Cleaning of the Healthcare Environment

Summary All NSW public health organisaitons are required to implement routine environmental programs. This Policy Directive describes the requirements that these programs must meet.

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Audience All Staff of NSW Health

Secretary, NSW Health

CLEANING OF THE HEALTHCARE ENVIRONMENT

POLICY STATEMENT

All NSW public health organisations (PHOs) must implement routine environmental cleaning programs that meet the requirements outlined in this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

All PHOs must have adequately resourced systems and processes in place that ensure that:

- Routine cleaning of the healthcare environment meets required minimum standards.
- Staff undertaking cleaning are trained in all aspects relevant to cleaning in healthcare environments.
- The effectiveness of the environmental cleaning program undergoes regular cleaning audits as per the Policy's requirements
- If required, appropriate action is taken to improve cleaning performance.

REVISION HISTORY

Version	Approved by	Amendment notes
July-2020 (PD2020_022)	Deputy Secretary, Patient Experience and System Performance	This Policy supersedes PD2012_061 Environmental Cleaning Policy
PD2012_061	Director General	New policy

ATTACHMENTS

1. Cleaning of the Healthcare Environment: Procedures.

CONTENTS

1 BACKGROUND

1.1 About this document

Effective environmental cleaning improves the safety of patients, staff and visitors, as it reduces the risk of transmitting infections, and is an essential component of any effective infection prevention and control program aimed at providing high-quality healthcare for patients and a safe working environment for staff working in healthcare settings.

1.2 Legislative requirements

All public health organisations (PHOs) and their health workers have a duty of care under common law to take all reasonable steps to safeguard patients, health workers and the broader community from infection and harm. This Policy must be read and interpreted alongside the following legislation:

- Health Practitioner Regulation National Law (NSW) No 86a
- Public Health Act (NSW) 2010 No 127
- Food Act (NSW) 2003
- Therapeutic Goods Act (Commonwealth) 1989
- Schedule 3 - Code of Conduct of the Public Health Regulation (NSW) 2012
- Work Health and Safety Act (NSW) 2011 No 10
- Protection of the Environment Operations Act (NSW) 1997 No 156

1.3 Associated policies

1.3.1 NSW Infection Prevention and Control Policy

NSW Health Infection Prevention and Control Policy (PD2017_013) requires that each PHO has an environmental cleaning program in place that is managed by suitably qualified personnel and overseen by an appropriate committee or directorate.

1.3.2 Preventing and Controlling Healthcare-Associated Infection Standard

The Preventing and Controlling Healthcare-Associated Infections Standard of the National Safety and Quality Health Service standards aims to improve infection prevention and control measures to help prevent infections and the spread of antimicrobial resistance.

Criterion 3.11 of the Standard requires that a health service organisation has processes to maintain a clean and hygienic environment, in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements, that:

- Respond to environmental risks
- Require cleaning and disinfection in line with recommended cleaning frequencies

- Include training in the appropriate use of specialised personal protective equipment for the workforce.

1.3.3 Australian Guidelines for the Prevention and Control of Infection in Healthcare

The Australian Guidelines for the Prevention and Control of Infection in Healthcare provide evidence-based recommendations that outline the critical aspects of infection prevention and control, focusing on core principles and priority areas for action.

They provide a risk-management framework to ensure the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

1.3.4 NSW Clinical and Related Waste Management for Health Services Policy

Management of clinical and other waste falls outside of the scope of this Policy. Refer to Clinical and Related Waste Management for Health Services.

2 REQUIREMENTS

2.1 Governance and accountability

The PHO executive is responsible for ensuring that cleaning of the healthcare environment meets required minimum standards, irrespective of whether cleaning is provided in-house by PHO staff or by external cleaning services.

The PHO executive is also responsible for ensuring that adequate resources are allocated for keeping the healthcare environment clean, including in facilities where dedicated cleaners are not onsite permanently.

If cleaning services are provided in-house, the accountability for all aspects of cleaning and staff lies with the healthcare facility management.

A PHO that purchases cleaning services from an external provider, must have a service level agreement with that provider that clearly defines and documents the roles, responsibilities and relationship between the facility and external provider.

