IMPROVING HEALTH IN WALES

GIG CYMRU NHS WALES

National Standards for Cleaning in NHS Wales

Revised October 2009

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Document Status Note:

The revised National Standards for Cleaning in Wales are applicable to the following organisations from the 1 October 2009 (and the shadow organisations in the interim period):

- Abertawe and Bro Morgannwg University Local Health Board.
- Aneurin Bevan Local Health Board.
- Betsi Cadwaladr University Local Health Board.
- Cardiff and Vale University Local Heath Board.
- Cwm Taf Local Health Board.
- Hywel Dda Local Health Board.
- Powys Teaching Local Health Board.
- Velindre NHS Trust.
- Public Health Wales NHS Trust.

The document uses the terminology Local Health Board (LHB) to apply to all of the above organisations, which for the purposes of this document includes Velindre NHS Trust and Public Health Wales NHS Trust.

The Welsh Assembly Government would like to thank the Department of Human Services, State Government of Victoria, Australia for its kind permission to reproduce parts of the Australian publication 'Cleaning Standards for Victorian Public Hospitals'.

This publication, as published in July 2003, was based on the NHS Estates documents entitled 'National standards of cleanliness for the NHS' published in April 2001, and it's 'Implementation Guidance (Toolkit)' published November 2001, published by the Department of Health for England.

This publication, as amended in October 2009, encompasses the recommendations from the Empowering Ward Sisters/Charge Nurses Ministerial Task and Finish Group Final Report entitled Free to Lead, Free to Care, June 2008.

Preface

These Standards update the National Standards of Cleanliness first published by the Welsh Assembly Government in July 2003. They provide a comparative framework within which hospitals and Local Health Boards (LHBs) in Wales can set out details for providing cleaning services and assessing environmental cleanliness.

The National Standards of Cleanliness have been reviewed and revisited to:

- Reflect the introduction of the Healthcare Standards for Wales in 2005, and the move from external assessment of the Welsh Risk Management Standard 40 by the Welsh Risk Pool, to internal assessment against the Healthcare Standards for Wales (specifically Standard 5) from 2007/08 onwards.
- Ensure the standards take account of changes occurring since the original Standards were published, specifically, but not restricted to The Empowering Ward Sisters Ministerial Task and Finish Group final report, Free to Lead, Free to Care published in June 2008.
- Ensure the audit methodology contained within these Standards incorporates the methodology and functionality of the All-Wales Monitoring Tool. This includes a change in the generic elements that are audited against.
- Include the revised generic elements against which all cleaning services must be audited, suggested **minimum** cleaning frequencies and a specimen cleaning responsibility framework.
- Reflect infection control best practice guidance contained in 'Healthcare Associated Infections - A Strategy for Hospitals in Wales' and 'Healthcare Associated Infections- A Community Strategy for Wales'.

These Standards are not a prescriptive cleaning manual: rather they provide a framework to support local decision making based on the identification and assessment of risks whilst maintaining compliance to the outcomes required by these Standards.

Ultimately each LHB is accountable for the effectiveness of the cleaning services, and these Standards do not provide instruction as to how services should be provided as these matters are for local determination. Rather, they provide clear advice and guidance on: what is required; how LHBs can demonstrate the way(s) in which cleaning services will meet these requirements; and how to assess performance.

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

Contents

Foreword

Everyone who enters a NHS Hospital in Wales should expect to find the highest possible standards of environmental cleanliness. A quality environment for health care is not a luxury- it is essential. This in itself hardly seems a stretching aspiration and the National Standards of Cleanliness for NHS Trusts in Wales first published in 2003 provided a framework based on outcomes so that this aspiration could be achieved.

The NHS in Wales has since delivered considerable improvements in the general standards of cleanliness routinely witnessed within our hospitals. These revised standards demonstrate the Welsh Assembly Governments' continued commitment to ensuring a clean, safe and hygienic environment is maintained at all hospitals, and incorporate policy developments, latest guidance, references and sources of information.

A Ministerial Task and Finish Group was established to identify recommendations that would expand the role of ward sister/charge nurse and to empower them to improve ward cleanliness, raise standards of care and protect patients' meal times, thereby improving the patient and public experience in our hospitals. The National Standards of Cleanliness have been revised in order to reflect these important policy decisions aimed at improving not only patient care but also the patient experience.

The core of this document provides clear instruction on the national minimum standards of cleanliness that should be achieved by the NHS in Wales. This is supplemented by advice and ideas, and complemented by an extensive reference section, along with examples of documentation and other useful information

The document also contains revised criteria for the assessment of standards achieved against the outcome requirements specified in accordance with the methodology of the All-Wales Monitoring Tool.

Paul Williams
Chief Executive NHS Wales

Rosemary Kennedy CBE
Chief Nursing Officer

Executive summary

Patients expect the healthcare facility to be clean and furnishings to be tidy and well maintained. They have a right to expect a welcoming environment at all times, particularly when they might be in pain and feel threatened by unfamiliar surroundings.

Healthcare buildings are the 'shop window' of the NHS. People may judge the quality of the service by the way it presents itself at first glance. A healthcare facility that appears dirty, untidy and uncared for may lead patients to believe that the care it offers is also poor. Staff may also feel demoralised and may not give of their best.

This document sets out the National Standards for Cleaning that will apply to all NHS facilities in Wales where patient services are delivered. The nature of health facilities varies widely according to local circumstances (patient mix, age and design of buildings) and each has different needs.

The Standards provide a framework that LHBs can adapt to meet local requirements. These requirements will include the development of cleaning plans, training programmes and decisions about staffing, including who is accountable and takes responsibility for cleaning.

Improving Health in Wales identified a need for environmental cleanliness to be monitored through consistent auditing procedures on a national basis. As such these National Standards for Cleaning includes a section outlining the process that all LHBs must follow when auditing the standards of the cleanliness services.

When applying the revised National Standards for Cleaning, it is important to bear in mind the introduction of the Healthcare Standards for Wales in 2005, and the move from external assessment of the Welsh Risk Management Standard 40 by the Welsh Risk Pool, to internal assessment against the Healthcare Standards for Wales from 2007/08 onwards. The Healthcare Standards for Wales establish a basis for continuous improvement and assurance and provide a framework that promotes quality improvements and supports integration of governance arrangements.

The Empowering Ward Sisters' Ministerial Task and Finish Group presented in the final report 'Free to Lead, Free to Care' a series of recommendations to the Minister for Health and Social Services for consideration. These have now been approved and all of the recommendations that relate to cleanliness issues have been incorporated into the National Standards for Cleaning.

In line with the Empowering Ward Sisters recommendations and to allow LHBs to consistently measure the efficacy of the cleaning service they administer against the National Standards, the auditing procedure to be followed is

included as Part Two of this document. In addition, an All-Wales Monitoring Tool has been introduced and audit results will be monitored centrally.

Since April 2004, it has been a requirement for the results of an external audit of cleaning outcomes for hospitals to feed into the Estates and Facilities Performance Management System (EFPMS) and ultimately form a part of the patient experience quality monitoring aspects of the Performance Improvement Framework. Results of external audits will continue to be monitored centrally through the All-Wales Monitoring Tool and reported in the EFPMS as required.

Who should apply the Standards?

A clean healthcare environment is of paramount importance to patients and staff and this document describes the Standards, the rationale for their introduction, and guidance on how to use them.

In general all staff and users of the service should be made aware of them.

Where necessary, staff should familiarise themselves with relevant components and in particular the following staff should ensure they are familiar with the Standards:

- ward sisters/charge nurses
- the responsible cleaning manager
- departmental managers
- cleaning staff
- ward managers
- clinical staff
- infection control staff
- central sterile supply staff
- works and estates staff; and
- Trust/LHB procurement manager.

In addition, Part Two of this document on performance auditing of healthcare facilities in terms of cleaning outcomes, incorporates a set of tools that should be used by ward and departmental managers, and by service providers, to monitor and improve their cleaning services.

1 - Introduction

Introduction of the National Standards of Cleanliness in Wales 2003 - the original rationale

1.1 'Improving Health in Wales - A Plan for the NHS and its partners', identified Clean Hospitals as a key component of health provision and that hygiene and infection control issues should become embedded as a core item of the management agenda and a key management responsibility.

1.2 It directed that an Executive Board member must be given responsibility for overseeing all aspects of healthcare facility hygiene, and that a review should be carried out of the management structure at ward level.

1.3 The plan also stated that similar processes would need to be introduced in all other appropriate areas and health facilities outside the confines of hospitals, and recognised the requirement for NHS Trusts to participate in national audits of the standards of environmental cleanliness in these facilities.

1.4 It followed that the Standards of Cleanliness set out specific requirements for healthcare facilities. These will ensure that a consistently high level of service will apply to all NHS Trust facilities that deliver patient services.

The revised National Standards for Cleaning in NHS Wales

The Welsh Assembly Government has taken the opportunity to revisit and revise the National Standards of Cleanliness for Wales to not only incorporate the recommendations outlined in 'Free to Lead, Free to Care' but also to update the standards to include the latest guidance, references and sources of information.

1.5 'One Wales a progressive agenda for the Government in Wales' an agreement between the Labour and Plaid Cymru groups in the National Assembly, 27 June 2007 stated a commitment to "improve hospital cleanliness".

1.6 The Empowering Ward Sisters Ministerial Task and Finish Group presented a series of recommendations to the Minister for Health and Social Services in the 'Free to Lead, Free to Care' Final Report, June 2008. All cleanliness related recommendations have been incorporated into the revised National Standards of Cleanliness for Wales.

1.7 Within each LHB, the Executive Nurse Director should be responsible for the implementation of the 'Free to Lead, Free to Care' recommendations and the LHB should appoint a non officer member to oversee and champion this process. An annual written update should be made to the Board until the implementation deadline (2010).

1.8 A patient champion for cleanliness, hygiene and infection control must be nominated in accordance with instruction issued under WHC (2006) 064 Standing Order 29 to NHS Trusts and Powys LHB - Guidance for nominated non-executive directors and non officer members.
This is superseded by Subordinate Legislation 2009.40 National Health Service Wales Directions to Local Health Boards, Velindre National Health Service Trust, Welsh Ambulance Service Trust and Public Health Wales NHS Trust 2009.

1.9 The Healthcare Standards for Wales were introduced in 2005. Internal assessment against these standards has been required since 2007/08. These internal assessments have replaced the external assessment of Welsh Risk Management Standard 40 by the Welsh Risk Pool.

1.10 In May 2006 Healthcare Inspectorate Wales were instructed by the Minister for Health and Social Services in Wales to conduct a rolling programme of unannounced hospital cleanliness spot checks.

1.11 This document sets out:

- the principles of cleanliness to be applied by LHBs in Wales
- the Standards and their requirements
- guidance on meeting the requirements of certain Standards
- the application of outcome and risk-based analysis
- measures for performance evaluation for LHBs to monitor cleaning outcomes and improve their cleaning services; and
- an audit process for use to monitor cleaning outcomes by all LHBs in conjunction with the All-Wales Monitoring Tool.

National Framework for Standards of Cleaning

1.12 The National Standards set out a framework of organisational and managerial standards for cleaning activites along with cleaning outcome requirements based on risk-assessments.

These have been designed to be used as:

- the basis for specifications for all service-level agreements and contracts
- standards against which the service provider can be benchmarked as part of an ongoing management process; and
- the basis for the auditing of cleanliness services. Audit scores will be reported through the All-Wales Monitoring Tool and the Estates and Facilities Performance Monitoring System (EFPMS) as required.

1.13 To encourage innovative and efficient cleaning practices, these Standards provide for a focus on outcomes, not methods. This will mean that the suitability of different methods can be demonstrated by assessing the outcomes of their use.

1.14 When the required outcomes are achieved, other stakeholders such as patients and visitors will see the results of the Standards being used.

Who are the stakeholders?

1.15 Within every healthcare environment there are many interested stakeholders. As well as staff, these will include:

- patients
- the public
- the media
- Government; and
- Patient representative groups (e.g. Community Health Councils).

1.16 All stakeholders have an interest in clean healthcare facilities. The National Standards for Cleaning and the identified cleaning outcomes to measure performance against have enabled common goals to be set to ensure that acceptable standards of cleanliness are achieved and maintained. As such, the Standards provide stakeholders with a common understanding of the question 'is this facility clean?'.

How are the outcome standards applied?

1.17 Assessment of risk - Throughout the Standards, the concept of 'risk' is applied. This helps identify the variety of problems that poor cleanliness can cause in a facility. Risks include:

- the risk of infection for patients
- the risk of a poor public image for the facility/LHB/NHS
- a health and safety risk for the public and staff; and
- the risk of a service providing poor value for money.

What are the key components?

1.18 Functional areas - A 'functional area' is the area in which the cleaning occurs (for example, a ward or operating theatre). This document groups functional areas according to risk, so that appropriate cleaning processes can be applied. For instance, Intensive Care Units (ICUs) and operating theatres are viewed as higher risk than plant rooms and medical record stores. (See Part Two for more on functional areas.)

