NHS
National Patient Safety Agency

The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes

April 2007

Preface

These specifications update the *National standards of cleanliness* first published by NHS Estates in 2001 and revised in August 2003 and December 2004 (in *Revised Guidance on Contracting for Cleaning* as *The National Specifications for Cleanliness*). They provide a comparative framework within which hospitals and trusts in England can set out details for providing cleaning services and assessing 'technical' cleanliness.

The national specifications have been reviewed and revised to:

- ensure they take account of changes occurring since the date of the last review, specifically, but not restricted to *Towards Cleaner Hospitals and Lower Rates of Infection*, *A Matron's Charter*, The Healthcare Commission's *Standards for Better Health* and the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* (introduced under the Health Act 2006);
- incorporate the recommended *Minimum cleaning frequencies* (first published separately in December 2004 in *Revised Guidance on Contracting for Cleaning*);
- include a specimen strategic cleaning plan, an operational cleaning plan and a cleaning responsibility framework.

These specifications are not a cleaning manual: rather they provide an assurance framework to support compliance with the core cleanliness standard and the code of practice. For further information on providing cleaning services, see *The NHS healthcare cleaning manual*.

Neither do these specifications seek to provide advice on precisely how cleaning services should be provided, for example, by direct employment or contracting out. These matters are for local determination. Ultimately, local managers are accountable for the effectiveness of cleaning services, and these specifications provide clear advice and guidance on: what is required; how trusts can demonstrate the way(s) in which cleaning services will meet these requirements; and how to assess performance.

Throughout this document reference is made to hospital cleaning. It is, however, recognised that delivery of healthcare takes place in a variety of settings. This document applies chiefly to 'traditional' hospitals – whether in the acute, mental health or primary care trust communities – but the principles contained apply equally to other settings and expressions such as 'hospital' and 'hospital cleaning' should be interpreted accordingly.

The specifications should be applied regardless of the manner in which cleaning services are provided. Compliance with the specifications, and the monitoring and auditing processes should be written into contracts with cleaning service providers.

Cleaning service managers and providers should read this document thoroughly and ensure that all staff are aware of its contents. All those involved in the provision of hospital cleaning services should be working towards the common and shared goal of high quality cleaning services that meet the needs and expectations of patients, the public and other hospital staff.

Patient Environment Action Team assessments and *The national specifications for cleanliness*

From 2007, the results of Patient Environment Action Team (PEAT) assessments will be calculated against these specifications and the auditing process which accompanies them.

It is, therefore, vital that all hospitals follow the auditing process and provide their annual score through the Estates Returns and Information Collection (ERIC) process. NHS trusts are reminded that providing this score through ERIC is a mandatory return.

Contents

Foreword 4
Service delivery 9
Principles and objectives 11
Operational delivery 12
Auditing and monitoring information 16
Auditing 17
- Audit principles 19
- Frequency 19
- Personnel 19
- Methodology 20
- Sampling 20

Identifying risk categories 24
- Very high-risk functional areas 24
- High-risk functional areas 25
- Significant-risk functional areas 25
- Low-risk functional areas 26
- Action 26

Appendix 1 – Element standards 27
Appendix 2 – Sample cleaning audit score sheet 32
Appendix 3 – Template cleaning audit score sheet 34
Appendix 4 – External audit score sheet 35
Appendix 5 – Specimen cleaning frequencies 37
Appendix 6 – Specimen cleaning responsibility framework 41
Appendix 7 – Cleaning procedure guidance 47
Appendix 8 – Definition of terms 48
Appendix 9 – References and useful sources of information 49
Appendix 10 – Code of practice for the prevention and control of healthcare associated infections *[separate document]*
Appendix 11 – Specimen operational plan *[separate document]*
Appendix 12 – Specimen strategic cleaning plan *[separate document]*

Foreword

Providing a clean and safe environment for healthcare is a key priority for the NHS and is a core standard in *Standards for better health*. Other publications such as *Towards cleaner hospitals and lower rates of infection* and *A Matron's Charter: An Action Plan for Cleaner Hospitals* have further emphasised this, and also recognise the role cleaning has in ensuring that the risk to patients from healthcare associated infections is reduced to a minimum. *The code of practice to the hygiene bill* (for the prevention and control of healthcare associated infections) will place further onus and responsibility on NHS trusts to ensure that local provision of cleaning services is adequately resourced; clearly defined through a strategic cleaning plan, and clear cleaning schedules and frequencies; and arranged to ensure that patients, the public and staff know what they can expect. Further information relating to each of these publications is detailed below.

This key priority, coupled with increasing public concern about healthcare associated infections, means hospitals need to not only be clean but able to demonstrate how and to what standard they are kept clean.

The national specifications for cleanliness in the NHS were launched in April 2001 as *The national standards of cleanliness*. In December 2004, the word 'standards' was replaced with 'specifications' to avoid confusion with the Healthcare Commission's *Standards for better health*.

What is ultimately most important is that hospitals are clean, and that must remain the focus of hospital cleaning services. Whilst the ability to demonstrate the levels of cleanliness being achieved is important, this should not be at the expense of service delivery.

The specifications have been designed to provide a simple, easy-to-apply methodology within which hospitals in England can assess the effectiveness of their cleaning services. Since their first publication, NHS managers have welcomed the opportunity both to measure performance in a uniform way and benchmark performance against similar healthcare environments. The specifications are now in daily use in most healthcare establishments.

High levels of cleanliness can only be achieved through:

- clear specifications;
- the proper training of staff;
- documented lines of accountability;

- involving patients;
- all staff recognising their responsibilities;
- a meaningful framework for measurement;
- NHS trust management board support, the appointment of a board nominee to represent cleaning-related issues at board level and board ownership to embed cleanliness as part of the trust's strategy;
- modern matrons taking the lead;
- direct links between NHS trusts' directors of infection prevention and control, and local infection control teams and policies.

The involvement of the board nominee has a significant influence on combatting healthcare associated infections. More closely involving matrons and patients in the setting and monitoring of standards is crucial to delivering consistently high levels of service.

NHS trusts now have greater freedom to decide how to organise their resources and the use of these specifications is a matter on which local managers must take a view. However *Standards for better health* require healthcare premises to be cleaned to national specifications. Applying both the standards and the monitoring and auditing processes set out in this document can help NHS trusts demonstrate their compliance with the standard relating to cleanliness. Additionally, they help reduce the risks associated with poor cleanliness, demonstrate due diligence, and promote a more consistent and high quality output that patients and the public will notice and appreciate.

The changing environment for clean hospitals

Much has changed in hospital cleaning since the publication of the *NHS Plan,* which brought a renewed emphasis on this area of hospital activity and led directly to the introduction of these national specifications.

Through the establishment of clear standards, and monitoring and auditing procedures, hospital cleanliness has significantly improved since 2000. However, patients and the general public expect there to be continuous improvements.

This expectation is reflected in a number of publications and activities since these national specifications were last reviewed which impact on the provision of cleaning services.

Towards cleaner hospitals and lower rates of infection

Published by the Department of Health in July 2004, this report highlights the importance of cleanliness to patients and notes that: "A clean environment provides the right setting for good patient care practice and good infection control. It is important for efficient and effective healthcare."

A Matron's Charter: An Action Plan for Cleaner Hospitals

Building on the undertaking in *Towards cleaner hospitals and lower rates of infection* to give matrons and nurses at ward level the practical advice and power to ensure high standards are maintained, *A Matron's Charter: An Action Plan for Cleaner Hospitals* has 10 commitments:

1. Keeping the NHS clean is everybody's responsibility.
2. The patient environment will be well-maintained, clean and safe.
3. Matrons will establish a cleanliness culture across their units.
4. Cleaning staff will be recognised for the important work they do. Matrons will make sure cleaning staff feel part of the ward team.
5. Specific roles and responsibilities for cleaning will be clear.
6. Cleaning routines will be clear, agreed and well-publicised.
7. Patients will have a part to play in monitoring and reporting on standards of cleanliness.
8. All staff working in healthcare will receive education in infection control.
9. Nurses and infection control teams will be involved in drawing up cleaning contracts, and matrons have authority and power to withhold payment.
10. Sufficient resources will be dedicated to keeping hospitals clean.

