

Cleanliness in healthcare facilities – Hospitals – Specification

FOR REVIEW PANEL

Draft 2.0

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Foreword

This draft Publicly Available Specification (PAS) was sponsored by the Department of Health (DH) and the National Patient Safety Agency (NPSA). Its development was facilitated by the British Standards Institution (BSI). It will come into effect on XXXX.

Acknowledgement is given to the following organizations that were involved in the development of this specification as members of the Steering Group:

[Steering Group list to be completed on publication]

BSI retains ownership and copyright of this PAS. BSI reserves the right to withdraw or amend this PAS on receipt of authoritative advice that it is appropriate to do so. This PAS will be reviewed at intervals not exceeding two years, and any amendments arising from the review will be published as an amended PAS and publicized in Update Standards.

This PAS is not to be regarded as a British Standard. It will be withdrawn upon publication of its content in, or as, a British Standard.

The PAS process enables a specification to be rapidly developed in order to fulfil an immediate need in industry. A PAS may be considered for further development as a British Standard, or constitute part of the UK input into the development of a European or International Standard.

Relationship with other publications

This PAS will build on the valuable experience and content of the existing National Specifications for Cleanliness in the NHS (NSC), published by the NPSA in April 2007. It is intended that PAS 5748 will eventually supersede the NSC. However, healthcare organizations using the NSC will be given prior notice of any supersession to allow providers to adapt to any change in practice.

The PAS is expected to be used in conjunction with The Revised Healthcare Cleaning Manual, published by the NPSA in June 2009. The purpose of this manual is to give general and specific guidance on how to operate the provision of cleaning services within a healthcare environment. It is intended to revise the manual prior to the supersession of the NSC by the PAS to ensure that it will specifically support compliance with the requirements of the PAS.

Information about this document

Users of this PAS are advised to consider the desirability of third-party certification/inspection/testing of product conformity with this PAS. Appropriate conformity attestation arrangements are described in [appropriate ISO/IEC Standard or Guide or equivalent European standard to be inserted]. Users seeking assistance in identifying appropriate conformity assessment bodies or schemes may ask BSI to forward their enquiries to the relevant association.

Use of this document

It has been assumed in the preparation of this PAS that the execution of its provisions will be entrusted to appropriately qualified and experienced people, for whose use it has been produced.

Presentational conventions

The provisions of this standard are presented in roman (i.e. upright) type. Its requirements are expressed in sentences in which the principal auxiliary verb is “shall”.

Commentary, explanation and general informative material is presented in smaller italic type, and does not constitute a normative element. The word “should” is used to express recommendations, the word “may” is used to express permissibility and the word “can” is used to express possibility, e.g. a consequence of an action or an event.

Contractual and legal considerations

This publication does not purport to include all the necessary provisions of a contract. Users are responsible for its correct application.

Compliance with a PAS cannot confer immunity from legal obligations.

Introduction

This PAS provides a risk-based framework for the delivery of clean, safe healthcare environments. It is designed for use in acute, community and mental health hospitals.

The development of a PAS in this area supports the principle of greater standardization. It provides a standardized means of demonstrating that measures are in place to ensure safe, clean healthcare environments.

Conformance to this PAS is intended to be no more onerous or expensive than following the existing National Specifications of Cleanliness (NSC). However, there have been changes, including a more comprehensive approach to risk assessment and a change in the composition of the 49 scored elements.

Organizations are required to comply with all the requirements of this PAS in order to achieve compliance. This includes:

- a) assessing and categorizing functional areas and elements within a healthcare facility according to the risk of a lack of cleanliness on:
 - 1) healthcare associated infections;
 - 2) patient, public and staff confidence;
- b) using the risk categorization to determine how to deliver cleanliness;
- c) assigning responsibility for the overall maintenance of cleanliness at:
 - 1) Board level;
 - 2) functional area level;
 - 3) staff group level;
- d) assigning responsibility for carrying out the cleaning of all elements in a healthcare facility, including fixtures and fittings, and clinical and non-clinical equipment;
- e) producing cleaning schedules for all functional areas, including routine and periodic cleaning; and
- f) maintaining a programme of audit and monitoring.

A pilot study is being conducted alongside this BSI public consultation to test the practicality of achieving conformance to the requirements of the PAS and identify whether any changes need to be incorporated.

Conformance to this PAS will be supported by a risk assessment tool and a technical audit tool soon after publication of the PAS.

Note that there will be a further opportunity to feed back comments on the PAS in the year that follows its publication. This will ensure it is fit for purpose before a decision on when to withdraw the existing NSC is made.

Also note that it is intended that the scope of the PAS will be broadened in future revisions to accommodate other types of healthcare facilities.

1 Scope

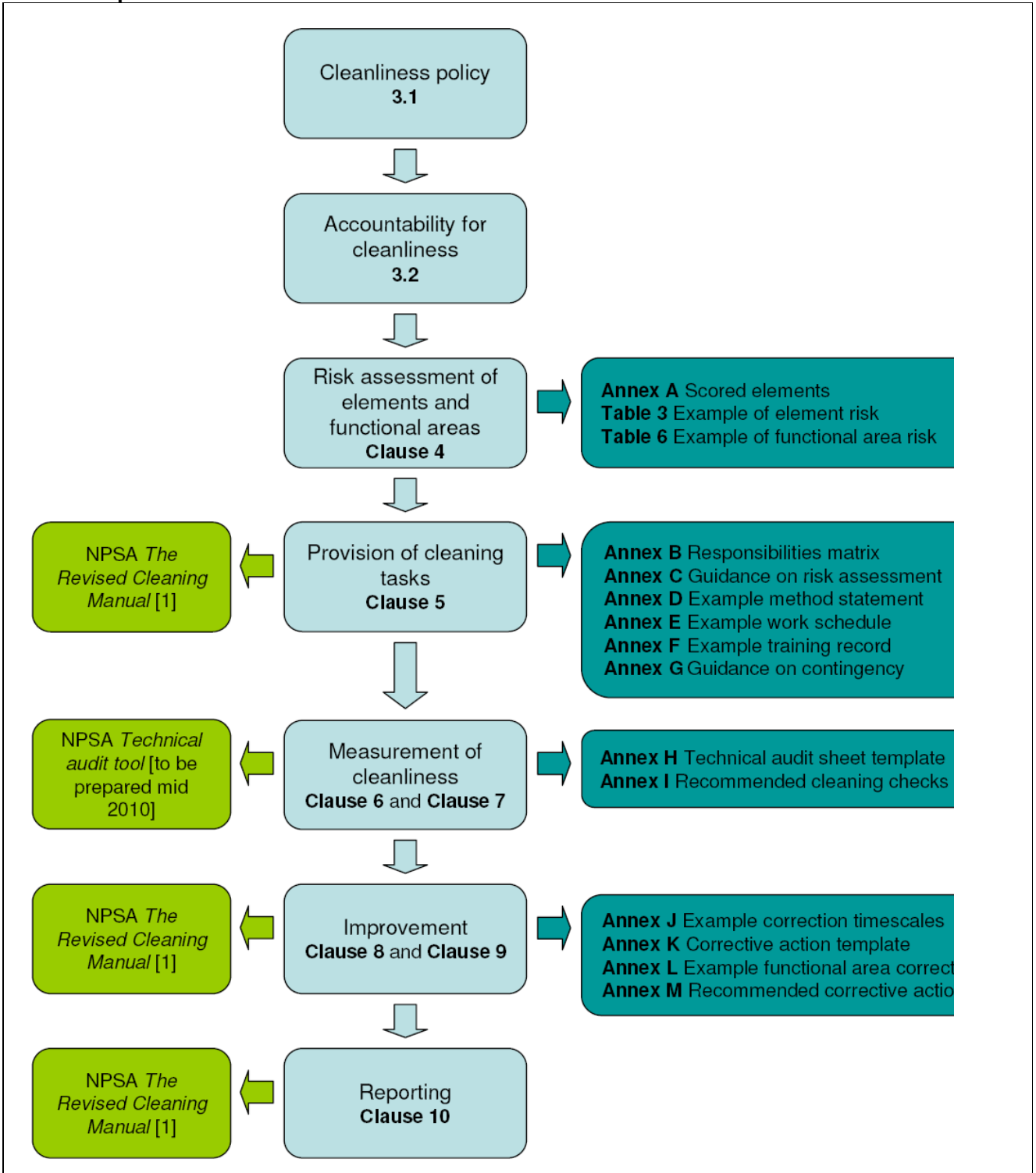
This PAS specifies requirements for identifying, providing, validating and improving cleanliness in acute, community and mental health hospitals.

It includes requirements for:

- a) managing cleanliness provision (see Clause 3);
- b) assessing risk and categorizing elements and functional areas (see Clause 4):
- c) providing cleaning tasks (Clause 5), including:
 - 1) identifying cleaning tasks;
 - 2) risk assessment of cleaning tasks;
 - 3) providing method statements;
 - 4) setting cleaning frequencies;
 - 5) setting work schedules;
 - 6) providing training;
 - 7) contingency planning;
- d) measuring cleanliness (see Clause 6);
- e) setting target cleanliness scores (see Clause 7);
- f) implementing corrective action (see Clause 8);
- g) providing a continuous service improvement plan (see Clause 9); and
- h) reporting cleanliness (see Clause 10).

NOTE The relationship between the requirements of this PAS, supporting annexes and other publications is shown in Figure 1. In particular, attention is drawn to the detailed guidance on the provision of cleanliness given in The Revised Healthcare Cleaning Manual [1].

Figure 1 – Overview of relationship between the requirements of this PAS, supporting annex and other publications



2 Terms and definitions

For the purposes of this PAS, the following terms and definitions apply.

2.1 board

top level of management responsible for a healthcare facility

NOTE Within the NHS this would be the Trust Board (or Board of Directors for Foundation Trusts).

2.2 cleaning task

process required to clean an element

2.3 cleanliness criteria

description of visual appearance signifying cleanliness

2.4 cleanliness score

score produced by a technical audit or by an averaged group of technical audits

2.5 corrective action

action to eliminate the cause of a detected nonconformity

[BS EN ISO 14001:2004, 3.3]

2.6 de-cluttering

tidying or removal of items from a functional area to facilitate the performance of cleaning tasks

2.7 dirt

matter adhering to or resting on an element, which is not part of that element

NOTE Dirt can include, for example:

- a) adhesive tape;
- b) blood;
- c) body substances;
- d) cobwebs;
- e) dead animals, birds or insects;
- f) dust;
- g) food debris;
- h) scum;
- i) smears; and
- j) spillages.