1.19 Elements - The 'element' is the surface, article or fixture being cleaned (for example, 'windows'). Items to be cleaned in a healthcare building have been broken down into forty nine generic elements. Particular outcome standards apply to these groups of elements. (See Part Two and Appendix 1 for more on elements.)

1.20 Inputs - The resources used at appropriate frequencies to produce and deliver outputs. Inputs may include staff, equipment and materials. (See Appendix 2 for more on suggested cleaning frequencies.)

1.21 Outputs - The actual product or service, for example, cleaning.

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

1.23 Outcomes - The effect or consequence of the output, for example, cleaning (output) produces a clean and safe environment (outcome) for patient care. (See Appendix 1 for outcome requirements and Part Two of this document on performance assessment for details of the Audit Tool).

Definitions of Terms Used

1.24 A range of terms is used in this document, and these often have special relevance to the way cleaning services are provided. A list of such terms is provided in the Glossary.

2 - Principles

Clear outcome statements

2.1 The Standards reflect the outcomes required of the cleaning service and keep the focus on the need to have a clean and safe environment. The outcome-based standards focus on:

- the patient and customer
- clarity for cleaners and service providers
- consistency with infection control standards and requirements; and
- clear outcome statements, which can be used as benchmarks and output indicators.

The patient and customer

2.2 Everyone who enters a healthcare facility, whether as a patient, visitor or member of staff, is a customer of the cleaning service. The Standards have to focus clearly on their expectations. Although the main users of these Standards will be the service providers, they must be easy for everyone to understand.

In order to undertake work on public and patient involvement, it is important that LHBs have a common understanding of what the term means and take a consistent approach.

Public and patient involvement needs to be carried out across two levels:

- the individual - the involvement of patients in discussions and decisions concerning their own individual care and treatment. It is closely linked to the overall care experience for individual patients; and
- the collective - the involvement of patients and the wider public in decisions concerning the delivery and planning of services.

2.3 Standards are set for both patients and other stakeholders. The patient's perspective will feature in the annual Hospital Patient Environment (HPE) assessments conducted by members of the Community Health Council (CHC) which assess a range of environment issues, one of which is cleanliness.

2.4 Patient Representatives will report patient observations to the non-officer member who has been nominated to take personal responsibility for acting as patient champion for cleanliness issues. In this way, patients will directly influence the quality of their healthcare environment.

2.5 LHBs must ensure that patients are made aware of internal systems for expressing their views.

Clarity for cleaners and service providers

2.6 The clarity of standards for cleaning outcomes is of paramount importance. All staff involved in cleaning procedures need to have the same understanding of the standards and task requirements to ensure that they are working towards and assessing the same cleanliness outcomes.

2.7 It is essential that clinical staff in particular ward sisters/charge nurses and departmental managers, be involved in the provision of cleaning and ensuring that their wards and departments are kept clean. Where a ward or departmental manager is unable to resolve problems directly with cleaning service providers, there should be a clear mechanism that is agreed locally and well documented for resolving them, and if necessary to provide alternative arrangements for continuity of service in the interim.

Part 1: The Standards

I Management of environmental cleanliness

LHBs are able to demonstrate clear management arrangements for environmental cleanliness, linked to corporate and clinical governance.

II Local cleanliness strategies

A consistently high standard of environmental cleanliness is delivered in all LHBs.

III Involving and listening to patients

Patient views on cleanliness are integrated into the planning, implementation and monitoring process.

IV Education and development

Staff are trained to undertake their duties in ensuring that the cleanliness standards are met.

V Risk-based analysis for service provision

The most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities.

VI Facility management

LHB owned buildings and fixtures are maintained to an acceptable condition to enable the effective and safe cleaning of the patient environment.

VII Monitoring of cleaning outcomes

The standard of cleanliness of the healthcare environment is assessed by both internal and external audit.

Standard 1 - Management of environmental cleanliness

LHBs are able to demonstrate clear management arrangements for environmental cleanliness linked to corporate and clinical governance.

The standard requires that:

1.1 Overall accountability for all aspects of cleanliness and cleaning staff rests with the LHB Chief Executive and the Board.

1.2 Each LHB has an Executive Board Member who takes personal responsibility for environmental cleanliness.

1.3 There should be evidence of linkages between responsibilities for Cleanliness and Infection Control within the Organisational Structure.

1.4 Within each LHB, the Executive Nurse Director should be responsible for the implementation of the 'Free to Lead, Free to Care' recommendations and the LHB should appoint a non-officer member to oversee and champion this process. An annual written update should be made to the Board until the implementation deadline (2010).

1.5 Each LHB must ensure a multi-disciplinary standard of cleaning group continues to take responsibility for implementing the Standards and report to the Executive Board Member on progress made against the objectives at least twice a year, and an annual report submitted to the Executive Board

1.6 Targets for environmental cleanliness will be set as part of the LHBs Corporate Plan.

1.7 The LHB will be able to demonstrate linkages with the standards of environmental cleanliness to corporate and clinical governance, along with risk and performance management systems.

1.8 The role of staff with responsibility for cleanliness is clearly set out in their job description.

1.9 The lines of accountability for all managers and supervisors with a responsibility for cleanliness are clearly set out.

1.10 In the few instances where cleaning services are provided by an external provider, the roles and responsibilities between the purchaser and the provider are defined at the start of the commercial relationship and written into the contract. The National Standards for Cleaning apply even if cleaning services are provided through an external provider.

1.11 While a contractor may be responsible for service provision, the accountability relating to that service remains with the Chief Executive and the Board.

Guidance

With regard to the assignment of domestic staff, regular domestic staff should be allocated to particular wards or work areas to enable them to work as part of the team and take pride in their ward. Day-to-day functional responsibility and accountability should be to the ward sister/charge nurse. The domestic services manager should retain managerial responsibility.

The ward sister/charge nurse should be routinely involved in the recruitment process for the ward housekeeper/domestic staff that will be allocated to their team.

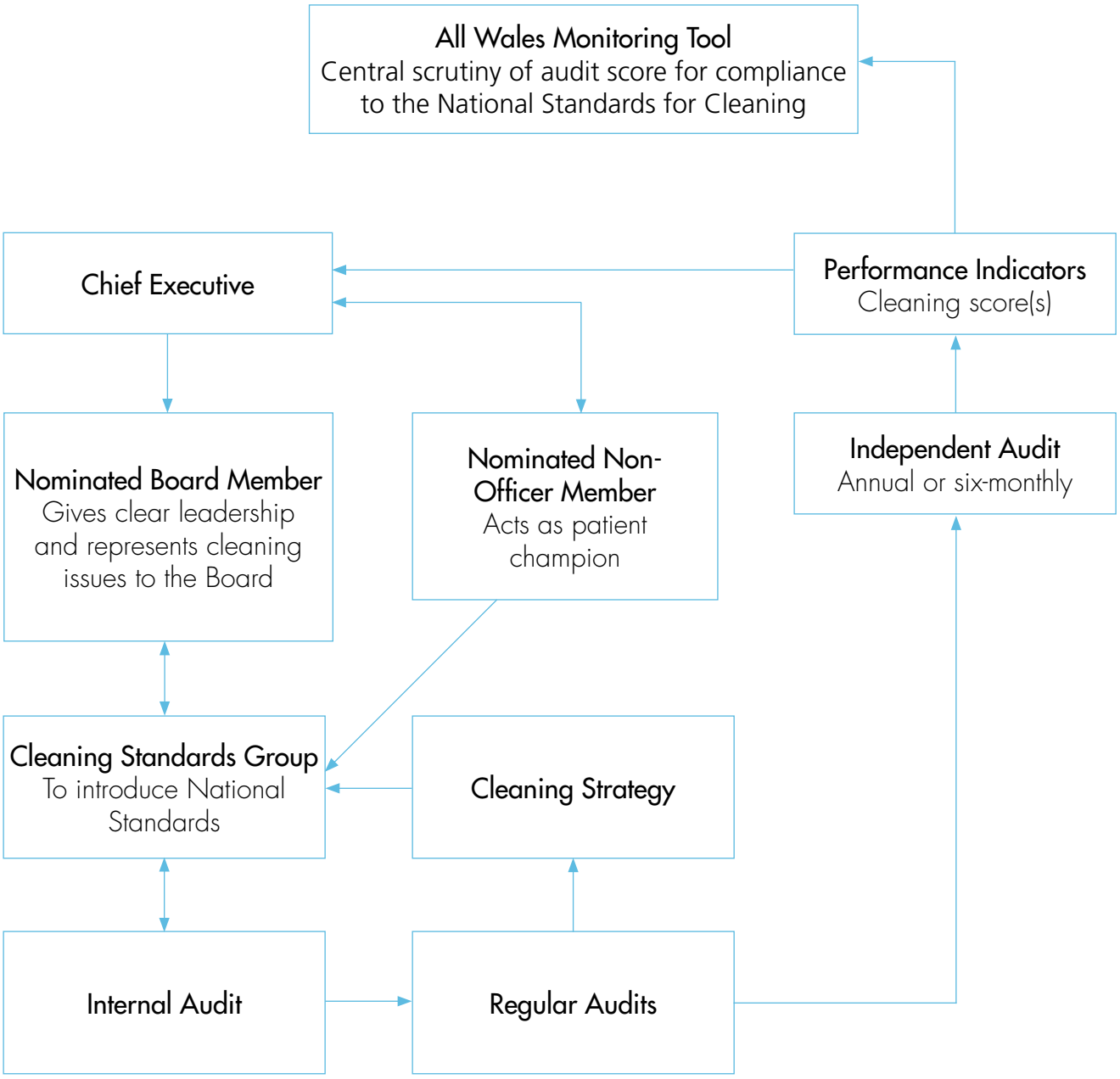
The ward sister/charge nurse should delegate clearly any general cleanliness/tidying tasks that are the responsibility of health care support workers.

Ward sisters/charge nurses should be involved in the development of LHB-wide schedules which clearly identify who is responsible for cleaning specific items of patient equipment.

The ward sister/charge nurse has a key role in monitoring standards, effectively acting as the arbiter of local standards. The ward sister/charge nurse should work closely with the cleaning services provider to ensure the highest possible standards of cleanliness are achieved.

Ward sisters/charge nurses should have the authority to decide at an individual ward level whether flowers are allowed or not. This decision should be made based on considerations around cleanliness or health and safety and not on misperceptions of hospital acquired infection. The use of disposable vases and sealed containers (oasis arrangements) should be considered.

Schema for Groups and Reporting



Standard II - Local cleaning strategies

A consistently high standard of environmental cleanliness is delivered in all LHBs.

The standard requires that:

2.1 Existing implementation/action plans should be updated to reflect the requirements of the revised National Standards for Cleaning in NHS Wales. In particular to reflect the amended generic cleaning elements, the recommendations included in the 'Free to Lead, Free to Care' Final Report in June 2008 and the introduction of the All-Wales Monitoring Tool.

2.2 Each LHB should continue to have action plans covering one, three and five-year periods, that include clear, consistent contracts or service level agreements between service providers and users. Please see Appendix 4 for an exemplar Operational Cleaning Plan.

2.3 The action plans must set out the range and scope of the work to be undertaken and identify the process by which they are continuously monitored and updated to ensure levels of cleanliness that consistently comply with the **minimum** standards.

2.4 LHBs must give full consideration to estates issues to ensure that the physical environment experienced by the patient supports their expectations.

2.5 All managers, including infection control and ward sisters/charge nurses, are fully consulted regarding the content of service specifications and have a key role in ensuring that standards are met.

2.6 Each LHB develops detailed operational policies and procedures for environmental cleanliness, including those relating to equipment used in the cleaning process, linen/laundry services and patient's own clothing.

2.7 An annual report is presented to the LHB Board on the progress made with the improvements to the patient environment, a copy of which is sent to the Infection Control Committee.

Guidance

Standards for Cleaning Group

To focus on the delivery of the National Standards for Cleaning, it is essential for a multidisciplinary group to continue to take responsibility for their implementation.

The group will be responsible for the following:

- ownership of the National Standards for Cleaning for the NHS
- continued implementation and further development of existing Cleaning Plans
- continued implementation of the Standards
- responsibility for maintaining acceptable Standards
- advising the Board on performance against Standards
- development of a communications plan for Standards (as and when necessary)
- continuous review, feedback and improvement of the above; and
- to receive 'exception' reports that directly impact the capability within the LHB to clean to the Standards and, where necessary, advise the Board on any remedial action.

It is anticipated that members of the group be drawn from the following areas:

- Patient representative group (e.g. CHC).
- Domestic Management.
- Hotel Services.
- Estates Department.
- Infection Control Nursing.
- Patient Representative.
- Staff Representative and/or Union Representative.
- Ward/Departmental Representative.