Standards for better health

Introduced in 2006 to replace the star-ratings system, these are the standards against which all NHS trusts will need to report and, where appropriate, provide evidence to the Healthcare Commission to support their statements.

There are two standards which relate to cleanliness:

1 Standard C4 (a): "Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin Resistant Staphylococcus Aureus (MRSA)."

2 Standard C21: "Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well-designed and well-maintained with cleanliness levels in clinical and non-clinical areas that meet the national specifications for clean NHS premises."

Applying the standards and processes set out in this document will provide NHS trusts with valuable information which they may wish to provide to the Healthcare Commission in support of these standards.

Health Act 2006: The code of practice for the prevention and control of healthcare associated infections

The code of practice includes a duty to provide and maintain a clean and appropriate environment and specific provisions include the appointment of a lead manager for cleaning and publicly available cleaning arrangements. There is also a duty to provide all staff with training on infection prevention and control. A copy of the code of practice is in Appendix 10.

Saving Lives: a delivery programme to reduce healthcare associated infections including MRSA

Building on previous policy and guidance, *Saving Lives* set out nine challenges in the form of a self-assessment and planning tool, including:

Challenge 6 requires organisations to 'ensure that all employee's have a programme of education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take'. This made specific reference to induction and on-going training for all staff.

Challenge 8 requires organisations to 'review the status of the built environment and the effectiveness of facilities management services, including cleaning, in order to provide a safe and clean environment for patient care'.

Specific assurance was required for:

- compliance with legislation;
- compliance with specifications;
- assessment of quality;
- availability of cleaning when it was required.

Service delivery

These specifications were originally developed by a group of experienced cleaning services managers from both the NHS and private sector companies, along with members of the Infection Control Nurses Association. They drew on work already undertaken by the State of Victoria in Australia. The National Patient Safety Agency (NPSA) is grateful to both the Australian authorities and other organisations and individuals who have assisted in reviewing and revising the specifications to ensure they are based on current and accepted best practice.

NHS trusts need to be able to demonstrate that the hospitals under their authority are clean, and that risks to patient safety from inadequate or inappropriate cleaning have been minimised.

These specifications aim to provide a common understanding of what it means to be a clean healthcare setting. The aim is to improve the quality of health service by ensuring that all cleaning-related risks are identified and managed on a consistent, long-term basis, irrespective of where the responsibility for providing cleaning services lies.

These specifications focus on outcomes rather than the method by which they are achieved, since the responsibility for day-to-day arrangements rests entirely with individual NHS trusts. They can be used as:

- a basis for developing specifications for service level agreements;
- a standard against which services can be benchmarked;
- an aid to establishing the right staffing levels (see also Appendix 5 on cleaning frequencies);
- part of an ongoing performance management process;
- a framework for auditing;
- a benchmark in the drive to reduce healthcare associated infections;
- a useful support tool in improving patient and visitor satisfaction levels.

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Infection control

The chief executive of each NHS trust is responsible for ensuring that there are effective arrangements for infection control throughout the trust. A director of infection prevention and control has been appointed in every NHS trust to help their healthcare setting meet this requirement.

These specifications support local risk management plans by assessing the effectiveness of cleaning programmes. The director of infection prevention and control and the local infection control committee, infection control teams and nurses must be involved in their use and regularly appraised of the results of assessment, and monitoring and audit findings.

Crucial to the success of cleaning services is that the issues of personal responsibility and accountability are addressed. Key personnel should have reflected in their objectives the deliverable outcomes for cleanliness to ensure that it is incorporated into the trust's core business through performance frameworks and that they are held to account for their elements of it.

Principles and objectives

The delivery of a high quality cleaning service is complex, demanding and should not be underestimated. However, at all times it should be kept in mind that the single most important factor is the outcome of the service – how clean the hospital is.

Key attributes of service delivery are that it:

- is patient and customer-focused;
- provides clarity for all staff responsible for ensuring a hospital is clean and safe;
- enhances quality assurance systems;
- addresses governance and risk assessment;
- is consistent with infection control standards and requirements;
- meets the requirements of core standard C21;
- set clear outcome statements, which can be used as benchmarks and output indicators;
- has clear objectives that provide a foundation for service improvements;
- allows scope for precise arrangements to be determined locally in the light of circumstances and priorities;
- provides for a culture of continuous improvement.

Operational delivery

Strategic operational cleaning plans, schedules and frequencies, and cleaning responsibility frameworks

Setting out clear local policies and arrangements as detailed above is best achieved through the production of a board-approved strategic cleaning plan and the development of an operational cleaning plan. These will also help NHS trusts meet the Healthcare Commission's requirements in terms of documentary evidence around the provision of cleaning services, and the legislative requirements of *The code of practice for the prevention and control of healthcare associated infections*.

There is no national standard for a strategic or operational cleaning plan, and it is for each NHS trust to produce their own. However, there is an example of each in Appendices 11 and 12 that can act as guides.

In order to ensure timely and effective action, local standards and policies should clearly set out the range and scope of work to be undertaken. These should stipulate:

- the standards to be achieved;
- clear and measurable outcomes sought;
- clear allocation of responsibility for cleaning all areas of, and items within, the hospital;
- the cleaning lead manager;
- cleaning schedules and frequencies;
- the systems to be used to measure outcomes;
- the reports required and the managers who should receive them;
- operational and training policies and procedures, including how the NHS trust will ensure all staff receive appropriate training prior to being allocated to specific cleaning tasks;
- the risk assessment protocols;
- the service level agreements for each functional area;
- how cleaning services operations and controls dovetail with arrangements for infection control, including training for all cleaning service staff in infection control policies and procedures;
- how cleaning training for nursing staff (and others as appropriate) will be delivered.

These are important since unclear or inadequately identified local cleaning standards and policies could result in:

- risk to the health and safety of patients, visitors and staff through poor or poorly applied cleaning protocols and processes;
- poor public image;
- lack of public confidence;
- clinical governance issues;
- poor value for money;
- poor infection prevention and control;
- litigation.

Recommended minimum cleaning frequencies

Revised Guidance on Contracting for Cleaning published the first set of recommended minimum cleaning frequencies to ensure a minimum standard of cleanliness.

Discussions with NHS cleaning service providers suggests that, whilst it is important that NHS trusts locally produce a cleaning frequency schedule, a single national version is inappropriate since it cannot meet every NHS organisation's needs. It would also stifle trusts' ability to allocate cleaning resources where they are most needed. It would also frustrate the requirement to give more control to matrons and senior nurses in terms of deciding where available cleaning resources are best deployed. It is also the case that few, if any, NHS trusts have applied these exactly, rather their use has been concerned with identifying the precise cleaning resource needed to keep hospitals clean.

Nonetheless, it is important that NHS trusts have locally determined frequencies to meet the requirements of the code of practice and to identify the resources needed to keep the hospital clean, and therefore demonstrate to the Healthcare Commission that sufficient resources are being allocated. The precise allocation of resources, and the actual frequency of cleaning, varies according to locally determined need.

The existing minimum recommended frequencies are therefore reproduced in Appendix 5 to help NHS trusts produce their own frequencies specific to their own needs.

Cleaning responsibility framework

Hospitals have varying shapes, sizes and ranges of equipment, both clinical and non-clinical, which require cleaning. Responsibility for cleaning can also vary and will include, at least, domestic cleaning services providers, nursing and other ward staff (including housekeepers) and estates staff. There are also items, such as windows and carpets, that require less frequent cleaning and may be cleaned by contractors.

Ensuring all items which require cleaning are cleaned is a significant but important task. Experience suggests that the opportunities for items such as ward-based equipment to 'fall through the gaps' is considerable.

The specification in Appendix 1 includes a range of 49 elements listed under broad headings which, taken together, will cover the entirety of items and areas to be cleaned. However, within these broad headings, there are a much greater range of specific items for which a national list could not be produced with any reliable degree of accuracy.

It is recommended that NHS trusts produce a schedule of cleaning responsibility, specifically for each hospital, and list either:

- all items to be cleaned; or
- all items not covered by domestic cleaning services.

The schedule should identify who is responsible for cleaning each item. NHS trusts may also find it helpful to include a locally agreed cleaning frequency schedule within this document.

Appendix 6 has a specimen cleaning responsibility framework with suggested cleaning frequencies.