2.8 element

item within a functional area, or any part of the fabric or fittings of a functional area, which requires cleaning

NOTE For example, a bed or a ceiling.

2.9 functional area

room or physically contiguous group of rooms within a hospital deemed by a healthcare organization to constitute a discrete area of operational activity

2.10 healthcare facility

building or group of buildings, including contiguous grounds, in which healthcare services are provided

2.11 hospital

institution for the reception and treatment of persons suffering from illness, any maternity unit, and any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation

[derived from National Health Service Act 1977 [2], section 128(1)]

2.12 hospital types

2.12.1 acute hospital

hospital for which a main purpose is the reception as inpatients, and treatment, of those requiring surgical or medical treatment, or maternity care

2.12.2 community hospital

hospital providing a range of healthcare services to a defined local community

2.12.3 mental health hospital

hospital for which the main purpose is the reception as inpatients, treatment and care of persons suffering from acute or chronic mental illness

2.13 healthcare associated infection (HCAI)

infection by any infectious agent acquired as a consequence of a person's treatment by a healthcare organization, or which is acquired by a healthcare worker in the course of their healthcare duties

[derived from NHS Evidence website, last reviewed 12/08/08]

2.14 method statement

description of the way in which a cleaning task is to be performed and the materials and equipment, including personal protective equipment, required to perform it

2.15 net internal floor area

floor area of a building or part thereof calculated with the exclusion of walls, voids, service ducts and areas which are not in operational use and required for the purpose of delivering the function and/or activities of the healthcare facility

2.16 nonconformity

non-fulfilment of a requirement

[BS EN ISO 9000:2005, 3.3]

2.17 organization

company, corporation, firm, enterprise, authority or institution, or part or combination thereof, whether incorporated or not, public or private, that has its own functions and administration

[BS EN ISO 14001:2004, 3.16]

NOTE For organizations with more than one operating unit, a single operating unit may be defined as an organization.

2.18 scored element

one of 49 elements that form a representative selection for the measurement of cleanliness

NOTE The 49 scored elements are listed in Annex A.

2.19 stain

discolouration appearing on an element which is not caused by the natural aging of the element

NOTE A stain can be attributed to, for example:

- a) *lime scale;*
- b) *scuff marks; and*
- c) *watermarks.*

2.20 technical audit

measurement of the cleanliness of elements against stated cleanliness criteria

NOTE A technical audit is not necessarily identical to contract monitoring.

2.21 unscored element

element other than a scored element, which is audited for cleanliness and corrective actions identified but is not used in the recorded measurement of cleanliness

2.22 work instruction

document that informs a staff member or staff group which cleaning tasks to perform and when to perform them

2.23 work schedule

plan of work for the performance of cleaning tasks in a functional area, describing each cleaning task, and indicating when it will be performed and how long it will take

3 General

This clause specifies requirements for the overall governance of the cleaning function.

3.1 Policy

A documented cleanliness policy shall be produced that details:

- a) the name of the healthcare organization;
- b) the name and type of all healthcare facilities managed by the healthcare organization;
- c) which healthcare facilities are covered by the cleanliness policy;
- d) the net internal floor area of all healthcare facilities covered by the cleanliness policy;
- e) a commitment to provide cleanliness in accordance with this PAS;
- f) a commitment to set and meet target cleanliness scores;
- g) a commitment to report the cleanliness scores achieved; and
- h) a commitment to continuous service improvement in the provision of cleanliness.

3.2 Accountability

A documented schedule of accountability for cleanliness shall be produced and shall identify:

- a) a named person, at Board level, with overall accountability for cleanliness;
NOTE This role is referred to in this PAS as the Director with Responsibility for Cleanliness.
- b) a named person in each functional area with accountability for the cleanliness of that functional area; and
NOTE This role is referred to in this PAS as the Functional Area Manager.
- c) a named person for each staff group identified in **5.1.1** with accountability for the cleaning services provided by that staff group.
NOTE This role is referred to in this PAS as the Staff Group Manager.

3.3 Documentation

3.3.1 There shall be a documented procedure for the management and retention of all documentation established for the provision of cleaning in accordance with this PAS.

NOTE Documentation can be retained in any format, including paper or electronic formats.

3.3.2 Where a procedure requires the production of any proforma, the arrangements for controlling the issue and review of that proforma shall be documented.

NOTE Examples of proforma include technical audit sheets and corrective action sheets.

3.3.3 Where a procedure requires the production of any documented information, the arrangements for controlling the issue and review of that documented information shall itself be documented.

NOTE Examples of documented information include work schedules and technical audit scores.

4 Risk assessment

A clean hospital is a foundation for infection prevention, and promotes patient, public and staff confidence. This PAS uses the concept of relative risk to help healthcare organizations to define cleaning frequencies, identify critical “must-clean” areas and deploy staff effectively.

Elements carry a certain risk, irrespective of where they are. A WC for instance, carries a high risk for both infection and confidence. A floor is a low risk for infection, but a high risk for confidence.

Likewise, for some parts of a hospital, the risk of poor standards of cleanliness is greater than in others. A poorly-cleaned main entrance carries a particular risk of damaging confidence.

This clause specifies the need for a comprehensive risk assessment that takes account of both elements and functional areas. It provides a minimum set of requirements but allows for more sophisticated risk assessments to be implemented locally so long as conformance to the minimum requirements is achieved.

The clause specifically requires, as a minimum, that risk is assessed first for elements and second for functional areas. It requires that an overall risk descriptor for a particular element in a particular functional area is assigned to that element by combining the outcomes of the element risk assessment and the functional area risk assessment. The overall risk descriptor can be used to guide decisions on cleaning frequencies.

4.1 General

4.1.1 A procedure for the risk assessment of each element in each functional area within a hospital shall be produced and documented. It shall include, as a minimum:

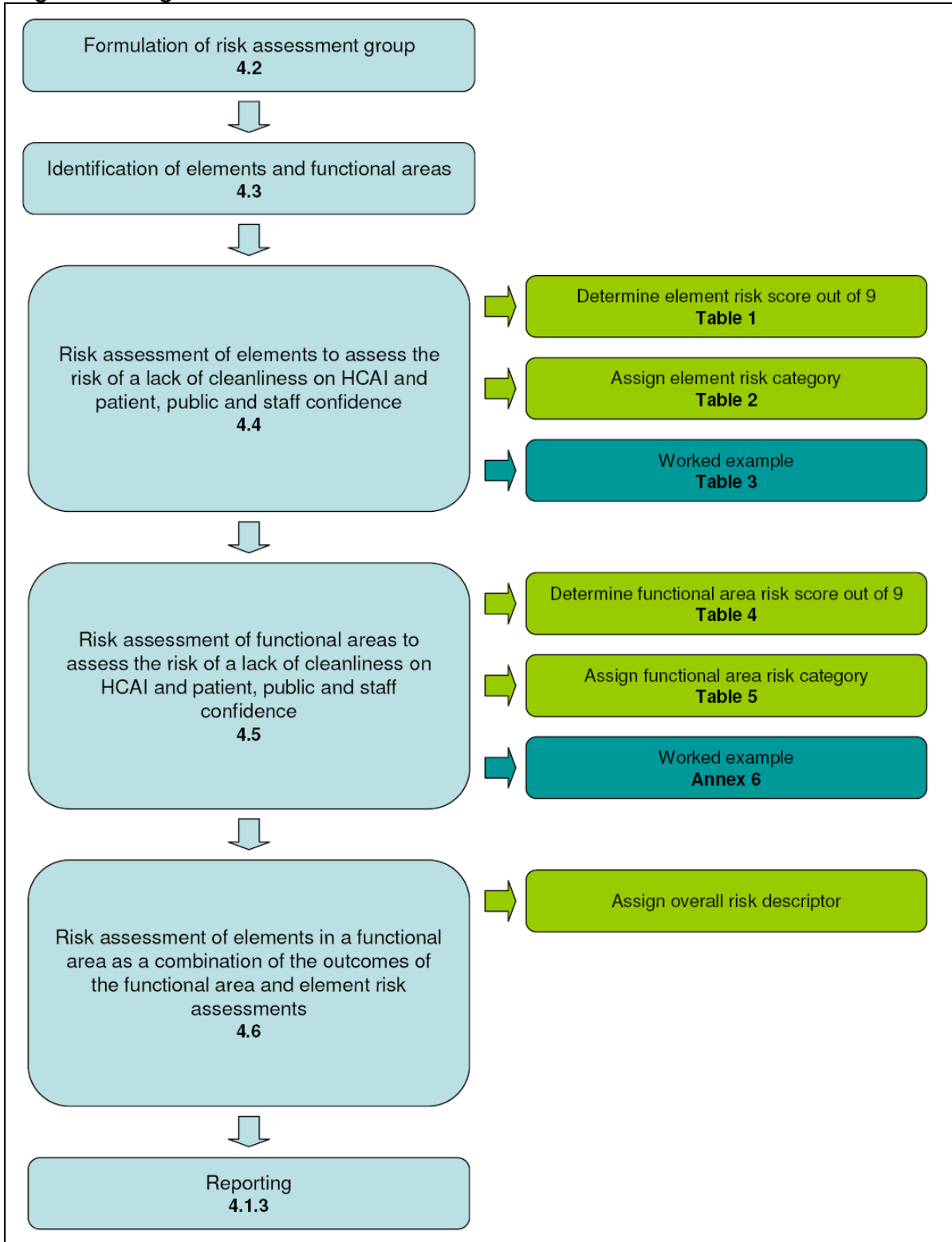
- a) the allocation of responsibility for the risk assessment in accordance with **4.2**;
- b) the risk categorization of elements in accordance with **4.3**;
- c) the risk categorization of functional areas in accordance with **4.5**;
- d) the provision of overall risk descriptors for elements in functional areas in accordance with **4.6**;
- e) a description of how identified risks are used to determine cleaning frequencies for each element in each functional area;
- f) a description of when the risk assessment is to be conducted; and
- g) a description of when the risk assessment procedure is to be reviewed.

4.1.2 The results of any risk assessment conducted in accordance with **4.1.1** shall be documented.

4.1.3 The risk assessment procedure in **4.1.1** and the results generated in **4.1.2** shall be approved by the Board and the approval documented.

NOTE A flow chart representing the minimum elements of a risk assessment is given in Figure 2.