Cleaning Plan

The cleaning plan should include the following as a **minimum**:

- The requirements of the standard.
- An audit of compliance with the standard covering:
  a) all existing work schedules
  b) all existing service level agreements
  c) all existing service specifications.
- A detailed plan for any changes required in (a) to (c) above.
- A briefing paper for feedback into the strategy document.

Please see Appendix 4 for an exemplar Cleaning Plan.

Cleanliness Strategy

All LHBs will continue to develop and regularly review a Strategy for cleaning in order to provide focus for this initiative. The agreed Cleanliness Strategy will be presented to the Board and clearly set out the current situation, the desired future position and the actions necessary to move from the current to future positions.

The content of the document should be concise and cover the following with respect to the Standards:

a) Where you should be.

b) Where you are.

c) What needs to be done.

d) Who will be doing it.

e) When it will be done by.

It would be appropriate for the document to contain the following as a **minimum**:

- Introduction.
- Baseline audit (more details can be found in Part 2 of this document on performance auditing).
- GAP analysis.
- Action Plan giving short term (1year), medium term (2year), and long term (5year) objectives.
- Cleaning Plan.

Please see Appendix 5 for an exemplar Cleaning Strategy.

Communications

Communication is vitally important in raising both the importance and awareness of the National Standards. The LHB Standards and Cleanliness Group will send out the Cleanliness Strategy to all of the LHBs Board members.

For other groups who need to be aware of what action is being taken, but do not have any direct involvement in the actual implementation, a shortened form of the full cleanliness strategy might be considered. The target audience for this will be:

- Finance Department.
- Procurement Section.
- Communications and PR.
- Patient Representative Groups (e.g. CHC).
- Risk Management.
- Other stakeholders.

For notice boards and the wider health community, a shortened version of the document may be released once approved by the LHB.

Standard III - Involving and listening to patients

Patient's views on cleanliness are integrated into the planning, implementation and monitoring processes.

The standard requires that:

3.1 A patient champion for cleanliness, hygiene and infection control must be nominated in accordance with instructions issued under WHC (2006) 064 Standing Order 29 Directions to NHS Trusts and Powys LHB- Guidance for nominated non-executive directors and non-officer members. This will be superseded by Subordinate Legislation 2009 no.40 National Health Service Wales Directions to Local Health Boards, Velindre National Health Service Trust, Welsh Ambulance Service Trust and Public Health Wales NHS Trust 2009.

3.2 The non-officer board members are responsible for ensuring patient participation in the development of the cleanliness strategy and the cleaning plan.

3.3 Trends in patient compliments and complaints are made available to the Board and used to evaluate, and where necessary amend, the cleanliness strategy and cleaning plans.

3.4 Information obtained from the local Community Health Council's 'Quality Monitoring Visit' reports is utilised to evaluate and, where necessary, amend the cleanliness strategy and implementation plan.

3.5 The Board nominee meets regularly with the Patient Representatives and CHC's, and ensures that the patient's views are reported to the LHBs Board.

Guidance

The patients' voice is of key importance in the drive for service improvement. The involvement of patients and their representatives will underpin the process of continuous service improvement. This will allow patients to have a direct impact on the health care environment.

It is an important part of the nominated non officer member's role to ensure that patient views are central to the monitoring process and that patient views are made available to the LHB Board for action.

Patient views will be reported by the non-officer member to the LHBs Executive Board member who has been nominated to take personal responsibility for cleanliness in the healthcare facility. In this way, patients will directly influence the quality of the health care environment. Cleanliness is an integral part of patient satisfaction surveys. However, LHBs should ensure a more extensive feedback of patient views.

The views of patients and their representatives will be obtained by:

1. Local patient surveys, patients will be asked their views about their satisfaction with the patient environment and issues regarding cleanliness.
2. Trends from patient complaints and compliments regarding cleanliness.
3. Community Health Council 'monitoring visit' reports.

LHBs should have a form of 'Patient Involvement Group' that will be involved in the continued implementation of the National Standards. In support of this Group the statutory role of the Community Health Council in monitoring NHS services and representing the patient will be recognised and CHCs actively engaged in the process.

Standard IV - Education and development

Staff are trained to undertake duties in ensuring that the cleanliness standards are met.

The standard requires that:

4.1 The nominated Executive Board Member will ensure that all staff are aware of the cleaning standards.

4.2 The service provider is responsible for training staff adequately to meet the Standards for Cleaning.

4.3 All staff who undertake cleaning duties must be trained to an appropriate level in the following:

- customer service
- health and safety issues
- control of substances hazardous to health
- relevant infection control principles and procedures
- manual handling; and
- cleaning techniques.

4.4 All domestic staff should be trained to the current national **minimum** standards. Please see guidance **below**.

4.5 There is a planned training programme which is regularly updated to ensure that all staff are competent to carry out the tasks required of them.

Guidance

All staff employed within Domestic Services should be suitably trained to meet the national **minimum** standard of training:

• *Cleaning Operatives Proficiency Certificate (COPC)*

To ensure the ward sister/charge nurse is able to maintain the highest standards of cleanliness on the wards, the NHS in Wales should adopt a Cleaning Operatives Proficiency Certificate award such as that offered by the British Institute of Cleaning Science as the national **minimum** standard of training for all cleaners. The ward sister/charge nurse must understand the requirements of the COPC.

The training programme should be targeted towards domestics who are regularly assigned to ward areas in the first instance and be rolled out across the LHB so that all domestics receive the national **minimum** standard of training. It is expected that all domestics working in NHS healthcare facilities will be trained to the same national **minimum** standards regardless of whether they are directly employed NHS staff or are employed as bank and agency staff, etc.

There should be evidence of competency based training plans, and the LHB must determine locally how often to conduct refresher training to ensure competency levels are maintained to the **minimum** standards.

Assembly guidelines will be issued in due course containing full instructions for the implementation of the training scheme including compulsory modules and timescales for training completion.

Technical hygienists

Consideration should be given to the development of new roles such as technical hygienists who are directly accountable to the ward sister/charge nurse in areas where there is a higher degree of clinical equipment.

- The technical hygienists is a new role, which brings together domestic cleaning and clinical cleaning traditionally undertaken by nursing staff.
- Technical hygienists may be more suited to areas where there is significant risk to patients from environments where there is a high degree of dedicated and shared equipment that needs specialist cleaning.
- Such environments may include critical care areas, theatres and specialist wards for example, renal units, haematology units etc.
- Training of all technical hygienists should be competency based and certified against specific tasks and ward speciality.
- Advanced training for clinical equipment (monitors, ventilators, syringe drivers etc) should be conducted in conjunction with original equipment manufacturer, clinical staff and Electro-Biomedical Engineering (EBME) colleagues.
- Technical hygienists must have an understanding of cleaning and disinfection techniques both in daily practice and when outbreaks of infection occur.
- Technical hygienists may be drawn from existing staff and provided with accelerated training and certification.

Recruitment for ward housekeeper/domestic staff

The ward sister/charge nurse should be routinely involved with the recruitment process for the ward housekeeper/domestic staff that will be allocated to their team.

Standard V - Risk-based analysis for service provision

The most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities.

The standard requires that:

5.1 Areas to be cleaned in a healthcare facility are broken down into risk based functional areas.

5.2 Items to be cleaned in a healthcare facility are accounted for in terms of the forty nine generic elements set out in the schedule in Appendix 1.

5.3 The suggested **minimum** cleaning frequencies are set out in Appendix 2. These frequencies outline the suggested **minimum** requirements and can be increased if considered necessary at a local level, based on the assessment of the relative risks posed by the functional area and the likelihood of the occurrence.

5.4 Appendix 2 provides **minimum** suggested cleaning frequencies from the domestic services. Additional cleaning may be required by other staff groups (e.g. nursing) and should be documented separately under the cleaning responsibilities framework. For example some items, such as baths, may require cleaning after every use by nursing staff in addition to the domestic input.

5.5 A cleaning responsibility framework should be developed clearly specifying the staff group accountable for all items within the healthcare facility. An example cleaning responsibility framework is included at Appendix 3.

5.6 The required cleaning outcome for an element of a functional area is achieved in accordance with the schedule set out in Appendix 1, irrespective of where it is located within a healthcare facility.

5.7 Each LHB develops detailed operational policies and procedures to achieve the required cleaning outcomes for each functional area.

5.8 The actual cleaning outcomes achieved for each functional area are audited in compliance with the All-Wales Monitoring Tool, and these audits are externally verified on an annual basis.

5.9 The regular cleanliness audits at ward level must be signed off by the ward sister/charge nurse.

Guidance

A rapid response cleaning service

Every LHB should consider developing a stand-alone 'rapid response' cleaning service (in addition to the ward-based cleaning team). Though the management of this service should remain a central function, ward sisters and the infection control team should be able to request this service and expect a response within a reasonable period of time, depending on the nature of the request (please see below for further guidance). This should include the ability to request 'deep cleaning' following outbreaks, refurbishments and where standards have fallen consistently below the National Standards.

The following activities may be considered locally when deep cleaning is deemed necessary:

- Dismantling/cleaning beds/bedrails.
- Cleaning equipment, e.g. commodes.
- Cleaning ductwork.
- Steam cleaning.
- Ultrasonic cleaning.
- Hydrogen peroxide fogging.
- Restoration of surfaces.
- Wall-washing.
- High cleaning.
- Cleaning entrances/common areas.
- Floor scrubbing.
- Curtain changing.
- Cleaning behind radiators, fitments.
- Cleaning soft furnishings.
- De-cluttering.
- Cleaning cupboards/storage space.
- Cleaning kitchens/food prep areas.
- Cleaning trolleys/trolley wheels.
- Doors and door furniture.
- Light fittings.
- Telephones/IT equipment.
- Window washing.

It is important to bear in mind that, in some instances, it may be more appropriate to replace items that cannot be satisfactorily cleaned or to replace damaged finishes to make subsequent cleaning easier.

The rapid response cleaning service should aim to rectify cleanliness issues within the following timeframes

Functional Area	Timescale for rectifying problems
Very High and High Risk Functional Areas	Immediately or as soon as is practically possible. Cleaning is a team responsibility and if domestic 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.
Significant Risk Functional Areas	0-3 hours for patient areas (to be rectified by daily scheduled cleaning service for non-patient areas).

Standard VI - Facilities management

LHB owned buildings and fixtures are maintained to an acceptable condition to enable the effective and safe cleaning of the patient environment.

The standard requires that:

6.1 Financial and management responsibility for utilities, consumables, waste disposal and other facilities-related issues associated with the core cleaning functions are defined and included as part of the service specification.

6.2 The LHB should take action to rectify any problems with a facility that make it impossible to achieve the standards of cleanliness within a timeframe commensurate with risk.

6.3 All procurement of new equipment and/or new or upgraded buildings should take into consideration the ability of service providers to clean properly when installed and review the implications, with advice sought from infection control teams where appropriate.

Guidance

Operational policies should set out the range and scope of the work to be undertaken, including:

- the standards to be achieved
- clear and measurable outcomes, including response time to clean spills or body fluids
- systems that routinely measure these outcomes and report the results
- working methods, including equipment, materials and frequencies that are to be applied; and
- contingencies in the event of major incidents, potential and actual outbreaks of infection, and decontamination, e.g. chemicals.

An example of where new equipment and/or new or upgraded buildings can affect the ability of service providers to clean properly may be the purchase of equipment with porous surfaces or which needs special cleaning techniques, as this may lead to increased costs or risk of infection. (N.B. - The Infection Control Team must always be consulted on such matters in keeping with Healthcare Standard 5).

Infrastructure maintenance and facility management

As buildings and fixtures become old they become more difficult to clean and maintain in an acceptable condition. Providers of cleaning services are not generally expected to contribute to infrastructure maintenance or capital expenditure, or undertake painting/refurbishment programmes.

The line between cleaning and maintenance

The most common point of dispute in this context is exactly where cleaning ends and maintenance or engineering work begins. The specification must be clear at this point.

To prevent disputes, it may help if the service provider and the purchaser's representative carry out a baseline audit of the facilities to document problems that may make it difficult or impossible, to meet the Standards for Cleaning. The audit should note, for example, any floor surfaces that need repair and walls or ceilings that require painting. Other areas might include significant staining of the carpets, curtains, etc., and the condition of the air ducting. The LHB should take action to rectify any problems that make it impossible to achieve good standards of cleanliness.

Where problems cannot be resolved directly with cleaners, their supervisors or the cleaning service manager, ward sisters/charge nurses and departmental managers should be aware of the mechanisms at their disposal to resolve such problems.

Specific items schedule

Ward sisters/charge nurses should be involved in the development of LHB-wide schedules which clearly identify who is responsible for cleaning specific items of patient equipment. An example cleaning responsibility framework is included at Appendix 3.

Internal audit procedures should identify the extent to which these schedules are being utilised and their effectiveness in ensuring the cleanliness of patient equipment.