The PHO must enable for cleaning to be undertaken in a safe manner.

All staff undertaking cleaning are to be trained and assessed in all aspects relevant to cleaning in healthcare environments, including:

- Apply infection prevention and control principles
- Apply work health and safety principles
- Safely and correctly use cleaning chemicals
- Correctly perform cleaning tasks.

At least one cleaning manager is to be included as a member of the PHO's infection prevention and control committee and/or relevant other committees.

2.1.1 Roles and responsibilities

PHO chief executives and health service executive managers allocate the resources needed to ensure and monitor compliance with this policy, and ensure that the PHO's environmental cleaning program is managed by suitably qualified personnel and overseen by an appropriate committee or directorate.

Health facility managers are responsible for ensuring that the healthcare facility is well-maintained and clean through an environmental cleaning program that meets the requirements of this policy.

Cleaning service managers/supervisors are responsible for overseeing and monitoring that the healthcare facility is well-maintained and clean, and staff undertaking cleaning comply with the relevant requirements and directions.

Cleaning staff are to perform cleaning tasks correctly, utilising the correct cleaning and personal protective equipment.

All staff are responsible for maintaining a safe and clean environment.

The NSW Clinical Excellence Commission provides tools and resources to support the implementation, monitoring and evaluation of this Policy.

2.2 Environmental cleaning procedures

The design of a healthcare facility can influence the transmission of healthcare associated infections by air, water and contact with the physical environment.[1] The risks of transmission of infections can be reduced through a number of design features, including having surface finishes (floors, walls, benches, fixtures and fittings) that are easy to maintain and clean; and adequate systems and procedures for waste management, cleaning and linen handling.[2]

Healthcare facilities are to be:

- Visibly clean and free from non-essential items and equipment to facilitate effective cleaning
- Well maintained and in a good state of repair
- Routinely cleaned in accordance with a documented routine cleaning schedule.

This Policy **does not** prescribe equipment, products and processes. Cleaning outcomes can be achieved in various ways and this Policy encourages innovative and efficient cleaning methods with proven efficacy.

Detailed procedures for environmental cleaning in healthcare facilities are described in the Environmental Cleaning Standard Operating Procedures.

2.3 Documentation of cleaning procedures

Cleaning procedures must be documented and available to relevant staff. At a minimum the documentation must include:

[1] Australian Guidelines for the Prevention and Control of Infection in Healthcare, Canberra: National Health and Medical Research Council (2019), p 223

[2] Australasian Health Facility Guidelines, Part D - Infection Prevention and Control, p 4

- Healthcare facility accountability and reporting lines
- Minimum cleaning and disinfection frequencies and methods, including chemicals used and specific training required by staff
- Safety data sheets of chemical agents used
- Information on correct use of personal protective equipment (PPE)
- Equipment used, maintenance and servicing of equipment and financial asset identification
- Contingency plans, including outbreak management and leave requirements of cleaning staff.

2.4 Maintenance issues affecting cleaning

As buildings and fixtures age they become more difficult to clean and maintain in an acceptable condition. PHOs are to conduct annual preventative maintenance reviews to identify problems with existing infrastructure (i.e. buildings and fixtures) that may make it difficult or impossible to meet cleaning standards. These reviews are to record those areas that require repair, resurfacing, repainting or recovering. Infrastructure problems that are found to increase the risk of infection (i.e. worn porcelain, lack of storage, thread bare carpet) are to be documented and reported to the PHO's infection prevention and control committee and/or relevant other committees. In extreme and high risk areas (refer to Appendix 2) in particular these problems are to be rectified as soon as practicable.

2.5 Cleaning after refurbishment, construction or new build

PHOs are to have local protocols for cleaning after new construction or building work or refurbishment. After completion and prior to occupation, the entire new build or refurbished area is to be cleaned and assessed as per local protocol.

2.6 Cleaning methods

2.6.1 Detergents and disinfectants

Routine cleaning with detergent, suitable for the surface (or item) to be cleaned, and water is recommended for most situations. The use of disinfectants as part of routine cleaning is only recommended for:

- Extreme risk areas
- As part of outbreak management
- Terminal cleaning following a multidrug-resistant organism (MRO)/infectious disease
- Toilets.

