Cleaning of the Healthcare Environment

Summary All NSW public health organisations 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

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

NSW Health

POLICY DIRECTIVE

Cleaning of the Healthcare Environment

POLICY STATEMENT

NSW Health is committed to the implementation of environmental cleaning programs across NSW Health organisations to reduce the risk of healthcare associated infections.

SUMMARY OF POLICY REQUIREMENTS

All NSW Health organisations 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.
- Scheduling and frequency of environmental cleaning are based on assessment of risk to patients, visitors and staff.
- The effectiveness of the environmental cleaning program undergoes regular cleaning audits.
- If required, appropriate action is taken to improve cleaning performance.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2023_018 August-2023	Deputy Secretary, System Sustainability and Performance	Updated document to include changes to cleaning audit requirements.
PD2020_022 July-2020	Deputy Secretary, Patient Experience and System Performance	This policy supersedes PD2012_061 Environmental Cleaning Policy
PD2012_061 November-2012	Director General	New policy

CONTENTS

1. BACKGROUND

Effective environmental cleaning is an essential component of any effective infection prevention and control program aimed at providing safe, high-quality healthcare for patients and a safe working environment for health workers in healthcare settings.

1.1. About this document

NSW Health organisations must implement routine environmental cleaning programs that meet the requirements outlined in this Policy Directive.

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

Detailed procedures for environmental cleaning in healthcare facilities are described in the Clinical Excellence Commission's *Environmental Cleaning Standard Operating Procedures*.

1.2. Key Definitions

Cleaning	The removal of visible soil (such as inorganic and organic material) from objects and surfaces, and is normally accomplished manually or mechanically using water with detergents or enzymatic products.
Cluster	A disease cluster is an unusually high incidence of a particular microorganism occurring in close proximity in terms of both time and geography. A closely grouped series of events or cases of diseases that fulfils the definition of a case, such as two or more surgical site infections from the same surveillance period or theatre session of the same type of surgery.
Disinfection	A process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects.
Functional Area	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 standards. See Appendix 1 for examples of functional areas in each risk category.
Health worker	Refers to all staff delivering or supporting healthcare services in a NSW Health organisation. Including any person employed or contracted by a NSW Health agency either on a permanent, temporary, casual, volunteer, agency or student basis.

Healthcare facility	In this Policy Directive, 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.
Infection prevention and control	Refers to evidence-based practices and procedures that, when applied consistently in healthcare settings, can prevent or reduce the risk of transmission of microorganisms to healthcare providers, clients, patients, residents and visitors.
Multidrug-resistant organism (MRO)	Microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.
NSW Health organisation	Refers to local health districts, statutory health corporations, affiliated health organisations and administrative units within the Health Administration Corporation, such as the NSW Ambulance Service, HealthShare NSW and the Ministry of Health.
Outbreak	The occurrence of disease exceeding the expected level for a given population within a specific timeframe. This includes single cases of some diseases not previously seen or those that have previously been eliminated. Typically, in healthcare this has been defined as two or more cases, which should trigger an outbreak management process.
Personal protective equipment (PPE)	A variety of protective barriers used alone, or in combination, to protect mucous membranes, skin, and clothing from contact with recognised and unrecognised sources of infectious agents in healthcare settings.
Terminal clean	Cleaning process required after patient(s) have vacated the room, either through room transfer or discharge.

1.3. Legislative requirements

All NSW Health organisations 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 Directive must be read and interpreted alongside the following legislation:

- *Health Practitioner Regulation National Law 2009* (NSW)
- *Public Health Act 2010* (NSW)
- *Food Act 2003* (NSW)

- *Therapeutic Goods Act 1989* (Commonwealth)
- *Public Health Regulation 2022* (NSW)
- *Work Health and Safety Act 2011* (NSW)
- *Work Health and Safety Regulation 2017* (NSW)
- *Protection of the Environment Operations Act 1997* (NSW)

1.4. Associated policies

1.4.1. Infection Prevention and Control Policy

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

Detailed, practical day-to-day guidance to support implementation of the NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013) is provided in the Clinical Excellence Commission's *Infection Prevention and Control Practice Handbook*.

