

**Roundtable discussion with Department of Health, Muslim Chaplain and Islamic scholars  
To formulate advice on Implementation of infection control guidelines**

**10 January 2008**

**Present:**

Prof C Beasley, Prof Brian Duerden DHMs Carole Fry, Vicki Finlay, Monique Akosa, Janet Rawson Shuja Shafi (Chairman) Chowdhury Mueen-Uddin, Imam Yunus Dudhwala	Chief Nursing Officer Inspector of Microbiology & Director Infection Prevention & Control, Senior Nursing Officer, Communicable Diseases, DH Uniforms and Professional Dress, DH, Equality and Human Rights, NHS, HCAI Improvement Team, DH Chair, Muslim Spiritual Care Provision in the NHS Project Muslim Spiritual Care Provision in the NHS, Head of Chaplaincy & Bereavement Services, Newham University
Dr. Usama Hasan Imam Abu Sayeed Mowlana Ilyas Dalal Mufti Zubair Butt Sr Rehanah Sadiq	Hospitals NHS Trust Middlesex University Chaplain, University College Hospital, London Chaplain, Dewsbury District Hospital Muslim Chaplain, Leeds Teaching Hospital Muslim Female Chaplain, University Hospitals Birmingham NHS Foundation Trust
Mr Tim Battle Imam Ibrahim Mogra Dr June Jones Sr Maryam Riaz Mowlana Mohammed Arsahd Sr Musarrat Tariq,	Adminstrator, MFHC Group, Chair, Multi Faith Committee, MCB Chair, Religious and Cultural Beliefs Forum, Birmingham University Female Chaplain Bradford Teaching Hospitals NHS Foundation Trust Muslim Chaplain Bradford Teaching Hospitals NHS Foundation Trust Multi Faith Support Officer, Queens' Medical Centre, Nottingham

**Apologies:**

Imam Shafique Rahman Sheikh Khurram Bashir	Chaplain, Royal London & Barts Hospitals, London Chaplain, Solihull Mental Health Hospital, Birmingham
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Dr Shuja Shafi, Chair of the *Muslim Spiritual Care Provision in the NHS* Project formally initiated the proceedings and Moulana Ilyas Dalal, Chaplain Dewsbury District Hospital opened the programme with recitation from the Holy Qur'an.

Welcoming the delegates, Dr Shafi thanked them for finding the time to come to this meeting despite the short notice. In his opening remarks Dr Shafi stated that infection control has always been an important component of healthcare and the current drive to reduce health care associated infections is very welcome. The local translation of the recently issued DH guidance on Dress Code was causing difficulty for some female Muslim healthcare professionals in some Trusts. Hygiene and cleanliness are very important in

Islam. On the face of it, therefore there should be no problems. This meeting was organised to explore the surrounding issues, improve our understanding and hope to find solutions. The support of the Chief Nursing Officer and Prof Duerden in this regard was much appreciated. Despite pre-arranged meetings, Prof Beasley, CNO had found time to join the group for part of the meeting .

Prof. Brian Duerden, Inspector of Microbiology and Infection Control, DH, presented the NHS Guidance on Infection Control. He outlined the importance of good hand hygiene and proper implementation of aseptic protocols in the control of healthcare associated infection. Observation shows that unless people have bare arms, without jewellery, they are unlikely to apply rigorous hand hygiene. The NPSA *cleanyourhands* campaign recommends hand washing including the wrists and lower arms to achieve rigorous hand hygiene.

Prof. Duerden said this the basic reason why in September 2007, the government announced a dress code requiring the clinical staff in NHS acute hospitals to be 'bare below the elbows' when carrying out clinical duties. This meant wearing short sleeves with no wrist watch or other hand jewellery (other than plain wedding band that is deemed acceptable).

Prof. Christine Beasley, the Chief Nursing Officer spoke at this stage welcoming the delegates and thanked them for taking the time to contribute to this very important issue. She assured that the views expressed in the discussion would be useful in taking forward and implementing the guidance.

Imam Ibrahim Mogra, chair of MCB's Interfaith Committee gave an overview of the importance of cleanliness and personal hygiene in Islam. 'God loves those who are clean and hygienic' says the Qur'an and he quoted the *Hadith* (saying or tradition of the Prophet of Islam Muhammad (pbuh) in which cleanliness is described as half of ones Faith. Imam Mogra stated that thorough washing of hands and other exposed parts of their body is incumbent on Muslims and indeed an integral part of ablution performed before each of the five daily obligatory prayers. Islam insists that spiritual purification cannot be achieved without external purification.