When selecting a cleaning agent (detergent, disinfectant or dual-purpose cleaner/ disinfectant) for a cleaning task, the purchasing team/committee is to ensure that:

- The cleaning agent is approved by Therapeutic Goods Administration (TGA)

- The cleaning agent is effective against particular organisms including microbiological activity and contact time to kill microorganisms
- The intended purpose of the product is as per the manufacturer's instructions
- The cleaning agent is suitable for the surface or setting
- The facility has the capacity to comply with the manufacturer's instructions
- The cleaning agent has the appropriate environmental sustainability credentials
- The cleaning agent's safety data sheet is available and accessible for cleaning staff
- The facility has the capacity to ensure that cleaning staff have access to the relevant cleaning equipment and PPE to be used with the cleaning agent.

2.6.2 Cleaning equipment

PHOs are to have documented procedures for effective use, maintenance and storage of cleaning equipment such as mops, cloths and solutions.[3]

Reusable cleaning equipment must be maintained, used, cleaned/laundered and stored in accordance with their manufacturer's instructions and national and international standards. After use, single-use cleaning equipment is to be disposed of in accordance with their manufacturer's instructions.

Ward and unit staff must have access to cleaning equipment during times when regular cleaning staff are not available.

Before commencing a cleaning task, staff must check that the selected equipment is in good working order and appropriate for the cleaning task as per the manufacturer's instructions and facility requirements.

On completion of the task, reusable cleaning equipment must be cleaned and, if required, disinfected, laundered and stored as per the manufacturer's instructions and relevant national and international standards. Disposable or single-use cleaning equipment must be disposed of in the correct waste stream and as per the manufacturer's instructions.

2.6.3 Colour coding cleaning equipment

Identification through colour coding of reusable cleaning equipment utilised in the different areas of a health organisation is recommended as the most effective method for restricting equipment to individual areas of health organisations.

[3] NHMRC, p 58

Table 1: Colour codes for reusable cleaning equipment

Infectious/Isolation Areas	Yellow
Toilets/Bathrooms/Dirty Utility Rooms	Red
Food Service and Food Preparation Areas	Green
General Cleaning	Blue
Operating Theatres	White

2.7 Cleaning blood and other body substance spills

PHOs are to have local protocols to ensure that spots and spills of blood and other body substances are cleaned as soon as practicable to reduce contamination:[4]

- Small spills (up to 10 cm) are wiped up with absorbent material (e.g. paper towels) and cleaned immediately or as soon as practical.
- Larger spills are first contained and confined with absorbent material, followed by removal of any broken glass or sharp material as required, and then cleaned as soon as practical.
- The use of disinfectants in the cleaning of blood or other body substances is to be based on an assessment of risk of transmission of infectious agents from the spill, which should be done in consultation with local infection prevention and control staff.

2.8 Cleaning under transmission-based precautions

For patients managed under transmission-based precautions, requirements for routine daily cleaning and discharge cleaning, including disinfection requirements of rooms and ensuite bathrooms, are to be developed in consultation with local infection prevention and control staff.

3 RISK CATEGORIES

3.1 Concept of risk

Each PHO must use a risk management framework to determine individual and collective risk(s) and inform management options and priorities to reduce the risk of HAIs.[5,6] The

[4] NHMRC, p 66
[5] NSW Health Infection Prevention and Control Policy (PD2017_013), p 5
[6] Risk Management - Enterprise-Wide Risk Management Policy and Framework – NSW Health (PD2015_043)

methods, thoroughness and frequency of cleaning and the products used for different surfaces are to be determined by risk analysis and reflected in PHO policy.[7]

The various types of risk this Policy is based on are:

- Risk of infection or colonisation for patients, visitors and staff
- Risk of contamination of the healthcare environment and equipment
- Work health and safety risk for staff and public
- Risk of a loss of public confidence in the healthcare facility
- Financial and legal risk.

A clearly defined contract between a cleaning service and a health organisation forms the foundation of a sound risk management program. It is vital that the relative risk and likelihood of occurrence of events associated with cleaning are identified, assessed and addressed.

