NHS
National Patient Safety Agency
National Reporting and Learning Service

The national specifications for cleanliness in the NHS:

A framework for setting and measuring performance outcomes in ambulance trusts

Preface

These specifications complement the *National specifications for cleanliness in the NHS* published in April 2007. They provide a comparative framework within which healthcare providers in ambulance trusts* can set out details for providing cleaning services and assessing 'technical' cleanliness. They should be read alongside *Ambulance guidelines: reducing infection through effective practice in the pre-hospital environment June 2008* and the *National Guidance and Procedures for Infection, Prevention and Control: managing healthcare associated infection and control of serious communicable diseases in ambulance services*, version 2: ASA November 2005.

These specifications take account of all relevant publications including, but not restricted to:

- *Towards cleaner hospitals and lower rates of infection, A matron's charter: an action plan for cleaner hospitals, Standards for better health and the Code of practice for the prevention and control of healthcare associated infections* (Health and Social Care Act 2008) (see also Foreword - page 5).

They also include:

- suggested minimum cleaning frequencies;
- a specimen strategic cleaning plan, an operational cleaning plan and a cleaning responsibility framework.

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

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

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

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

*NB: referred to as 'healthcare providers' from this point

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Foreword

Providing a clean and safe environment for healthcare is a key priority for the NHS and is a core standard in *Standards for better health*. Other publications such as *Towards cleaner hospitals and lower rates of infection* and *A matron's charter: an action plan for cleaner hospitals* have further emphasised this, and also recognise the role cleaning has in ensuring that the risk to patients from healthcare associated infections is reduced to a minimum. It is recognised that these publications were predominantly aimed at hospital settings - nevertheless the principles they advocate hold true for other healthcare settings and should be reflected accordingly.

The *Code of practice for the prevention and control of health care associated infections* places further onus and responsibility on healthcare providers to ensure that local provision of cleaning services is adequately resourced; clearly defined through a strategic cleaning plan, and clear cleaning schedules and frequencies; and arranged to ensure that patients, the public and staff know what they can expect. Further information relating to each of these publications is detailed below.

This key priority, coupled with increasing public concern about healthcare associated infections, means healthcare premises (which includes ambulance vehicles) need to not only be clean but must also have mechanisms in place to demonstrate how and to what standard they are kept clean.

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

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

High levels of cleanliness can only be achieved through:
- clear specifications;
- the proper training of staff;
- documented lines of accountability;
- where appropriate, the involvement of patients/public;
- all staff recognising their responsibilities;
- a meaningful framework for measurement;
- Trust management/board support (with consideration also given to the appointment of a board nominee to represent cleaning-related issues);
- direct links between cleaning services and local infection control teams and policies.

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

The changing environment for cleanliness in the NHS

Much has changed in the provision of cleaning services since the publication of the *NHS Plan* first brought a renewed emphasis on this area of hospital activity and led directly to the introduction of the national specifications for cleanliness in the NHS.

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

This expectation is reflected in a number of recent publications and activities, which impact on the provision of cleaning services.

Towards cleaner hospitals and lower rates of infection

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

A matron's charter: an action plan for cleaner hospitals

This document has several principles transferable to ambulance trusts including:

1. Keeping the NHS clean is everybody's responsibility.
2. The patient environment will be well-maintained, clean and safe.
3. Cleaning staff will be recognised for the important work they do and will be part of the team.
4. Specific roles and responsibilities for cleaning will be clear.
5. Cleaning routines will be clear, agreed and well-publicised.
6. Patients will have a part to play in monitoring and reporting on standards of cleanliness.
7. All staff working in health care will receive education in infection control.

8 Infection control teams will be involved in drawing up cleaning contracts.
9 Sufficient resources dedicated to keeping the environment clean.

Health and Social Care Act 2008: Code of practice for the prevention and control of healthcare associated infections

Duty 4 of the code of practice confers a duty on NHS bodies to provide and maintain a clean and appropriate environment for healthcare and indicates (in Appendix 1 of the document) where this duty is applicable to ambulance trusts. A copy of the code of practice is in Appendix 10.

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

There are three standards which relate to cleanliness:

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

2 **Standard C4 (c): "**All reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed."

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

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

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

Building on previous policy and guidance, Saving lives set out nine challenges in the form of a self-assessment and planning tool, including:
Challenge 6 requires organisations to 'ensure that all employees have a programme of

education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take'. This makes specific reference to induction and ongoing training for all staff.

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

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

Service delivery

The original national specifications for cleanliness in the NHS were developed by a group of experienced cleaning services managers from both the NHS and private sector companies, along with members of the Infection Control Nurses Association. They drew on work already undertaken by the State of Victoria in Australia.

This iteration has been produced with the help, advice and expertise of a number of groups and individuals from ambulance trusts, amongst others. The National Patient Safety Agency (NPSA) is grateful to both the Australian authorities and other organisations and individuals who have assisted them.