Figure 2 – Stages in the risk assessment of elements in a functional area



4.2 Responsibility

A risk assessment of elements in a functional area shall be undertaken by a risk assessment group, the membership of which shall be documented.

NOTE The risk assessment group should include Functional Area Managers and Staff Group Managers (see 3.2). Where a hospital is served by an infection control team, a member of that team should be included within the group.

4.3 Identification of functional areas and elements

4.3.1 Every area within a hospital shall be assigned to a functional area.

4.3.2 All functional areas within a hospital shall be defined and documented.

NOTE 1 A functional area is a discrete area of operational activity (see 2.8), that is defined as such because, for example:

- a) it is the location for different clinical activity from neighbouring areas;
- b) it is differently managed from neighbouring areas; or
- c) it exhibits a level of risk that differs from neighbouring areas.

Typical examples of functional areas in a hospital include a ward, a department and a suite of offices.

NOTE 2 Where the risk assessment group find that a discrete area within a defined functional area would have a different risk rating from the rest of the functional area, e.g. a part of an imaging department where invasive procedures are conducted, the discrete area should be redefined as a functional area in its own right.

4.3.3 All rooms within a functional area shall be defined and documented.

4.3.4 All elements that are located, or might be used, within a hospital shall be identified and documented.

4.3.5 All elements that are located, or might be used, within each functional area shall be identified and documented.

4.3.6 Any element listed in Annex A shall be identified as a scored element and any other elements shall be identified as unscored elements.

NOTE Scored elements are identified separately because they will be used in the measurement of cleanliness in Clause 6.

4.4 Risk assessment of elements

4.4.1 Each element shall be assigned a risk score using a three point scale, where 1 is low risk and 3 is high risk, that reflects the risk of a lack of cleanliness on:

- a) healthcare associated infections (HCAI); and
- b) patient, public and staff confidence (PPSC).

NOTE Guidance on assigning a risk score out of three for an element for both HCAI risk and PPSC risk is given in Table 1. Scores should be assigned on the basis of the relative risk of the elements within a healthcare facility and therefore elements should not, for example, all be assessed as "red" risk just because they are in a hospital.

Comment [AK1]:
FOR REVIEW PANEL:

Does the list of scored elements in Annex A cover all the frequent touch points that should be included?

Table 1 – Guidance on risk scores for elements

Risk score	Description	HCAI risk	PPSC risk
1	Low	Elements with which patients, public and staff normally have little direct contact or which are unlikely to act as dangerous reservoirs of infective material. These may include floors, mirrors, internal glass, microwaves, fridges and freezers.	Elements which are unlikely to be seen by patients, public and staff or which, when seen in an unclean condition, are only likely to lead to a formal or informal complaint or adverse comment being made in a relatively small proportion of instances. These may include pest control devices and dishwasher.
2	Medium	Elements with which patients, public and staff normally have a medium degree of contact or which are likely to act as reservoirs of infective material. These may include high services, low surfaces, chairs, curtains and ventilation grilles.	Elements which are occasionally seen by patients, public and staff or which, when seen in an unclean condition, may lead to a formal or informal complaint or adverse comment being made. These may include high surfaces, microwaves and linen trolleys.
3	High	Elements with which patients, public and staff normally have extensive and very frequent contact or which are certain to act as reservoirs of infective material. These may include toilet, commodes, medical equipment attached to a patient and beds.	Elements which are highly visible to patients, public and staff or which, when seen in an unclean condition, are likely to lead to a formal or informal complaint or adverse comment being made. These may include floors and toilets.

4.4.2 Each element shall be assigned an element risk score, which shall be the product of the risk score for HCAI and risk score for PPSC for that element.

4.4.3 Each element shall be assigned to an element risk category in accordance with Table 2 on the basis of the element risk score.

Table 2 – Element risk categories

Element risk category	Element risk score	Description
Green	1-2	Low risk
Amber	3-4	Significant risk
Red	6 and 9	High risk

4.4.4 Any element with an HCAI risk score of 3 shall be assigned to element risk category “red”, irrespective of the total element risk score.

4.4.5 The element risk category assigned to each element shall be documented.

NOTE An example risk assessment of elements is given in Table 3.

Table 3 – Example risk assessment of elements in Hospital A

Element	Risk score for HCAI	Risk score for PPSC	Element risk score	Element risk category
Commode, bed pans and bed pan holders	3	3	9	Red
Macerator and bed pan washer	3	2	6	Red
Weighing scale, manual handling equipment, bathroom hoist	2	2	4	Amber
Drip stand	3	2	6	Red
Mirror	1	2	2	Green
Hard floor	1	3	3	Amber
Ice machine, hot water boiler and drinking water dispenser	2	2	4	Amber

4.5 Risk assessment of functional areas

4.5.1 Each functional area shall be assigned a risk score using a three point scale, where 1 is low risk and 3 is high risk, that reflects the risk of a lack of cleanliness on:

- a) healthcare associated infections (HCAI); and
- b) patient, public and staff confidence (PPSC).

NOTE Guidance on assigning a risk score out of three for a functional area for both HCAI risk and PPSC risk is given in Table 4.

Table 4 – Guidance on risk scores for functional areas

Risk score	Description	HCAI risk	PPSC risk
1	Low	Functional areas in which patients are not usually present. These may include offices and store rooms.	Functional areas which are unlikely to be seen by patients, public and staff or which, when seen in an unclean condition, are only likely to lead to a formal or informal complaint or adverse comment being made in a relatively small proportion of instances. These may include offices and store rooms.
2	Medium	Functional areas in which patients, other than those undergoing invasive procedures or acutely or critically ill, are present. Also functional areas through which patients and public	Functional areas which are occasionally seen by patients, public and staff or which, when seen in an unclean condition, may lead to a formal or informal complaint or adverse comment being

Table 4 – Guidance on risk scores for functional areas

Risk score	Description	HCAI risk	PPSC risk
		regularly pass. These may include non-acute wards, outpatient departments.	made. These may include infrequently used corridors and emergency exits.
3	High	Functional areas in which invasive procedures are performed or which house acutely or critically ill patients. These may include intensive therapy departments and some inpatient wards.	Functional areas which are highly visible to patients, public and staff or which, when seen in an unclean condition, are likely to lead to a formal or informal complaint or adverse comment being made. These may include main entrances, wards, and outpatient departments.

4.5.2 Each functional area shall be assigned a functional area risk score, which shall be the product of the risk score for HCAI and the risk score for PPSC for that functional area.

4.5.3 Each functional area shall be assigned to a functional area risk category in accordance with Table 5 on the basis of the functional area risk score.

Table 5 – Functional area risk categories

Functional area risk category	Functional risk score	Description
1	1-2	Low risk
2	3-4	Significant risk
3	6	High risk
4	9	Very high risk

4.5.4 Any functional area with an HCAI risk score of 3 shall be assigned to functional area risk category 4, irrespective of the total functional area risk score.

4.5.5 The functional area risk category assigned to each functional area shall be documented.

NOTE An example risk assessment of functional areas is given in Table 6.

Table 6 – Example risk assessment of functional areas in Hospital A

Functional area	Risk score for HCAI	Risk score for PPSC	Functional area risk score	Functional area risk category description	Functional area risk category
Main entrance (external)	1	3	3	Significant risk	2
Main entrance (internal)	2	3	6	High risk	3
Corridor A	2	3	6	High risk	3
Archive store	1	1	2	Low risk	1
Office suite A – head offices	1	1	2	Low risk	1
ITU unit A	3	3	9	Very high risk	4
Ward A	3	3	9	Very high risk	4

4.6 Risk assessment of each element in a functional area

4.6.1 An overall risk descriptor shall be assigned to each element in each functional area.

4.6.2 The overall risk descriptor for each element in a functional area shall be generated by combining the functional area risk category determined in 4.5 with the element risk category in 4.4.

NOTE For example, using the outcomes of the risk assessments in Table 6 and Table 3, a commode in a ward would be assigned an overall risk descriptor of “4 red”, and a hard floor in an archive store would be “1 amber”.

4.6.3 The overall risk descriptor assigned to each element in each functional area shall be documented.

COMMENTARY ON CLAUSE 4

The purpose of the risk assessment is to provide a risk-based framework for informing decisions on:

- a) the frequency with which to undertake the cleaning tasks relating to elements in a functional area; and*
- b) the consequent allocation of resources.*

Having a risk-based framework is intended to increase the accuracy of the decision-making process, and enhance its credibility for the Board. It is also intended to provide the opportunity for cleaning risks to be entered onto existing risk registers if this has not already been achieved.

5 Cleaning tasks

This clause describes the actions necessary in cleaning a hospital. This includes identifying what needs to be cleaned, who ought to clean it, how (and how often) it ought to be cleaned, how clean it ought to be and what training is needed.

It introduces the concept of scored and unscored elements. A scored element is one of 49 elements identified as forming part of a representative selection of elements for the measurement of cleanliness. An unscored element is a element other than a scored element which is audited for cleanliness and corrective actions identified but is not used in the recorded measurement of cleanliness.

Note that a requirement for how clean elements in a hospital have to be (i.e. the cleanliness criteria) is given in **6.1**.

5.1 Responsibilities

5.1.1 A documented cleaning responsibilities matrix shall be produced and shall:

- a) list all elements within a hospital that require cleaning, indicating which are scored elements as listed in Annex A;
- b) assign the responsibility for the cleanliness of each element to a named staff group; and
- c) provide a definition and details of each of the staff groups referenced.

COMMENTARY ON 5.1.1

An example of a cleaning responsibilities matrix is given at Annex B.

The 49 scored elements should be listed, in the order in which they are listed in Annex A, at the top of the cleaning responsibilities matrix. All unscored elements should be listed below these, in any order.

Typically, cleaning tasks are assigned to the following three staff groups.

- a) *Cleaning staff. In most healthcare facilities, the majority of cleaning tasks are undertaken by a dedicated cleaning service. The dedicated cleaning service may be provided directly by the healthcare organization, or may be outsourced either to a neighbouring healthcare organization under a SLA, or to a commercial provider, under a standard contract or as part of a private finance initiative (PFI) agreement.*
- b) *Nursing or departmental staff. Some cleaning tasks are undertaken by those staffing the functional area in which the cleaning tasks are to be undertaken. For example, nurses in wards and pharmacy and physiotherapy staff in their respective departments. This staffing group is usually employed directly by the healthcare organization they serve.*
- c) *Estates staff. A small minority of cleaning tasks are undertaken by the healthcare organization's estates service. These may be either directly employed by the healthcare organization they serve or under another contractual arrangement.*

In addition to these three main staff groups, cleaning tasks can also be identified as being the responsibility of other staff groups, such as porters.