3.2 High-touch vs low-touch surfaces

Any surface may become contaminated, and the risk of contamination is greater for surfaces and items that are touched or handled more frequently.

High-touch surfaces are those that are frequently touched by staff, patients and/or visitors. In areas where clinical care occurs, high-touch surfaces require more frequent cleaning than low-touch surfaces.

Surfaces and items in proximity to patients that are more vulnerable to infection require more frequent cleaning. More heavily contaminated surfaces require more frequent cleaning than less contaminated items.

3.3 Functional areas

A functional area refers to any area in a healthcare facility that requires cleaning. The functional areas have been grouped under four risk categories: extreme, high, medium and low. These risk categories reflect the frequency and intensity of cleaning required to meet minimum cleaning outcomes (see Table 2).

Each facility must determine the frequency and intensity of cleaning each functional area that is required to meet the cleaning standards. It is recommended that high and medium risk functional areas start with a daily clean, then intensity and capacity are increased according to risk assessment of the patient, procedure type and frequency and possible risk of MRO/communicable disease transmission.

All rooms and corridors with direct open access into a designated functional area require cleaning to the same level of cleaning as the functional area. Bathroom and toilet cleaning frequency should be appropriate for the number of people using them.

See Appendix 2 for examples of functional areas in each risk category.

[7] NHMRC, p 56

3.3.1 Extreme risk areas

Extreme risk areas are areas with the greatest risk of transmission of infection, as patients in these areas are very susceptible to infection (i.e. are immune-compromised and/or have significant comorbidities) and/or are undergoing highly invasive procedures. Cleaning outcomes must be achieved through the highest level of cleaning intensity and frequency.

3.3.2 High risk areas

High risk areas are areas where infection transmission risk is high because patients are susceptible to infection and invasive procedures are conducted here. Cleaning outcomes must be maintained by a frequent cleaning schedule with capacity for rapid spot cleaning.

3.3.3 Medium risk areas

Medium risk areas are areas where there is a medium risk of infection. Cleaning outcomes must be maintained through scheduled regular cleaning with capacity for spot cleaning.

3.3.4 Low risk areas

Low risk areas are areas where the risk of infection is low as there are no invasive procedures performed. Cleaning outcomes must be maintained through scheduled regular cleaning with capacity for spot cleaning.

3.3.5 Change to risk classification of a functional area

A PHO is to increase the risk level of a functional area if the patients in that area are at an increased risk of infection, such as during an outbreak. Once this risk is no longer a factor the area may be returned to its previous functional category. Both the decision to increase a functional area's risk level and when to return to its original risk level are to be taken in consultation with local infection prevention and control staff and clinical management.

4 CLEANING AUDITS

4.1 Internal cleaning audits

All PHOs must have a cleaning audit system that measures and records cleaning outcomes. Internal cleaning audits must be performed in all functional areas across all risk categories.

A template for an internal cleaning audit is available in the Quality Auditing Reporting System[8]. While this template may be modified to suit the individual needs of facilities, the core functional areas, the acceptable quality level, and frequency may not be changed.

[8] Questionnaire name: 3_11_CEC_Cleanliness of the Clinical Healthcare Environment V3 (Questionnaire ID=5247; Audit Entry ID=8884)

Cleaning audit scores must be equal to or higher than the minimum acceptable quality level for each functional area. The frequency of cleaning audits for each functional area depends on the risk category allocated to that area.

Table 2: Cleaning Audit Frequency for Risk Categories

Functional area risk category	Minimum required frequency of auditing	Minimum acceptable quality level
Extreme	All rooms in all extreme risk areas are audited at least once a month	90%
High	All rooms in every high risk area are audited at least once every two months	88%
Medium	At least 50% of rooms in every medium risk area are audited at least once every three months, and all rooms at least every six months	85%
Low	All rooms in all low risk areas are audited at least once a year	80%

The staff member undertaking internal cleaning audits must be trained in undertaking cleaning audits and have a thorough knowledge of both the cleaning standards and cleaning processes.

During the cleaning audit the cleaning auditor is to be accompanied by a staff member of the area being assessed to ensure issues are identified, ratified and validated by the area.

