Aiming higher: HARTMANN's Hand Hygiene Evolution Concept.
Geared towards sustainability.

When hand disinfection becomes second nature: the new Hand Hygiene Evolution Concept guides the way to a permanently better compliance – step by step.

<table>
<thead>
<tr>
<th>EDITORIAL</th>
<th>03</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
<td>04</td>
</tr>
<tr>
<td>Isolation rooms: safely keeping pathogens at a distance</td>
<td>04</td>
</tr>
<tr>
<td>Study: MRSA colonies on high-touch surfaces</td>
<td>14</td>
</tr>
<tr>
<td>FOCUS</td>
<td>06</td>
</tr>
<tr>
<td>Step by step to sustainable hand hygiene</td>
<td>06</td>
</tr>
<tr>
<td>The scientific basis of the Evolution Concept</td>
<td>09</td>
</tr>
<tr>
<td>Experience with the Observe plus App</td>
<td>10</td>
</tr>
<tr>
<td>The IMPULSA hand hygiene programme in daily routine</td>
<td>12</td>
</tr>
<tr>
<td>EXPERTISE</td>
<td>13</td>
</tr>
<tr>
<td>Distinguished: Sterillium is Brand of the Century</td>
<td>13</td>
</tr>
<tr>
<td>Surface disinfection: effective barriers against microorganisms</td>
<td>18</td>
</tr>
<tr>
<td>INSIGHTS</td>
<td>16</td>
</tr>
<tr>
<td>Greater safety in ORs thanks to well-coordinated teams and optimised processes</td>
<td>16</td>
</tr>
<tr>
<td>PRACTICE</td>
<td>20</td>
</tr>
<tr>
<td>Exposure time of alcohol-based rapid disinfectants</td>
<td>20</td>
</tr>
</tbody>
</table>

DISINFECTS 2/16 page 2
Dear Reader,

Lasting success is no coincidence. On the contrary: for the most part it originates from planned action and a great deal of tenacity.

These are also the factors that play a big role in achieving improved hand hygiene behaviour that is sustainable. Especially when looking at the many compliance barriers that are opposed to adhering to hygiene protocols. Overcoming these barriers and establishing hand hygiene as second nature requires a smart strategy.

A solution of this kind is the new Hand Hygiene Evolution Concept. The highlight: this programme has no one-time campaign character, but is implemented in daily routine. HARTMANN’s individualised consulting approach picks up on and proceeds from wherever clinics stand in hand hygiene compliance. Additionally, the continuous onsite support assists with adapting the measures and achieving the respective targets.

In the FOCUS section you will read how exactly the Evolution Concept promotes compliance, what elements it comprises, and what experience facilities have already gained with the individual elements.

I hope this DISINFACTS issue will inspire you. Enjoy!

Dr. Henning Mallwitz
Head of Research & Development
Safely keeping pathogens at a distance

Pneumonia, intestinal infection, influenza, and tuberculosis are among the most common pathogen-related diseases in hospitals. To prevent infections when treating patients with communicable diseases it is necessary to take special measures beyond basic hygiene. These particularly include the accommodation of patients. In its new recommendation, the Commission for Hospital Hygiene and Infection Prevention (KRINKO) at the Robert Koch-Institute explains what needs to be observed in terms of isolation rooms and wards [1].

Protecting patients, staff and visitors against transmissible infectious diseases – that is the key objective of the KRINKO recommendation on Infection Prevention when caring for and treating patients with communicable diseases. The 20-page recommendation is the first guideline on hygienic measures necessary when caring for and treating patients with infectious diseases.

In addition to a compact summary of the basic hygiene, it comprehensively outlines the extended protective measures that exceed basic hygiene. These extended preventive precautions are derived from the risk analysis.

accordingly, these rooms have to fulfil several criteria. The basic principle is: isolation rooms or isolation rooms with anteroom should be used as single rooms to isolate patients. This includes an own bathroom with direct access from the patient room and a toilet with hand disinfectant dispenser. Additionally, the isolation room should have an entrance area that is large enough to put on protective clothing and, before leaving the room, discard it without risk of contamination.