### **Use of Alcohol Gels in Infection Control**

Janet Rawson, HCAI Improvement Team of the DH discussed the hand hygiene issues in general and provided the scientific basis for alcohol gel and said that at 70% alcohol concentration, most bacteria are killed within 1 minute during hand-rubbing. Frequent use of alcohol gel in clinical setting is central to controlling healthcare associated infections. Imam Yunus Dudhwala, Chaplaincy manager of the Newham Teaching Hospital presented the Islamic view point on this subject. He explained that consumption of alcohol is totally forbidden, and according to some Schools, alcohol itself is considered impure. External application of synthetic alcohol gel, however is considered permissible within the remit of infection control because (a) it is not an intoxicant and (b) the alcohol used in the gels is synthetic, ie, not derived from fermented fruit. Alcohol gel is widely used throughout Islamic countries in health care setting. Any controversy, therefore, is likely to be in perception rather than principle within Islam. Any confusion in this respect may be avoided by if references to and labelling of alcohol gel bottles emphasized the disinfection properties rather than its alcohol content – use of the term ethanol to describe the contents was to be encouraged. Bradford Chaplaincy has devised leaflets for patients, relatives and staff explaining that Alcohol gel is permissible and should be used.

It was agreed to circulate the leaflets and the DH team undertook to make use of this useful resource. The advice on labelling was welcomed and the DH team will explore how best to roll out this concept, clearly this will take time.

### **'Bare Below the Elbow' policy in Infection Control**

Prof. Brian Duerden explained that there was a general perception that infection has been conquered, but experience and data show a rise in healthcare associated infections. Over 7000 annual cases of MRSA bacteraemias (infection in the blood, which is normally sterile) in 2003-05 and 70,000 cases of *Clostridium*

*difficile* infections in 2006 highlight the extent of the problem. These rates are unacceptable and urgent action was necessary. The DH has made infection control a high priority. The wide ranging initiatives to reducing healthcare associated infections (HCAIs) include emphasis on cleaning, segregation of infected patients, and hand hygiene. Good hand hygiene and implementation of aseptic procedures are key factors in the prevention of HCAIs. A significant proportion of healthcare associated infections may be transmitted through contaminated hands of healthcare professionals. Good practice requires that hands including the wrists and lower arms should be washed and decontaminated. Long sleeves and/or watches, jewellery etc make it impossible to wash and decontaminate the hands satisfactorily. The DH issued *Guidance on Uniforms and Work wear* provided an evidence base for developing local policy. The bare below the elbow policy is designed to facilitate thorough hand-washing/hand hygiene to reduce bacterial contamination as well as removing elements of clothing that are readily contaminated during clinical work..

Mufti Zubair Butt, Muslim Chaplain of Leeds Teaching Hospital gave a power point presentation on Islamic stand point on this issue. He said, reasonable measures to ensure hand-hygiene are entirely in keeping with the spirit of Islam. However, in Islamic dress code covering certain part of their body is an obligation and non-negotiable for practicing Muslims. He said it may be the case that not exposing wrists impedes thorough hand-washing and increases the risk of contamination to patients. Most of the Trusts have developed local policies by accommodating the needs of female Muslim healthcare workers without compromising the principles. A minority of Trusts however, were interpreting the policy as exposing the whole lower arm whilst in the clinical area.

Sr. Maryam Riaz, female Muslim Chaplain of Bradford General Hospital said, Muslim women want to protect their modesty because it is integral to their faith. Modesty has internal and external elements, and both are related.

Sr. Rehanah Sadiq, Muslim chaplain of University Hospital Birmingham further emphasised the point. She said it is something Muslim women hold dear and it will be wrong not to look for some alternative that can satisfy both needs. She presented a range of solutions and said  $\frac{3}{4}$  length sleeves would be preferable for many women during direct patient contact, enabling them to wear long sleeves at all other times. For women who are unable to expose their wrists there may be the facility to wear disposable sleeves, although this would need a fundamental change to the policy. There was a suggestion to pilot the use of disposable gloves.