5.1.2 The matrix shall be produced by a cleaning responsibilities group.

5.1.3 The membership and terms of reference of the cleaning responsibilities group shall be documented.

COMMENTARY ON 5.1.3

The cleaning responsibilities group are likely to have to make decisions relating to the development of the cleaning responsibilities matrix with significant financial and labour resource implications.

Therefore, the group should be made up of senior individuals and given a place in a healthcare organization's governance structure that allows it to make these decisions.

For example, for an NHS Trust, a cleaning responsibilities group should comprise:

- *a Non-Executive Director;*
- *the Director for Infection Prevention and Control (DIPC);*
- *the Director with responsibility for cleanliness (see 3.2), if not the DIPC;*
- *the Director of Nursing (if not the DIPC);*
- *the Director of Facilities or equivalent (if not the DIPC);*
- *Functional Area Managers (see 3.2), e.g. matrons;*
- *Staff Group Managers (see 3.2), e.g. Cleaning Managers;*
- *at least one experienced cleaner;*
- *a Control of Infection Nurse;*
- *a Senior Finance Manager.*

The group's terms of reference should be to:

- *identify all elements in a hospital;*
- *identify existing arrangements for cleaning these elements;*
- *identify areas of a lack of clarity, non-performance or inconsistent performance;*
- *define and review competence levels required to complete cleaning tasks;*
- *own, and if necessary create, a cleaning responsibilities matrix allocating the responsibility for cleaning each element to a staff group;*
- *ensure that adequate resource is available for the cleaning of all elements;*
- *ensure that the cleaning responsibilities matrix is clearly understood by all parties, and is accurately reflected in work planning, work schedules and team briefs; and*
- *review the cleaning responsibilities matrix.*

5.1.4 The matrix shall be approved by the Board and the approval documented.

5.1.5 The matrix shall be communicated to Staff Group Managers (see 3.2).

5.1.6 The matrix shall be available on request.

5.1.7 The matrix shall be reviewed by the cleaning responsibilities group and approved by the Board at least once every 12 months or more frequently if there is a change in circumstances that might affect the matrix.

5.2 Identification

All cleaning tasks relating to the cleanliness of the elements assigned to staff group shall be identified and documented by the Staff Group Manager (see 3.2).

5.3 Risk assessment

5.3.1 A documented risk assessment shall be produced for each cleaning task identified in 5.2. It shall identify the risks involved in performing the cleaning task and the actions to be implemented to mitigate against these risks.

5.3.2 The date of completion of the mitigating actions identified in 5.3.1 shall be documented.

NOTE Further guidance on the risk assessment of cleaning tasks is given in Annex C.

5.4 Method statements

5.4.1 A documented method statement shall be produced for each cleaning task identified at **5.2**.

5.4.2 The method statement for a cleaning task shall include a description of any mitigating actions or procedures identified for that cleaning task in the risk assessment undertaken in **5.3**.

NOTE Method statements should be written with the aim of achieving the cleanliness criteria in 6.1. They should give full instruction in the performance of a cleaning task and list all equipment required for it. Instructions common to all cleaning tasks, or applicable to most cleaning tasks, may be contained in a separate section added to the start of each method statement. An example of a method statement is given in Annex D.

5.5 Frequencies

5.5.1 The frequency with which to clean each of the elements in a functional area in accordance with the cleaning tasks identified in **5.2** shall be determined and documented.

NOTE 1 The outcome of the risk assessment in Clause 6 can be a useful aid in the determination of cleaning frequencies.

NOTE 2 Further guidance on setting cleaning frequencies will be added into The Revised Healthcare Cleaning Manual [1] to coincide with the publication of this PAS.

5.5.2 A documented procedure for setting cleaning frequencies that are higher or lower than those given in **5.5.1** shall be produced.

NOTE Higher cleaning frequencies can be implemented when, for example, there is an identified heightened risk of infection.

5.5.3 The frequencies determined in **5.5.1** and the procedure in **5.5.2** shall be approved by the Board and the approval documented.

5.6 Work schedules

5.6.1 Work schedules shall be created and documented for each functional area.

5.6.2 Each work schedule shall identify each cleaning task to be performed in the functional area, and indicate when it should be performed and how long it should take.

5.6.3 Each work schedule shall be approved by the Functional Area Manager (see **3.2**).

5.6.4 Each work schedule shall be approved by the Board and the approval documented.

5.6.5 Work schedules for each functional area shall be displayed in a public part of that functional area.

5.6.6 Each work schedule shall be reviewed every 12 months or more frequently if there is a change in circumstances that might affect the work schedule.

NOTE 1 Different work schedules for each functional area may be produced for different staff groups, allowing the work schedule to perform a secondary function as a work instruction. For example, there may be two work schedules for a typical hospital ward, one detailing the cleaning tasks performed by dedicated cleaning staff and another detailing the cleaning tasks performed by the nursing staff.

An example of a work schedule is given in Annex E. It shows how a work schedule can be useful as a work instruction for a particular staff group in a particular functional area.

NOTE 2 Some cleaning tasks are typically performed less frequently than once per week, but require regular performance at defined intervals, which may range from fortnightly to six-monthly or even annually. Examples of such tasks include the cleaning of external facing surfaces of external glass, carpet shampooing, curtain changing, floor stripping and application of polish or sealant, and window cleaning.

The performance of these tasks should be planned in advance every year and documented in a "periodic work schedule". This should be done in detail, so that, for example, the periodic work schedule produced in December 2010 for the following year will show that curtain changing in "Ward A" will be performed on 17 February, 18 May, 15 August and 19 November, while carpet shampooing in the "Physiotherapy Offices" will occur on 3 March and 4 September. Some tasks may be more flexibly scheduled, so that, for example, the floors in "Corridor C" will be stripped and resealed in February, May, August and November.

A periodic work schedule usually covers more than one functional area and therefore one periodic work schedule can be used to form part of the work schedule for each of several functional areas.

5.7 Training

5.7.1 Each cleaning task shall be conducted by persons who have completed training in:

- a) how to perform the cleaning task in accordance with the hospital's method statements in **5.4**;
- b) site orientation;
- c) control of infection;
- d) fire safety;
- e) manual handling; and
- f) health and safety.

5.7.2 Training in how to conduct a cleaning task shall consist of instruction, demonstration, questioning and observation of performance.

5.7.3 Training shall be repeated until the trainee is observed as conducting the cleaning task in accordance with the instructions given in **5.7.1** and **5.7.2**.

5.7.4 The criteria by which a person delivering the training in **5.7.1**, **5.7.2** and **5.7.3** is deemed competent to do so shall be documented.

5.7.5 A procedure for assessing performance and rectifying identified underperformance shall be documented.

5.7.6 A documented training record shall record the completion of training in accordance with **5.7.1** to **5.7.5**. It shall include the date of completion and the signatures of both the trainer and trainee.

NOTE An example of a training record is given in Annex F.

5.8 Contingency

A documented procedure shall be produced for:

- a) mitigating the effects of a temporary requirement for the additional cleaning; and

NOTE For example, an infection outbreak will require additional resource for a defined period of time. This need might suddenly become apparent and require immediate action.

- b) mitigating the effects of a temporary unavailability of staff for the performance of cleaning tasks.

NOTE For example a number of staff might suddenly be affected by an outbreak of sickness and not report to work.

NOTE 1 Guidance on contingency planning for the provision of cleaning tasks is given in Annex G.

NOTE 2 Contingency planning for the provision of cleaning tasks forms part of a wider need for business continuity management within a healthcare organization.

6 Measurement of cleanliness

Organizations need to demonstrate a robust audit process, with strong mechanisms for identifying problems. This clause describes how this is conducted.

Essentially, it specifies how clean elements are required to be (i.e. the cleanliness criteria), how to audit whether the cleanliness criteria has been achieved and how to record the results of these audits.

6.1 Cleanliness criteria

An element shall be identified as clean if all parts of the element have the visual appearance of being free of dirt and stains.

NOTE Definitions of dirt and stain are given in 2.7 and 2.19 respectively.

6.2 Technical audit

6.2.1 Technical audits shall be conducted to assess whether each scored element in each room in each functional area conforms to the cleanliness criteria in **6.1**.

6.2.2 Technical audits shall score each scored element in accordance with Table 7.

Table 7 – Technical audit score criteria

Technical audit score	Criteria
0	Element does not conform to the cleanliness criteria in 6.1
1	Element conforms to the cleanliness criteria in 6.1

6.2.3 The criteria by which the persons permitted to undertake technical audits are deemed competent to do so shall be documented.

NOTE Technical audits should be undertaken as a joint exercise by:

- a) the Functional Area Manager (see **3.2**);
- b) the Staff Group Manager (see **3.2**); and
- c) other interested persons, if any, such as control of infection team members.

6.2.4 Technical audits shall be conducted in accordance with the frequencies in Table 5.

Table 8 – Frequency of technical audits

Functional area risk category	Description	Frequency
1	Low risk	Half-yearly
2	Significant risk	Quarterly
3	High risk	Four-weekly
4	Very high	Fortnightly

Comment [AK2]:
FOR REVIEW PANEL:

Please consider whether these frequencies are set at the right level.

6.2.5 The results of each technical audit shall be recorded on a technical audit sheet prepared for each functional area. The technical audit sheet shall list each of the scored elements in Annex A as columns, and each of the rooms comprising the functional area as rows.

NOTE A technical audit sheet template is given in Annex H.

6.2.6 Where a scored element is not present in a room, this shall be recorded in the cell for that element on the technical audit sheet.

6.2.7 The cleanliness of each scored element shall be assessed as it appears on first inspection. If the element does not conform to the cleanliness criteria in 6.1, it shall be scored 0, irrespective of whether it is immediately cleaned thereafter.

6.2.8 Any scored element in any room that receives a technical audit score of 0 shall be assigned a corrective action which shall be completed in accordance with Clause 8.

6.2.9 Corrective actions shall also be assigned to unscored elements that receive a technical audit score of 0 in accordance with cleanliness criteria in 6.1.

6.2.10 The score for each room in a functional area shall be expressed on the functional area technical audit sheet as the percentage of scored elements present which scored 1.

6.2.11 The score for each functional area shall be expressed as the average (mean) percentage score achieved by each room comprising the functional area, irrespective of size or function.