An isolation room with additional anteroom allows to consistently separate the contaminated patient room and the non-contaminated exterior area. To fully fulfil its function as separation zone, however, the anteroom should be large enough to separate the clean and unclean side (see figure 1). KRINKO advises to preferably isolate patients suffering from measles, chickenpox or multidrug-resistant tuberculosis in isolation rooms with anteroom.

According to the recommendation, the following four factors are important for the risk analysis and the corresponding necessary measures:
1) transmission path
2) possible vaccination and the risk potential for risk groups
3) personal protective equipment, and
4) accommodation of patients.

And – in the face of the growing share of patients colonised with multidrug-resistant pathogens – increasingly focus on the accommodation

**Isolation room requirements**

Often, standard accommodation is not enough to prevent the transmission of contagious infections. In fact, patients rather need to be isolated in rooms specifically intended for such cases, as one important infection control rule is to create a distance between potentially infectious patients and patients at risk of infection.

**Fig. 1: Isolation room with anteroom**
Separated or together
Depending on the patients’ disease and condition it is necessary to isolate them separately or it is possible to isolate them together (cohort isolation).

Separate accommodation is needed:
- when pathogens may be transmitted via droplets and particles in the air;
- in case of special diseases or disease stages, e.g. profuse diarrhoea;
- when transmission paths are difficult to ascertain, e.g. in case of ectoparasites;
- when patients cannot take care of basic hygiene.

When several patients are infected with the same pathogen they may be accommodated in a cohort. However, this must only be done when there are no limiting conditions, for example immunosuppression or the potential for a superinfection.

Isolation wards
When there are certain specialist departments in a hospital that often treat contagious patients, it is reasonable to set up a ward with several isolation rooms. To ensure smooth processes and thus reliable infection protection the wards should also have a range of rooms additional to the isolation rooms, for example a clean and an unclean working room.

In your next DISINFAC: how to use personal protective equipment correctly when treating patients with communicable diseases.

At www.bode-science-center.com under CENTER / Hygienic Measures, you will find an infographic on the spatial requirements of isolation wards.

Source:
Step by step to sustainable hand hygiene

The individual consulting approach and interrelated modules of HARTMANN’s new Evolution Concept paves the way to sustainability in hand hygiene – step by step.

It is known that there are aplenty reasons for inadequate compliance with hand hygiene protocols. Hence, experts throughout the world rightly opt for multimodal hand hygiene strategies. The programmes comprise evidence-based instruments that proved to be successful. However, much is not necessarily better. A long-term success depends on whether the measures are incorporated into clinical practice or not.

The new Hand Hygiene Evolution Concept from HARTMANN therefore goes beyond the mere campaign approach and focuses on a consistent implementation in daily routine.

It offers a customised modular system that hospitals can use to develop and establish an optimal hygiene management starting from their respective hygiene status.

**Compliance is (not) rocket science**
The Hand Hygiene Evolution Concept is based on the consensus of international experts from WHO, Robert Koch-Institute and national associations.
The Hand Hygiene Evolution Concept

The advantages:
- implemented in daily routine – no one-time campaign character
- individualised approach
- every hospital is guided from its individual hand hygiene status
- evidence-based modules
- personal on-site support
- adaptation of measures to the conditions and targets
- most modern didactics
- sophisticated tools providing high quality in terms of contents and technology

The starting point: The assessment of the potential
Implementation of the Hand Hygiene Evolution Concept begins with analysing the potential: you get to know the compliance rate in the wards, whether your training activities are up to date, whether your hand disinfectants are in the right location, whether your hand hygiene management meets current guidelines, and much more.

Since the WHO initiative “Clean Care is Safer Care” started, there has been wide agreement on which instruments promote hand hygiene compliance. These milestones in hand hygiene were transferred to the Evolution Concept’s modular system and complemented by many practical tools.

Modular design
Depending on the status quo, clinics can start right away with the adequate module. Thus, the modular structure solves a dilemma of many hospitals: on the one hand, not all wards necessarily perform equally well in terms of hand hygiene, but on the other hand they are expected to deliver high quality.