Management of staff

All levels of the cleaning team should be clear about their roles and responsibilities. Each member of staff should have:

- a clear understanding of their specialised responsibility, in a form of a work schedule;
- detailed and appropriate training and continued refresher training with the opportunity to gain qualifications;
- a clear career ladder available should they wish;
- an appraisal in line with agenda for change and their Knowledge and Skills Framework;
- the attendance management policy freely available and applied appropriately.

Cleaning equipment

The cleaning equipment that is regularly used should be fit for purpose, easy-to-use and well-maintained. It is imperative that each trust regularly reviews it's cleaning equipment to ensure that it is fit for purpose and, importantly, can demonstrate that it has clear infection control benefits.

The NPSA issued a safer practice notice that set out a National Colour Coding System. Each trust must make sure that it's equipment conforms to this notice.

IT

In the modern, changing healthcare environment, patient-centred service that needs to be flexible is highly difficult to achieve. Some trusts have found the need to modernise their administrative system by using appropriate IT software packages. There are many available and they must be able to:

- adjust cleaning specification according to need;
- produce service level agreements and work schedules;
- allocate and manage staff against the agreed specifications;
- data compute audit information and produce results;
- analyse service performance and trends.

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Auditing and monitoring information

This section explains how to establish the cleanliness of equipment, fixtures and fittings, and buildings so that a whole hospital score can be calculated by collecting area-specific scores. Results can be established for the same equipment across a whole hospital site, parts of buildings, all wards or departments, or groupings of wards. This allows any variations in quality across similar areas to be identified, and the causes of any unclean areas to be addressed.

The specification operates according to risk categories through which each cleanable area of the hospital (known as functional areas, and covering both clinical and non-clinical) is allocated a risk factor on a scale from very high to low. This is a crucial first step in applying the specifications since the level of monitoring and audit is directly linked to the identified risk factor. The specifications include advice on which areas might be allocated within each functional area, but ultimately this is a decision to be made locally in consultation with the NHS trust's director of infection prevention and control, and the local infection control committee.

Quality standards are set out according to the 49 elements (equipment, fixtures, fittings and buildings (or part thereof)) which, taken together, comprise the broad range of items commonly found in hospitals. However, as noted earlier, it is not possible to list every item which may be present in a hospital. NHS trusts should ensure that all items in their hospital are included through, for example, a cleaning responsibility framework (see Appendix 6).

The appendices provide a range of information relating to the elements, sample scoring sheets, cleaning frequencies and other useful information.

To accompany these specifications, an Excel spreadsheet with frameworks for gathering, reviewing and reporting audit information is available from: **www.npsa.nhs.uk/health/currentprojects/cleaningandnutrition**

Timeframe for rectifying problems

The table overleaf can be used to measure the importance of cleaning each element in any particular functional area. For example, a toilet in an operating theatre and a toilet in a waiting room should be equally clean. However, the floor of a plant room requires less attention than the floor in an ITU/ICU.

Elements in every room should be assigned one of the three levels of priority described overleaf.

Priority	Timeframe for rectifying problems
A - Constant Cleaning critical (very high-risk and high-risk functional areas).	Immediately or as soon as is practically possible. Cleaning should be recognised as a team responsibility. If domestic or cleaning staff are not on duty, cleaning should be the responsibility of other ward or department personnel. These responsibilities should be clearly set out and understood.
B - Frequent Cleaning important and requires maintaining (significant risk functional areas).	0–3 hours for patient areas (to be rectified by daily scheduled cleaning service for non-patient areas).
C - Regular On a less frequent scheduled basis, and as required in-between cleans (low-risk functional areas).	0–48 hours.

Auditing

The audit process should encourage quality improvements and should not be punitive. Two levels of audit should be employed:

- technical;
- managerial.

The precise arrangements for undertaking technical and managerial audits may vary according to local arrangements (for example where a contracted cleaning services provider undertakes the technical audits with trust hotel services departments (or similar) undertaking managerial style audits). Such arrangements are acceptable provided they deliver the same or a broadly similar level of audit to that set out above.

NHS trusts may wish to consider a third, external level of audit and reach an agreement with another local NHS trust to provide this on a reciprocal basis. Alternatively, they could consider asking their local patient and public involvement or other patient group to carry out an independent audit.

There are no national targets within these specifications, however, good practice would suggest that individual hospitals/trusts set their own aims. These should be realistic, achievable, challenging and regularly reviewed to ensure they contribute to an ethos of continuing improvement.

To assist trusts in determining their own targets, the following are provided as indicative aims for each of the four 'risk categories':

Very high	98 per cent
High	95 per cent
Significant	85 per cent
Low	75 per cent

Once hospitals have determined their target scores by risk category, an overall target score can be calculated by determining the per cent of the hospital which falls into each risk category and applying the following formula:

$$\frac{\mathbf{98x10 + 95x70 + 85x10 + 75x10}}{\mathbf{100}} \quad \mathbf{= 92.30\ per\ cent}$$

An overall trust target rate can be calculated by applying the aggregation process described on page 21 using bed numbers to ensure the varying size of hospital is accurately reflected.

Technical audits

These are regular audits by appropriately qualified staff which form a continuous and inseparable part of the day-to-day management and supervision of cleaning services.

Technical audits should be conducted as a joint exercise between the staff responsible for cleanliness, infection control teams and matrons as well as service users.

Managerial audits

These ad hoc audits should verify cleaning outcomes of technical audits and identify areas for improvement. The audit team should consist of senior NHS trust management, and nurses and modern matrons with responsibility for cleaning and infection control. In addition there should be a board representative, preferably the person with board-level responsibility for cleaning services, and a patient or service user representative.

Managerial audits should be conducted as a joint exercise between the staff responsible for cleanliness and service users.

External audits

External audits are not an intrinsic part of the auditing process but are recommended as good practice since they provide an

independent view of cleanliness and validate the NHS trust's own internally awarded scores.

Collaborating with neighbouring facilities or NHS trusts is often the easiest way to get appropriately qualified staff or managers to take part in an external audit process. It also minimises travel costs and expenses.

However, there can also be value in reciprocal arrangements between facilities and NHS trusts where managers do not know each other and some distance separates them. Such situations may provide more opportunities to share best practice.

Audit principles

Issues to be considered when designing and implementing an audit process include:

- frequency;
- personnel;
- methodology;
- sampling;
- scoring;
- action.

Frequency

In healthcare premises where standards are deemed acceptable, the following frequencies of audit are recommended:

- **technical** – in accordance with the relevant risk category;
- **managerial** – quarterly (usually best undertaken as a rolling programme so that all aspects are reviewed in a 12 month period);
- **external** – annually (often undertaken on a reciprocal basis with a neighbouring NHS trust), taking more than one day to complete.

External audit frequencies should be increased where these scores differ noticeably from scores derived from audits undertaken by the NHS trust.

Personnel

Audits (particularly technical audits) should not be the sole responsibility of the cleaning services department. The task should be shared amongst all of the relevant stakeholders in the healthcare facility.

Managers and staff involved with audits should:

- have a detailed knowledge of healthcare establishments and procedures;

- be professionally competent to judge what is 'acceptable' in terms of cleanliness and infection prevention and control;
- be able to make discriminating judgements on risk in relation to the areas being cleaned;
- be able to make informed judgements on the extent to which existing cleaning frequencies may be insufficient.

Patients and patient representatives would not be expected to have a detailed knowledge of the healthcare establishment or its procedures.

Methodology

Audits should involve three interrelated levels of score:

- room score;
- functional area score;
- overall score.

The following methodology is recommended in establishing scores for these levels:

- auditors assign a score to each individual room in the functional area (the room score);
- the room scores in any functional area are averaged to establish the score for the functional area itself (the functional area score);
- the scores of all the functional areas are averaged to give the overall score.

There are a number of commercially-available computer packages that can aid the monitoring and auditing process and NHS trusts may wish to explore these and their applicability.

Sampling

Technical audits

Technical audits should be ongoing. The regularity of reviews of functional areas and rooms should be undertaken in accordance with the relevant risk category. Each quarter, the functional area scores should be collated and averaged to form the quarterly summary score.

This may require some room and/or functional area scores to be brought forward if they are not scheduled for audit in the corresponding review period.

The healthcare facility's overall score is the most recent quarterly summary score.