1.4.2. Preventing and Controlling Infections Standard

The *Preventing and Controlling Infections Standard* (the 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.

Action 3.13 of the Standard requires that all NSW Health organisations have processes to maintain a clean, safe 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, including novel infections (such as COVID-19)
- require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies
- provide access to training on cleaning processes for routine and outbreak situations, and novel infections
- audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy
- use the results of audits to improve environmental cleaning processes and compliance with policy.

Action 3.14 of the Standard requires all NSW Health organisations minimise infection risks to patients and the workforce from equipment, device, product and environmental hazards. To achieve this, they must have processes to evaluate and respond to infection risks for:

- new and existing equipment, devices and products used in the organisation

- clinical and non-clinical areas, and workplace amenity areas
- maintenance, repair and upgrade of buildings, equipment, furnishings and fittings
- handling, transporting and storing linen
- novel infections, and risks identified as part of a public health response or pandemic planning.

1.4.3. Waste and linen

Both management of clinical and other waste and of handling, disposal and transport of used linen fall outside of the scope of this Policy Directive.

For more information on management of clinical and other waste refer to the NSW Health Policy Directive *Clinical and Related Waste Management for Health Services* (PD2020_049) and the section on waste disposal in the *Infection Prevention and Control Practice Handbook*.

For more information on handling, disposal and transport of used linen, refer to the section on clean linen in the *Infection Prevention and Control Practice Handbook*.

1.5. Other related NSW Health and national policies

Reference	Document title
Guideline	*Australian Guidelines for the Prevention and Control of Infection in Healthcare*
Guideline	*Australasian Health Facility Guidelines: Part D: Infection and Prevention Control*
PD2017_013	*Infection Prevention and Control Policy*
PD2020_049	*Clinical and Related Waste Management for Health Services*
PD2022_023	*Enterprise-wide Risk Management*
Manual	*Infection Prevention and Control Practice Handbook*
Standard	National Safety and Quality Health Service Standards - Preventing and Controlling Infections Standard

2. REQUIREMENTS

2.1. Governance and accountability

The NSW Health organisation chief executive is responsible for ensuring that cleaning of the healthcare environment meets required minimum standards outlined in this Policy Directive, irrespective of whether cleaning is provided in-house or by external cleaning services.

The chief 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. They must also ensure that cleaning can be undertaken in a safe manner.

All health workers undertaking cleaning are to be trained and assessed as competent in all aspects relevant to cleaning in healthcare environments, including:

- application of infection prevention and control principles, including correct use of personal protective equipment (PPE)
- application of work health and safety principles
- safe and correct use of cleaning chemicals
- performing cleaning tasks safely and correctly.

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

NSW Health organisations should actively engage with patients, carers and visitors to obtain feedback on their experiences of the cleanliness of the healthcare environment. This may include:

- seeking feedback from patients, carers and visitors on the cleanliness and maintenance of the healthcare environment
- acting on feedback where appropriate
- engaging with patients, carers and visitors during development of improvement plans, as appropriate.

2.1.1. Roles and responsibilities

Chief executives and health service executive managers are to ensure that the organisation's environmental cleaning program is managed by suitably qualified personnel and overseen by an appropriate committee or directorate.

If a NSW Health organisation purchases cleaning services from an external provider, they must have a service level agreement with that provider that clearly defines and documents the roles, responsibilities, scope of services, and relationship between the organisation and the external provider. This agreement is to ensure that the relative risk and likelihood of occurrence of events associated with cleaning are identified, assessed, and addressed.

NSW 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 Directive.

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.

All health workers are responsible for maintaining a safe and clean environment. Health workers are to perform cleaning tasks correctly, utilising the correct cleaning and PPE.