Standardising products for cleaning and infection control

To support the ward sister/charge nurse role a national advisory forum, hosted by Welsh Health Supplies in association with Welsh Health Estates, will be established to review standardising products for cleaning and infection control across the NHS in Wales. This forum will also review new and innovative technologies for cleaning and infection control and advise the NHS accordingly. This forum will have ward sister/charge nurse representation.

Additional information on the national advisory forum will be available from Welsh Health Supplies.

Central storage to facilitate general tidiness

To ensure access to bathrooms and other ward areas the storage of equipment, mattresses, etc. should be pooled centrally to reduce the amount stored at ward level.

Where central storage is not appropriate, the ward sister/charge nurse should determine local solutions to ensure the appropriate storage of patient equipment so that general levels of tidiness are maintained and the ability to clean is not impaired.

Standard VII - Monitoring of cleaning Outcomes

The state of cleanliness of the healthcare environment is assessed by both internal and external audit.

The standard requires that:

7.1 Three levels of audit are undertaken:

- internal technical audits
- internal managerial audits
- external audits by Health Inspectorate Wales to ensure that the All-Wales Monitoring Tool is consistently utilised across Wales.

7.2 All cleaning service providers for healthcare facilities undertake regular internal audits of cleanliness, including where there may be joint facility/provider arrangements. This process will highlight areas that fall short of the expected standards and provide an opportunity to negotiate targets for improvement over a period of time.

7.3 Regular comprehensive internal audits that cover multiple elements and functional areas are scored in accordance with the monitoring schedule provided by the All-Wales Monitoring Tool. The auditing process that must be complied with is provided in Part Two of this document.

7.4 Along with auditing cleanliness outcomes, LHBs will undertake wider performance management audits. This will include monitoring costs, activity (such as input hours, patient days, etc.), absence and turnover, and setting targets for cost and quality.

7.5 LHBs must establish formal systems to accurately reflect cost and activity and benchmark these against other service providers to demonstrate best value.

7.6 All managers, supervisors and infection control teams:

- have a key role in monitoring compliance with agreed policies and procedures in relation to issues such as poor cleanliness that directly affect the patient environment
- are fully consulted on the development of service specifications for cleaning services, whether provided by in-house or external contractors; and
- have a key role in monitoring cleanliness standards at ward and departmental level and in ensuring that corrective action is taken where standards fall short of what is expected.

7.7 The assessments collected in any audit are acted upon as part of the process of continuous improvement.

Guidance

Guidance on the audits and performance assessments are contained in Part Two of this document on performance assessment against the National Standards for Cleaning.

Part Two: Performance Measurement - The Auditing Process

1. Cleaning Outcome Requirements

Items to be cleaned in a healthcare facility have been broken down into forty nine generic elements. The cleaning outcome requirement applicable to each of these groups of elements are stated in Appendix 1. The element should be cleaned to the stated outcome requirement irrespective of where it is located within the healthcare facility. Suggested **minimum** cleaning frequencies are included as Appendix 2. These frequencies should be used as the **minimum** requirement, and increased where necessary due to risk or activity levels so that the cleaning outcomes are achieved at all times.

The standards do not prescribe inputs such as techniques, equipment or processes, although they do provide suggested **minimum** cleaning frequencies that must be assessed for applicability at local level. All cleaning inputs will be determined by the LHB managing the healthcare facility according to risk-based analysis, and the resultant cleaning outcomes used as a measure of performance against the requirements set out in the Standards for the functional area and element concerned.

Using outcome measures allows different healthcare facilities to use different methods, yet still be assessed in the same way.

To recap on this principle the concept of 'risk' helps identify the variety of problems that poor cleanliness can cause in a facility.

Risks include:

- the risk of infection for patients
- the risk of a poor public image for the facility and health authorities
- a health and safety risk for the public and staff; and
- the risk of a service providing poor value for money.

With the key components of the analysis being:

- Functional areas - A functional area is the area in which the cleaning occurs, for example, a ward or operating theatre. The standards document groups functional areas according to risk, so that appropriate cleaning processes can be applied.
- Elements - An element is the surface, article or fixture being cleaned, for example, 'windows'. Items to be cleaned in a healthcare building are broken down into forty nine generic elements. Particular outcome standards apply to these groups of elements.

- Inputs - The resources used at appropriate frequencies to produce and deliver outputs. Inputs may include staff, equipment and materials.
- Outputs - The actual product or service, for example, cleaning.
- Processes - The procedures, methods and activities that turn the inputs into outputs, for example, mopping a floor.
- Outcomes - The effect or consequence of the output, for example, cleaning (output) produces a clean and safe environment (outcome) for patient care.

2. Applying outcome and risk based analysis

The frequency of cleaning is dependent upon:

- the room or area in which the cleaning is occurring (the functional area)
- the surface, article or fixture being cleaned (the element); and
- any exceptional activity performed in the functional area (the activity).

Functional areas

Areas to be cleaned in a healthcare facility have been broken down into functional areas. Maintaining the required standard of cleanliness is more important in some functional areas than others. They are therefore grouped into four levels of cleaning intensity, based on the risks associated with inadequate cleaning in that functional area. The four risk based categories are:

- Very high risk.
- High risk.
- Significant risk.
- Low risk.

3. Identifying Risk Categories

3.1 Very high risk functional areas

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, infection control team and ward sister/charge nurse 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.

3.2 High Risk functional areas

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, infection control team and ward sister/charge nurse are satisfied that consistently high standards are being achieved, after which the audit frequency may be reduced to no less than bi-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.

3.3 Significant risk functional areas

In these areas, high standards are required both for 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 other areas adjoining significant risk functional areas should be treated as having the same risk category and receive the same regular levels of cleaning.

3.4 Low risk functional areas

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 administration areas, non-sterile supply areas, record storage and archives.

Additional internal areas

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

4. Performance Assessment

Baseline audits and on-going audits against the cleaning outcome requirements will provide LHBs with the basis on which progress with meeting the organisational and management requirements of the National Standards of Cleanliness will be progressed.

Major factors in making progress may include:

- Having clear lines of accountability up to Board level.
- Ensuring regular meetings of the Standards for Cleaning Group.
- Updating the cleanliness strategy in light of the revised Standards.
- Ensuring the mechanism for patient involvement is appropriate.
- Updating the cleaning plan in light of the revised Standards.
- Communicating all activities with all departments and patient groups.

- Delivering appropriate training to staff at all levels.
- Clear policies on building infrastructure/maintenance with respect to cleaning.
- On-going auditing of performance in terms of cleaning outcomes.

Activities will include:

- Ensuring regular meetings of the Standards for Cleaning Group.
- Update cleanliness strategy in light of revised standards.
- Update cleaning plan in light of the revised standards.
- Prepare baseline audit of cleaning outcomes and calculate score.
- Submit exception report to Board nominee and relevant departments.
- Communicate all activities with all departments and patient groups.
- External audit of Audit Tool score.
- Prepare Board report.
- Ensure score uploaded to the All-Wales Monitoring Tool system for central scrutiny.
- Provide score to Welsh Health Estates with EFPMS data submission as appropriate.

The All-Wales Monitoring Tool must be utilised to generate internal audit scores, which must be kept up-to-date to facilitate central scrutiny by the Welsh Assembly Government or a nominated agency.

5. Baseline Audit

The baseline audit is considered to be a fundamental prerequisite of implementing the revised National Standards for Cleaning for the NHS. The baseline audit of cleaning outcomes will provide a detailed report on the current state of cleanliness within the healthcare environment. The audit will highlight any issues which impact directly on cleanliness or the capability to effectively clean any area, room or element. It is imperative for the baseline audit to be repeated to take into consideration the revised Standards for Cleaning.

It is anticipated that the baseline audit, should be fully documented and submitted to the Standards for Cleaning Group. If there are major issues which affect capability to clean, these may need to be reported to the board.

- The audit should clearly identify anything that impacts on the capability to clean.
- The audit should clearly identify tidiness issues that impact on the capability to clean.

- The audit should identify any areas/items/elements that are not within the remit of the cleaning team.
- For all ward areas, the ward sister/charge nurse should be actively involved in the baseline audit and 'sign off' the audit report for their ward.
- The audit will be an integral part of updating the strategic cleaning plan and the operational cleaning plan.
- The audit should clearly highlight the gap between current levels of cleanliness and the outcome requirements laid down in the National Standards.
- All issues/items identified as part of the audit will generate exception reports*.

* A report giving detail of failures or defects that require immediate inspection as they impact the capability to clean. Such reports would be escalated to the relevant professional lead and the Standards for Cleaning Group.

A typical problem for a baseline audit to note may be, for example, any floor surfaces that need repair and walls or ceilings that require painting. Other areas might include significant staining of the carpets, curtains, etc., and the condition of the air ducting.

6. Ongoing Audits

Internal audits

Purpose: To verify cleanliness outcomes for a particular healthcare facility and identify areas for improvement. These comprehensive audits are scored.

Internal audits form part of the quality programme. They should be followed up according to the magnitude and location of any problems identified and lead-times identified for corrections specified. For example, a problem in the operating theatres will need to be resolved immediately, while one in a stationery storeroom may require checking in a week or during the next scheduled audit. There should be two levels of internal audit.

- **Technical.** These take the form of regular weekly audits which form a continuous and inseparable part of the day-to-day management and supervision of the cleaning services. Technical audits are undertaken by the domestic supervisor and are signed off by the ward sister/charge nurse, where appropriate. The frequency of these audits is in accordance with the relevant risk category.
- **Managerial.** These are planned audits that should verify cleaning outcomes of technical audits and identify any areas for improvement. The audit team should consist of senior domestic management,

ward sisters/charge nurses with responsibility for cleaning, infection control and estates. These audits are undertaken at least quarterly to ensure a representative sample is achieved during a twelve month period. The team validates a sample of technical audit information by sampling some elements across all functional areas, some room types or one or more functional areas. The decision concerning the scale of the review is based upon cleanliness levels already achieved; where the team feel emphasis should be placed; or randomly chosen elements, rooms or functional areas generated by the All-Wales Monitoring Tool.

External Review of the National Standards for Cleaning

External review of the National Standards for Cleaning in NHS Wales will comprise of physical inspection undertaken by Healthcare Inspectorate Wales as part of their existing programme of hospital spot checks and central scrutiny of the information contained within the All-Wales Monitoring Tool by the Welsh Assembly Government.

Healthcare Inspectorate Wales

Purpose: To provide an independent view about how the National Standards for Cleaning in NHS Wales are being met.

Healthcare Inspectorate Wales (HIW) will assess compliance with the National Standards for Cleaning in NHS Wales as part of its unannounced cleanliness spot check visits. HIW will also use information gathered centrally by the Welsh Assembly Government through the All-Wales Monitoring Tool to prioritise its programme of cleanliness inspections.

Welsh Assembly Government

Purpose: To provide an independent view of the cleaning audit process and ensure consistency in utilisation of the All-Wales Monitoring Tool.

The external review process is designed to ensure the following:

1. The All-Wales Monitoring Tool is being used consistently across Wales.
2. The All-Wales Monitoring Tool is being used to generate random samples for auditing in accordance with the audit frequencies outlined in the National Standards for Cleaning in NHS Wales.
3. The external review exercise will provide assurance that the internal audit scores reflect the actual standards of cleanliness.

The data submitted through the All-Wales Monitoring Tool system will be centrally monitored and, where significant cause for concern is identified, the Welsh Assembly Government may require immediate remedial action. Significant concern may arise because of the following:

- Failure to demonstrate compliance with the auditing process.
- Audit scores consistently lower than what is considered acceptable.

7. The Audit Process

Issues for consideration

Important issues when designing and implementing an audit of cleaning outcomes include:

- frequency
- personnel
- sampling
- scoring
- targets
- reporting; and
- action.

Frequency

The following table seeks to give guidance based on the audit requirements.

They are all scored audits.

	Minimum requirement
1. Very High Risk - Score	Weekly
2. High Risk - Score	Monthly
3. Significant Risk - Score	Quarterly
4. Low Risk - Score	6 monthly
5. Whole Healthcare Facility	6 monthly

By following this guideline, a full score for a healthcare facility will be achieved twice a year.

Audit personnel

General

All audit staff are expected to have substantial knowledge of healthcare facilities and their procedures and be able to make discriminating judgements on risk in relation to the areas being cleaned.

Internal audit team

The composition of the internal audit team is very important. The overriding factor is to ensure that audits and monitoring are, as far as possible, undertaken by first line supervisory staff. The following staff/groups should be included in some/all stages of the audit process:

1. Supervisor - domestic.
2. Manager - domestic.
3. Housekeeper or similar.
4. Infection control representative.
5. Ward sister/charge nurse for all ward areas.
6. Departmental manager or a nominated deputy.
7. Estates.
8. Risk manager.
9. Monitoring officer.
10. Nominated executive board member.
11. Patient Representative (periodic attendance).
12. CHC's (as part of an agreed programme of attendance).