Calculating NHS trust scores

Where an overall NHS trust score is required, or there is a need to group facilities within an NHS trust, an aggregated score can be used to form the overall score for cleanliness. However, account must be taken of the relative size of each of the healthcare facilities being aggregated.

Example

Within an NHS trust, Facility A has 200 beds and a score of 86 per cent, Facility B has 1000 beds and a score of 42 per cent. The overall score must be calculated by weighting the individual scores by the bed numbers:

$$\frac{\textbf{(86 per cent x 200) + (42 per cent x 1,000)}}{\textbf{1.200}} \quad \textbf{= 49 per cent}$$

Managerial audits

The managerial audit review team should validate a sample of audit information arising from the technical audits on a quarterly basis.

For example, each quarter, the managerial audit team may decide to review each quarter:

- some elements across all functional areas;
- some room types; or
- one or more functional areas.

The decision should be based on:

- the standards already being achieved;
- where local NHS trust managers feel emphasis should be placed;
- randomly chosen elements, rooms or functional areas.

The frequency of reviews, what to sample and the sample size should be appropriate to the risk category. For example, high-risk areas should be audited more frequently and comprehensively than low-risk areas.

Where there are particular problems, the sample size should be increased to better inform the audit process.

External audits

Where employed, external audits should be undertaken at least once a year to:

- validate the results generated by the host facility or NHS trust;
- provide peer review and opportunities for the sharing of best practice.

The external audit review team should be looking to see if the most recent quarterly summary score provided by the NHS trust matches with the general standards seen on the day of the external review.

Where the score provided by the facility differs to that provided by the external audit team, assessment feedback should be provided to NHS trust managers.

External auditors should be given the opportunity to determine what they wish to review, and the extent to which it should be reviewed. To be effective, external auditors will need to access the outcomes from the past four quarterly summary score calculations and outcome information from the technical audits.

A sample format for an external audit is given in Appendix 4.

Scoring

The auditor must decide the cleanliness of each element in a room using the element standard criteria, acceptable (score 1) or unacceptable (score 0).

Elements are categorised under eight headings and comprise 49 element standards (as set out in Appendix 1).

Each room must first be reviewed for those elements not present and these should be discounted on the audit score sheet as not applicable.

An example of a completed audit score sheet for use in scoring rooms in functional areas is set out in Appendix 2. Appendix 3 is a blank format.

An audit score sheet and 13-week format for monitoring functional areas over a quarter period are available from **www.npsa.nhs.uk/health/currentprojects/cleaningandnutrition**

The score sheet provides the opportunity to assign general responsibility for elements within a functional area to cleaning, nursing or estates services. This is achieved by entering C (cleaning), N (nursing) or E (estates) in the line marked responsibility.

The electronic version of the score sheet will calculate the percentage score achieved for each of the departments in addition to the functional area overall percentage score.

The score sheet allows for calculations to be made horizontally (outcome per room) and vertically (outcome per element) along with the totals referred to above.

Thereafter, each element should be scored in accordance with the principles set out in the section headed 'Methodology'

Where an element is assigned a score of 0 (unacceptable) then the reason for failure and an appropriate time for remedial action to be taken (see page 17) should be entered in the record. This record sheet forms the second page of the cleaning audit score sheet (see Appendix 4).

Once all elements in the room have been scored, the total number of acceptable scores should be expressed as a percentage of the total possible number of 'acceptable' scores in that room. For example, if the sanitary area had a maximum of 12 elements, and 10 were acceptable, the overall percentage would be calculated as 10/12 or 83 per cent.

The functional area score is calculated by taking an average of the individual room scores as follows:

Ward 12

Bay A	70%
Bay D	80%
Sanitary area 2	90%
Ward office	100%
Side room 6	90%

$$\frac{70 + 80 + 90 + 100 + 90}{5} = 86 \text{ per cent}$$

Overall functional area score is 86 per cent.

Auditors need to exercise discretion in judging the acceptability of any element. For example, one or two scuff marks on a floor or an isolated smudge on a window should not indicate that the element should necessarily be scored as unacceptable.

Identifying risk categories

All healthcare environments should pose minimal risk to patients, staff and visitors. However, different functional areas represent different degrees of risk and, therefore, require different cleaning frequencies and different levels of monitoring and auditing. Consequently, all functional areas should be assigned one of four risk categories: very high, high, significant and low. These categories are explained below.

Risk categories are used to set SLAs and outcome auditing levels. To ensure that auditing processes are continuous and equal they should take place within the timeframes outlined below.

Informal monitoring should take place in areas where standards are considered poor or where routine monitoring reveals consistent weaknesses.

Very high-risk functional areas

Required service level

Consistently high cleaning standards must be maintained. Required outcomes will only be achieved through intensive and frequent cleaning.

Both informal monitoring and formal auditing of standards should take place continuously. Areas and rooms allocated a very high-risk category should be audited at least once a week until the lead cleaning manager and infection control team are satisfied that consistently high standards are being achieved, after which the audit frequency may be reduced to no less than monthly.

Functional areas

Very high-risk functional areas may include operating theatres, ICUs, SCBUs, accident and emergency (A&E) departments, and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care.

Additional internal areas

Bathrooms, toilets, staff lounges, offices and other areas adjoining very high-risk functional areas should be treated as having the same risk category, and receive the same intensive levels of cleaning.

High-risk functional areas

Required service level

Outcomes should be maintained by regular and frequent cleaning with 'spot cleaning' in-between.

Both informal monitoring and formal auditing of standards should take place continuously. Rooms in a high-risk functional area should be audited at least once a month until the lead cleaning manager and infection control team are satisfied that consistently high standards are being achieved, after which the audit frequency may be reduced to no less than twice-monthly.

Functional areas

High-risk functional areas may include general wards (acute, non-acute and mental health), sterile supplies, public thoroughfares and public toilets.

Additional internal areas

Bathrooms, toilets, staff lounges, offices and other areas adjoining high-risk functional areas should be treated as having the same risk category and receive the same regular levels of cleaning.

Significant-risk functional areas

Required service level

In these areas, high standards are required for both hygiene and aesthetic reasons. Outcomes should be maintained by regular and frequent cleaning with 'spot cleaning' in-between.

Both informal monitoring and formal auditing of standards should take place continuously. Rooms in a significant-risk functional area should be audited at least once every three months.

Functional areas

Significant-risk functional areas may include pathology, outpatient departments, laboratories and mortuaries.

Additional internal areas

Bathrooms, toilets, staff lounges, offices and any other areas adjoining significant-risk functional areas should be treated as having the same risk category and receive the same regular levels of cleaning.

Low-risk functional areas

Required service level

In these areas, high standards are required for aesthetic and, to a lesser extent, hygiene reasons. Outcomes should be maintained by regular and frequent cleaning with 'spot cleaning' in-between.

Both informal monitoring and formal auditing of standards should take place continuously. Rooms within a low-risk functional area should be audited at least twice a year.

Functional areas

Low-risk functional areas may include administrative areas, non-sterile supply areas, record storage and archives.

Additional internal areas

Bathrooms, staff lounges, offices and other areas adjoining low-risk functional areas should be treated as having the same risk category and receive the same level of cleaning.

The auditor should also take into account the physical condition of the infrastructure when making the assessment. For example, it may not be possible to obtain a uniform lustre on a damaged floor surface.

However, poorly-maintained buildings are no excuse for low cleaning standards and auditors should not be overly generous with their discretion in most of these situations.

Action

Regular audits should form part of the cleaning services quality assurance programme. Issues raised should be followed up according to their magnitude and location. Lead times should be identified for remedial action. For example, a problem in an operating theatre will need to be resolved immediately, while one in a stationery storeroom may require checking in a week or during the next scheduled audit.

Appendix 1 – Element standards

See Appendix 8 for definitions.

Cleaning standards guarantee

Environment

Patient equipment

Direct contact

Element	Standard
1. Commodes	All parts including underneath should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
2. Bathroom hoists	As above
3. Weighing scales, manual handling equipment	As above
4. Drip stands	As above
5. Other medical equipment NOT connected to a patient, e.g. intravenous infusion pumps and pulse oximeters	All parts including underneath should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
6. Medical equipment connected to a patient, e.g. intravenous infusion pumps drip stand and pulse oximeters	All parts including underneath should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
7. Patient washbowls	All parts including underneath should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. Patient washbowls should be decontaminated appropriately between patients and should be stored clean, dry and inverted. Badly scratched bowls should be replaced.
8. Medical gas equipment	All parts including underneath should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
9. Patient fans	All parts including the blades/fins and the underside should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.