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

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

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

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

Infection control

All healthcare providers are responsible for ensuring that there are effective arrangements for infection control. In hospitals, this responsibility rests with chief executive, although it is frequently delivered by another nominated individual, for example, the director of infection prevention and control. In ambulance trusts there should be clear arrangements setting out who is responsible for ensuring effective infection control practice.

These national specifications support local risk management plans by assessing the effectiveness of cleaning programmes. The local infection control committee, infection control team, or other body as appropriate, must be involved in their use and regularly appraised of the results of assessment, and monitoring and

audit findings.

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

Principles and objectives

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

Key attributes of service delivery are that it:

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

Operational delivery

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

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

There is no national standard for a strategic or operational cleaning plan, and it is for each healthcare provider to produce their own. However, there are examples of each in Appendices 6 and 7 that can act as guides.

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

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

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

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

Recommended minimum cleaning frequencies

Discussions with cleaning service providers suggest that, whilst it is important that healthcare providers locally produce a cleaning frequency schedule, a single national version is inappropriate since it cannot meet every NHS organisation's needs. It would also stifle the ability to allocate cleaning resources where they are most needed.

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

These specifications therefore include suggested cleaning frequencies, recognising that it will be for individual healthcare providers to determine the precise frequencies that best meet their own identified needs.

Cleaning responsibility framework

The provision of healthcare takes place in settings that vary enormously, and the range of equipment (both clinical and non-clinical) that requires cleaning will differ. Responsibility for cleaning can also vary and will include, at least, domestic cleaning services providers, crew members and estates staff. In addition, items such as windows and carpets require less frequent cleaning and may be cleaned by contractors.

Ensuring all items that require cleaning are cleaned is a significant and important task.

The cleanliness standards in Appendices 1 and 2 include a range of elements listed under broad headings that, taken together, should cover the entirety of items and areas to be cleaned. However, within these broad headings, there may be a much greater range of specific items for which a national list could not be produced with any reliable degree of accuracy.

It is recommended that healthcare providers produce a schedule of cleaning responsibility, specifically for each premises/vehicle, and list either:
- all items to be cleaned; or
- all items not covered by non-crew/domestic services.

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

Appendix 8 has a specimen cleaning responsibility framework with suggested cleaning frequencies.

Management of staff

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

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

Cleaning equipment

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

Appendix 9 also sets out suggested colour coded systems for cleaning materials. Each healthcare provider should consider ensuring its equipment conforms to these.

IT

In the modern, changing healthcare environment, patient-centred service that needs to be flexible is difficult to achieve. Some NHS trusts have found the need to modernise their administrative system by using appropriate IT software packages. The areas of healthcare delivery to which these specifications apply may be too small to warrant such systems, however where they are introduced they should be able to:

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

Auditing and monitoring information

In addition to having the right systems in place to deliver high-quality cleaning, it is also important to have mechanisms in place that allow healthcare providers to demonstrate to others - whether statutory bodies such as the Healthcare Commission, local commissioners or patients/the public - that high standards are being achieved and/or the steps being taken to achieve these.

It is also important to ensure that the auditing and monitoring process is appropriate to

the healthcare setting, takes account of the identified risks and does not act to interfere in the timely delivery of healthcare. It follows therefore that a one-size fits all approach will be neither appropriate nor achievable, and healthcare providers will need to exercise a considerable degree of discretion to identify precisely what auditing and monitoring arrangements they need.

Notwithstanding this, the following sections set out a mechanism to establish the cleanliness of equipment, fixtures and fittings, and premises so that a 'whole score' can be calculated. In an ambulance trust setting it may apply to the vehicle fleet, station or a combination of the two. By collecting area/vehicle specific scores, results may be established. This allows any variations in quality across similar areas to be identified and the causes of any unacceptable variations to be addressed.

The specifications operate according to identified risk categories through which each cleanable area of the premises (known as functional areas, and covering both clinical and non-clinical) is allocated a risk factor on a scale from very high to low. This is a crucial first step in applying the specifications since the level of monitoring and audit is directly linked to the identified risk factor. Because the 'premises' to which these specifications apply are likely to be very small (in the case of ambulances), healthcare providers may decide to allocate the same level of risk to all areas. In this case, the level of risk allocated should be the highest that applies regardless of whether this is the majority of the premises.

In determining the risk category(ies) to be applied, appropriate infection control advice should be sought.

Standards of cleanliness

Quality standards are set out according to the range of items to be cleaned (known as elements and which include equipment, fixtures, fittings and buildings [or part thereof]) that, taken together, comprise the broad range of items commonly found in ambulance trust premises/vehicles). However, as noted earlier, it is not possible to list every item that may be present and healthcare providers should ensure that all items in their premises are included through, for example, a cleaning responsibility framework (see Appendix 8).

Further appendices provide a range of information relating to the elements, sample scoring sheets, cleaning frequencies and other useful information. To accompany these specifications, an Excel spreadsheet with frameworks for gathering, reviewing and reporting audit information is available from:
www.npsa.nhs.uk/patientsafety/improvingpatientsafety/cleaning-and-nutrition/

Timeframe for rectifying problems

It is important that there are clear arrangements for ensuring that remedial/additional cleaning can be carried out as and when required. It is also recommended good practice that there are clear timescales for such cleaning, which take into account the degree of urgency and/or the extent to which patients, staff or visitors may be put at risk if urgent cleaning is not carried out. The table on the following page provides example timeframes that ambulance trusts/practitioners may wish to use to base a local policy on.