Hand hygiene needs to be optimised step by step. “It is not reasonable to intensively train the 5 Moments when there is no hand disinfectant available at the point of care,” Sven Frohard, Director Strategic Marketing & Sales Disinfection explains. Currently, there are six differing modules available. The Concept is advanced continually.
The modules of the Hand Hygiene Evolution Concept

**Basis: Hand disinfection vs. hand washing**
Goal: Implement alcohol-based hand disinfection as gold standard
**Instruments:** Training, e.g. on skin health, measurement of HD consumption

**Module 1: The right hand disinfectant**
Goal: Select products meeting the needs and use hand disinfectants economically
**Instruments:** Studies, expert opinions, recommendations

**Module 2: Infrastructure – Dispenser**
Goal: Make hand disinfectants available following the 5 Moments
**Instruments:** Animated placement overview, checklists, eye-catching displays

**Module 3: How to rub**
Goal: Know and master the rub-in technique for hygienic hand disinfection
**Instruments:** Training, posters, Derma Lite and/or other innovative scan technologies incl. documentation

**Module 4: E-learning – When to rub**
Goal: Implement the 5 Moments in daily routine
**Instruments:** Interactive 5 Moments for Hand Hygiene e-learning tools based on concrete nursing activities (online and offline versions)

**Module 5: Monitoring – Observe App**
Goal: Improve compliance by observation and feedback.
**Instruments:** Digital recording and measurement of the hand hygiene behaviour by using the APP and an iPad

**Module 6: Process optimisation – Observe plus App**
Goal: Increase hygiene safety during nursing activities involving risk of infection
**Instruments:** Digital training, observation, documentation and statistical evaluation of SOPs involving risk of infection by using the App and an iPad
Knowledge inspires confidence:
The scientific basis of the Evolution Concept

Why is it that the hand hygiene compliance is so poor throughout the world? Scientists around the globe are concerned with this question. Many studies investigate how interventions and multimodal programmes influence hand hygiene. And researchers worldwide agree: particularly multistage strategies that offer individual solutions to differing compliance barriers lead to long-term and sustainable success. In the following, you will find a selection of current studies that scientifically underpin the Evolution Concept:

**Multimodally successful: Compliance increased by up to 83.8 %**

In their review, Luangasanatip et al. (2015) investigated how the multimodal WHO-5 Campaign and further measures influence the compliance and the rate of nosocomial infection. Their result: the five modules of the WHO campaign was able to considerably and sustainably increase the compliance. In 14 of the analysed studies, the average compliance among healthcare workers increased by up to 83.3 %. Additional complementary measures amplify the effect and increase the compliance even further. According to the authors effective complementary elements include rewards, incentives, and encouraging employees to take responsibility.

**Preventing nosocomial infections effectively**

Kirkland et al. (2012) examined what influence a hospital-wide hand hygiene programme has on infection rates. They conducted various interventions in a 383-bed clinic, carried out covert compliance observations, and recorded the monthly rates of nosocomial infections. They witnessed that the compliance improved continuously: it increased from 41 % to 91 % within three years. At the same time, the number of nosocomial infections decreased by around a quarter. With their study, Kirkland et al. demonstrate that multimodal interventions may increase compliance rates significantly and sustainably — and thus prevent nosocomial infection.

**Promising: An up to 27 % increase in compliance**

Rodriguez et al. (2015) put the effect of a multimodal intervention to the test as well. In their cluster-randomised study, they investigated whether five interventions could improved the compliance rate in differing intensive care units within six months. Their results prove that multimodal programmes are promising: the participating wards were able to increase their compliance by up to 27 %.

Read the complete study abstracts under SCIENCE by entering the search word “hand hygiene programme”.

DISINFACTS 2/16 page 9
Experience with the Observe plus App, or:

When will you come to us?

Pilot testing the Observe plus App, St. Nikolaus-Stiftshospital in Andernach, Germany used one of the modules of the Hand Hygiene Evolution Concept. Claudia Becker, specialist hospital hygiene nurse, assisted the implementation of the App to improve nursing activities. She introduced her experience at the 13th Congress of the German Society for Hospital Hygiene in Berlin.

What role does hygiene play in your facility?
We are an independent acute care hospital with 257 beds and nine units. And we attach great priority to hygiene. I work together with another colleague, who is infection control practitioner. This way we have the opportunity to be present in the individual wards and offer advice, training, work shadowing, and active surveillance.