Sampling

Audits may only address a small sample of the healthcare facility and may be element-based, for example, all floor surfaces are audited or based on functional areas, for example, a number of rooms in several wards are reviewed. However, where there are particular problems, the sample size should be increased to better inform the audit process.

Random sampling in a range of areas will ensure that areas are more uniformly cleaned. There should be different sampling cycles for different areas: high-risk areas should be audited more frequently than low-risk areas. The All-Wales Monitoring Tool should be used to generate random samples of functional areas to be audited in accordance with the risk based category allocated to them.

Scoring

1 The scoring system has to mirror the standard.

2 The standard is **acceptable** or **unacceptable** - Therefore acceptable is clean and unacceptable is *dirty*. Where an element is not present within a functional area it should be marked as **not applicable**.

3 The standard system based on pass or fail satisfies the criteria in (1) and (2) above.

4 This concept will ensure focus on a systematic, honest and consistent approach.

Scoring of audits provides an objective relative assessment of the cleanliness of the healthcare facility. The internal audit team should undertake regular comprehensive audits in accordance with the All-Wales Monitoring Tool and these should be scored. If it is deemed necessary additional audits may be undertaken and not scored.

Audits will need to be regularly discussed with ward sisters/charge nurses and departmental managers and reviewed as required. They should cover a variety of areas within the facility and cover all functional areas. The scoring of these audits provides the baseline data and an ongoing measurement of the effectiveness of the cleaning process.

The score will be reported to the Board through the Standards for Cleaning Group and recorded centrally through the All-Wales Monitoring Tool, submitted with EFPMS data as required, and will contribute to the overall assessment of the LHBs performance.

Targets

To assist LHBs 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

Reporting

Departmental level:

- Departmental scores and exception reports.
- Standards for Cleaning Group.
- Twice yearly area scores plus whole healthcare facility scores.
- Exception reports.

Infection Control Committee:

- Twice yearly area scores plus whole healthcare facility scores.
- Exception reports.

Action

The assessments collected in any audit must be acted upon as part of the process of continuous improvement.

Steps of the Audit Process

1 At the baseline audit stage for cleaning outcomes, a full review must be made of the elements list to agree who is responsible for cleaning each of the forty nine generic elements. For example, responsibility can lie with the following staff groups; the domestic department, estates or nursing. These should be documented in the LHB Cleaning Responsibility Schedule.

2 It must be documented as part of the audit process which staff group holds responsibility for the cleanliness of any elements that are scored as unacceptable.

3 Action plans should be generated after each audit that clearly outline which of the staff groups has responsibility for rectifying any problems identified during the audit.

4 Any items which directly impact the capability to clean should be documented on an exception report for remedial action by the responsible party.

5 The Standards for Cleaning Group must ensure that there is clear definition of the responsibilities and accountabilities of the cleaning team- some aspects will be general nursing responsibilities.

6 The sampling pattern must be random to ensure that there is no predictable pattern.

7 The audit can be conducted on a 'room' or 'element' basis. It is for the Standards for Cleaning Group in each LHB to determine this at the start of the process, providing the basic process for auditing and scoring are followed.

8 Where maintenance issues impact on the audit process, or poor maintenance is seen to contribute to a low score, this must be recorded in the audit comment sheet and in an exception report for the Standards Group, and the Board Nominee.

8. Calculation of Audit Scores

The following audit tool is written with reference to hospitals but the principles should be adopted, as appropriate for all healthcare facilities. Audits are for quality improvement purposes and should not be punitive. This approach is consistent with the outcome focus of the National Standards.

Information collected during the audit should be made available to all staff groups that have responsibility for the cleanliness/maintenance of any of the forty nine generic elements. As such an action plan should be produced following an audit for:

1. Domestic department.
2. Estates department.
3. Nursing staff.

The ward sister/charge nurse must be involved in the audit of ward areas and should sign off the audit report.

9. Internal Audit

Internal audit will be a continuous process in accordance with audit frequencies set out in the National Standards for Cleaning in NHS Wales. The audit will be evidence-based. If an element is not acceptable, then the auditor must make a comment as to why it is not acceptable and indicate the corrective action needed. A timescale for corrective action should be recorded.

10. How to score a functional area

There are a maximum of forty nine elements that can apply to any one functional area. The audit sheet should record how many of the forty nine elements apply to the functional area being audited.

For each element, the auditor should deem it to be 'acceptable' (score 1), or 'not acceptable' (score 0). Where the element is not present, it should be marked as not applicable (N/A).

This scoring is subjective and the auditor should exercise some discretion in judging the acceptability of an element. For example, one or two scuffmarks on a floor or an isolated smudge on a window does not indicate that the element should necessarily score as unacceptable.

The auditor should also take into account the physical condition of the infrastructure when making the assessment. For example, it may be impossible to obtain a uniform lustre on a damaged floor surface.

Once all elements have been scored, the total number of 'acceptable' scores should be expressed as a percentage of the total possible number of scores in that functional area. For example, if the operating theatres had a maximum of 30 elements, and 25 were acceptable, the overall percentage would be calculated as 25/30 or 83%.

11. Audit Methodology

The audit methodology should involve three inter-related levels of score as follows:

- 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 each functional area are averaged to establish the score for the functional area itself (the functional area score); and
- the scores of all the functional areas are averaged to give the overall score.

12. Calculating LHB Audit Scores

Where an overall LHB score is required, or there is a need to group facilities within an LHB, 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 LHB, Facility A has 200 beds and a score of 86%, Facility B has 1,000 beds and a score of 42%. The overall score must be calculated by weighting the individual scores by the bed numbers:

$$\frac{(86\% \times 200) + (42\% \times 1{,}000)}{1{,}200} = 49\%$$

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WHC (2006) 064 - Standing Order 29 Directions to NHS Trusts and Powys Local Health Board- Guidance for nominated Non-Executive Directors and Non Officer Member. Welsh Assembly Government, 2006 (patient's champions on cleaning, hygiene and infection management issues) http://howis.wales.nhs.uk/doclib/WHC(2006)064a.pdf

Welsh Risk Management Standard 14: Infection Control, Welsh Risk Pool. http://howis.wales.nhs.uk/gsiteCW/home.cfm?OrgID=287

Other Useful Weblinks

Clean Your Hands Campaign: http://www.npsa.nhs.uk/cleanyourhands

National Patient Safety Agency: www.npsa.nhs.uk

Wales

!000 lives campaign:
http://howis.wales.nhs.uk/sites3/home.cfm?orgid=781

NPHS for Wales' Welsh Healthcare Associated Infection Programme (WHAIP):
http://www.wales.nhs.uk/sites3/home.cfm?OrgID=379

Welsh Health Estates: http://howis.wales.nhs.uk/whe/

England

Clean Hospitals
http://www.dh.gov.uk/en/Managingyourorganisation/
Leadershipandmanagement/Healthcareenvironment/DH_4116447

Department of Health Estates & Facilities Management Division
http://www.dh.gov.uk/en/Managingyourorganisation/
Estatesandfacilitiesmanagement/index.htm

Appendix 1

Element Standards

Environment, Patient Equipment, Direct Contact

Element	Standard
1. Commodes	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
2. Bathroom hoists	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
3. Weighing scales, manual handling equipment	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
4. Drip stands	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
5. Other medical equipment NOT connected to a patient, e.g. intravenous infusion pumps and pulse oximeters	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
6. Medical equipment connected to a patient, e.g. intravenous infusion pumps and pulse oximeters	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
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.

Element	Standard
8. Medical gas equipment	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
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. All parts should be free of any materials (e.g. tape) that may compromise cleaning.

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. The 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 drug trolley	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.
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. The ward sister/charge nurse will have overall accountability for the tidiness of patient areas.
13. Linen trolley	All parts including underneath, equipment legs, wheels and castors should be visibly clean with no blood and body substances, dust, dirt, debris or spillages. All parts should be free of any materials (e.g. tape) that may compromise cleaning.

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. Ceilings	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 and body substances, dust, dirt, debris, adhesive tape or spillages.
18. All Internal glazing including partitions	All internal glazed surfaces should be visibly clean 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 parts 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 parts 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 inlet	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 spaces should have a uniform finish or shine and be visibly clean with no blood and body substances, dust, dirt, debris, spillages or scuff marks.

Soft Floors

Element	Standard
26. Soft floor	The complete floor including the 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 be 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 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 or spillages.
36. Hand wash containers	All parts of the surfaces of hand soap and hand towel dispensers should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
37. Hand hygiene alcohol rub dispensers	All parts of the hand hygiene alcohol rub dispensers should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
38. Waste receptacles	The waste receptacle should be visibly clean including the lid and pedal with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.
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, stains, 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, stains, 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, dirt, debris, lime scale, stains, deposits or smears.
46. Toilets and bidets	The toilet and bidet should be visibly clean with no blood and body substances, scum, dust, dirt, debris, lime scale, stains, deposit or smears.
47. Replenishment	There should be sufficient stock of all consumables and soap at all times.
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

Element	Minimum cleaning frequency			
	Very high risk	High risk	Significant risk	Low risk
1. Commodes	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
2. Bathroom Hoists	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
3. Weighing scales, manual handling equipment	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
4. Drip stands	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
5. Other medical equipment e.g. intravenous infusion pumps, pulse oximeters, etc. NOT connected to a 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. Other medical equipment e.g. intravenous infusion pumps, pulse oximeters, etc. connected to a 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
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	N/A
8. Medical gas equipment	One full clean daily	One full clean daily	One full clean daily	N/A
9. Patient fans	One full clean daily and between patient use	One full clean daily and between patient use	Clean daily	N/A
	One full clean weekly	One full clean monthly	One full clean quarterly	

Element	Minimum cleaning frequency			
	Very high risk	High risk	Significant risk	Low risk
10. Bedside alcohol hand wash container, clipboards & notice boards	Clean daily and between patient use	One full clean daily and between patient use	One full clean daily and between patient use	N/A
11. Notes & drugs trolleys	One full clean weekly	One full clean weekly	One full clean weekly	N/A
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 points daily	Contact points daily	N/A
	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	N/A
15. Walls	Check clean daily	One check clean daily	Check clean weekly	Check clean weekly
	Dust weekly	Dust weekly	Dust monthly	
	One full wash yearly	One full wash yearly	One full wash yearly	Washing once every 3 years
16.Ceiling	Dust monthly	Dust monthly	Dust monthly	One check dust monthly
	One full wash yearly	One full wash yearly	One full wash yearly	Washing once every 3 years
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 quarterly	One full clean quarterly	One full clean quarterly	N/A
20. Mirrors	One full clean daily	One full clean daily	One full clean daily	One full clean weekly
21. Bedside patient TV	One full clean daily	One full clean daily	One full clean daily	
22. Radiators	One full clean daily	One full clean daily	One full clean daily	One full clean monthly

Element	Minimum cleaning frequency			
	Very high risk	High risk	Significant risk	Low risk
23. Ventilation grilles extract and inlet	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 & one check clean daily	Dust removal daily	Dust removal one full clean & one check clean weekly
	Wet mop two full cleans daily	Wet mop one full clean & one check clean daily	Wet mop daily	Wet mop one full clean & 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 bi-annually
25. Floor - non slip	Dust removal two full cleans daily	Dust removal one full clean & one check clean daily	Dust removal daily	Dust removal one full clean & one check clean weekly
	Wet mop two full cleans daily	Wet mop one full clean & one check clean daily	Wet mop daily	Wet mop one full clean & 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 & one check clean daily	One full clean daily	One full clean & one check clean weekly
	Shampoo six-monthly	Shampoo six-monthly	Shampoo yearly	Shampoo bi-annually
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
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 daily
	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 & one check clean daily	One full clean daily	One full clean weekly

Element	Minimum cleaning frequency			
	Very high risk	High risk	Significant risk	Low risk
31. High surfaces	Twice weekly	One full clean & one check clean weekly	One full clean weekly	One full clean weekly
32. Chairs	One full clean & one check clean daily	One full clean & one check clean daily	One full clean daily	One full clean weekly
33. Beds	Frame daily	Frame daily	Frame daily	N/A
	Underneath weekly	Underneath weekly	Underneath weekly	
	Whole on discharge	Whole on discharge	Whole on discharge	
34. Lockers	Twice daily	One full clean & one check clean daily	One full clean daily	N/A
35. Tables	Twice daily	One full clean & one 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	One full clean & one check clean daily	One full clean & one check clean daily	One full clean daily	One full clean daily
	Deep clean weekly	Deep clean weekly	Deep clean weekly	Deep clean weekly
39. Curtains and blinds	Clean, change or replace yearly	Clean, change or replace yearly	Clean, change or replace yearly	Clean change or replace bi-annually
	Bed curtains change four monthly	Bed curtains change six monthly	Bed curtains replace 12 monthly	
40. Dishwasher	One full clean & two check clean daily	One full clean & 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 and 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	One full clean weekly	One full clean weekly
	Defrost monthly	Defrost monthly	Defrost monthly	Defrost monthly
42. Ice machines and hot water boilers	One check clean daily	One check clean daily	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 clean and two check cleans daily	One full clean and two check cleans daily	One full clean daily	One full clean daily
45. Showers	One full clean & one check clean daily	One full clean & one check clean daily	One full clean daily	One full clean daily
46. Toilets & bidets	Three full cleans daily	Two full cleans and one check clean daily	One full clean daily	One full clean daily
47. Replenishment	Three times daily	Three times daily	Once daily	Once daily
48. Sinks	Three full cleans daily	Two full cleans & one check clean daily	One full clean daily	One full clean daily
49. Baths	One full clean & one check clean daily	One full clean & one check clean daily	One full clean daily	One full clean daily

Appendix 3

Specimen Cleaning Responsibility Framework

The table contains a specimen cleaning responsibility framework which will assist LHBs 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, LHBs 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' instruction's where applicable.