6.2.12 Quarterly and annual scores for functional areas shall be expressed as the average (mean) percentage score achieved in technical audits by the functional area over 13 weeks or one year respectively.

6.2.13 Quarterly and annual scores for the hospital shall be expressed as the average (mean) of all technical audits undertaken in the preceding 13 weeks or one year respectively, weighted by the corresponding total internal floor area assigned to each functional area risk category in a hospital as a proportion of the total internal floor area of the hospital.

NOTE For example, in a hospital with a total net internal floor area of 100 000 m², the functional areas in risk category four have a total net internal floor area of 7 000 m², those in category three 63 000 m², those in category two 20 000 m², and those in category one 10 000 m². Therefore, functional areas in risk category four make up 7% of the total, those in category three 63%, those in category two 20% and those in category one 10%. In order to produce the score for the hospital, the percentage figures are multiplied by the average (mean) technical audit scores for each functional area risk category, which is the average (mean) of all the functional area technical audit scores within the same risk category. In the following example, the determination of the average (mean) technical audit score has not been shown.

$$99\left(\frac{7\,000}{100\,000}\right) + 96\left(\frac{63\,000}{100\,000}\right) + 87\left(\frac{20\,000}{100\,000}\right) + 81\left(\frac{10\,000}{100\,000}\right) = 92.91\%$$

6.2.14 Quarterly and annual scores for the organization, if more than one hospital is operated, shall be expressed as the average (mean) of all technical audits undertaken in the preceding 13 weeks or one year respectively, weighted by the corresponding total internal floor area assigned to each functional area risk category in a hospital as a proportion of the total internal floor area of the hospital.

NOTE For example, in an organization operating three hospitals (A, B, and C), hospital A has a net internal floor area of 70 000 m², and a target cleanliness score of 92.4%, hospital B has a net internal floor area of 30 000 m², and a target cleanliness score of 91.8% and hospital C has a net internal floor area of 12 000 m², and a target cleanliness score of 88.2%. The total net internal floor area of the three hospitals is 112 000 m², of which 62.5% is in hospital A, 26.79% in hospital B, and 10.71% in hospital C. The percentage figures are multiplied by the average (mean) scores for each hospital to produce the score for the organization, i.e.:

$$92.4 \left(\frac{70\,000}{112\,000} \right) + 91.8 \left(\frac{30\,000}{112\,000} \right) + 88.2 \left(\frac{12\,000}{112\,000} \right) = 91.79\%$$

6.2.15 A score for each identified staff group shall be expressed on the functional area technical audit sheet as the average (mean) percentage score achieved by each room in a functional area for which that staff group is responsible.

6.2.16 At least once a quarter a technical audit assurance check shall be undertaken. This shall determine whether technical audits are being conducted in accordance with **6.2.1** to **6.2.15** and shall be conducted in accordance with a documented procedure.

6.2.17 The technical audit assurance check in **6.2.16** shall be conducted by persons permitted to undertake managerial audits in accordance with **6.3.2**, **6.3.3** and **6.3.4**.

6.3 Managerial audit

6.3.1 A documented procedure for conducting managerial audits shall be produced. It shall define the frequency with which, and locations in which, managerial audits are to be conducted.

6.3.2 A managerial audit shall be conducted by one or more representatives of the Board.

6.3.3 The criteria by which the persons permitted to undertake managerial audits are deemed competent to do so shall be documented.

6.3.4 The names of persons permitted to undertake managerial audits shall be documented.

NOTE Managerial audits will usually be conducted by the Director with Responsibility for Cleanliness.

6.3.5 The outcomes of a managerial audit shall be documented.

COMMENTARY ON CLAUSE 6

The purpose of the managerial audit is to allow the Board to form an impression of the cleanliness of the functional area and the satisfaction of the users of the functional area. If the managerial audit identifies a need for improvement, this should be communicated to the Functional Area Manager and the Staff Group Manager and an additional technical audit should be conducted.

Managerial audits also serve the subsidiary function of visually demonstrating the commitment of the Board to the provision of cleanliness.

The audits in Clause 6 are not intended to represent the totality of auditing performed. Additional cleanliness checks that should be in place in each functional area are given in Annex I.

Corrective actions identified as part of the recommended additional checks in Annex I should be performed in accordance with Clause 8 and the outcomes recorded according to local protocol.

7 Target cleanliness scores

This PAS requires organizations to declare their cleanliness targets. Such targets are set and justified locally.

7.1 Functional area

7.1.1 A target cleanliness score for each functional area risk category shall be set and documented along with a justification for the chosen scores.

7.1.2 The target cleanliness score for a functional area shall be the minimum percentage score expected to be achieved by that functional area during a technical audit conducted in accordance with **6.2**.

NOTE 1 Target cleanliness scores are compared against the technical audit scores determined in 6.11.

NOTE 2 An example set of target scores is given in Table 6.

Table 9 – Example target cleanliness scores by functional area risk category

Functional area risk category	Description	Target cleanliness score %
1	Low risk	?
2	Significant risk	?
3	High risk	?
4	Very high	?

Comment [AK3]:
FOR REVIEW PANEL:

Would it be helpful to offer an example of target cleanliness scores, if so what should the figures be for each functional area risk category?

7.2 Hospital

7.2.1 A target cleanliness score for a hospital shall be calculated.

7.2.2 The target cleanliness score for the hospital shall be the sum of each of the target cleanliness scores set in **7.1** weighted by the corresponding total internal floor area assigned to each functional area risk category in a hospital as a proportion of the total internal floor area of the hospital.

NOTE For example, in a hospital with a total net internal floor area of 100 000 m², the functional areas in risk category four have a total net internal floor area of 7 000 m², those in category three 63 000 m², those in category two 20 000 m², and those in category one 10 000 m². Therefore, functional areas in risk category four make up 7% of the total, those in category three 63%, those in category two 20% and those in category one 10%. The percentage figures are multiplied by the target cleanliness scores set in 7.1 to produce the target cleanliness score for the hospital, i.e.:

$$98 \left(\frac{7\,000}{100\,000} \right) + 95 \left(\frac{63\,000}{100\,000} \right) + 85 \left(\frac{20\,000}{100\,000} \right) + 75 \left(\frac{10\,000}{100\,000} \right) = 91.21\%$$

7.3 Organization

7.3.1 Where a group of hospitals is operated by an organization, a target cleanliness score for the organization shall be calculated, in addition to the target cleanliness score for each hospital in **7.2**.

7.3.2 The target cleanliness score for the organization shall be calculated as the sum of each of the target cleanliness scores for each hospital weighted by the

corresponding internal floor area of each hospital as a proportion of the total internal floor area of all hospitals.

NOTE For example, in an organization operating three hospitals (A, B, and C), hospital A has a net internal floor area of 70 000 m², and a target cleanliness score of 92.4%, hospital B has a net internal floor area of 30 000 m², and a target cleanliness score of 91.8% and hospital C has a net internal floor area of 12 000 m², and a target cleanliness score of 88.2%. The total net internal floor area of the three hospitals is 112 000 m², of which 62.5% is in hospital A, 26.79% in hospital B, and 10.71% in hospital C. The percentage figures are multiplied by the target cleanliness scores for each hospital to produce the target cleanliness score for the organization, i.e.:

$$92.4 \left(\frac{70\,000}{112\,000} \right) + 91.8 \left(\frac{30\,000}{112\,000} \right) + 88.2 \left(\frac{12\,000}{112\,000} \right) = 91.79\%$$

8 Corrective action

When audit demonstrates a shortfall in cleaning, corrective action needs to be timely and thorough. This clause defines a mechanism for planning and recording corrective actions. It requires organizations to declare their targets timescales for completion of corrective actions. Such targets are set and justified locally.

8.1 Corrective actions shall be documented by the technical auditors wherever an element in a room within a functional area is given a technical audit score of 0.

NOTE A corrective action normally demands the performance of a specific cleaning task, for example “perform high dusting to top of curtain rail in room 15”.

Occasionally, a corrective action may require a non-cleaning action in addition to a cleaning task, for example, “remove stored archives to allow cleaning of the hard flooring in room 15” or “an element is worn or damaged and needs replacing”.

A corrective action should not take the form of a general comment on the cleanliness of a room or functional area, e.g. “room 15 dusty”.

8.2 Corrective actions shall be recorded on a corrective action sheet and passed to the Staff Group Manager.

NOTE A corrective action sheet should be passed to the Staff Group Manager without delay.

8.3 Target timescales for the completion of corrective actions shall be determined and documented along with a justification for the chosen targets.

NOTE 1 An example set of corrective action completion timescales is given in Annex J.

NOTE 2 Where this does not delay the process, elements requiring corrective action should be corrected in order of element risk category (i.e. red, amber, green).

8.4 The completion of corrective actions and the timescale taken to achieve completion shall be documented.

NOTE A corrective action sheet template is given at Annex K.

8.5 The technical audit scores determined for each functional area for each technical audit conducted in accordance with Clause 6 shall be compared against the target cleanliness scores set in 7.1.

8.6 A procedure for addressing functional areas that do not achieve the target cleanliness scores in 7.1 shall be produced and documented. It shall include, as a minimum:

- a) a description of what corrective actions are to be undertaken; and
- b) a description of when the corrective actions are to be implemented.

NOTE An example set of corrective actions that can be used as part of a procedure for addressing functional areas that do not achieve their target cleanliness scores is given in Annex L.

COMMENTARY ON CLAUSE 8

The corrective actions in Clause 8 are not intended to represent the totality of corrective action performed. Additional corrective actions that should be in place in each functional area are given in Annex M.

Comment [AK4]: FOR REVIEW PANEL:

Should the PAS set scores for the timescales for corrective action and if so what should those timescales be?

9 Continuous service improvement

This PAS requires a commitment to continuous service improvement. This clause embeds this principle.

A documented plan to promote continuous service improvement relating to the provision of cleanliness shall be produced and maintained.

NOTE Guidance on continuous service improvement is given in The Revised Healthcare Cleaning Manual [1].

In summary, the commitment to continuous service improvement, which is detailed in the cleanliness policy in 3.1, does not necessarily imply additional service cost, and may indeed produce savings. Measures to promote continuous service improvement may include:

- a) more efficient use of labour;*
- b) better working or supervisory practices;*
- c) schemes to raise staff morale and reduce sickness absence and staff turnover; and*
- d) implementation of, or increased use of, technological advances.*

Commercial cleaning, nursing, departmental or estates contracts should be let on the basis that there will be an ongoing commitment to innovation and improvement in cleaning.