What measures have you used before to promote hand hygiene compliance?
For optimising hand hygiene, we had a similar approach as HARTMANN with its Evolution Concept modules. First, we integrated the 5 Moments for Hand Hygiene in the hygiene plan and trained them accordingly. Furthermore, we implemented active infection surveillance with KISS and recorded the consumption of hand disinfectants in a structured manner. And we participate in the German AKTION Saubere Hände (Clean Hands Campaign). Just recently, we received the Silver Certificate here.

Why did you decide to serve as pilot hospital to test the Observe plus App?
The work with the Observe plus App perfectly matched our hygiene management concept. We are already in a good position in terms of hygiene. However, with our measurements we had recognised that there was room for improvement, particularly concerning the hand disinfection compliance rate before aseptic activities. We therefore made increasing the compliance for this WHO Moment the focus target in our hygiene management for the years 2015 and 2016. With the Observe plus App allowing us to train, observe and evaluate the hygiene behaviour, including before aseptic tasks, it was the ideal instrument for our targets.
How did you integrate the Observe plus App in your hygiene management?

We concentrated on the SOP “Dressing change with and without wound management” and started with a kick-off event on the AKTION Saubere Hände day. It was agreed that we as infection control nurses accompany and record at least 25 dressing changes per month in two wards. During the dressing change, we documented and statistically evaluated the observed steps with the Observe plus App. In doing so, we distinguished physicians and nursing staff. Training and observation was done on the basis of a chart with the visual SOP description, training slides, the e-learning tool, a checklist, and the Observe plus App.

What changes did you achieve with your intervention?

For all individual steps, the compliance considerably increased from November 2015 to January 2016: before touching a patient and during the aseptic dressing change from 75 % to 88 %. For the dressing change without wound management, the compliance with all individual steps even rose to 100 % in April 2016. At the same time, we witnessed a decrease in the rate of surgical site infection for the indicator surgery ‘colon’.

What are the most important insights that you gained with the intervention?

Before the intervention, most employees knew the 5 Moments. After the implementation of the Observe plus App, they were applied more consciously. In addition, the processes are screened and monitored holistically today. We could not only improve hand hygiene, but also discussed aspects of basic hygiene such as the use of protective clothing, skin antisepsis, and much more. I was especially pleased with the positive reaction of the employees that had a positive impact on the whole facility. Other wards already ask: “When will you come to us?” My conclusion: concepts to improve hand hygiene that measure the compliance and offer the opportunity to perform observations and provide feedback are only successful when they have a long-term and continuous approach.
Impulses for improved hand hygiene

HARTMANN’s new Evolution Concept was preceded by a pilot project in Spain: the IMPULSA intervention programme. In the DISINFECTS interview, infection control nurse Eva Redon reports on the experiences the hospital in Mollet del Vallès made with this multimodal hand hygiene programme.

What is so special about the multimodal IMPULSA programme?
The decisive factor is that IMPULSA not only offers some but all necessary instruments to implement the multimodal strategy recommended by WHO. Our hospital particularly benefited from the comprehensive training services, including the e-learning tools, the training box for the right rub-in technique, the checklists – and, of course, from the Observe App to observe hand hygiene behaviour.

When implementing the programme, was there a key experience?
Yes, when we introduced the Observe App. Before, until 2014, we had conducted hand hygiene behaviour observations using a WHO questionnaire. That consumed much time and resources. Particularly the data entry, evaluation and the creation of diagrams. The Observe App marked the start of a radical change. We were able to observe and analyse the employees’ hand hygiene behaviour much more often and without much effort and provide qualified feedback immediately. This was a big step forward for us.

You have conducted a large number of direct observations. What is the advantage?
Together with the feedback, the large number of observations has considerably raised the staff’s awareness of disinfecting their hands in the right moment. In addition, the frequent observations helped us identify further weak points in hand hygiene.

These included the wrong use of gloves, the unnecessary combination of soap, water and alcohol-based solution as elictor of hand dermatitis, and wrong rub-in techniques. In training sessions, we could work on and overcome these shortcomings in a targeted manner.

Ms Redon, thank you very much for this interview.

Read the complete interview with Eva Redon at www.bode-science-center.com under CENTER / Hand Hygiene / Hand Disinfection.
Sterillium makes hygiene history – and has been doing so for half a century. As a fitting tribute to the big birthday Sterillium received a very special present: the “Deutsche Standards” publishing house crowned the classic as “Star of the 2016 brand universe”.