Close contact

Element	Standard
10. Bedside alcohol hand wash container, clipboards and notice boards	All parts including holder of the bedside alcohol hand wash container should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. Hand wash dispenser should be free of product build-up around the nozzle. Splashes on the wall, floor, bed or furniture should not be present.
11. Notes and drugs trolley	All parts including underneath and inside of the notes trolley should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
12. Patient personal items e.g. cards and suitcase	All parts of the patient's items should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. Loose items such as clothing should be stored away either in the locker or bag.
13. Linen trolley	All parts including underneath of the linen trolley should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.

Fixed assets

Element	Standard
14. Switches, sockets and data points	All wall fixtures e.g. switches, sockets and data points should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
15. Walls	All wall surfaces including skirting should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
16. Ceiling	All ceiling surfaces should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
17. All doors	All parts of the door structure should be visibly clean so that all door surfaces, vents, frames and jambs have no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
18. All internal glazing including partitions	All internal glazed surfaces should be visibly clean and smear-free with no blood and body substances, dust, dirt, debris, adhesive tape or spillages. They should have a uniform shine appearance.
19. All external glazing	All external glazed surfaces should be clean.
20. Mirrors	Mirrors should be visibly clean and smear-free with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
21. Bedside patient TV including earpiece for bedside entertainment system	All part of the bedside patient TV should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or stains.
22. Radiators	All part of the radiator (including between panels) should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
23. Ventilation grilles extract and inlets	The external part of the ventilation grille should be visibly clean with no blood and body substances, dust, dirt, debris or cobwebs.

Hard floors

Element	Standard
24. Floor – polished	The complete floor including all edges, corners and main floor spaces should have a uniform shine and be visibly clean with no blood and body substances, dust, dirt, debris, spillages or scuff marks.
25. Floor – non-slip	The complete floor including all edges, corners and main floor space should have a uniform finish or shine and be visibly clean with no blood and body substances, dust, dirt, debris or spillages.

Soft floors

Element	Standard
26. Soft floor	The complete floor including all edges and corners should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. Floors should have a uniform appearance and an even colour with no stains or watermarks.

Fixtures

Electrical fixtures and appliances

Element	Standard
27. Pest control devices	The pest control device should be free from dead insects, animals or birds and be visibly clean.
28. Electrical items	The casing of electrical items should visibly clean with no blood and body substances, dust, dirt, debris or adhesive tape.
29. Cleaning equipment	Cleaning equipment should be visibly clean with no blood and body substances, dust, dirt, debris or moisture.

Furnishings and fixtures

Element	Standard
30. Low surfaces	All surfaces should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
31. High surfaces	All surfaces should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
32. Chairs	All parts of the furniture should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape, stains or spillages.
33. Beds	All parts of the bed (including mattress, bed frame, wheels and castors) should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
34. Lockers	All parts of the locker (including wheels, castors and inside) should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape, stains or spillages.
35. Tables	All parts of the table (including wheels, castors and underneath) should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape, stains or spillages.
36. Hand wash containers	All part of the surfaces of hand soap, paper towel containers should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
37. Hand hygiene alcohol rub dispensers	All part of the surfaces of hand hygiene alcohol rub dispensers should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages. Dispensers should be kept stocked.
38. Waste receptacles	The waste receptacle should be visibly clean including lid and pedal with no blood and body substances, dust, dirt, debris, stains or spillages. Receptacles should be emptied frequently and not allowed to overflow.
39. Curtains and blinds	Curtains/blinds should be visibly clean with no blood and body substances, dust, dirt, debris, stains or spillages.

Kitchen fixtures and appliances

Element	Standard
40. Dishwashers	Dishwashers should be visibly clean with no blood and body substances, dust, dirt, debris, stains, spillages or food debris.
41. Fridges and freezers	Fridges and freezers should be visibly clean with no blood and body substances, dust, dirt, debris, spillages, food debris or build up of ice.
42. Ice machines and hot water boilers	Ice machines and hot water boilers should be visibly clean with no blood and body substances, dust, dirt, debris or spillages.
43. Kitchen cupboards	Kitchen cupboards should be visibly clean with no blood and body substances, dust, dirt, debris, stains, spillages or food debris.
44. Microwaves	All microwave surfaces should be visibly clean with no blood and body substances, dust, dirt, debris, spillages or food debris.

Toilets, sinks, wash hand basins and bathroom fixtures

Element	Standard
45. Showers	The shower, wall-attached shower chairs should be visibly clean with no blood and body substances, scum, dust, lime scale, stains, deposit or smears.
46. Toilets and bidets	The toilet and bidet should be visibly clean with no blood and body substances, scum, dust, lime scale, stains, deposit or smears.
47. Replenishment	There should be plenty of all consumables and soap.
48. Sinks	The sink and wall-attached dispensers should be visibly clean with no blood and body substances, dust, dirt, debris, lime scale, stains or spillages. Plugholes and overflow should be free from build-up.
49. Baths	The bath should be visibly clean with no blood and body substances, dust, dirt, debris, lime scale, stains or spillages. Plugholes and overflow should be free from build-up.

Appendix 2 – Sample cleaning audit score sheet

CLEANING AUDIT SCORE SHEET | **Functional area:** | **Auditors:** | **Audit date:**

Responsibility

Room name	1. Commodes	2. Bathroom hoists	3. Weighing scales, manual handling equipment	4. Drip stands	5. Other medical equipment e.g. intravenous infusion pumps, pulse oximeters, etc. NOT CONNECTED TO PATIENT	6. Medical equipment e.g. intravenous infusion pumps drip stand, pulse oximeters, etc. CONNECTED TO PATIENT	7. Patient washbowls	8. Medical gas equipment	9. Patient fans	10. Bedside alcohol hand wash container, clipboards & notice boards	11. Notes & drugs trolley	12. Patient personal items e.g. cards, suitcase	13. Linen trolley	14. Switches, sockets & data points	15. Walls	16. Ceiling	17. All doors
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Achievable score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Room name	18. All internal glazing including partitions	19. All external glazing	20. Mirrors	21. Bedside patient TV including ear piece for bedside entertainment system	22. Radiators	23. Ventilation grilles extract and inlets	24. Floor – polished	25. Floor – non slip	26. Floor – soft floor	27. Pest control devices	28. Electrical items	29. Cleaning equipment	30. Low surfaces	31. High surfaces	32. Chairs	33. Beds
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Achievable score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Room name	34. Lockers	35. Tables	36. Hand wash containers	37. Hand hygiene/alcohol rub dispensers	38. Waste receptacles	39. Curtains & blinds	40. Dishwashers	41. Fridges & freezers	42. Ice machines and hot water boilers	43. Kitchen cupboards	44. Microwaves	45. Showers	46. Toilets & bidets	47. Replenishment	48. Sinks	49. Baths	**Actual score**	**Percentage attained**
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Achievable score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

Percentage score achieved				Functinal area
Cleaning service ########	**Nursing** ########	**Estates** ########		**Overall percentage score** #DIV/0!