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

2.2. Environmental cleaning procedures

The design of a healthcare facility can influence the risks of transmission of healthcare associated infections. These risks can be reduced through design features, including having

surface finishes that are easy to maintain and clean, and adequate systems and procedures for waste management, cleaning, and linen handling[1].

Healthcare facilities are to be:

- visibly clean and free from non-essential items, equipment and clutter to facilitate effective cleaning
- well-maintained and in a good state of repair
- routinely cleaned in accordance with a documented routine cleaning schedule.

For detailed procedures for environmental cleaning in healthcare facilities, refer to the Clinical Excellence Commission's *Environmental Cleaning Standard Operating Procedures*.

2.3. Documentation of cleaning procedures

Cleaning procedures must be documented and available to relevant staff, including external cleaning providers if cleaning services are contracted out. At a minimum the documentation is to include:

- 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 appropriate number of cleaning staffing required
- information on appropriate selection and correct use of PPE
- equipment used, maintenance and servicing of equipment and financial asset identification
- safe work practices for each task
- contingency plans, including on managing outbreak or clusters of common communicable diseases and multidrug-resistant organism (MROs).

2.4. Maintenance issues affecting cleaning

As buildings and fixtures age they may become more difficult to clean and maintain in an acceptable condition. NSW Health organisations are to conduct annual preventative maintenance reviews to identify problems with existing infrastructure (such as 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[2].

[1] Refer to Australasian Health Facility Guidelines – Part D: Infection Prevention and Control
[2] See the *Infection Prevention and Control Practice Handbook*, Section 2.4 Preventative maintenance and asset management

Surfaces that cannot be cleaned due to damage, residue from sticky tape or other adhesives, or disrepair are to be reported for the purpose of environmental cleaning audits and risk assessed against patient safety.

Infrastructure problems identified (such as worn porcelain, lack of storage, threadbare carpet) are to be reported to the NSW Health organisation's infection prevention and control committee and/ or relevant other committees. In extreme and high-risk areas (refer to Section 3.3) these problems are to be rectified as soon as practicable.

2.5. Cleaning after refurbishment, construction, or new build

NSW Health organisations must have local procedures or 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[3].

2.6. Cleaning methods[4]

2.6.1. Detergents and disinfectants

A neutral detergent[5] and water is recommended for routine cleaning.

The use of disinfectants for routine cleaning is only recommended for:

- extreme risk areas
- as part of management of an outbreak or cluster of infections
- terminal cleaning following an MRO/ infectious disease
- toilets.

When selecting a disinfectant or dual-purpose cleaner/ disinfectant for a cleaning and disinfection task, the purchasing team/ committee is to ensure that:

- The disinfectant or dual-purpose cleaner/ disinfectant is listed on the Australian Register of Therapeutic Goods.
- The disinfectant or dual-purpose cleaner/ disinfectant is effective against the targeted organism(s) including microbiological activity and contact time to kill microorganisms.
- The intended purpose of the disinfectant or dual-purpose cleaner/ disinfectant is as per the manufacturer's instructions.
- The disinfectant or dual-purpose cleaner/ disinfectant is suitable for the surface or setting.

[3] See the section on preventative maintenance and asset management in *Infection Prevention and Control Practice Handbook*.
[4] See *Australian Guidelines for the Prevention and Control of Infection in Healthcare* – Section 3.1.3: Routine management of the physical environment.
[5] Neutral detergents are intended for general cleaning (not for people or for specific medical devices). Without disinfectant claims or where the ingredients do not produce a microbicidal effect are not regulated by the Therapeutic Goods Administration.

- The facility has the capacity to comply with the manufacturer's instructions.
- The disinfectant or dual-purpose cleaner/ disinfectant has the appropriate environmental sustainability credentials.
- The disinfectant or dual-purpose cleaner/ disinfectant's safety data sheet is available and accessible for health workers undertaking cleaning.
- The facility has the capacity to ensure that health workers have access to the relevant cleaning equipment and PPE to be used with the disinfectant or dual-purpose cleaner/ disinfectant and have been trained in appropriate use of PPE.