All cleaning service managers and other managers responsible for the delivery of cleaning services should consider joining a professional association, in order to ensure that they keep abreast of new developments, innovations and evolving best practice.

10 Reporting

Patients, public and staff need to be reassured that high standards are being maintained across their hospitals. This PAS requires organizations to make information available on request.

10.1 Functional areas

10.1.1 The most recent technical audit score for any functional area determined in accordance with **6.2.11** shall be available on request.

10.1.2 The average (mean) technical audit score for the most recent quarter and for the most recent year for any functional area determined in accordance with **6.2.12** shall be available on request.

10.1.3 A trend chart, showing the ten most recent technical audit scores for any functional area shall be available on request.

10.2 Board

10.2.1 A documented report to the Board shall be made each quarter by the Director with Responsibility for Cleanliness (see **3.2**).

10.2.2 The documented report shall include:

- a) a summary of all technical audits carried out in the 13 week reporting period, an overall hospital cleanliness score for the reporting period, and an overall organization cleanliness score if more than one hospital is covered by the report;
- b) the target cleanliness score for the hospital determined in accordance with **7.2** and for the organization, if more than one hospital is covered by the report, determined in accordance with **7.3**;
- c) a summary of the findings of managerial audits undertaken in accordance with **6.3** during the reporting period;
- d) a summary of corrective actions documented and conducted in accordance with Clause **8**; and
- e) a continuous improvement plan completed in accordance with Clause **9**.

NOTE The report may contain other information relevant to hospital cleanliness. An example report is given in The Revised Healthcare Cleaning Manual [1].

10.3 Organizational

10.3.1 The annual overall cleanliness score for each hospital determined in accordance with **6.2.13**, and the overall organization score determined in accordance with **6.2.14** if more than one hospital is covered by the report, shall be available on request.

10.3.2 The target cleanliness score for each hospital determined in accordance with **7.2**, and the target cleanliness score for the organization determined in accordance with **7.3** if more than one hospital is covered by the report, shall be available on request.

Annex A (normative)

Scored elements

A list of 49 scored elements is given in Table A.1.

Table A.1 – Scored elements

No.	Element name
1	Commode, bed pan and bed pan holder
2	Macerator and bed pan washer
3	Weighing scale, manual handling equipment, bathroom hoist
4	Catheter, drip and IV stand
5	Medical equipment not connected to a patient
6	Medical equipment connected to a patient, e.g. infusion pump
7	Patient washbowl
8	Medical gas and suction equipment including gas cylinder holder
9	Patient fan
10	Bedside alcohol hand wash container including nozzle and holder, clipboard and notice board
11	Notes, drugs and resuscitation trolley
12	Telephones and faxes
13	Linen trolley
14	Wall fixture, e.g. switch, socket and data point
15	Wall surfaces including skirting
16	Ceiling
17	Door including all parts of the door structure, e.g. frame, handle, jamb, push plate, snib and vent
18	Internal glass, including partitions and vision panels, the interior surface of external facing windows
19	Computer equipment, including keyboard, mouse, monitor and printer
20	Mirror
21	Bedside patient TV including earpiece for bedside entertainment system and public area information touch screens
22	Radiator including the space between radiator plates
23	Ventilation grille
24	Hard floor
25	Soft floor
26	Toy
27	Pest control device
28	Portable electrical item casing, e.g. kettle and toaster
29	Cleaning equipment
30	Low surface
31	High surface
32	Chair
33	Bed including mattress, bed frame, cotside, wheels and castors
34	Locker including wheels and castors
35	Table including wheels and castors
36	Hand wash container including hand soap container and nozzle and paper towel

Table A.1 – Scored elements

No.	Element name
	container
37	Alcohol gel dispenser including holder and nozzle
38	Waste receptacle including lid and pedal
39	Curtain and blind
40	Dishwasher
41	Fridge and freezer
42	Ice machine, hot water boiler and drinking water dispenser
43	Ward pantry cupboard
44	Microwave
45	Shower including shower head and wall-attached shower chair
46	Toilet and bidet
47	Paper towel holder
48	Sink and wash hand basin including taps
49	Bath

Annex B (informative)

Example cleaning responsibilities matrix

A cleaning responsibility matrix for Hospital A is given in Table B.1 and includes:

- a definition of the different staff groups responsible for cleaning elements;
- the 49 scored elements and corresponding staff groups; and
- all unscored elements and corresponding staff groups.

Table B.1 – Cleaning responsibilities matrix for elements in Hospital A

Staff group name	Description
Cleaning staff	Dedicated cleaning services can be provided directly by the healthcare organization it serves or outsourced either to a neighbouring healthcare organization under a service level agreement (SLA) or to a commercial provider under a standard contract or as part of a private finance initiative (PFI) agreement.
Nursing or departmental staff	Those staffing the functional area, for example nurses in wards, pharmacy and physiotherapy staff in their respective departments are usually employed directly by the healthcare organization they serve.
Estates staff	Estates service can be either directly employed by the healthcare organization they serve or under another contractual arrangement.

No.	Element type	Element	Staff group responsible	Comments
1	Scored	Commode, bed pan and bed pan holder	Cleaning staff	Cleaned after each use by nursing/departmental staff, weekly clean by cleaning staff
2	Scored	Macerator and bed pan washer	Cleaning staff	–
3	Scored	Weighing scale, manual handling equipment, bathroom hoist	Nursing or departmental staff	–
4	Scored	Catheter, drip and IV stand	Nursing or departmental staff	–
5	Scored	Medical equipment not connected to a patient	Cleaning staff	–
6	Scored	Medical equipment connected to a patient, e.g. infusion pump	Nursing or departmental staff	–
7	Scored	Patient washbowl	Nursing or departmental staff	–
8	Scored	Medical gas and suction equipment including gas cylinder holder	Nursing or departmental staff	–

Table B.1 – Cleaning responsibilities matrix for elements in Hospital A

9	Scored	Patient fan	Estates staff	Externally cleaned by cleaning staff, periodic removal of safety covers and internal clean by estates staff
10	Scored	Bedside alcohol hand wash container including nozzle and holder, clipboard and notice board	Cleaning staff	–
11	Scored	Notes, drugs and resuscitation trolley	Nursing or departmental staff	–
12	Scored	Telephones and faxes	Cleaning staff	–
13	Scored	Linen trolley	Cleaning staff	–
14	Scored	Wall fixture, e.g. switch, socket and data point	Estates staff	–
15	Scored	Wall surfaces including skirting	Cleaning staff	–
16	Scored	Ceiling	Cleaning staff	Deep clean/specialist clean performed by specialist contractor, supervised by cleaning service
17	Scored	Door including all parts of the door structure, e.g. frame, handle, jamb, push plate, snib and vent	Cleaning staff	–
18	Scored	Internal glass, including partitions and vision panels, the interior surface of external facing windows	Cleaning staff	–
19	Scored	Computer equipment, including keyboard, mouse and printer	Cleaning staff	Performed by specialist contractor, supervised by cleaning service
20	Scored	Mirror	Cleaning staff	–
21	Scored	Bedside patient TV including earpiece for bedside entertainment system and public area information touch screens	Cleaning staff	Following system owner's method statement and using materials supplied by system owner
22	Scored	Radiator including the space between radiator plates	Estates staff	Externally cleaned by cleaning staff, periodic removal of safety covers and internal clean by estates staff
23	Scored	Ventilation grille	Estates staff	Externally cleaned by cleaning staff, periodic removal of safety covers and internal clean by estates staff
24	Scored	Hard floor	Cleaning staff	–
25	Scored	Soft floor	Cleaning staff	–
26	Scored	Toy	Cleaning staff	–

Table B.1 – Cleaning responsibilities matrix for elements in Hospital A

27	Scored	Pest control device	Cleaning staff	Performed by specialist contractor, supervised by cleaning service
28	Scored	Portable electrical item casing, e.g. kettle and toaster	Cleaning staff	–
29	Scored	Cleaning equipment	Cleaning staff	–
30	Scored	Low surface	Cleaning staff	–
31	Scored	High surface	Cleaning staff	–
32	Scored	Chair	Cleaning staff	–
33	Scored	Bed including mattress, bed frame, cotside, wheels and castors	Cleaning staff	–
34	Scored	Locker including wheels and castors	Cleaning staff	–
35	Scored	Table including wheels and castors	Cleaning staff	–
36	Scored	Hand wash container including hand soap container and nozzle and paper towel container	Cleaning staff	–
37	Scored	Alcohol gel dispenser including holder and nozzle	Cleaning staff	–
38	Scored	Waste receptacle including lid and pedal	Cleaning staff	–
39	Scored	Curtain and blind	Cleaning staff	–
40	Scored	Dishwasher	Cleaning staff	–
41	Scored	Fridge and freezer	Cleaning staff	–
42	Scored	Ice machine, hot water boiler and drinking water dispenser	Cleaning staff	–
43	Scored	Ward pantry cupboard	Cleaning staff	–
44	Scored	Microwave	Cleaning staff	–
45	Scored	Shower including shower head and wall-attached shower chair	Cleaning staff	–
46	Scored	Toilet and bidet	Cleaning staff	–
47	Scored	Paper towel holder	Cleaning staff	–
48	Scored	Sink and wash hand basin including taps	Cleaning staff	–
49	Scored	Bath	Cleaning staff	–

Table B.1 – Cleaning responsibilities matrix for elements in Hospital A

50	Unscored	Lift carriages – internal glass, floors, walls and hand rails	Cleaning staff	–
51	Unscored	Food regeneration units	Cleaning staff	–
52	Unscored	Planters, large plants	Cleaning staff	–
53	Unscored	Magazine racks	Cleaning staff	–
54	Unscored	Leaflet holders	Cleaning staff	–
55	Unscored	External face of external facing windows	Cleaning staff	–
56	Unscored	Cutlery and serving implements	Cleaning staff	–
57	Unscored	Crockery	Cleaning staff	–
58	Unscored	Drugs fridges	Nursing or departmental staff	–
59	Unscored	Conventional cookers, ovens and hobs	Cleaning staff	–
60	Unscored	Drinks trolleys	Cleaning staff	–
61	Unscored	Drugs cupboards	Nursing or departmental staff	–
62	Unscored	Additional plug-in heaters used in cold weather	Estates staff	Estates department issues on a time-limited basis and remains responsible for cleaning
63	Unscored	Desk accessories – staplers, hole punches, in-trays	Nursing or departmental staff	–
64	Unscored	Flip charts	Nursing or departmental staff	–
65	Unscored	Overhead projectors and projector screens	Nursing or departmental staff	–
66	Unscored	CCTV equipment	Estates staff	Performed by specialist contractor, supervised by estates service
67	Unscored	Sprinkler system heads	Estates staff	–
68	Unscored	Photocopiers	Nursing or departmental staff	–
69	Unscored	CD players, record players, radios	Cleaning staff	–
70	Unscored	Televisions, where not part of bedside entertainment systems	Cleaning staff	–
71	Unscored	Raised toilet seats	Cleaning staff	–