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

The frequencies contained in the framework are the required **minimum** cleaning frequencies. LHBs may increase the frequencies on the advice from Microbiologists or Infection Prevention and Control Professionals.

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Ward patient equipment (medical)					
IV Stand		Weekly	Detergent wipes	Ward Staff	Include wheels
IV pumps/syringe drivers		Weekly	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Cardiac monitors		Daily and after use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Blood gas machines		Weekly	Alcohol wipes	Ward Staff	Cleaned by med phys after repair
Dressing trolleys		Weekly	Detergent wipes	Ward Staff	Include wheels
Linen trolleys		Weekly and after use	Detergent wipes	Ward Staff	Include wheels
Tea trolleys		Weekly and after use	Detergent wipes	Ward Staff	Include wheels
Notes trolleys		Weekly	Detergent wipes	Ward Staff	Include wheels
Drug trolleys		Weekly	Detergent wipes	Ward Staff	Include wheels
Sharps bins trolleys		Weekly and after use	Detergent wipes	Ward Staff	Include wheels
Blood pressure cuffs		Daily and after use	Alcohol wipes	Ward Staff	Cleaned by med phys after repair
Pillows		After use	Det/water/bowl/ disposable wipes	Ward Staff	
Mattresses		After use	Det/water/bowl/ disposable wipes	Ward Staff	
Cotsides		After use	Det/water/bowl/ disposable wipes	Ward Staff	

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Wheelchairs		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	
Commodes		Daily	Det/water/bowl/ disposable wipes	Ward Staff	
Cushions		After use	Detergent wipes	Ward Staff	
Oxygen sat probes		After use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Wash bowls		After use	Det/water/bowl/ disposable wipes	Ward Staff	Invert to dry
Pressure relieving mattress CVRS		After use	Det/water/bowl/ disposable wipes	Ward Staff	
Hoists		Daily	Det/water/bowl/ disposable wipes	Ward Staff	
Pat slides		After use	Det/water/bowl/ disposable wipes	Ward Staff	
Easy slides		After use	Det/water/bowl/ disposable wipes	Ward Staff	Consider laundry
Hoist slings		After use	Detergent wipes	Ward Staff	Consider laundry
Stands aids		Daily	Det/water/bowl/ disposable wipes	Ward Staff	
Handling belts		After use	Detergent wipes	Ward Staff	Consider laundry

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Resuscitation trolleys		Daily	Detergent wipes		
D/W/B/ disposable wipes	Ward Staff	Include wheels			
Carrying handles		Daily and after use	Detergent wipes	Ward Staff	Medical physics
Oxygen /suction equipment		Daily and after use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Oxygen /suction equipment (portable)		Weekly	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Wall humidifiers		After use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Portable nebulisers		Weekly and after use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Ventilator equipment		Daily and After use	Detergent wipes	Ward Staff	Cleaned by med phys after repair
Catheter stands		Weekly and after use	Washer disinfector	Ward Staff	
Bed pans/holders		After use	Washer disinfector	Ward Staff	
Slipper pans		After use	Washer disinfector	Ward Staff	
Urine bottles		After use	Washer disinfector	Ward Staff	
Urine jugs		After use	Washer disinfector	Ward Staff	
Raised toilet seats		Daily	Det/water/bowl/ disposable wipes	Ward Staff	
Scanners		Daily and After use	Detergent wipes	Ward Staff	Medical physics

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Scales		Weekly and after use	Det/water/bowl/ disposable wipes	Ward Staff	
Gas cylinder holders		After use	Detergent wipes	Ward Staff/ Porters	Gas cylinder holders
Tower balconies		Weekly	Det/water/bowl/ disposable wipes	Estates	Tower balconies
Traction beams		Daily and after use	Det/water/bowl/ disposable wipes	Ward Staff	
Thomas splints		After use	Detergent wipes	Ward Staff	
Monkey poles		After use	Detergent wipes	Ward Staff	
Weights		After use	Detergent wipes	Ward Staff	
Braun frames		After use	Detergent wipes	Ward Staff	
Ward Media Equipment					
TVs		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	
Hi-fis		Weekly	Detergent wipes	Ward Staff	
Telephones		Daily	Detergent wipes	Ward Staff	
Computer/keyboards		Weekly	Detergent wipes	Ward Staff	
Printers		Weekly	Detergent wipes	Ward Staff	
Fax		Weekly	Detergent wipes	Ward Staff	
Audio/visual systems		Daily	Detergent wipes	Ward Staff	

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Photocopiers		Monthly	Detergent wipes	Ward Staff	
Screens		Weekly	Detergent wipes	Ward Staff	
CCTV equipment		Monthly	Detergent wipes	Security Staff	
OHPs		Monthly	Detergent wipes	Ward Staff	
Flip charts		Monthly	Detergent wipes	Ward Staff	
Accessories i.e. staplers, hole punches		Monthly	Detergent wipes	Ward Staff	
Other Ward Equipment					
Portable heaters		After use	Detergent wipes	Estates	
Hand cleaning product holders		Daily	Detergent wipes	Ward Staff	Alcohol rub/ hibiscrub
Pest control devises		Weekly	Detergent wipes	Contractor	
Recycling bins		Weekly	Detergent wipes	WasteDepartment	
Items					
Ward staff equipment	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Drugs cupboard		Weekly	Detergent wipes	Ward Staff	
Drugs fridges		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	
Bed pan washer		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Macerator		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	
Isolation trolleys		Daily	Alcohol wipes	Ward Staff	Include wheels
Fridges/freezers		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Refer to cleaning manual
Cookers		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Refer to cleaning manual
Microwaves		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Refer to cleaning manual
Toasters		Weekly	Detergent wipes	Ward Staff	
Ice machines		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Refer to cleaning manual
Kettles		Weekly	Detergent Wipes	Ward Staff	Also descale
Kitchen Cupboards		Daily	Det/water/bowl/ disposable wipes	Ward Staff	Inside and out
Milk fridges		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Refer to cleaning manual
Crockery		After use	Dishwasher	Catering	
Cutlery		After use	Dishwasher	Catering	Cutlery
Water boilers		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Water boilers

Total cleaning responsibility framework (i.e. cleaning not covered by domestic services)					
Items	Time (mins) (estd)	Frequency	Method	Staff group responsible	Comments
Water coolers		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	Water coolers
Dishwashers		Weekly	Det/water/bowl/ disposable wipes	Ward Staff	

Appendix 4

Exemplar Operational Cleaning Plan

The National Standards of Cleanliness published in 2003 required that NHS Trusts develop an operational cleaning plan which stated specifically the existing standards of cleanliness, the gap between existing standards and the requirements of the National Standards, and the necessary actions to facilitate continued improvements in the actual standards of cleanliness. The plan should be regularly updated and informed by the work of the One full clean daily and between patient use Group.

The requirement for an operational cleaning plan is also included in the revised National Standards for Cleaning and this exemplar plan may be used as a template to amalgamate existing plans with the development of a new plan to meet the requirements of the revised National Standards for Cleaning in NHS Wales.

XXX Local Health Board

Operational Cleaning Plan

Date

Contents

1. Introduction

The cleanliness of any hospital environment is important for infection control and patient well being. Cleaning staff play an important role in quality improvement, in the confidence the public has in hospitals, and in reducing infection related risks.

The National standards for cleanliness in NHS Trusts in Wales, published in 2003, were developed following consultation with experts and professionals in the fields of cleanliness and infection control in order to raise standards of cleanliness to an acceptable level throughout the NHS.

XXX NHS Trust followed the recommendations of developing a plan for cleaning in order to provide focus for this important initiative and this was first issued in 20??.

It has been necessary to update the plan to reflect the publication of the revised National Standards for Cleaning in NHS Wales, issued in November 2009. The Standards have been updated to incorporate the latest guidance including the recommendations outlined in the Ministerial Empowering Ward Sisters Task and Finish Group final report Free to Lead, Free to Care published in June 2008.

The revised National Standards for Cleaning in NHS Wales recognises that, whilst many improvements in the standards of cleanliness have been made over recent years within the NHS in Wales, there is still much work to be done. All too often, cleaning service level agreements are driven by price, with insufficient focus and weighting being placed on quality. This new document clearly sets out the suggested **minimum** cleaning frequencies in order for hospitals to achieve the national standards.

2. The broad principles that have been used to develop the cleaning plan are:

- To understand the performance issues of the domestic services department.
- To develop specific objectives to enable domestic services to meet the national standards for cleanliness in the NHS in Wales.
- To develop an appropriate performance management framework to ensure implementation.
- To ensure the implementation of the All-Wales Monitoring Tool for the auditing of achieved standards of cleanliness.

3. Objectives of the cleaning plan

- To ensure that domestic services can over a period of time meet and maintain the requirements of *National Standards for Cleaning in NHS Wales*.
- To respond to the challenges set by a more informed and involved public, with high expectations of cleanliness in hospitals.
- To assist the LHB in creating the right environment for patients through cultural change by providing a new focus for staff through effective leadership.
- To ensure that domestic services secures and retains the manpower required to meet the demands of the future.

4. Goals

- To be recognised throughout the LHB for providing a quality customer focused service.
- To enhance the reputation of the LHB, both locally and nationally.
- To maintain and develop a well trained, flexible and motivated workforce capable of delivering excellent services.

5. National Standards of Cleaning group

In order to focus on the delivery of the National Standards for Cleaning in NHS Wales, the trust set up a multi disciplinary national standards of cleanliness group. The remit of the group is to introduce the *National Standards for Cleaning in NHS Wales* into their hospitals.

Membership

- Director of Estates and Facilities.
- Director of Nursing.
- Hotel services manager.
- Domestic services manager.
- Ward/Department representative.
- Estates manager.
- Infection Control lead.
- Staff representative and/or Union representative.
- Patient representative.

Terms of reference

- To take ownership of the national standards of cleanliness.
- To develop strategic and operational plans for cleaning.
- To oversee the implementation of the national cleaning standards.
- Responsibility for maintaining acceptable standards of cleanliness and to produce reports on performance against standards.
- To discuss and implement non-clinical service improvements in relation to the national cleaning standards and the Patient Environment (HPE).
- To update the strategic and operational cleaning plans as necessary.
- To implement a process of continuous review, feedback and improvement.
- To receive and act upon 'exception' reports that directly impacts on the capability within the LHB to clean to the national standards of cleanliness.
- To review staff training requirements in accordance with the **minimum** standard of training outlined in the national cleaning standards.

6. Hospital Patient Environment Action Group (HPEAG)

Following the initial Hospital Patient Environment (HPE) external assessment conducted by members of the Community Health Council (CHC) a Hospital Patient Environment Action Group was established. Membership of the group was made up of:

- Director of estates and facilities.
- Director of nursing.
- Hotel services manager.
- Domestic manager.
- Infection Control lead.
- Lead nurses.
- Estates manager.
- CHC representative.

The terms of reference are:

- To develop strategies that supports the modernisation and continual improvement of the patient environment.
- To input into the work of the National Standards for Cleaning group (strategic group).
- To ensure that HPE recommendations are acted upon in a timely and cost-effective manner.

- To act as the decision-making group for all aspects of the maintenance of a pleasant patient environment, incorporating patient views and involvement whenever possible.

The function of the Hospital Patient Environment Action Group is:

- The group will be responsible for responding to reports and actioning recommendations from the Welsh Assembly Government and other approved bodies as appropriate.
- The Hospital Patient Environment Action Group will normally meet on a quarterly basis and is responsible for submitting reports to the LHB Excutive board.

7. National Standards for Cleaning in NHS Wales principles and objectives

The outcome-based cleaning standards have been developed using current best practice within the NHS in Wales. The outcome based standards offer:

- patient and customer focus
- clarity for housekeeping staff and service providers
- an effective aid to management
- consistency with infection control standards and requirements; and
- clear outcome statements, which can be used as benchmarks and output indicators.

Patient and customer focus

Everyone, who enters a hospital, whether as a patient, visitor or member of staff, is a customer of the cleaning service. The standards have to focus clearly on their expectations.