CLEANING AUDIT SCORE SHEET **Functional area:** Area 1 **Auditors:** AN Other **Audit date:** 01:12:04

Responsibility:

Room name	1. Commodes	2. Bathroom hoists	3. Weighing scales, manual handling equipment	4. Drip stands	5. Other medical equipment e.g. intravenous infusion pumps, pulse oximeters, etc. NOT CONNECTED TO PATIENT	6. Medical equipment e.g. intravenous infusion pumps drip stand, pulse oximeters, etc. CONNECTED TO PATIENT	7. Patient washbowls	8. Medical gas equipment	9. Patient fans	10. Bedside alcohol hand wash container, clipboards & notice boards	11. Notes & drugs trolley	12. Patient personal items e.g. cards, suitcase
Room 1	1	1	1	1	1	1	1	1	1	1	1	1
Room 2	1	1	1	1	1	1	1	1	1	1	1	1
Room 3	1	0	1	0	1	1	1	1	1	1	1	1
Room 4	1	1	1	1	1	1	1	1	1	1	1	1
Room 5	1	0	1	0	1	1	1	1	1	1	1	1
Room 6	1	0	1	1	1	1	1	1	1	1	1	1
Room 7	1	0	0	0	1	1	1	1	1	1	1	1
Room 8	1	0	0	1	0	1	1	1	1	1	1	1
Room 9	1	0	x	x	1	1	1	1	1	1	1	1
Room 10	1	1	1	1	1	1	1	1	1	1	1	1
Achievable score	9	10	9	9	10	10	10	10	10	10	10	10
Total score	9	4	7	6	9	10	10	10	10	10	10	10

Room name	13. Linen trolley	14. Switches, sockets & data points	15. Walls	16. Ceiling	17. All doors	18. All internal glazing including partitions	19. All external glazing	20. Mirrors	21. Bedside patient TV including ear piece for bedside entertainment system	22. Radiators	23. Ventilation grilles extract and inlets	24. Floor – polished
Room 1	1	1	1	1	1	1	1	1	1	1	1	1
Room 2	1	1	1	1	1	1	1	1	1	1	1	1
Room 3	1	1	1	1	1	1	1	1	1	1	1	1
Room 4	1	1	1	x	1	0	1	0	1	1	1	1
Room 5	1	1	1	x	x	1	x	1	1	1	1	1
Room 6	1	1	x	1	x	1	1	1	1	1	x	1
Room 7	1	1	1	1	1	1	1	1	1	x	1	1
Room 8	1	1	0	0	0	0	0	0	0	0	0	0
Room 9	1	1	1	1	x	1	1	1	1	1	1	1
Room 10	1	1	1	1	1	1	1	1	1	1	1	1
Achievable score	10	10	9	8	7	10	9	10	10	9	9	10
Total score	10	10	8	7	6	8	8	8	9	8	8	9

Room name	25. Floor – non slip	26. Floor – soft floor	27. Pest control devices	28. Electrical items	29. Cleaning equipment	30. Low surfaces	31. High surfaces	32. Chairs	33. Beds	34. Lockers	35. Tables	36. Hand wash containers
Room 1	1	1	1	1	1	1	1	0	1	1	1	1
Room 2	1	1	1	1	1	1	1	1	1	1	1	1
Room 3	1	1	1	1	1	1	1	1	1	1	1	0
Room 4	1	1	1	1	1	0	1	1	1	1	1	0
Room 5	0	0	1	1	1	x	1	1	0	1	x	1
Room 6	1	1	1	x	0	1	1	1	1	1	1	1
Room 7	1	1	1	1	1	1	1	1	1	1	1	1
Room 8	0	0	0	0	0	x	0	1	1	0	0	1
Room 9	1	1	1	1	1	1	0	1	1	1	1	1
Room 10	1	1	1	1	1	1	1	1	1	1	1	1
Achievable score	10	10	10	9	10	8	10	10	10	10	9	10
Total score	8	8	9	8	8	7	8	9	9	9	8	8

Room name	37. Hand hygiene/alcohol rub dispensers	38. Waste receptacles	39. Curtains & blinds	40. Dishwashers	41. Fridges & freezers	42. Ice machines and hot water boilers	43. Kitchen cupboards	44. Microwaves	45. Showers	46. Toilets & bidets	47. Replenishment	48. Sinks	49. Baths	Actual score	Percentage attained
Room 1	1	1	1	1	1	1	1	1	1	1	1	0	1	47	96
Room 2	1	1	1	1	1	1	1	1	0	0	0	1	0	45	92
Room 3	0	0	0	0	0	0	0	0	0	0	0	1	0	34	69
Room 4	1	1	1	1	1	x	x	x	x	x	0	1	0	37	86
Room 5	1	1	0	1	1	1	1	1	1	x	0	1	0	35	81
Room 6	1	1	1	0	1	1	1	1	x	x	0	1	0	38	88
Room 7	0	1	0	1	1	1	1	1	1	1	0	1	0	41	85
Room 8	1	1	1	1	1	1	1	1	1	1	0	1	0	25	52
Room 9	1	x	1	0	1	1	1	1	1	1	0	1	0	39	89
Room 10	1	1	1	1	1	1	1	1	1	1	0	1	0	47	96
Achievable score	10	9	10	10	10	9	9	9	8	7	10	10	10	465	
Total score	8	8	7	7	9	8	8	8	6	5	1	9	1	388	

Percentage score achieved

Cleaning service ######## Nursing ######## Estates ########

Functional area

Overall percentage score #DIV/0!

Appendix 3 – Template cleaning audit score sheet

NATIONAL CLEANING STANDARDS – COMMENTS RECORD

Functional area :

Audited by:

Date:

Room specific:

Problem:

To nursing/estates:

To other action:

Required:

Action:

Taken:

Appendix 4 – External audit score sheet

This form may be used by the external audit team to structure their review/report.

In order to validate an overall score of a facility, one score sheet should be completed. When reviewing an overall score for a multi-site trust, one score sheet should be completed for the trust as a whole. However, this score sheet should demonstrate how representative the audit has been at all of the facilities concerned.

A copy of the completed form(s) should be left with the facility/trust under review by the team leader

Name of trust:

Name(s) of facilities in the trust covered by this review:

Lead trust director:

External audit team – names, role, positions and employing trust:

Date of audit:

Name of lead external auditor:

External audit scores

Insert scores arising from the review of functional areas chosen at random for inclusion in the sample.

Functional area name:

Risk category percentage:

Attained:

Quarterly percentage scores provided by the trust

Most recent quarterly summary score – (quarter ending) per cent.

Comments by the external audit team, to be completed if required

On the basis of the functional areas reviewed in this external audit and the information provided by the trust, we do (or do not) agree with the either:

1. The most recent quarter score

and/or

2. The trust's overall score

We feel that ____ per cent reflects the standards currently being achieved.

To be completed by lead auditor

Name:

Auditor:

Date:

Appendix 5 – Specimen cleaning frequencies

Element	Minimum cleaning frequency			
	Very high-risk	**High-risk**	**Significant-risk**	**Low-risk**
1.Commodes, weighing scales, manual handling equipment	Clean contact points after each use	Clean contact points after each use	Clean contact points after each use	N/A
	One full clean daily	One full clean daily	One full clean daily	
2. Bathroom hoists	Clean contact points after each use	Clean contact points after each use	Clean contact points after each use	
3. Weighing scales, manual handling equipment	Clean contact points after each use	Clean contact points after each use	Clean contact points after each use	N/A
4. Drip stands	Clean contact points after each use	Clean contact points after each use	Clean contact points after each use	N/A
5. Other medical equipment e.g. intravenous infusion pumps, pulse oximeters, etc. NOT CONNECTED TO PATIENT	One full clean daily and between patient use	One full clean daily and between patient use	One full clean daily and between patient use	N/A
6. Medical equipment e.g. intravenous infusion pumps drip stand, pulse oximeters, etc. CONNECTED TO PATIENT	One full clean daily and between patient use	One full clean daily and between patient use	One full clean daily and between patient use	
7. Patient washbowls	One full clean daily and between patient use	One full clean daily and between patient use	One full clean daily and between patient use	
8. Medical gas equipment	One full clean daily	One full clean daily	One full clean daily	
9. Patient fans	One full clean daily and between patient use	One full clean daily and between patient use	Case daily	
	One full clean weekly	One full clean monthly	One full clean quarterly	
10. Bedside alcohol hand wash container, clipboards & notice boards.	Case daily and between patient use	One full clean daily and between patient use	One full clean daily and between patient use	
11. Notes & drugs trolley	One full clean weekly	One full clean weekly	One full clean weekly	
12. Patient personal items e.g. cards, suitcase	One full clean daily	One full clean daily	One full clean daily	N/A
13. Linen trolley	Contact points daily	Contact point clean daily	Contact points daily	
	One full clean weekly	One full clean weekly	One full clean weekly	
14. Switches, sockets & data points	One full clean daily	One full clean daily	One full clean weekly	
15. Walls	Check Clean daily	One check clean daily	Check clean weekly	Check clean weekly
	Dust weekly	One full clean weekly (dust only)	Dust monthly	
	Washing yearly	One full washing yearly	Washing yearly	Washing once every three years

