated **dedicated budget**. Systems have also included product evaluations.
- Exercises to understand the **adequate numbers of products** that are required, as well as the distribution process, have been performed and have included **IPC input**.
- Steps to confirm **sustainable systems for reliable product/resource availability in patient care areas** have been put in place, even if previously thought to be a good system (e.g. a process that includes an alert mechanism for things that could still go wrong) with **IPC input**. **Roles and responsibilities** for having clean, stocked dispensers for masks and tissues, functioning hand hygiene facilities, waste disposal containers/bins have been outlined with **IPC input**. This includes replacement/replenishment.
- Systems that ensure **easy-to-access products**, which are reliably available, have been established and included **IPC input**, i.e. products positioned in places that are best placed for those who need to use them, and are in line with **IPC-informed policies** or standard operating procedures (SOPs), e.g. meetings have been held to discuss point of care locations for ABHR, depending on the setting.
- **Up-to-date policies** for respiratory and hand hygiene have been provided.
- **SOPs** for use in patient care areas have been provided, including safe use of masks and tissues, cough etiquette, hand hygiene, and cleaning and waste disposal actions. SOPs in paper or in electronic format have been made available, and are easily accessible to those who need them.
- **Budgets for targeted training, monitoring and reminders** (see other actions) have been pursued, identified and secured.
- Approaches to ensure **functioning environmental ventilation** (e.g. natural ventilation such as open windows) have **always included IPC input**.
- **Annual water service plans** in settings where water access/quality is an issue have been put in place with **IPC input**, to ensure infrastructure for action on hand hygiene (i.e. functioning sinks, etc.).
- A local **ABHR production plan** (WHO formulation/local company) has been put in place with **IPC input**, e.g. on volumes required, where these products are not reliably available from a credible company source.
- **Temporary strategies** on rational but safe use of masks where there are issues with supply, such as a temporary and time-limited SOP, have been considered and are clearly outlined **always with IPC input**.
A sample of WHO resources that can help you if you do not know how to start


A CULTURE OF SAFETY TO FACILITATE AN ORGANIZATIONAL CLIMATE THAT VALUES THE INTERVENTION – “LIVE IT”.

Read and use the statements below to ensure that a range of proven improvement actions have been taken.

Your action checks

- The right leaders’/role models have been identified and engaged with IPC input, with teams formed, where relevant (these may be from many different settings, including in health care or community leaders/families). Staff has been asked which role models they would best respond to (these can be very different in different settings and come from all levels).

- Leaders/role models with the right expertise for championing and influencing respiratory and hand hygiene have been engaged and identified, with IPC input, e.g. a “champion” badge to show that a culture of safety has been considered serious.

- Leaders/senior managers have been encouraged to have done the following (not exhaustive):
  - understood and actively supported actions in line with SOPs;
  - role modelled the right practices for respiratory and hand hygiene (and physical distancing) by performing these correctly in front of staff. Training sessions have also been attended alongside staff, particularly while (acute respiratory) infections are prevalent;
  - encouraged “buddy” systems to suit the local setting, to promote the right practices, as per SOPs, including having engaged supervisors specifically in how they can be ongoing role models;
  - made visible the commitment to budget allocation for respiratory and hand hygiene resources;
  - shown commitment to protected time for targeted, real-time training. Training plans have been signed off for all levels of staff;
  - provided written or auditory messages (with plans made to update regularly, i.e. monthly), with IPC input;
  - held discussions (at both facility and national levels as appropriate), e.g. virtual or on-site meetings/focus groups with all the right people and an agenda to allow for problems to be discussed, questions to be heard and solutions to improvements outlined, with IPC input. Suitable, regular times for “safety talks” have been set, using a range of ways that make sure the right people are available. Discussions have been facilitated in a way that allows everyone to have a chance to talk;
  - promoted and supported motivational activities with IPC input, e.g. in the form of an award that is announced publicly to encourage staff to continue to adhere to respiratory and hand hygiene practices as per SOPs.

A sample of WHO resources that can help you if you do not know how to start


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1 Leaders: anyone in administrative or management positions.
Read and use the statements below to ensure that a range of improvement actions have been taken.

Your action checks

- **Accurate reminders** (based on WHO recommendations) have been sourced/developed/adapted if not by IPC then with **IPC input** and used to champion respiratory and hand hygiene, mask use, and associated environmental cleanliness and waste management (these may also include segregation/distancing measures). Directions on when and how to use products/equipment have been included, and cleaning/disposal, as relevant, as well as motivational slogans (posters, short videos and electronic reminders, where possible, are some examples).

- **Decisions** have included staff, on the types of reminders that will engage them, as well as on the content, where applicable, **always with IPC input**. The target audience for reminders has been considered, e.g. whether these should be written or illustrative.