Dr. June Jones, Chair, Religious and Cultural Beliefs Forum University of Birmingham explained the problems that many of her female Muslim students are facing. Attempts of find alternative solutions have been met with lack of flexibility within some of the Trusts. Some are finding this very difficult and it is possible that many may decide to discontinue their education. This in her view will be a shame when authorities are keen to empower Muslim women. She said if NHS is concerned about compliance it can be rest assured that it will never find a more complaint community than the Muslims if their minimum requirement is respected. Dr Jones mentioned that issues have arisen also with regard to wearing of a silver wrist bangle which is a religious requirement of the Sikh community.

### **Summary of the discussion following the presentations:**

Discussion followed these presentations - contributors included, Moulana Mohammad Arshad, Chaplain Bradford Teaching Hospital, Carole Fry, Nursing Officer, DH, Sr. Musarrat Tariq, Chaplain Queens' Medical Centre, Nottingham, Vicki Finlay, Uniforms and Professional Dress, DH, Monique Akosa, Equality and Human Rights, NHS, Chowdhury Mueen-Uddin, Muslim Spiritual Care Provision in the NHS, Dr. Usama Hasan, Middlesex University and Imam Abu Sayeed, Chaplain, UCH.

Patient safety is paramount and measures to reduce transmission of infection should be welcomed and observed. Because infections may be transmitted from one patient to the other through contaminated hands of health care professionals, thorough washing of hands between patients is a key infection control measure. Wrist watches, jewellery interferes with correct hand- and wrist- washing procedures. The DH

guidance therefore advises healthcare staff to avoid wearing wrist watches, an exception is made for simple band wedding rings. It is preferable for clinicians to wear short sleeves. Cuffs or long sleeves can become contaminated with micro organism and therefore should be avoided during patient contact. Long sleeves interfere with effective hand washing, so wearing half sleeves is preferable. One simple approach could be to use three quarters sleeves that do not interfere with effective hand and wrist washing; however, there needs to be further discussion in relation to those HCW who would wish to cover their arms to the wrist to determine how the hand hygiene requirement for clinical contact activities can be best implemented. This is where some alternative solutions have been agreed at local level. These appear to be wide ranging. The guidelines must be sensitive to different religious groups. In devising local dress code most Trusts have followed the NHS advice with regard to being sensitive to local cultural and religious requirements. NHS Employers Equality and Diversity advice is that 'employers must ask themselves whether the dress code will require employees to dress in a way that contravenes their religion or belief'. There must be sensitivity in the approach to the enforcement - a heavy-handed approach is likely to be unhelpful. Our experience is that most Trusts have shown this sensitivity by being flexible and accommodated the requirements without compromising infection control principles. A minority of Trusts, however, have not shown this flexibility and causing much unrest among the affected staff. There is an urgent need for a consistent approach in this matter. The meeting felt that it would be preferable for the guidance to stress the need for Trusts to implement the policy reasonably according to local contexts, allowing Muslim women to maintain their dignity and maintain patient care where it does not compromise patient safety.

It was suggested that a sub group should review all the alternatives and evaluate them. The objective then will be to advise alternative approaches that have been scrutinised for their effectiveness, simplicity and ease of monitoring compliance. A Committee to be formed with Dr. Shafi, Prof. Duerden, Maryam Riaz, Rehanah Sadiq and Carole Fry to consider the alternatives and way forward.

Mr Tim Battle suggested that the DH should find out from SHAs their local experiences in implementing the dress code, any areas of difficulty that might have arisen and collect examples of good practice that could then be shared with the rest of the NHS. It was agreed that this would be a good way forward to allay anxieties among the healthcare professionals and obviate the need for individuals having to leave their jobs and education.

Summing up the discussion the Chairman stated that the meeting had been very useful and educational. We have improved our understanding and, considering importance of hygiene and cleanliness in Islamic teaching (over 1400 years ago), modern day infection control in healthcare setting appears a repackaged version of those principles. So there should be no doubt about the commitment of Muslim healthcare professionals in conforming to patient safety and infection control requirements. We learnt that while most Trusts have locally adopted dress code without any cultural or religious conflict but a small number have been less accommodating. The meeting heard about some examples of good practice, there may be many more. We have found a way forward to learn more about them and undertake an evaluation. The Chairman thanked the Chief Nursing Officer, the Inspector of Microbiology and Infection Control and the DH team for their support and hospitality.