Table B.1 – Cleaning responsibilities matrix for elements in Hospital A

72	Unscored	Wall humidifiers	Nursing or departmental staff	Routine cleaning by nursing and departmental staff. Responsibility of nursing and departmental staff to ensure cleanliness before sending to EME for servicing or repair. EME is responsible for ensuring that equipment is returned to wards and department clean and fit for use.
73	Unscored	Pressure relieving mattress and cushion	Nursing or departmental staff	–
74	Unscored	Wheelchairs	Cleaning staff	–
75	Unscored	Pillows	Nursing or departmental staff	–
76	Unscored	Sharps bin trolleys	Nursing or departmental staff	Including wheels
77	Unscored	Dressing trolleys	Nursing or departmental staff	Including wheels
78	Unscored	Sink outlet strainers	Cleaning staff	–

Annex C (informative)

Risk assessment of cleaning tasks

C.1 General

An overview of some of the risks associated with the provision of cleaning tasks is given in **C.2**, **C.3** and **C.4**. However, note this does not purport to be an exhaustive description of all the factors that need consideration when conducting a risk assessment of cleaning tasks.

C.2 Health and safety at work

It is the responsibility of employers, under the Health and Safety at Work Act 1974 [3], to undertake risk assessments of all activities, tasks and procedures carried out by its employees and, if necessary, to take measures to eliminate or reduce risk.

Guidance on risk assessment is available from the Health and Safety Executive (HSE). The HSE's five-step process to risk assessment [4] should be followed. The five steps include:

- identifying the hazard;
- deciding who might be harmed and how;
- evaluating the risks and deciding on precautions;
- recording findings and implementing them; and
- reviewing the assessment and updating if necessary.

The specific precautionary measures taken to mitigate against the risks associated with cleaning tasks are incorporated into the cleaning task method statements and associated training modules.

C.3 Control of substances hazardous to health

Employers are required, under The Control of Substances Hazardous to Health Regulations 2002 (COSHH) [5], to protect employees and others who may be exposed to substances potentially hazardous to health, including cleaning agents.

COSHH sets out eight basic measures which employers must take. These are to:

- assess the risks;
- decide what precautions are necessary;
- prevent or adequately control exposure;
- ensure that control measures are used and maintained;
- monitor the exposure;
- carry out appropriate health surveillance;
- prepare plans and procedures to deal with accidents, incidents and emergencies; and
- ensure employees are properly informed, trained and supervised.

Further guidance can be found in the HSE guidance leaflet, *Working with substances hazardous to health – What you need to know about COSHH* [6].

Typical actions arising out of the COSHH risk assessment of cleaning tasks include:

- the maintenance and issue of up-to-date COSHH sheets relating to each product used, including actions to be taken in the event of an accident;
- insistence on wearing appropriate personal protective equipment;
- the labelling of chemical containers;
- the storage of chemical products in a secure area;
- recorded health and safety training; and
- regular inspection of the use and storage of chemicals.

C.4 Personal protective equipment

The issue and use of personal protective equipment (PPE) is governed by The Personal Protective Equipment at Work Regulations 1992 [7].

The regulations define PPE as all equipment, including clothing affording protection against the weather, which is intended to be worn or held by a person at work and which protects the person against one or more risks to their health and safety.

PPE is required to be supplied and used at work whenever there are risks to health and safety that cannot be adequately controlled in any other way. No charge, not even a refundable deposit, may be made for the supply of PPE.

PPE is also required to be:

- properly assessed before use to ensure that it is suitable;
- maintained and stored properly;
- provided with instructions on how to use it safely; and
- used correctly by employees.

All PPE used is required to bear the CE mark.

Further guidance is available in the HSE's *A Short Guide to the Personal Protective Equipment at Work Regulations 1992* [8] and *Personal Protective Equipment at Work Regulations – Personal Protective Equipment at Work Regulations 1992 (as amended) – Guidance on Regulations* [9].

Annex D (informative)

Example method statement for a cleaning task

An example method statement for dust controlling is given in Table D.1. It incorporates some general elements that are intended for use with all method statements.

Table D.1 – Example method statement for dust controlling

Topic	Guidance
General	<ul style="list-style-type: none"> a) Refer to work schedule and identify the task to be performed. b) Identify type of area in which cleaning is to be performed, and select the correct colour coded equipment for the task, by reference to the colour coding chart. c) Ensure that all equipment to be used is clean and dry. a) Check equipment for damage or wear which might potentially be dangerous. Additionally, check that there is a current Portable Appliance Test (PAT) sticker in place on any electrical equipment to be used. Any damaged or untested equipment should be reported immediately to a supervisor, who will ensure that the equipment is labelled as faulty and removed from use. b) Prepare cleaning solutions in strict accordance with the manufacturer's instructions and with your training. If using spray bottles ensure that these are clearly-labelled, and are thoroughly cleaned before refilling. Do not mix chemicals, and do not use any cleaning product not provided by your employer. c) Briefly plan your work, and where necessary temporarily move items which might obstruct you to a new, safe location. d) Use hazard signs to warn other users of the area that you are carrying out a cleaning task. e) When using electrical equipment, plan your work to ensure that the cable will always be behind the machine. Ensure that the switch is in the "off" position before plugging machinery into a wall socket. Always unplug machinery before changing fittings or settings. f) The electrical cable must never be draped over your shoulder or over the handle of the machine while you are working. g) Disposable plastic aprons should be worn for all cleaning tasks in which splashes to clothing is likely to occur. h) After use, all equipment should be left clean, dry and tidy in a secure storage area.

Table D.1 – Example method statement for dust controlling

Topic	Guidance
Equipment and materials required	<ul style="list-style-type: none"> • Colour coded dustpan and brush • Colour coded long-handled dust control system tool • Colour coded dust control system mop head or static cloth • Colour coded domestic gloves • Colour coded hand-held scraper • Cleaning trolley • Laundry bag • Warning signs
Health and safety notes	<ul style="list-style-type: none"> • Refer to risk assessment to determine whether further personal protective equipment should be worn or any other additional precautions are necessary • Work in small, square sections to avoid over-stretching • When dust controlling on or near a staircase, ensure that the area is effectively cordoned off by greater use of warning signs
Method	<ol style="list-style-type: none"> 1) Wash hands and put on gloves 2) Display the warning signs 3) Attach the static cloth or the mop head to the dust control system tool 4) Pick up all large items of litter, for example tissues and sweet wrappers 5) Use the scraper to remove any chewing gum or other large deposits attached to the floor. Very gently run the scraper blade along the surface towards the deposit, then work it gently in a semi-circular motion until the deposit is removed. Take care not to damage the surface 6) When dust controlling in a room, aim to finish by the door, and start at the furthest point away from it. When dust controlling a long corridor, aim to perform the task in small sections of between ten and fifteen paces 7) Clean the edges of the floor first, with the leading edge of the dust control tool, then work backwards, dusting the area using an overlapping figure of eight pattern. The dust control tool should remain in contact with the floor at all times 8) When the cloth or mop head has become full of dust, remove it, dispose of it, and replace it with a new one. Disposable cloths should be placed in a domestic waste bag, cleanable heads into a laundry bag 9) Use the dustpan and brush to collect remaining particles 10) On completion of the task, clean and dry all equipment and store safely and tidily in a secure storage area 11) Remove gloves and wash hands

Annex E (informative)

Example work schedule

A work schedule for Ward A in Hospital A is shown in Table E.1. It covers a portion of the cleaning tasks to be performed on the ward and also serves as the work instruction for one of the dedicated cleaning staff.

Table E.1 – Example work schedule

Healthcare organization	NHS Trust A
Healthcare facility type	Acute hospital
Healthcare facility name	Hospital A
Cleaning work schedule number	1
Cleaning work schedule name (functional area)	Ward A
Cleaning work schedule sub number	1.1
Cleaning work schedule sub number name (staff group)	Dedicated cleaning staff
Staff name or organization	Cleaner A
Time period	07.30 – 15.30, Monday – Friday
Issued	9 June 2010
Issue status	Revision 2
Issued by Cleaning Manager (signature)	

Issued by Matron (signature)

Time	Daily duties
08.00 – 08.40	<ul style="list-style-type: none"> • Clean all toilets: Clean bidet, toilet and urinal; damp dust horizontal and vertical surfaces; clean internal glass and mirrors; damp mop floors • Check clean bath, shower and sluice: Damp dust horizontal and vertical surfaces, clean internal glass and mirrors, spot mop floors as necessary • Replenish hand soaps, paper towels, toilet rolls and alcohol gel dispensers
08.40 – 10.00	<ul style="list-style-type: none"> • Wash and dry crockery for mid-morning drink and stack ready for housekeeper • Begin cleaning bed bays, nurses station and corridors: collect and dispose of refuse, clean bins and refit bags; damp dust horizontal and vertical surfaces, bedside lamps, chairs and beds; clean internal glass and mirrors; spot clean walls; clean hand wash basins; replenish hand soaps, paper towels, toilet rolls and alcohol gel dispensers; damp mop floors, planning your route and pulling out furniture as necessary
10.00 – 10.15	<ul style="list-style-type: none"> • Break
10.15 – 12.00	<ul style="list-style-type: none"> • Wash and dry crockery for lunch and stack ready for housekeeper • Continue cleaning bed bays, nurses station and corridors as above
12.00 – 12.30	<ul style="list-style-type: none"> • Lunch

Table E.1 – Example work schedule

12.30 – 13.30	<ul style="list-style-type: none"> • Collect and dispose of refuse, clean bins and refit bags as required in all areas • • Clean shower rooms, bathroom and sluice: damp dust horizontal and vertical surfaces; clean shower cubicles, wash hand basins and baths; replenish hand soaps, paper towels, toilet rolls and alcohol gel dispensers; damp mop floors • Check clean toilets
13.30 – 14.30	<ul style="list-style-type: none"> • Report to the nurse in charge to receive any new instructions on cleaning barrier-nursed single rooms • Clean the three single rooms: collect and dispose of refuse, clean bins and refit bags; damp dust horizontal and vertical surfaces, bedside lamps, chairs and beds; clean internal glass and mirrors; spot clean walls; clean hand wash basins; replenish hand soaps, paper towels, toilet rolls and alcohol gel dispensers; damp mop floors, planning your route and pulling out furniture as necessary
14.30 – 15.15	<ul style="list-style-type: none"> • Carry out weekly cleaning duties (refer to Work Instruction 6.6 - Weekly Duties)
15.15 – 15.30	<ul style="list-style-type: none"> • Tidy and clean cleaning cupboard; complete cleaning cupboard checklist • Inform nurse in charge and leave ward at 15.30

Annex F (informative)

Example training record

An example of a training record is given in Table F.1.