2.6.2. Cleaning equipment

NSW Health organisations must have documented procedures for effective use, maintenance, and storage of cleaning equipment such as mops, cloths, and solutions.

Reusable cleaning equipment must be maintained, used, cleaned, laundered, and stored in accordance with their manufacturer's instructions and national and international standards[6].

After use, single-use cleaning equipment is to be disposed of in accordance with their manufacturer's instructions.

In wards and units, health workers must have access to cleaning equipment during times when regular cleaning staff are not available.

Before commencing a cleaning task, health workers must check that the selected equipment is clean, 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[7].

2.6.3. Colour coding cleaning equipment

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

[6] Examples of items to be stored in designated clean storage rooms and dirty utility rooms are included in the section on cleaning and disinfection in *Infection Prevention and Control Practice Handbook*.
[7] See NSW Health Policy Directive *Clinical and Related Waste Management for Health Services* (PD2020_049).

Table 1: Colour codes for reusable cleaning equipment[8]

Area	Colour coding of 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

2.6.4. Environmental sustainability

As NSW Health is committed to an environmentally sustainable footprint, all NSW Health organisations are to work towards a high quality, low carbon and climate resilient health system. When planning and undertaking cleaning of healthcare environments NSW Health organisations are to choose equipment and processes with the least environmental impact, including by reducing:

- waste
- water usage
- energy usage
- use of single use or disposable cleaning equipment where practical and appropriate
- unnecessary use of disinfectants when use of neutral detergent suffices.

When considering introducing more sustainable options for undertaking environmental cleaning, NSW Health organisations are to consult with both infection prevention and control and cleaning staff to ensure that these options meet minimum standards for cleaning of healthcare environments.

2.7. Cleaning blood and other body substance spills

NSW Health organisations must have local protocols to ensure that spots and spills of blood and other body substances are cleaned as soon as practicable to reduce contamination[9], such as:

- Small spills (up to 10cm diameter) are wiped up with absorbent material (such as paper towels) and cleaned immediately or as soon as practical.

[8] This Policy Directive 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 Directive. These types of kitchens are covered under the *Food Act 2003* (NSW).

[9] See the *Environmental Cleaning Standard Operating Procedures*, Module 4.1 Cleaning blood or other body substance spills; and *Australian Guidelines for the Prevention and Control of Infection in Healthcare*, Section 3.1.3 Routine management of the physical environment.

- Larger spills (more than 10cm diameter) 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 is to be based on an assessment of risk of transmission of infectious agents from the spill, which is to 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 terminal cleaning, including disinfection requirements of rooms and bathrooms, are to be developed in consultation with local infection prevention and control staff.

Where the presence of infectious agents that require transmission-based precautions is suspected or known, surfaces are to be physically cleaned with a detergent solution followed by disinfection (if required) with disinfectant listed on the Australian Register of Therapeutic Goods.

3. RISK CATEGORIES

3.1. Concept of risk

The methods, thoroughness and frequency of cleaning and the products used for different surfaces are to be determined by risk assessment and reflected in local policy.

All NSW Health organisations must use a risk management framework that is consistent with the current NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013). They are to determine individual and collective risk(s)[10] in specific situations, procedures or programs and inform management options and priorities to reduce the risk of healthcare associated infections.

The aim of determining specific risk(s) is to ensure that appropriate controls may be implemented to protect all patients, carers, visitors, and staff without compromising clinical care.

Types of risk may include:

- risk of infection or colonisation from contaminated (such as unclean) surfaces or equipment 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.

[10] See NSW Health Policy Directive *Enterprise-wide Risk Management* (PD2022_023).

A clearly defined contract between a cleaning service and a NSW 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, carers, and/ or visitors. In areas where clinical care occurs, high-touch surfaces (such as bedrails, trolleys, commodes, doorknobs, light switches, tap handles) require more frequent cleaning than low-touch surfaces (such as floors, ceilings, walls, blinds).