Element	Minimum cleaning frequency			
	Very high-risk	**High-risk**	**Significant-risk**	**Low-risk**
16. Ceiling	Dust monthly	One full clean monthly (dust only)	Dust monthly	One check dust monthly
	Washing yearly	One full washing yearly	Washing yearly	Washing three-yearly
17. All doors	One full clean daily	One full clean daily	One full clean daily	One full clean weekly
18. All internal glazing including partitions	One full clean daily	One check clean daily	One check clean daily	One full clean weekly
		One full clean weekly	One full clean weekly	
19. All external glazing	One full clean every three months	One full clean every three months	One full clean every three months	N/A
20. Mirrors	One full clean daily	One full clean daily	One full clean daily	One full clean weekly
21. Bedside patient TV incl. ear piece for bedside ent. system	One full clean daily	One full clean daily	One full clean daily	N/A
22. Radiators	One full clean daily	One full clean daily	One full clean daily	One full clean monthly
23. Ventilation grilles extract and inlets.	One full clean weekly	One full clean weekly	One full clean monthly	One full clean monthly
24. Floor - polished	Dust removal two full cleans daily	Dust removal one full clean daily + one check clean daily	Dust removal daily	Dust removal one full clean weekly + one check clean weekly
	Wet mop two full cleans daily	Wet mop one full clean daily + one check clean daily	Wet mop daily	Wet mop one full clean weekly +one check clean weekly
	Machine clean weekly	Machine clean weekly	Machine clean monthly	Machine clean quarterly
	Strip & reseal yearly	Strip & reseal yearly	Strip yearly	Strip & reseal twice-yearly
25. Floor – non-slip	Dust removal two full cleans daily	Dust removal one full clean daily + one check clean daily	Dust removal daily	Dust removal one full clean weekly + one check clean weekly
	Wet mop two full cleans daily	Wet mop one full clean daily + one check clean daily	Wet mop daily	Wet mop one full clean weekly + one check clean weekly
	Machine clean weekly	Machine clean weekly	Machine clean monthly	Machine clean quarterly
26. Soft floor	Two full cleans daily	One full clean daily + one check clean daily	One full clean daily	One full clean weekly + one check clean weekly
	Shampoo six-monthly	Shampoo six-monthly	Shampoo 12-monthly	Shampoo twice-yearly
27. Pest control devices	Dust removal one full clean daily	Dust removal one full clean daily	Dust removal one full clean daily	Dust removal one full clean daily
	Full clean monthly	Full clean monthly	Full clean monthly	Full clean monthly

Element	Minimum cleaning frequency			
	Very high-risk	**High-risk**	**Significant-risk**	**Low-risk**
28. Electrical items	Dust removal one full clean daily	Dust removal one full clean daily	Dust removal one full clean daily	Dust removal one full clean weekly
	Full clean monthly	Full clean monthly	Full clean monthly	Full clean quarterly
29. Cleaning equipment	Full clean after each use	Full clean after each use	Full clean after each use	Full clean after each use
30. Low surfaces	Twice daily	One full clean daily and one check clean daily	One full clean daily	One full clean weekly
31. High surfaces	Twice weekly	One full clean weekly and one check clean weekly	One full clean weekly	One full clean weekly
32. Chairs	Daily and one check clean	One full clean daily and one check clean daily	One full clean daily	One full clean weekly
33. Beds	Frame daily	Frame daily	Frame daily	N/A
	Under weekly	Under weekly	Under weekly	
	Whole on discharge	Whole on discharge	Whole on discharge	
34. Lockers	Twice daily	One full clean daily and one check clean daily	One full clean daily	N/A
35. Tables	Twice daily	One full clean daily and two check clean daily	One full clean daily	One full clean weekly
36. Hand wash containers	Daily	Daily	Daily	N/A
37. Hand hygiene/ alcohol rub dispensers	Daily	Daily	Daily	N/A
38. Waste receptacles	Daily and one check clean	One full clean daily and one check clean daily	One full clean daily	One full clean daily
	Deep clean weekly	Deep clean weekly	One deep clean weekly	One deep clean weekly
39. Curtains and blinds	Clean, change or replace yearly	Cleaned, changed or replaced yearly	Clean change or replace yearly	Clean change or replace twice yearly
	Bed curtains change four-monthly	Bed curtains change six-monthly	Bed curtains replace 12-monthly	
40. Dishwasher	One full and two check clean daily	One full clean daily and two check clean daily	One full clean daily	One full clean daily

Element	Minimum cleaning frequency			
	Very high-risk	High-risk	Significant-risk	Low-risk
41. Fridges & freezers	Three check cleans daily	Three check cleans daily	Three check cleans daily	One check clean daily
	One full clean weekly	One full clean weekly (remove all content to clean)	One full clean weekly	One full clean weekly
	Defrost monthly	Defrost freezer monthly	Defrost monthly	Defrost monthly
42. Ice machines and hot water boilers	Daily check clean	One daily check clean	One check clean daily	N/A
	One full clean weekly	One full clean weekly	One full clean weekly	
43. Kitchen cupboards	One full clean weekly	One full clean weekly	One full clean monthly	One full clean quarterly
44. Microwaves	One full and two check clean daily	One full clean daily and two check cleans daily	One full clean daily	One full clean daily
45. Showers	One full and one check clean daily	One full clean daily and one check clean daily	One full clean daily	One full clean daily
46. Toilets & bidets	Three full cleans daily	Two full cleans daily and one check clean daily	One full clean daily	One full clean daily
47. Replenishment	Three times daily	Three times daily	Once daily	One times daily
48. Sinks	Three full cleans daily	Two full cleans daily and one check clean daily	One full clean daily	One full clean daily
49. Baths	One full and one check clean daily	One full clean daily and one check clean daily	One full clean daily	One full clean daily

Appendix 6 – Specimen cleaning responsibility framework

The table overleaf contains a specimen cleaning responsibility framework which will assist trusts in ensuring all items which require cleaning are cleaned, regardless of whether they are included in domestic services schedules and regardless of who has responsibility for cleaning them.

All frequencies, methods, responsibilities and comments are examples only and should not be interpreted as requirements or recommendations.

In completing this framework, trusts should have regard to the Microbiology Advisory Committee manual which provides advice and guidance on what level of decontamination is required, for example, cleaning or disinfection.

What is suggested in the table does not replace manufacturers' instructions where applicable.

This framework should also not replace local infection control policy. For example, in the case of specific infections, a higher level of decontamination may be required.

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)						
Items	**Time (mins) (estd)**	**Frequency e.g. daily/ weekly**	**Method (see procedures)**	**Staff group responsible ('ward staff' means any healthcare or clinical staff as appropriate)**	**Comments**	**Frequency (for local determination - see appendix 5 for guidance)**
Ward patient equipment (medical)						
IV stand		W	Detergent wipes	Ward staff	Include wheels	
IV pumps/syringe drivers		W	Detergent wipes	Ward staff	Cleaned by med phys after repair	
Cardiac monitors		D and AU	Detergent wipes	Ward staff	Cleaned by med phys after repair	
Blood gas machines		W	Alcohol wipes	Ward staff	Cleaned by med phys after repair	
Dressing trolleys		W	Detergent wipes	Ward staff	Include wheels	
Linen trolleys		W and AU	Detergent wipes	Ward staff	Include wheels	
Tea trolleys		W and AU	Detergent wipes	Ward staff	Include wheels	
Notes trolleys		W	Detergent wipes	Ward staff	Include wheels	
Drugs trolleys		W	Detergent wipes	Ward staff	Include wheels	
Sharps bin trolleys		W and AU	Detergent wipes	Ward staff	Include wheels	
Blood pressure cuffs		D and AU	Alcohol wipes	Ward staff	Cleaned by med phys after repair	
Pillows		AU	Det/water/bowl/disposable cloths	Ward staff		
Mattresses		AU	Det/water/bowl/disposable cloths	Ward staff		

