LETTERS TO THE EDITOR

Cleanyourhands Campaign: a critique of the critique

Madam,

We would like to reassure Gould et al. that their concerns about the Cleanyourhands Campaign (CYHC) may be misplaced, and to bring to their attention important details regarding the preparation and implementation of this campaign.

The authors rightly point out that the evidence underpinning the campaign is limited, a legitimate criticism of all hospital epidemiology literature.1,2 The Geneva study is, however, one of the better ones, and therefore offers a reasonable hypothesis to test.2 The study on which the patient empowerment element of CYHC is based is weak, as are the studies that Gould et al. put forward as alternative sources of evidence, including that associating alcohol hand rub (AHR) with Clostridium difficile-associated diarrhoea (CDAD). We make this observation on the basis of appraising the literature using the ORION statement.1 Gould et al. charge the NHS with placing ‘undue emphasis’ on the CYHC as a ‘quick fix to solve the high rates of HCAI’. This is not true. There is no mention in their review of ‘Saving Lives’ nor of the Health Act. They state that ‘risk assessment before … introduction would have revealed unintended but predictable barriers to success’. They make no mention of the six-month pilot study and its detailed evaluation, which preceded the campaign, addressing issues of institutional engagement, impact of posters, concerns about patient empowerment and acceptability of hand-hygiene products.3 The Procurement and Supplies Agency performed a detailed evaluation of AHR products, including rigorous allergy testing, available on the web. Gould et al. also state that UK policy-makers have ignored the ‘strong institutional commitment’ that was ‘key to the success of the Geneva initiative’. This is not so. Both the evaluation of the CYHC pilot (3) and ‘Ready Steady Go’, which guides Trusts through the three-month preparation for CYHC, prioritized securing institutional support.4

The campaign posters are criticized as not sufficiently eye-catching. Senior practitioners of the public relations, communications, media, marketing and design industries awarded the campaign a prestigious Excellence Award 2005. The Design Business Association gave it two Design Effectiveness Awards. Gould et al. are concerned lest AHR cause CDAD to rise by reduction of soap use. They quote no real evidence of a rise in one or a fall in the other. The Geneva study found that soap use remained stable. It is often not appreciated that AHR kills the vegetative form, and reduces spore carriage, although it does not do the latter as effectively as soap and water. ‘Flowing with the Go’, which launched the campaign’s second year and recommends soap and water for CDAD,5,6

The review would have preferred an AHR containing chlorhexidine, and a greater focus on ‘techniques’ required to use hand rub. Chlorhexidine was excluded because AHR with glycerol produces less contact dermatitis. The authors provide no evidence of a widespread increase in dermatitis. Their reference to soaps and exhaustion of supplies on NHS wards was published 14 years ago.

Regarding technique, controlled trials have reduced enteric infection, without refining hand washing technique. Although this is a consideration, the NHS is faced with high rates of MRSA and low levels of hand hygiene. To wait for perfect evidence of the best possible intervention, rather than develop and evaluate an intervention on current evidence, would not be in the best interests of patients, staff or taxpayers. Policy-makers can only use the best evidence available. The CYHC was preceded by a pilot evaluation. An independent study (NOSEC) was commissioned to evaluate the national campaign, as was a controlled trial to examine a behavioural intervention to sustain better hand-hygiene in the long term [the Feedback Intervention Trial (FIT) study].6 This represents implementation of pragmatic health and research policy.

We are puzzled that Gould et al. did not contact us in the background research leading up to their review. ‘Flowing with the Go’ refers to both NOSEC and FIT.7 Data have already been presented at conferences.7,8
The latest NOSEC results (see the ‘Early communication’ in this issue, p. 293) should reassure them. The campaign appears to have changed many aspects of hand-hygiene behaviour, increasing AHR use across acute Trusts without reducing soap use, or increasing CDAD. Our experience in FIT, in which more than 8500 hand hygiene opportunities have been observed on three or four wards in 20 hospitals, is that soap is used in 42% of hand-hygiene episodes. The campaign appears to have engaged institutions, although this may change as time proceeds from implementation, and as other initiatives are implemented. In summary, the campaign made best use of the available evidence as well as commissioning independent research to evaluate the campaign and improve the evidence base through a trial. It was adequately piloted and evaluated, pre-implementation, as were the alcohol hand-rub products. Its campaign materials have been acclaimed by peers. Although implemented quickly, it appears to have engaged institutions and driven up AHR use, but not at the expense of soap.

References


Reply to Stone et al.

Madam,

We would like to thank Stone et al. for their thoughtful and comprehensive critique of our