The cleaning auditor is to provide feedback to individual areas along with a plan to rectify any highlighted problems. Results of cleaning audits, together with quality improvement plans and outcomes, are to be documented and tabled at the PHO's quality and risk committee, infection prevention and control committee and other relevant committees.

The cleaning auditor is to always refer to the previous cleaning audit to understand what sections were audited, identify any previous actions and to know what sections are required to be audited.

PHOs that utilise external cleaning providers are responsible for ensuring that cleaning audits are undertaken as required.

4.2 External cleaning audits

At a minimum cleaning of all extreme and high risk functional areas of a healthcare facility must be externally audited every two years. These external cleaning audits are to include review and validation of the internal cleaning audit program; all the cleaning audit results; variance results; action plans and policies related to cleaning and cleaning audits.

External cleaning audits are to be conducted by cleaning auditors who are trained in undertaking cleaning audits and have a thorough knowledge of both cleaning standards and cleaning processes. External cleaning auditors may be staff of the PHO or

HealthShare NSW (if cleaning services are provided by HealthShare NSW), provided they do not work at the site being audited. External cleaning audits are not be undertaken by staff from a PHO's external cleaning provider.

External cleaning audit findings are to be documented and reported to the management team, and through them to the quality and safety committee, infection prevention and control committee and other relevant committees.

4.3 Cleaning evaluation and cleaning audit methods

Evaluations and audits of cleaning can be performed through a variety of different methods, including process testing and outcome testing. Cleaning audits of environmental cleanliness can also facilitate education programs and motivate staff to strive for improvements in routine cleaning practices.[9]

The primary approach to reviewing cleanliness following cleaning is visual assessment.

PHOs are to consider using additional methods of evaluation of cleaning, such as fluorescent gel testing or ATP bioluminescence testing. These additional methods of evaluating cleaning forms may be particularly useful:

- As an additional validation control process
- After an outbreak of an MRO or infectious disease
- For education and training purposes
- For assessing high touch surfaces in extreme risk areas (even if this method can only assess that the correct cleaning method and process was used to clean items, and cannot assess environmental contamination or bioburden).

Microbiological testing is only recommended as part of outbreak management investigations.

[9] NHMRC, p 60.

5 APPENDIX LIST

1. Key definitions
2. Functional areas categorised according to risk
3. Implementation / Compliance Checklist

Appendix 1: Key definitions

Cleaning	The removal of visible soil, inorganic and organic contamination from devices or a surface, using either the physical action of scrubbing with a surfactant/detergent and water, or with appropriate chemical agents.[10]
Disinfection	Reduction of the number of viable microorganisms (by physical or chemical means) on a product to a level previously specified as appropriate for its intended further handling or use.[11]
Functional Area	Any location in a healthcare facility that requires cleaning.
Healthcare facility	For the purpose of this Policy, a healthcare facility is any facility or service that delivers healthcare services. Healthcare facilities include hospitals, multi-purpose services, aged care facilities, emergency services, ambulatory care services, Aboriginal Medical Services, community health services and community based health services such as needle and syringe programs.
MRO	Multidrug resistant organism - in general, bacteria that are resistant to one or more classes of antimicrobial agents and are usually resistant to all but one or two commercially available antimicrobial agents.[12]
Outbreak	A state characterised by an increased incidence of an infection greater than what is typically expected in a particular healthcare setting. The clustering of cases by microorganism, time, person and place may signal the possibility of an outbreak.[13]
Staff	For the purpose of this Policy, staff refers to any person working in any capacity within NSW Health, including contractors, students and volunteers.

[10] CDC. *Guideline for disinfection and sterilization in healthcare facilities, 2008*.
[11] NHMRC, P303
[12] NHMRC, p305
[13] PD2017_013, p3

Appendix 2: Functional areas categorised according to risk

(Note: refer to the Standard Operating Procedures for a more comprehensive listing)

Each risk category has its own timeframe for rectifying identified issues when they occur. This timeframe has been developed to minimise the time a patient is placed at risk of infection whilst the issue is being corrected.