Table F.1 – Example training record

Training module	2007			Interim training (if required)				2008		
	Trainer's signature	Trainee's signature	Date	Trainer's signature	Trainee's signature	Date	Notes	Trainer's signature	Trainee's signature	Date
Site orientation	Muriel Young	David X	14/02/07	–	–	–	–	NA	NA	NA
Control of infection	Chris Haye	David X	19/02/07	–	–	–	–	Chris Haye	David X	08/01/08
Fire	John Hollins	David X	21/02/07	–	–	–	–	Johnny Neill	David X	10/01/08
Health and safety	Joan Griff	David X	21/02/07	–	–	–	–	Joan Griff	David X	11/01/08
Manual handling	Brian Hare	David X	22/02/07	–	–	–	–	Brian Hare	David X	15/02/08
Dust controlling	Lillian Barns	David X	24/02/07	Lillian Barns	David X	09/06/07		Lillian Barns	David X	05/02/08
Damp mopping (single bucket, single solution), using conventional cleaning product	Lillian Barns	David X	28/02/07	–	–	–	–	Lillian Barns	David X	05/02/08
Damp mopping (single bucket, single solution), using chlorine-based disinfectant cleaning product	Lillian Barns	David X	28/02/07	–	–	–	–	Lillian Barns	David X	05/02/08
Damp mopping (double bucket, double solution), using conventional cleaning product	Lillian Barns	David X	28/02/07	–	–	–	–	Lillian Barns	David X	05/02/08

Annex G (informative)

Contingency planning for the provision of cleaning tasks

Each staff group should have an established procedure for managing the requirement for additional labour hours and the unavailability of staff for the performance of cleaning tasks. The exact method will vary considerably depending on size, geography and other local factors. The amount of notice given will also affect the method used.

As guidance, the requirement for additional labour and the unavailability of staff, at relatively short notice, is normally approached by taking the following measures, in the following order.

- a) Variation to periodic work schedule. The periodic work schedule will contain tasks which can be performed flexibly within a month. In a well-managed service, this will be used to allow cleaning staff to be diverted from periodic cleaning duties to cover temporary unavailability of staff. In addition to this, where there is a sudden demand for increased labour, for example in a localized infection outbreak, it may be necessary to postpone planned and dated periodic tasks to release additional staff. The periodic work schedule should be amended and the users of the affected area informed and advised of a revised date.
- b) Additional hours worked by part-time staff. If demand cannot be met by alterations to the periodic work schedule, additional hours should in the first instance be offered to staff employed to work part-time.
- c) Overtime hours worked by full-time staff. If demand cannot be met by part-time staff, overtime working should be offered to full-time staff. This is usually preferable to the use of agency staff who will typically be less familiar with the work area, but should not be over-used. Regular and continued working in excess of full-time hours by any members of staff should not be permitted.
- d) Use of agency staff. Cleaning services should, where possible, have a current call-off contract with at least one staffing agency. This contract should specify that staff provided will be fully trained in cleaning techniques and possess a signed training record, and will have criminal records bureau (CRB) clearance. The use of agency staff is relatively costly and inefficient, as site induction and orientation training must be given, and an increased level of supervision will be necessary.
- e) Direct labour of supervisors. This should not be used unless robust efforts to provide cover by the means listed in a) to d) have failed. The absence of supervision of the routine cleaning service will have a serious adverse effect on the cleaning service and use of this option will be reported to the Director with Responsibility for Cleanliness (see **3.2**).
- f) Prioritization of work areas. In extreme situations, the Staff Group Manager may need to postpone or cancel routine cleaning in areas, beginning with those identified as "low risk". This should not be done without consultation with the control of infection team and Functional Area Managers, and will be reported to the Director with Responsibility for Cleanliness (see **3.2**).

Annex I (informative)

Recommended additional cleanliness checks

Cleanliness checks that should be conducted in each functional area in addition to the audits described in Clause 6 are given in Table I.1.

Table I.1 – Recommended Additional cleanliness checks

Functional area risk category	Description	Recommended additional cleanliness checks
1	Low risk	<ul style="list-style-type: none"> Daily monitoring by person in charge Monthly audit by person accountable for the cleanliness of the functional area Unannounced spot monitoring bi-monthly by person accountable for the cleanliness of the functional area
2	Significant risk	<ul style="list-style-type: none"> Continuous monitoring during working hours by person in charge Weekly audit by person accountable for the cleanliness of the functional area Unannounced spot monitoring monthly by person accountable for the cleanliness of the functional area
3	High risk	<ul style="list-style-type: none"> Continuous monitoring during working hours by person in charge Twice-weekly audit by person accountable for the cleanliness of the functional area Unannounced spot monitoring weekly by person accountable for the cleanliness of the functional area
4	Very high	<ul style="list-style-type: none"> Continuous monitoring during working hours by person in charge Daily audit by person accountable for the cleanliness of the functional area Unannounced spot monitoring weekly by person accountable for the cleanliness of the functional area

Annex J (informative)

Example corrective action completion timescales

An example set of corrective action completion timescales is given in Table J.1.

Table J.1 – Corrective action completion timescales

Functional area risk category	Description	Completion timescale
1	Low risk	The performance of corrective actions shall commence within 48 hours and be completed within one week.
2	Significant risk	The performance of corrective actions shall commence within 24 hours and be completed within 72 hours.
3	High risk	The performance of corrective actions shall commence within 4 hours and be completed within 24 hours.
4	Very high	The performance of corrective actions shall commence immediately and not cease until all are completed.

Annex K (informative)

Corrective action sheet template

A corrective action sheet template is given Table K.1.

Table K.1 – Corrective action sheet template

Functional area	Room	Element	Corrective action	Owner	Target completion date	Completion date	On time
7. Ward A	1. Inpatient area	-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		39. Curtain	Wash	Cleaning staff	12/11/10	12/11/10	Yes
	2. Waiting area	-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-

Annex L (informative)

Corrective actions for addressing underperforming functional areas

L.1 Functional areas not achieving the target cleanliness scores should undergo an additional technical audit not earlier than 24 hours and not later than 120 hours after the initial technical audit.

L.2 If any functional area does not achieve the target cleanliness score after the additional technical audit in **L.1**:

- a) the frequency of the technical audit should be increased in accordance with Table L.1 until such time as the functional area achieves the target cleanliness score in three successive technical audits;
- b) a managerial audit of the functional area should be undertaken;
- c) the annual review of the work schedules for that functional area should be brought forward and commenced within one week of the additional technical audit conducted in **L.2**; and
- d) a documented rectification plan should be produced for that functional area and should include the corrective actions in a), b), c) and **L.2**.

NOTE The rectification plan for a functional area should be produced by the Functional Area Manager and may include de-cluttering, changes to staff groups responsible for the cleaning of elements and changes to organization-wide operational practice.

NOTE Guidance on addressing sustained underperformance is given in The Revised Healthcare Cleaning Manual [1].

Table L.1 – Recommended frequency of technical audits conducted after failure to achieve target cleanliness score

Functional area risk category	Description	Frequency
1	Low risk	Fortnightly
2	Significant risk	Quarterly
3	High risk	Monthly
4	Very high	Weekly

Annex M (informative)

Recommended additional corrective actions

Corrective actions that should be conducted in each functional area in addition to the corrective actions described in Clause 8 are given in Table M.1.

Table M.1 – Recommended additional corrective actions

Functional area risk category	Description	Corrective action	Responsibilities
1	Low risk	<ul style="list-style-type: none"> Soiling of an element in such a way that constitutes a slip hazard, to be corrected immediately so that it no longer constitutes a slip hazard Soiling of an element with bodily fluids to be corrected within 5 minutes Any other soiling of an element such as to make the person responsible (see Clause 6) believe that the element would be given a score of "0" in a technical audit to be corrected within one week. 	<ul style="list-style-type: none"> Correction of soiling with bodily fluids to be undertaken by the nearest available members of any staff group trained to do so, irrespective of the formal responsibility for the routine performance of this task. Correction of other soiling can wait for the availability of members of the staff group with responsibility for the cleaning of the element concerned (see 3.2)
2	Significant risk	<ul style="list-style-type: none"> Soiling of an element in such a way that constitutes a slip hazard, to be corrected immediately so that it no longer constitutes a slip hazard Soiling of an element with bodily fluids to be corrected within 5 minutes Any other soiling of an element such as to make the person responsible (see Clause 6) believe that the element would be given a score of "0" in a technical audit to be corrected within 72 hours. 	
3	High risk	<ul style="list-style-type: none"> Soiling of an element in such a way that constitutes a slip hazard, to be corrected immediately so that it no longer constitutes a slip hazard Soiling of an element with bodily fluids to be corrected within 5 minutes Any other soiling of an element 	

Table M.1 – Recommended additional corrective actions

Functional area risk category	Description	Corrective action	Responsibilities
		such as to make the person responsible (see Clause 6) believe that the element would be given a score of “0” in a technical audit to be corrected within 24 hours	
4	Very high	<ul style="list-style-type: none"> • Soiling of an element in such a way that constitutes a slip hazard, to be corrected immediately so that it no longer constitutes a slip hazard • Soiling of an element with bodily fluids to be corrected within 5 minutes • Any other soiling of an element such as to make the person responsible (see Clause 6) believe that the element would be given a score of “0” in a technical audit to be corrected within 30 minutes 	<ul style="list-style-type: none"> • Corrective actions to be undertaken by the nearest available members of any staff group trained to do so, irrespective of the formal responsibility for the routine cleaning of the element (see 3.2)

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