- The most **appropriate placement** of reminders has been arranged between IPC and staff, and has **focused on the point of care** wherever persons with (acute respiratory) infections are (both inpatient and outpatient settings).

- **Any issues with placement** of reminders have been addressed with **IPC input**, including allocated notice board approvals, wall placement (to avoid damage), any “competition” with other reminders.

- **Regular replenishment** of reminders (posters)/other communications have been planned with **IPC input**, including auditory messages from leaders, e.g. on a monthly basis. Slight variations in how the reminders are presented have been planned, in order to keep people’s attention.

- **Scripts/prompts** for local champions/role models have been provided, to use when talking about prevention measures for (acute respiratory) infection.

- A **range of messages** have been developed and issued to drive action and ensure ongoing motivation; this might be compliance feedback or facts about the prevalent (acute respiratory) infections, and have been arranged between IPC and leaders.

A sample of WHO resources that can help you if you do not know how to start


Read and use the statements below to ensure that a range of improvement actions have been taken.

Your action checks

☐ Responsibility for checking that current training and education programmes have included the correct, up-to-date respiratory and hand hygiene actions (and associated environmental cleaning and waste management) has been allocated. To address any staffing/responsibility changes, a mechanism for reassigning responsibility has also been put in place.

☐ A plan for all training resources to be updated where and when necessary, mapping guideline/policy/SOP recommendations to training content, has been put in place.

☐ Mechanisms, such as a reliable annual and/or “new guidance issued” alert have been put in place to ensure timely updates to training resources, including allocated responsibilities.

☐ Training needs assessments have been conducted across different disciplines/levels, and any other assessments (from monitoring activities) have also been used to inform training.

☐ The required expertise to conduct targeted training and answer questions (this may mean asking external experts) has been identified and confirmed.

☐ A schedule has been prepared and targeted training of staff and identified others has been delivered, including refresher courses.

☐ Different (practical) approaches, as necessary, have been used, including demonstrations in person or through online tools (the type of training should be relatable to the target audience). Staff has ultimately been empowered through training, which will lead to autonomy, encouraging them to consistently do the right thing and to serve as role models to others.

☐ Easily accessible training schedules with deadlines for completion and targets have been made available for all staff to view. Different methods have been applied to motivate training attendance/completion, e.g. certificates of completion, recognition/rewards, statements from leaders who have already completed the training.

☐ Depending on the setting, additional educational materials for patients and visitors have been prepared always with IPC input, and, for example, train-the-trainer sessions have been offered to support these communities.

☐ Direction/training materials on producing ABHR (pharmacy staff) and local production of masks, if relevant, have been supported with IPC input.

A sample of WHO resources that can help you if you do not know how to start


MONITORING AND FEEDBACK TO ASSESS THE PROBLEM, DRIVE APPROPRIATE CHANGE AND DOCUMENT IMPROVEMENT OF PRACTICES – “CHECK IT”.

Read and use the statements below to ensure that a range of improvement actions have been taken.

Your action checks

☐ Dedicated, trained staff has been identified to execute monitoring activities.

☐ Monitoring tools have been checked for validity and reliability in line with guidance/SOPs and data collection recommendations, if not already done, and have been made available for use.

☐ An audit/surveillance monitoring schedule has been created to include roles and responsibilities, and made available to ensure that staff engage with this as an improvement approach (different from formal monitoring that is seen as “inspection”).

☐ The audit/surveillance reporting and feedback schedule has been executed.

☐ Monitoring activities have embraced alert mechanisms, not just routine planned activities, to highlight in real time when systems and processes fail and when, for example, products are not reliably available or not functioning.

☐ Additional mechanisms for patient/visitor feedback have been considered, depending on the setting, with IPC input.

☐ Audit and surveillance activities, with reporting and feedback, have included at least the following:

  • reliable, sufficient availability of quality products/equipment for respiratory and hand hygiene, and associated environmental cleaning and waste management, considering end-to-end distribution (tissues, masks, water, soap, towels, ABHR, the right cleaning and waste products, all functioning and correctly placed). The impact of any changes to procurement plans has also been addressed, e.g. a new ABHR and the need for staff acceptability and tolerability surveys, as well as review of the impact upon the built environment, i.e. from new holders to be placed on walls, etc.;

  • respiratory and hand hygiene practices, including timing and techniques;

  • consumption/utilization rate and replenishment of products;

  • staff knowledge and perceptions on respiratory and hand hygiene, mask use, and associated environmental cleaning and waste management;

  • availability, positioning and legibility of reminders (e.g. posters, leaflets, auditory messages), as well as their ability to engage the audience, and frequency of replacement;

  • training attendance records and evaluations, including information on informed and empowered staff;

  • infection rates, aimed at stimulating improved practices.

A sample of WHO resources that can help you if you do not know how to start

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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