Surfaces and items in proximity to patients that are more vulnerable to infection require more frequent cleaning.

3.3. Functional areas

Each functional area is given a risk score based on the likelihood of contamination; vulnerability of the patients to infection; and potential for exposure to microorganisms (such as through invasive devices). The resulting risk score for the functional area is determined and cross referenced with a risk matrix which determines the risk classification. These risk categories reflect the frequency and intensity of cleaning required to meet minimum cleaning outcomes (see Appendix 1).

Each facility is to 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 multidrug-resistant organism (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 must be appropriate for the number of people using them.

3.3.1. Extreme risk areas

Extreme risk areas are areas with the greatest risk of transmission of infection to patients, as patients in these areas are very susceptible to infection (for example 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 as there are no invasive procedures performed, such as outpatient departments, non-emergency transport vehicles, pharmacy. 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 is no patient care performed, e.g. ambulance stations, offices, non-patient transport vehicles. 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

NSW Health organisations are 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

NSW Health organisations must have a cleaning audit system that measures and records cleaning outcomes. Internal cleaning audits[11] must be performed in all functional areas across all risk categories.

Health workers 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 audit the cleaning auditor, where possible, is to be accompanied by a staff member from the area being assessed to ensure identified issues are validated and understood. The auditor is to provide feedback and explain areas of concern.

In order to pass the audit the 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.

For functional areas where compliance is not met, actions to rectify cleaning issues are implanted within the timeframes outlined in Appendix 1.

[11] A template for an internal cleaning audit is available in the Quality Auditing Reporting System. 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.

Results of cleaning audits, together with quality improvement plans and outcomes, are to be documented and tabled at the organisation's quality and risk committee, infection prevention and control committee and other relevant committees.

Table 2: Cleaning Audit Frequency for Risk Categories

Functional area risk category	Minimum required frequency of auditing	Minimum acceptable quality level
Extreme	Aim = To audit all rooms at least once a month. Minimum requirement = At least 50% of rooms are audited each month, and all rooms every 2-months.	90%
High	Aim = To audit all rooms at least once every 2-months. Minimum requirement = At least 50% of rooms are audited every 2-months, and all rooms every 4-months.	88%
Medium	Minimum requirement = At least 50% of rooms are audited every 3-months and all rooms every 6-months.	85%
Low	Minimum requirement = All rooms are audited once a year.	80%

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.

NSW Health organisations that utilise external cleaning providers are responsible for ensuring that cleaning audits are undertaken as required.

If an audit fails to meet the minimum acceptable quality level, a new audit is to be conducted as soon as identified issues have been rectified.

See Appendix 1 for information about recommended actions for areas with consecutive cleaning audit scores below acceptable level.

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 2-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
- 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 NSW Health organisation or HealthShare NSW (if cleaning services are provided by HealthShare NSW), provided they do not work at the site being audited. External cleaning audits may not be undertaken by staff from the organisation's external cleaning provider.

The cleaning auditor, where possible, is to be accompanied by a staff member from the area being assessed to ensure identified issues are validated and understood, and to inform quality improvement plans if required.

External cleaning audit findings, together with quality improvement plans and outcomes, are to be documented and reported to the management team and clinical governance, quality and safety committee, infection prevention and control committee and other relevant committees.

NSW Health organisations that utilise external providers are responsible for ensuring that cleaning audits are undertaken as required in Table 2.

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.

The primary approach to reviewing cleanliness after cleaning is by visual assessment.

NSW Health organisations can consider using additional methods of evaluation of cleaning, such as fluorescent gel testing or adenosine triphosphate (ATP) bioluminescence testing. These additional methods of evaluating cleaning forms may be particularly useful:

- as an additional validation control process
- after an outbreak or cluster of an multidrug-resistant organism (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 can be useful for outbreak and cluster management investigations, if recommended by the outbreak management team.