The employees of the Bacillolfabrik Dr. Bode & Co in Hamburg, Germany, today HARTMANN, certainly did not imagine what will happen when the first Sterillium bottles left the production line on 4 June 1965: 50 years later, the “Deutsche Standards” publishing house included the blue classic in the league of the “2016 Brands of the Century”. The first marketable alcohol-based hand disinfectant at that time has revolutionised hand hygiene: since then, the distinctive bottle has been a symbol for trust, safety and hygienic protection against infection.

“A Brand of the Century has made it to the “Champions League” – it is a brand that defines a whole genus of products,” the publisher and author continued. Many brand names have become part of common parlance: Sterillium is considered the eponym of hand disinfectants – similar to Kleenex of tissues. This is not very surprising: every year, the preparation in the blue bottle disinfects more than three billion pairs of hands and thus effectively helps prevent infections.

**Brand of the Century: the Champions League of German products**

“Brands are stars that are rooted in our brains and hearts,” explained Dr. Florian Langenscheidt in his laudation for the prize winners. Brands especially stand for quality – a promise that large teams have established, partially over decades or centuries.
Transmission of MRSA: Risks due to frequently touched surfaces

Methicillin-resistant Staphylococcus aureus (MRSA) find many ways to reach their target: it can be transmitted by direct contact, but also indirectly via contaminated objects or surfaces. In their recent study, Villamaria et al. examined the role of frequently touched surfaces as transmission path for MRSA [1]. Their focus was on the following questions: which surfaces are particularly concerned, what does that mean for the transmission paths, and what are the consequences for hygiene?

From seven days up to seven months – this is how long MRSA remains infectious on inanimate surfaces [2]. A constant threat of cross contamination, as the resistant pathogens can reach the hands of patients and employees via the surfaces and from there can be further spread throughout the facility. Especially surfaces that often come into contact with hands and skin present an increased risk of infection. Villamaria et al. took this as a reason to examine surfaces for MRSA contamination, in order to better understand the transmission paths of the pathogens [1].

Focus on five surfaces
The study was conducted in a 120-bed hospital in Texas, USA. In accordance with the hygiene plan established there, patients with current or previous MRSA colonisation or infection are isolated. The study involved a total of 100 rooms, 68 isolation rooms and 32 normal patient rooms. One decisive selection criterion: all rooms had been occupied for at least 48 hours before sampling.
The MRSA concentration on high-touch surfaces in isolation and normal patient rooms was determined and compared. For this, the researchers selected five kinds of surfaces: handrails in bathrooms, bedframes, call system buttons, toilet seats, and deposit tables. The samples were taken immediately after the patient got discharged and before the room was disinfected.

### Isolation room vs. patient room

The results show that MRSA contaminates surfaces in both isolation and patient rooms. However, the concentration was significantly higher in isolation rooms. The team of researchers identified a total of 1830 MRSA colonies in the samples from the isolation rooms, and 202 colonies in the samples from the normal rooms. So, an average of 5.4 colonies in isolation rooms compared to an average of 1.3 colonies in normal patient rooms.

A high MRSA concentration was found on call system buttons and toilet seats (see table). This was true for both isolation and normal patient rooms. On handrails in bathrooms and bedframes, the difference, however, was significant. Here, the MRSA concentration in normal rooms was considerably lower than in the isolation rooms.

### Preventing the spread of MRSA with targeted hand hygiene

A result that did not really surprise the authors, as they expected the MRSA concentration to be generally higher in isolation rooms. The fact that MRSA colonies of unknown origin were also found in patient rooms, however, casts fresh light on the transmission paths of MRSA infections, the researchers concluded.

Hence, Villamaria et al. also consider consequences for infection control reasonable. Particularly hand hygiene before and after every patient contact is very important. All in all, the authors conclude that the insights gained in their study will help define interventions to prevent the spread of MRSA beyond isolation rooms.