	Timeframe for rectifying problems
A CONSTANT **Cleaning critical - very high risk/high risk.**	Immediately or as soon as is practically possible. Cleaning should be recognised as a team responsibility. If domestic or cleaning staff are not on duty, cleaning should be the responsibility of other personnel. These responsibilities should be clearly set out and understood. For an ambulance vehicle, this priority could be seen as 'between patient' cleaning in which case it would be the responsibility of the ambulance personnel on duty in the vehicle. For an ambulance station, this could be required e.g. if any part of the premises was contaminated by blood or other bodily fluids.
B FREQUENT **Cleaning important and requires maintaining - significant risk.**	0-3 hours for patient areas (to be rectified by daily scheduled cleaning service for non-patient areas). For an ambulance vehicle this could be seen as a daily scheduled clean by cleaning personnel.
C REGULAR **On a less frequent scheduled basis, and as required in-between cleans - low-risk.**	0-48 hours. For an ambulance vehicle this could be seen as a weekly deep-clean, including inside cupboards, which would be the responsibility of cleaning personnel.

Auditing and monitoring

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

- technical;
- managerial.

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

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

Technical audits

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

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

Managerial audits

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

External audits

External audits are not an intrinsic part of the auditing process but are recommended as good practice since they provide an independent view of cleanliness and validate the healthcare provider's own internally awarded scores.

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

Audit principles

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

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

Frequency

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

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

External audit frequencies (if undertaken) should be increased where these scores differ noticeably from scores derived from audits undertaken by the healthcare provider.

Personnel

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

Managers and staff involved with audits should:

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

Methodology

Audits should be arranged so that the frequency and extent of the audit is determined in accordance with risk identification. Put simply, this would mean that the interior of an ambulance and its contents should be audited far more frequently that the exterior since

the risk to patients of inadequate cleaning of the vehicle interior is far greater.

It follows that a key stage in applying these specifications is a risk analysis to determine which areas carry the most risk. It is suggested that a maximum of four risk categories be used:
- very high risk;
- high risk;
- moderate risk;
- low risk.

The precise risk category to be allocated will be for local determination on consultation with infection control teams/advisers.

Furthermore, because of the size and configuration of ambulances, it is likely that a single risk category will be applied to the entire vehicle and its contents. Where this happens, the risk category applied should be the highest that applies to any single element.

Sampling

Technical audits

Technical audits should be ongoing and the regularity of reviews should be in accordance with the relevant risk category. Every three months, the scores should be collated and averaged to form a quarterly summary score.

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

Managerial audits

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

For example, each quarter, the managerial audit team may decide to review:
- some elements across all areas/vehicles;
- some room/vehicle types; or
- one or more vehicle/area.

The decision should be based on:
- the standards already being achieved;
- where local managers feel emphasis should be placed;
- randomly chosen elements, rooms or vehicles.

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

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

External audits

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

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

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

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

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

Scoring

The auditor must decide the cleanliness of each element in a room/vehicle using the element standard criteria (see Appendices 1 and 2) using acceptable (score 1) or unacceptable (score 0).

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

An example of a completed audit score sheet for use in scoring rooms/vehicles in functional areas is set out in Appendices 4 and 5.

An audit score sheet and 13-week format for monitoring functional areas over a quarterly period are included in Appendix 3.

The score sheet provides the opportunity to assign general responsibility for elements within a functional area to crew, non-crew (domestic) and estates. This is achieved by entering C (crew), D (non-crew/domestics) or E (estates) in the line marked responsibility.

The electronic version of the score sheet will calculate the percentage score achieved for each of the departments in addition to the functional area overall percentage score. The score sheet allows for calculations to be made horizontally (outcome per room) and vertically (outcome per element) along with the totals referred to above.

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

Where an element is assigned a score of 0 (unacceptable) then the reason for failure and an appropriate time for remedial action to be taken (see page 15) should be entered in the record. This record sheet can be found in the cleaning audit score sheet in appendices 4 and 5.

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

Ambulance Trust

Vehicle 1	70%
Vehicle 2	80%
Vehicle 3	90%
Vehicle 4	100%
Vehicle 5	90%

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

Overall score is 86 per cent

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

Identifying risk categories

All healthcare environments should pose minimal risk to patients, staff and visitors. However, different functional areas represent different degrees of risk and, therefore, require different cleaning frequencies and different levels of monitoring and auditing. Consequently, all areas/elements should be assigned a risk category (see below for further advice on this point).

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

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

Very high risk functional areas

Required service level

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

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

High-risk functional areas

Required service level

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

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

Significant-risk functional areas

Required service level

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

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

Low-risk functional areas

Required service level

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

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

Additional factors

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

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

Action

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

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