5. APPENDICES

1. Functional areas categorised according to risk
2. Implementation Checklist

5.1. Appendix 1: Functional areas categorised according to risk[12]

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.

Table 3: Functional areas categorised according to Risk Categories

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 (for example are immune-compromised and/ or have significant comorbidities) and/ or (2) are undergoing highly invasive procedures – such as operating theatres, intensive care units, delivery suites, interventional suites, radiology.	Operating theatres and other procedural areas: • Before the first patient, between each case and at the end of the list. All other areas: • Daily at a minimum: patient beds, furnishings, fixtures, medical equipment, and high-touch points in patient zone, with capacity for additional cleaning if required • Between each patient • Capacity for rapid spot cleaning/ disinfection • Clean and disinfect toilets at least twice daily; and check toilets at least twice daily additional and spot clean if required.	At least 50% of rooms are audited each month, and all rooms every 2-months. Fluorescent gel testing or ATP bioluminescence testing of high-touch surfaces is recommended for cleanliness, cleaning audit and training purposes.	90%	Within 24-hrs Note: Risks to patient safety are rectified immediately	After 2 consecutive cleaning audit failures per area: • Targeted cleaning • Weekly inspection of **all** rooms until minimum benchmark is met. 6 cleaning audit failures per year: • External or independent cleaning audit of cleanliness and processes • Escalate cleaning audit failures and enter onto local risk register.

[12] Refer to the *Environmental Cleaning Standard Operating Procedures* for a more comprehensive listing.

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
High	Areas where infection transmission risk is high as: (1) patients are susceptible to infection and/ or (2) invasive procedures are conducted – such as general wards, special clinic treatment areas, mortuaries performing autopsies, emergency transport vehicles.	• Daily at a minimum: patient beds, furnishings, fixtures, medical equipment, and high-touch points in patient zone, with capacity for additional cleaning if required • Between each patient • Capacity for rapid spot cleaning • Clean and disinfect toilets at least daily and check toilets at least twice daily and spot clean if required.	At least 50% of rooms are audited every 2-months, and all rooms every 4-months. Fluorescent gel testing or ATP bioluminescence testing of high-touch surfaces may be useful for cleanliness, cleaning audit and training purposes.	88%	Within 48-hrs	After three consecutive cleaning audit failures per area: • Targeted cleaning • Weekly inspection of **all** rooms until minimum benchmark is met. 6 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 as there are no invasive procedures performed – such as outpatient departments, non-emergency transport vehicles, pharmacy	• Daily clean • Between each patient • 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 if required.	At least 50% of rooms are audited every 3-months, and all rooms every 6-months.	85%	Within 72-hrs	After three consecutive cleaning audit failures per area: • Monthly inspection until minimum benchmark is met • Review

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
Low	Areas where the risk of infection is low as there is no patient care performed – such as ambulance stations, offices, non-patient transport vehicles	• Clean as required • Planned targeted cleaning • Capacity for spot cleaning • Clean toilets at least daily; and check more often in areas of high use and spot clean if required.	All rooms are audited at least once a year.	80%	Within 7-days	N/A

NOTE: This Policy Directive 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 Directive. These types of kitchens are covered under the *Food Act 2003* (NSW).

5.2. Appendix 2: Implementation checklist

Local Health District/ Facility:

Assessed by:	**Date of Cleaning audit:**		
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. NSW Health organisation has developed a cleaning program as per this Policy	❑	❑	❑
	Notes:		
2. NSW Health organisation has allocated resources and assigned staff to undertake cleaning as per the local cleaning program	❑	❑	❑
	Notes:		
3. NSW Health organisation 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. NSW Health organisation takes appropriate action to improve cleaning performance (if and where required)	❑	❑	❑
	Notes:		
6. NSW Health organisation reviews the effectiveness of its cleaning program annually	❑	❑	❑
	Notes:		