Risk category	Examples of clinical functional areas	Frequency of Cleaning/Disinfection	Frequency of Assessing	Minimum Acceptable Quality Level	Timeframe for rectifying all failed elements	Consecutive cleaning audit failures
Extreme	Areas with the greatest risk of transmission of infection, as patients in these areas (1) are very susceptible to infection (i.e. are immune-compromised and/or have significant comorbidities) and/or (2) are undergoing highly invasive procedures – e.g. operating theatres, intensive care units, delivery suites	Operating theatres and other procedural areas: • Before the first patient, between each case and at the end of the list. All other areas: • Minimum daily of patient bed, furnishings, fixtures, medical equipment and frequent touch points in patient zone, with capacity for additional cleaning if required • Capacity of rapid spot cleaning/disinfection. • Clean and disinfect toilets at least twice daily and check toilets at least twice more daily and spot clean.	Each month all rooms are audited at least once. Fluorescent gel testing or ATP bioluminescence testing of high touch surfaces is recommended for cleanliness, cleaning audit and training purposes.	90%	Within 24hrs Note: Risks to patient safety are rectified immediately	After two consecutive cleaning audit failures: • Targeted cleaning • Weekly inspection of **all** rooms until improvement is sustained and benchmark met. Six cleaning audit failures per year: • External or independent cleaning audit of cleanliness and processes • Escalate cleaning audit failures and enter onto local risk register.

High	Areas where infection transmission risk is high as (1) patients are susceptible to infection and/or (2) invasive procedures are conducted – e.g. general wards, special clinic treatment areas, mortuaries performing autopsies, emergency transport vehicles	• Minimum daily of patient bed, furnishings, fixtures, medical equipment and frequent touch points in patient zone, with capacity for additional cleaning if required • Capacity for rapid spot cleaning. • Clean and disinfect toilets at least daily and check toilets at least twice daily and spot clean.	All rooms are audited at least once every two months. Fluorescent gel testing or ATP bioluminescence testing of high touch surfaces may be useful for cleanliness, cleaning audit and training purposes.	88%	Within 48hrs	After three consecutive cleaning audit failures: • Targeted cleaning • Weekly inspection of **all** rooms until improvement is sustained and benchmark met. Six cleaning audit failures per year: • External or independent cleaning audit of cleanliness and processes • Escalate cleaning audit failures and enter onto local risk register.
Medium	Areas where there is medium risk of infection transmission – e.g. outpatient departments, non-emergency transport vehicles, pharmacy	• Daily clean. • Capacity for spot cleaning. • Cleaning according to the volume of use. • Clean toilets at least daily and check toilets at least twice daily and spot clean.	At least 50% of rooms are audited at least once every three months.	85%	Within 72hrs	Three cleaning audit failures per year: • Monthly inspection until improvement is sustained and benchmark met • Review.
Low	Areas where the risk of infection is low as there are no invasive procedures performed – e.g. ambulance stations, offices, non-patient transport vehicles	• Clean as required. • Planned targeted cleaning. • Capacity for spot cleaning. • Clean toilets at least daily and check toilets at least twice daily and spot clean.	All rooms are audited at least once a year.	80%	Within 7 days	Three cleaning audit failures per year: • Bi-monthly inspection until improvement is sustained and benchmark met • Review.

* This policy only refers to small ward based kitchenettes. Kitchens where food is stored, prepared and cooked commercially or on a large scale, are not covered by this policy. These types of kitchens are under the Food Act (NSW) 2003 which must be followed.

Appendix 3: Implementation checklist

LHD/Facility:			
Assessed by:	**Date of Cleaning audit:**		
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. PHO has developed a cleaning program as per this Policy	❑	❑	❑
	Notes:		
2. PHO has allocated resources and assigned staff to undertake cleaning as per the local cleaning program	❑	❑	❑
	Notes:		
3. PHO assesses the cleaning program as per the requirements of this Policy	❑	❑	❑
	Notes:		
4. Cleaning audits are reviewed regularly as per the requirements of this Policy	❑	❑	❑
	Notes:		
5. PHO takes appropriate action to improve cleaning performance (if and where required)	❑	❑	❑
	Notes:		
6. PHO reviews the effectiveness of its cleaning program annually	❑	❑	❑
	Notes:		