Patients are asked to give their views on hospital cleanliness, and are asked directly about their satisfaction with the patient environment via local patient satisfaction surveys. These results form part of a performance measure in the performance assessment framework.

The LHB has nominated a non Officer Member who acts as patient champion for cleanliness, hygiene and infection control in accordance with instruction issued under WHC (2006) 064 Standing Order 29 Directions to NHS Trusts and Powys LHB- Guidance for nominated Non-Executive Directors and Non Officer Members. This will be superseded by Subordinate Legislation 2009, 40 National Health Service Wales Directions to Local Health Boards, Velindre National Health Service Trust, Welsh Ambulance Service Trust, Public Health Wales NHS Trust 2009. The non officer board member is responsible for ensuring patient participation in the development of the cleaning strategy and the Cleaning Plan.

Clarity for housekeeping services staff

The clarity of Cleaning Standards is of paramount importance. It is essential that the domestic staff have a clear understanding of the Standards and task requirements to ensure they are working towards and assessing the same cleaning outcomes. The Standards are to be realistic and achievable and the domestic staff must be able to carry out their jobs safely and in a controlled environment.

8. National standards of cleanliness

The following key objectives are of critical importance to improve the general standards of cleanliness:

8.1 Taking cleanliness seriously

To ensure that high standards of comfort and cleanliness are the norm, by:

- Setting clear local standards and policies, and keeping cleanliness high on the agenda.
- Identifying an executive board member to take personal responsibility for monitoring hospital cleanliness.

The accountability for all aspects of cleanliness lies with the Chief Executive and the LHB board.

8.2 Listening to patients

To ensure that patients receive care in an environment that is clean, safe and welcoming, through:

- Identifying a non officer member to act as patients champion for cleanliness, hygiene and infection control.
- Promoting strong, visible nursing leadership with clear authority at ward level, and acting on patient feedback.

8.3 Infection control

To ensure that the risk of hospital-acquired infection is minimised through:

- Developing, implementing and monitoring infection control policies; and learning from experience.

8.4 Education and development

To ensure those staff responsible for cleanliness have the ability and support to do a good job, by being trained to the national **minimum** standards. Training activities should include:

- Induction training.
- Cleaning Operatives Proficiency Certificate award.
- On-the-job support.
- Customer service training.
- Supervisory, managerial and leadership development training (where appropriate).

8.5 Monitoring and performance

To make sure those standards of comfort and cleanliness stay high, and that any slippage is recognised and corrected, through:

- setting targets that measure performance over a range of factors
- establishing management systems that support continuous improvement; and
- involving ward managers and ward sisters/ charge nurses in maintaining standards.

8.6 Recruitment and retention

Recruitment and retention of the workforce is essential to the long term stability of the Standards and will be achieved through:

- A streamlined and timely recruitment process.
- Robust sickness management policies.
- Regular reviews of changes and developments to ensure efficient workforce planning.
- Specific plans to enhance staff retention.

8.7 Resources

The appropriate levels of resource are essential in delivering and maintaining the Standards. Key to this will be:

- best value reviews and benchmarking, to ensure effective and efficient methods are being used, and that sufficient staff are always available; and that
- adequate and modern equipment is used to ensure the best achievable service.

8.8 Documentation

Comprehensive documentation should be available to ensure that operational and strategic needs are met in terms of the Standards and will be achieved through:

- an up-to-date cleaning manual that gives written guidance on how to complete each task
- comprehensive risk assessments undertaken to ensure working methods and staff are as safe as possible
- staff rota systems to ensure appropriately trained staff are available and deployed as necessary; and
- policies that involve cleaning service providers in future developments or changes.

9. Free to Lead, Free to Care

The Ministerial Empowering Ward Sisters Task and Finish Group final report 'Free to Lead, Free to Care' published in June 2008, contained a series of recommendations to ensure that ward sisters/charge nurses are empowered with the authority, knowledge and skills to improve the environment of care and patient experience.

The recommendations contained within the report are intended to expand the role of hospital ward sisters/charge nurses by giving them more power to improve ward cleanliness, raise standards of care and protect patients' meal times, thereby improving the patient and public experience in our hospitals.

The recommendations that directly relate to cleanliness have been incorporated into the revised *National Standards for Cleaning in NHS Wales* and as such have also been incorporated into the operational cleaning plan. The recommendations are as follows:

- The introduction of the Cleaning Operatives Proficiency Certificate award from the British Institute of Cleaning Science as the national **minimum** standard of training for domestic staff.
- The introduction of standardised products for cleaning and infection control.
- The revision of the National Standards for Cleaning in NHS Wales to include subsequent policy and evidence based developments and make explicit the responsibilities of the ward sister/charge nurse identified within Free to Lead, Free to Care.
- The introduction of an All-Wales monitoring tool for cleanliness that should be adopted across Wales.
- Consideration should be given to the introduction of a technical hygienist role.
- The development of LHB wide schedules that clearly identify who is responsible for cleaning specific items of patient equipment should be developed with an input from ward sisters/charge nurses.

- Regular domestic staff should be allocated to particular wards or work areas to enable them to work as part of the team and take pride in their work.
- The ward sister/charge nurse should be routinely involved in the recruitment process for the ward housekeeper/domestic staff that will be allocated to their team.
- Each LHB should introduce a stand-alone 'rapid response' cleaning team (in addition to the existing staff establishment).

10. Revised National Standards for Cleaning in NHS Wales

The revised *National Standards for Cleaning in NHS Wales* have been updated to include subsequent policy and evidence based developments and make explicit the responsibilities of the ward sister/charge nurse identified within Free to Lead, Free to Care. The document provides:

- Revised national specifications for cleaning which set out clearly the standards which hospitals should provide as a **minimum**.
- The recommended **minimum** cleaning frequencies which are suggested to be followed to achieve the national specifications.
- An audit procedure to measure results against the standards of cleanliness using the All-Wales monitoring tool.

11. Identifying risk

The areas that are to be cleaned in the hospital are broken down into functional areas. Maintaining the required standard of cleanliness is more important in some functional areas than others.

In line with the revised National Standards for Cleaning in NHS Wales, the functional areas will be grouped into four levels of cleaning intensity, based on the risks associated with inadequate cleaning in that functional area:

1. **Very high risk.** Consistently high levels of cleanliness **must be maintained**. Very high risk areas may include operating theatres, critical care areas, special care baby units, accident and emergency departments and other departments where invasive procedures are performed. Over a period of a week all rooms within these areas should be audited at least once.

2. **High risk.** Outcomes should be maintained by regular and frequent cleaning with 'spot' cleaning in between. High risk areas may include general wards, sterile supplies, public thoroughfares and public toilets. Over a period of one month all rooms within these areas should be audited at least once.

3. **Significant risk.** In these areas high levels of cleanliness are required for both hygiene and aesthetic reasons. Outcomes should be maintained

by regular and frequent cleaning with 'spot' cleaning in between. Significant risk areas may include pathology, out-patient departments, laboratories and mortuaries. Over a period of three months all rooms within these areas should be audited at least once.

4. **Low risk.** In these areas high levels of cleanliness 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. Low risk areas may include administrative areas, non-sterile supply areas, record storage and archives. Over a period of twelve months all rooms within these areas should be audited at least twice.

12. Elements

The items to be cleaned are broken down into 49 elements as defined in the national standards of cleanliness. The All-Wales Monitoring Tool will be utilised during all audits and scores will be made available through the system for central scrutiny.

13. Operational statements

An operational statement will be developed for each task that is to be carried out. The statement will cover the outcome required, the equipment required and the process that is to be applied which are compliant with the processes taught by the national training programme where applicable. These have been collated together in the *LHB operational cleaning manual* (to be issued in 20??).

In order to meet the national standards of cleaning and as part of this operational cleaning plan, cleaning frequencies will be developed, in line with the suggested **minimum** cleaning frequencies, which will detail how often these tasks should be undertaken.

Work schedules to form part of the operational cleaning plan will be developed for each area, which will detail the daily duties, weekly duties and periodic tasks.

14. Audit

The completion of an internal audit is a fundamental prerequisite of implementing the national standards of cleanliness. The baseline audit provides a detailed report on the current standard of cleanliness within the hospital.

The principles of the audit are:

1. The audit clearly identifies anything that impacts on the capability to clean.

2. The audit clearly identifies tidiness issues that impact on the capability to clean.

3. The audit identifies any areas/items/elements that are not within the remit of the cleaning team.

4. The audit clearly identifies the distance between current cleanliness levels and the standard levels of cleanliness.

5. The audit is an integral part of the strategic cleaning plan.

6. The audit clearly highlights the gap between current levels of cleanliness and the standards laid down in the national standards of cleanliness for the NHS.

7. All issues/items identified as part of the audit generate exception reports.*

* A report giving detail of failures or defects that require immediate inspection as they impact on the capability to clean. These reports are escalated to the relevant professional lead and where appropriate the National Standards of Cleaning Group.

The audit process

An audit process has been implemented in line with the recommendations in the national standards for cleanliness. Two levels of audit are undertaken:

- **Technical.** These take the form of regular weekly audits which form a continuous and inseparable part of the day-to-day management and supervision of the cleaning services. Technical audits are undertaken by the domestic supervisor and are signed off by the ward sister/charge nurse (where appropriate). The frequency of these audits is in accordance with the relevant risk category.
- **Managerial.** These are planned audits that should verify cleaning outcomes of technical audits and identify any areas for improvement. The audit team should consist of senior domestic management, ward sisters/ charge nurses with responsibility for cleaning, infection control and estates. These audits are undertaken at least quarterly to ensure a representative sample is achieved during a twelve month period. The team validates a sample of technical audit information by sampling some elements across all functional areas, some room types or one or more functional areas. The decision concerning the scale of the review is based upon cleanliness levels already achieved; where the team feel emphasis should be placed; or randomly chosen elements, rooms or functional areas generated by the All-Wales Monitoring Tool.

An annual programme for cleanliness audits will be generated via the All-Wales Monitoring Tool to ensure that each area receives regular audits. Obviously, higher risk areas receive a higher proportion of audits to ensure that the high standards of cleanliness required are achieved, these are randomly selected by the monitoring tool. The audits are evidence based and if an element is not acceptable, the auditor is required to make a comment as to why it is not acceptable and indicate the corrective action needed. A timescale for corrective action is recorded on the audit form and forwarded to the necessary personnel for action.

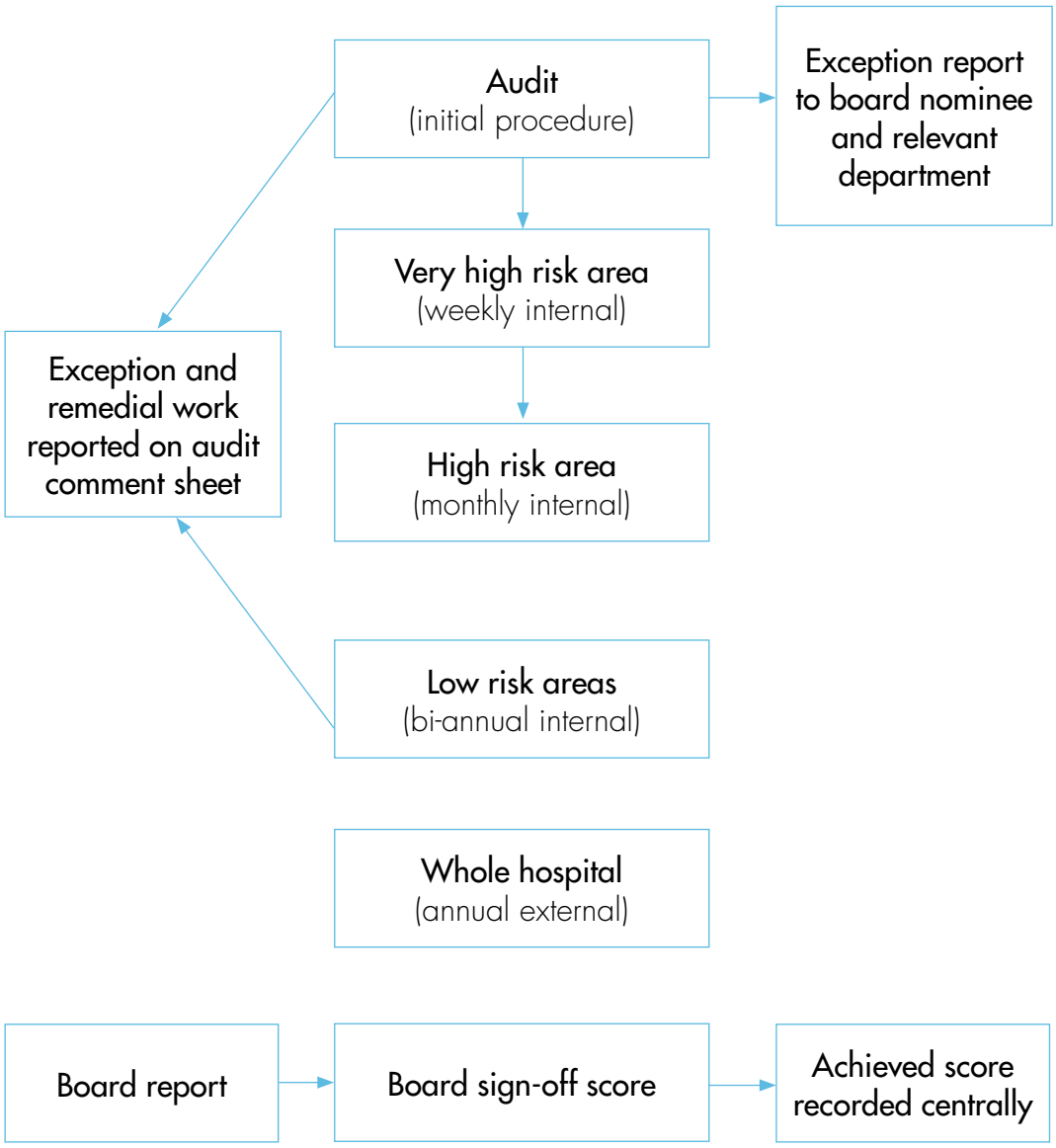
When the audit has been completed the score is produced and recorded. The audit scores will be made available for central scrutiny via the All-Wales Monitoring Tool. The relevant staff groups are informed of any issues that need to be rectified within agreed timescales. The following staff will be included in some/all stages of the auditing processes:

1. Hotel services manager.
2. Domestic services manager.
3. Infection control lead.
4. Estates manager/officer.
5. Domestic services supervisor/staff.
6. Nursing staff (ward sister/charge nurse).