AU = After use D = Daily W = Weekly

Items	Time (mins) (estd)	Frequency e.g. daily/ weekly	Method (see procedures)	Staff group responsible	Comments	Frequency
Cotsides		AU	Det/water/bowl/disposable cloths	Ward staff		
Wheelchairs		W	Det/water/bowl/disposable cloths	Ward staff		
Coin op wheelchairs		W	Det/water/bowl/disposable cloths	Mobility?		
Commodes		D	Det/water/bowl/disposable cloths	Domestic (TBC)		
Cushions		AU	Detergent wipes	Ward staff		
Oxygen sat probes		AU	Detergent wipes	Ward staff	Cleaned by medical Phys after repair	
Wash bowls		AU	Det/water/bowl/disposable cloths	Ward staff	Invert to dry	
Pressure relieving mattress CVRS		AU	Det/water/bowl/disposable cloths	Ward staff		
Hoists		D	Det/water/bowl/disposable cloths	Domestic (TBC)		
Pat slides		AU	Det/water/bowl/disposable cloths	Ward staff		
Easy slides		AU	Det/water/bowl/disposable cloths	Ward staff	Consider laundry	
Hoist slings		AU	Detergent wipes	Ward staff	Consider laundry	
Stands aids		D	Det/water/bowl/disposable cloths	Domestic (TBC)		
Handling belts		AU	Detergent wipes	Ward staff	Consider laundry	
Resuscitation trolleys		D	Detergent wipes D/W/B disposable cloths	Ward staff	Include wheels	
Larying handles		D and AU	Detergent wipes	Ward staff	Medical physics	

AU = After use   D = Daily   W = Weekly

Items	Time (mins) (estd)	Frequency e.g. daily/ weekly	Method (see procedures)	Staff group responsible	Comments	Frequency
Oxygen/suction equipment		D and AU	Detergent wipes	Ward staff	Cleaned by medical phys after repair	
Oxygen/suction equipment (portable)		W	Detergent wipes	Ward staff	Cleaned by medical phys after repair	
Wall humidifiers		AU	Detergent wipes	Ward staff	Cleaned by medical phys after repair	
Portable nebulisers		W and AU	Detergent wipes	Ward staff	Cleaned by medical phys after repair	
Ventilator equipment		D and AU	Detergent wipes	Ward staff	Cleaned by medical phys after repair	
Catheter stands		W and AU	Washer disinfector	Ward staff		
Bed pans/holders		AU	Washer disinfector	Ward staff		
Slipper pans		AU	Washer disinfector	Ward staff		
Urine bottles		AU	Washer disinfector	Ward staff		
Urine jugs		AU	Washer disinfector	Ward staff		
Raised toilet seats		D	Det/water/bowl/disposable cloths	Domestic (TBC)		
Scanners		D and AU	Detergent wipes	Ward staff	Medical physics	
Scales		W and AU	Det/water/bowl/disposable cloths	Ward staff		
Gas cylinder holders		AU	Detergent wipes	Porters (TBC)		

AU = After use D = Daily W = Weekly

Items	Time (mins) (estd)	Frequecny e.g. daily/ weekly	Method (see procedures)	Staff group responsible (future)	Comments	Frequency
Tower balconies		W	Det/water/bowl/disposable cloths	Estates		
Traction beams		D and AU	Det/water/bowl/disposable cloths	Domsestic (TBC)		
Thomas splints		AU	Detergent wipes	Ward staff		
Monkey poles		AU	Detergent wipes	Ward staff		
Weights		AU	Detergent wipes	Ward staff		
Braun frames		AU	Detergent wipes	Ward staff		
Ward media equipment						
TVs		W	Det/water/bowl/disposable cloths	Ward staff		
Hi-fis		W	Detergent wipes	Ward staff		
Telephones		D	Detergent wipes	Ward staff		
Computer/keyboards		W	Detergent wipes	Ward staff		
Printers		W	Detergent wipes	Ward staff		
Fax		W	Detergent wipes	Ward staff		
Audio/ visual systems		D	Detergent wipes	Contractor (premier)		
Photo-copiers		M	Detergent wipes	Ward staff		
Screens		W	Detergent wipes	Ward staff		
CCTV equipment		M	Detergent wipes	Estates		
OHPs		M	Detergent wipes	Ward staff		
Flip charts		M	Detergent wipes	Ward staff		
Accessories, i.e. staplers, in-trays, hole punchers		M	Detergent wipes	Ward staff		
Loan equipment, i.e. heaters		AU	Detergent wipes	Estates		
Hand cleaning holders		D	Detergent wipes	Ward staff	Alcohol rub/ Hibiscrub	
Pest control devices		W	Detergent wipes	Contractor (ROKILL)		

AU = After use D = Daily W = Weekly M=Monthly

Items	Time (mins) (estd)	Frequency e.g. daily/ weekly	Method (see procedures)	Staff group responsible (future)	Comments	Frequency
Recycling bins		W	Detergent wipes	Waste department		
Ward staff equipment						
Drugs cupboards		W	Detergent wipes	Ward staff		
Drugs fridges		W	Det/water/bowl/disposable cloths	Ward staff		
Bed pan washer		W	Det/water/bowl/disposable cloths	Ward staff		
Macerators		W	Det/water/bowl/disposable cloths	Ward staff		
Isolation trolleys		D	Alcohol wipes	Ward staff	Include wheels	
Fridges/freezers		W	Det/water/bowl/disposable cloths	Ward staff	Refer to cleaning manual	
Cookers		W	Det/water/bowl/disposable cloths	Ward staff	Refer to cleaning manual	
Microwaves		W	Det/water/bowl/disposable cloths	Ward staff	Refer to cleaning manual	
Toasters		W	Detergent wipes	Ward staff		
Ice machines		W	Det/water/bowl/disposable cloths	Ward staff	Refer to cleaning manual	
Kettles		W	Detergent wipes	Ward staff	Also descale	
Kitchen cupboards		D	Det/water/bowl/disposable cloths	Ward staff	Inside and out	
Milk fridges		W	Det/water/bowl/disposable cloths	Ward staff	Refer to cleaning manual	
Crockery		AU	Dishwasher	Catering		
Cutlery		AU	Dishwasher	Catering		
Water boilers		W	Det/water/bowl/ disposable Cloths	Ward staff		
Water coolers		W	Det/water/bowl/disposable cloths	Ward staff		
Dishwashers		W	Det/water/bowl/disposable cloths	Ward staff		

AU = After use D = Daily W = Weekly M=Monthly

Appendix 7 – Cleaning procedure guidance

- Refer to manufacturers' cleaning instructions.
- Wear personal protective equipment, i.e. gloves, aprons and/or as appropriate.
- Wipe all surfaces including underneath, paying special attention to 'contact' points.
- Apply colour coding policy.
- Use specified product, for example:
  - detergent wipes;
  - alcohol wipes;
  - detergent and disposable cloths.
- Always comply with heath and safety policies:
  - COSHH (refer to data/assessment sheets);
  - electrical equipment (switch off appliances and unplug);
  - manual handling (lift in pairs, empty contents wherever possible).
- Always comply with infection control policies and procedures:
  - good personal hygiene;
  - safer disposal of clinical waste;
  - adherence to standard infection control precautions;
  - adherence to decontamination policy;
  - seek specialist advice for cleaning of fabric finishes.

Appendix 8 – Definition of terms

A range of terms are used in this guide, and these have particular relevance to the way that cleanliness is achieved in healthcare premises. Definitions are not exhaustive.

Dust includes dust, lint, powder, fluff, cobweb.

Dirt includes mud, smudges, soil, graffiti, mould, fingerprints, ingrained dirt, scum.

Debris includes crisp packets, drinks cans and bottles, chewing gum, rubbish, cigarette buts, litter, adhesive tape, grit, lime scale.

Spillage includes any liquid, tea stains, sticky substances.

Room types are a subset of functional areas. For example, on a ward these could be bedded bays and sanitary areas. This allows cleaning managers the opportunity to more closely audit and manage standards in specific parts of functional areas.

Inputs are the resources used to produce and deliver outputs. Inputs may include staff, equipment or materials.

Outcomes are the effect or consequences of the output, for example, cleaning (output) produces a clean and safe environment for patient care (outcome).

Outputs are the actual product or service, for example, cleaning.

Processes are the procedures, methods and activities that turn the inputs into outputs, for example, mopping a floor.

Quality systems refer to integration of organisational structure, integrated procedures, resources, and responsibilities required to implement quality management. Taken together these provide for the development of a comprehensive and consistent service.

Appendix 9 – References and useful sources of information

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Appendices 10, 11 and 12

Available as separate documents from: www.npsa.nhs.uk/currentprojects/cleaningandnutrition

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