### MRSA colonies in isolation and patient rooms

<table>
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<tr>
<th>Tested surfaces</th>
<th>Patient rooms (32 rooms)</th>
<th>Isolation rooms (68 rooms)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of MRSA colonies</td>
<td>Average number of MRSA colonies</td>
</tr>
<tr>
<td>Handrails in bathrooms</td>
<td>9</td>
<td>0.3 ± 1.6</td>
</tr>
<tr>
<td>Bedframes</td>
<td>7</td>
<td>0.2 ± 0.9</td>
</tr>
<tr>
<td>Call system buttons</td>
<td>84</td>
<td>2.6 ± 7.8</td>
</tr>
<tr>
<td>Toilet seats</td>
<td>93</td>
<td>2.9 ± 15.9</td>
</tr>
<tr>
<td>Deposit tables</td>
<td>9</td>
<td>0.3 ± 1.0</td>
</tr>
<tr>
<td>Total</td>
<td>202</td>
<td>1.3 ± 8.0</td>
</tr>
</tbody>
</table>

Sources:


Greater safety in ORs
thanks to well-coordinated teams and optimised processes

This year’s World Hand Hygiene Day on 5 May WHO dedicated to better infection protection for surgical procedures. In DISINFACS, Dr. Nils Farhan, physician in the Centre for Orthopaedic Surgery at Tabea Hospital in Hamburg, Germany describes how he as surgeon perceives the hygiene safety during surgeries and what safety culture his clinic has established.

In surveys, patients claim that, when in hospital, they are more afraid of acquiring an infection than of experiencing improper treatment. Do you also experience this trend in the doctor-patient consultations?

Yes, these questions are raised more and more frequently. But we can reassure our patients that in our clinic we deal with another spectrum of microorganisms than other hospitals do. Clinics that, for example, have an A&E department or carry out major intestinal surgeries naturally have another risk profile due to the microorganisms present there.

What surgical procedures are carried out in your clinic and how do you assess the risk of infection?

At Tabea Hospital we have the Centre for Vain and Dermatosurgery and the Centre for Orthopaedic Surgery. We mainly perform dermatosurgical procedures and elective orthopaedic surgeries on all major joints. Superficial skin surgeries per se involve a lower risk of infection.

Due to their nature, elective joint surgeries such as in endoprosthetics or spinal surgery are of course associated with a higher risk. Here, we therefore have special requirements in terms of experience and technical performance.

You have a low rate of infection in your clinic. What preventive measures have you established?

In case of complex procedures, we always carry out a laboratory screening before the operation. One frequent source of infection are the patient’s own microorganisms, so we need to determine the status preoperatively. Unclear infection parameters are then clarified using dental and internal medicine – our threshold values are very low. With a large number of surgeries that are planned we are also able to carry out risk-adapted MRSA screenings, and if necessary, an eradication therapy. Thus, we have already covered all crucial risks of infection.
How do you and your team ensure greater safety in the operating room itself?

Optimised processes that derive from the specialisation and a well-coordinated team is very important. This way, we can considerably shorten the duration of a surgery. This again considerably decreases the risk of infection, especially in case of complex procedures.

We only work with experienced permanent staff, who not only perfectly master the processes, but also know and implement our hygiene plan.

In your opinion, what is integral part of a safety culture?

Certainly, the support from the clinic management is indispensible. All our employees undergo regular training. Furthermore, it is observed how hygiene is implemented in daily routine and the staff receives according feedback. Another part of our culture is that we deal with each other in an open manner and address colleagues in case we notice something.

Read the complete interview with Dr. Nils Farhan at www.bode-science-center.com under CENTER / Hygiene Measures.

Dr. Nils Farhan is orthopaedic trauma surgery specialist at the Centre for Orthopaedic Surgery of Tabea Hospital in Hamburg, Germany. In its two departments for endoprosthetics, joint surgery and spinal and neurosurgery, the specialised centre carries out more than 2 200 surgeries per year, and has received multiple awards. Dr. Farhan’s passion is sports traumatology. In his spare time, he is the team doctor of the ladies’ national league hockey team of the Club an der Alster in Hamburg.
Effective barriers against microorganisms

The higher the barriers for microorganisms, the safer the patients from nosocomial infection. Surface hygiene is an essential part of a multi-barrier system to protect patients and staff. The new guidelines of the Working Group of the German Association of the German Scientific Medical Societies (AWMF) provide a compact summary of the most important points regarding surface hygiene [1]. Modern convenience solutions help implement the key requirements of the guideline.