15. Results of the external audits for XXX LHB

In order to verify audit scores and ensure that the All-Wales Monitoring Tool is being utilised consistently across Wales a representative from Health Inspectorate Wales will join the managerial audit team at least once on an annual basis. This will allow for the audit scores to be externally verified.

16. Audit process flow chart



The strategy includes:

- A current situational analysis against the national standards of cleanliness for the NHS in Wales (baseline assessment).
- Identification of the gap between the two.
- A top line action plan for closing the gap.
- Operational cleaning plan.

The strategy details short term, medium term and long term objectives.

17. Operational cleaning manual

The clarity of cleanliness standards is of paramount importance. It is essential that the staff have a clear understanding of the standards and task requirements to ensure they are working towards and assessing the same cleanliness outcomes. The standards are to be realistic and achievable and the domestic staff must be able to carry out their jobs safely and in a controlled environment. In order to ensure that staff fully understand the national standards, an Operational cleaning manual has been developed and will be issued to all cleaning staff. The manual can then be used as a reference whilst working on wards or departments, and will assist staff in developing their understanding of their tasks and duties and what is required of them.

18. Conclusion

The implementation of the National Standards for Cleaning in NHS Wales has been an opportunity to encourage improvement in and measurement of cleaning standards through a multi disciplinary staff group. Whilst significant progress has been made, there is still much to do. The revised National Standards for Cleaning in NHS Wales has provided a framework and exemplar documents which will assist the LHB to continuously improve environmental cleanliness.

The ongoing use of the All-Wales Monitoring Tool will serve to focus attention on performance and quality and has been seen as a positive move forward. There are measurable improvements in service standards and an increased awareness among all staff of the standards to be achieved.

Appendix 5

Exemplar strategic cleaning plan

The National Standards of Cleanliness published in 2003 required that NHS Trusts develop a strategic cleaning plan that would provide the high-level strategic direction for cleanliness services and which would be supported by the operation cleaning plan. The strategic plan should be developed and updated by the National Standards of Cleaning Group.

The requirement for these plans are also included in the revised National Standards for Cleaning in NHS Wales and this exemplar plan may be used as a template to amalgamate existing plans with the development of a new plan to meet the requirements of the revised National Standards for Cleaning.

XXX Local Health Board

Strategic Cleaning Plan

Date

Statement of intent

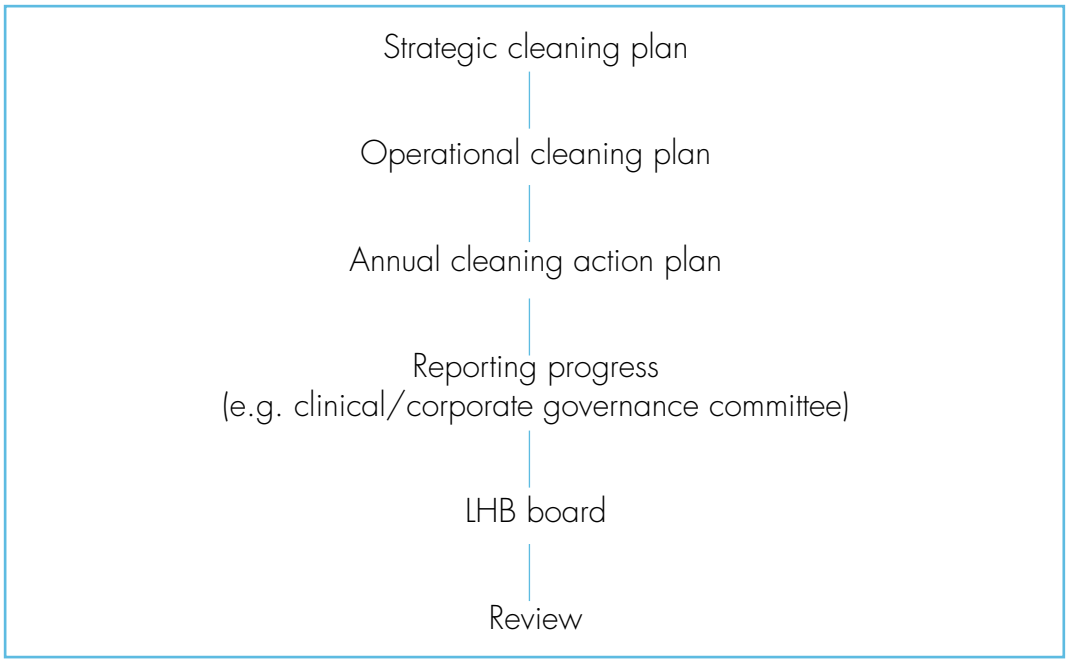
This document sets out a professional and effective approach for NHS organisations to deliver a clean and safe environment for everyone using healthcare facilities by:

a) Contributing to and supporting LHB HCAI control mechanisms.

b) Implementing a whole system approach that includes all healthcare and associated professionals.

Accountability

Whilst final accountability for all aspects of cleanliness lies with the Chief Executive and the LHB board, there is a designated executive board member accountable for reporting to the LHB board and ensuring, in liaison with the infection prevention and control lead, that proper systems and processes are in place to achieve high standards of cleanliness which will support the following:



Governance and risk

This strategic plan supported by the operational cleaning plan will enable the LHB to achieve compliance with all relevant legislation and guidance and fits within its organisational governance and risk management framework.

The operational cleaning plan must take account of:

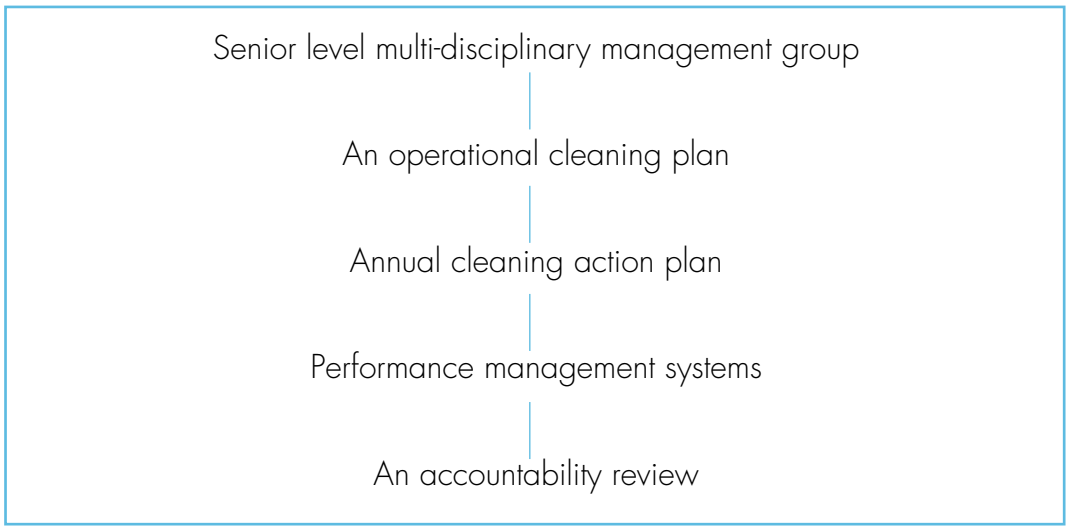
- Compliance with safe practice notices and management action plans.
- *The National Standards for Cleaning in NHS Wales* (2009), Healthcare Standards for Wales (in particular Standard 5).
- Demonstrating due diligence.
- Evidence based practice.
- The LHBs responsibility in ensuring competency, through training for all levels of individuals commensurate with their roles and responsibility in providing a clean environment.

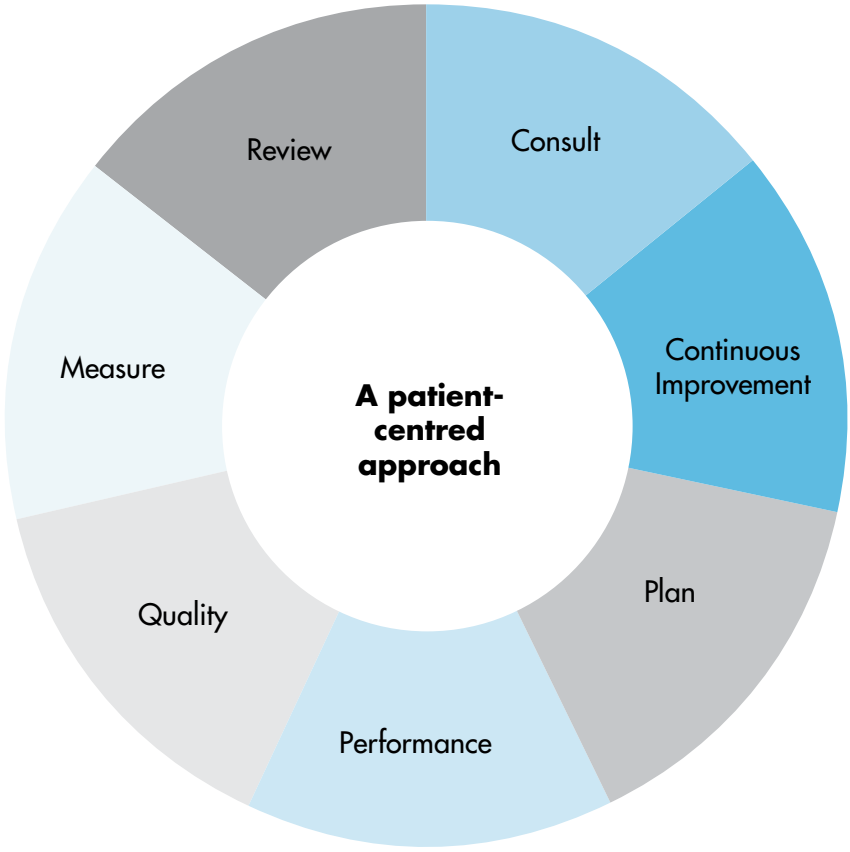
LHBs need to be able to demonstrate that healthcare premises are clean and that risks from inadequate or inappropriate cleaning have been minimised. All cleaning related risks should be identified and managed on a consistent long-term basis, irrespective of where the responsibility for providing cleaning services lies and if necessary entered onto the risk register.

This outcome can be used as a basis for developing service level agreements; benchmarking; and establishing the right staffing levels.

Process and delivery

The strategic plan must be reinforced and supported by:





Finance and resource

Many factors affect the investment needs of a particular area, including age, levels of maintenance and clinical speciality. Sufficient resources should be allocated for cleaning and investment must recognise this. The LHB board must also acknowledge that adequate investment is required for additional cleaning if there is an outbreak of infection or contamination.

Outcome

A clean environment provides the right setting for good patient care practice and good infection control. It is important for efficient and effective healthcare.

The LHBs board support of the strategic plan will ensure that the LHB complies with the code of practice for the prevention and control of Health Care Associated Infection's (HCAI) cleaning element. It sets out criteria by which managers of NHS organisations should ensure that patients are cared for in a clean environment, so that the risk of HCAI is kept as low as possible. Additionally it will help reduce the risks associated with poor standards of cleanliness, demonstrate due diligence and promote a more consistent and high quality output that patients, public and staff will notice and appreciate.

Appendix 6

Glossary 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 and cobwebs.

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

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

Spillage includes any liquid, tea/coffee stains and 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 the floor.

Quality systems refer to the 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.