Time will tell – in a figurative sense this also applies to surface hygiene. When the RKI (Robert Koch-Institute) Commission for Hospital Hygiene and Infection Control (KRINKO) recommendation on surface disinfection was published in 2014 [2], it was often difficult for healthcare facilities to fulfil the high requirements with the products available then. Today, more than ten years later, surface hygiene requirements are still as high.

HARTMANN’s portfolio of ready-to-use single-use tissues contributes to safely implementing key requirements of AWMF.

Dosage
The pre-soaked disinfection wipes from HARTMANN contain an exactly defined quantity of active substance solution.

- Microorganisms are inactivated safely; a selection of microorganisms is avoided.
- Development of disinfectant tolerances or resistances is prevented.

Preventing bacterial spread
In contrast to mob covers that require thermal or chemothermal reprocessing after use, single-use wipes can simply be disposed of after use.

- No risk of bacterial multiplication or spread.

Wetting
Featuring high-quality fleece, HARTMANN’s single-use wipes ensure a very good release of active ingredients.

- The surface to be disinfected is wiped and wetted with an adequate quantity of disinfectant.

Standing times
In contrast to open disinfection solutions that often may be used for up to 24 hours, disinfection wipes in ready-to-use dispensing systems such as Flowpacks can be used for up to three months after opening.

- No time needed for calculating and preparing disinfection solutions

High-risk areas
Pre-soaked wipes are used once and then discarded.

- No need of reprocessing; thus, the wipes are also suitable for areas involving particular risks of infection such as intensive care, haematological oncology, neonatology and burn units.
This also shows the recently published AWMF S1 guideline “Hygienic requirements for cleaning and surface disinfection” [1]. AWMF confirms the facts of the KRINKO recommendation. However, meanwhile – thanks to modern product solutions – the right implementation of surface disinfection has become much easier.

In daily routine, this is a noticeable relief for employees in hospitals and nursing homes. Especially when considering the workload that has increased continually in other areas over the past years. Also the facilities themselves benefit from the surface disinfectants that can be used efficiently: when applied rationally they spare valuable resources, e.g. water and energy. Convenience products, above all pre-saturated single-use tissues, have proved to be particularly practical. Featuring user-friendly properties, they help avoid faulty application and thus minimise hygiene risks. All these aspects are also focus of the new AWMF guideline on surface disinfection.

Sources:

Also read study abstracts on the use of pre-saturated disinfection wipes at www.bode-science-center.com under SCIENCE:

Schweins M. et al. Factors influencing the area output of pre-saturated disposable wipes for cleaning and disinfecting surfaces in the healthcare setting. Hygiene & Medizin 4/2015; 144-149.


What is the right exposure time for surface disinfection?

Observing the exposure time plays a key role for a safe surface disinfection. However, users are sometimes confused that the German Association for Applied Hygiene (VAH) recommends exposure times that are considerably longer than the ones in the manufacturers’ product sheets. In daily routine, this often raises the question which recommendation has to be followed.

The correct application of surface disinfectants requires users in healthcare facilities to have extensive know-how and consider many factors, including the spectrum of activity, concentration, material compatibility, listing, and the necessary exposure time. Especially the latter, so the right exposure time, can sometimes not be identified clearly, as the recommendations of VAH and manufacturers may differ considerably.

30 seconds vs. 5 minutes
With the alcohol-based rapid disinfectant Bacillol AF serving as example, the differing recommendations on the exposure time and their background becomes clear. Neutral expert opinions confirm that Bacillol AF is active within 30 seconds in accordance with the standard methods of the German Society for Hygiene and Microbiology (DGHM). Hence, this exposure time is listed in the Bacillol AF product sheet.

In the VAH list, however, the preparation is listed with an exposure time of 5 minutes. The reason: 5 minutes are the lowest value that VAH tests and therefore lists. Even if the products have proved to act faster, the shortest exposure time according to VAH will always be 5 minutes.

What does that mean for the practice? In accordance with legal provisions, you may use Bacillol AF to disinfect surfaces in healthcare settings as it is listed by VAH. Regarding the exposure times, you can follow the shorter exposure times in the product sheet that have been confirmed by an expert.