NHS
National Patient Safety Agency
National Reporting and Learning Service

The national specifications for cleanliness in the NHS:

Guidance on setting and measuring cleanliness outcomes in **primary care medical and dental premises**

Contents

Introduction

The cleanliness of health care premises and equipment has been firmly fixed on the NHS agenda as a key issue since 2000. Over these years, much has been issued in the way of advice and guidance but this has, in the main, been aimed at the acute sector.

The registration requirements of *The Health and Social Care Act 2008*, which will apply to primary dental care providers (from 2011) and primary medical care providers (from 2012), state:

Regulation of regulated activities

12 **(1)** The registered person must, so far as reasonably practicable, ensure that —

(a) service users;

(b) persons employed for the purpose of the carrying on of the regulated activity; and

(c) others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity,

are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2).

(2) The means referred to in paragraph (1) are —

(a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection;

(b) where applicable, the provision of appropriate treatment for those who are affected by a health care associated infection; and

(c) the maintenance of appropriate standards of cleanliness and hygiene in relation to —

(i) premises occupied for the purpose of the carrying on of the regulated activity,

(ii) equipment and reusable medical devices used for the purpose of carrying on the regulated activity, and

(iii) materials to be used in the treatment of service users where such materials are at risk of being contaminated with a health care associated infection.

(Health and Social Care Act 2008)

Criterion 2 of the Code of Practice levies on providers a specific duty to:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

(Health and Social Care Act 2008 Code of Practice criterion 2)

In addition to this requirement, practitioners are also likely to find that the issues of cleanliness and infection control feature significantly in commissioning arrangements and local performance management mechanisms.

Accordingly, the National Patient Safety Agency (NPSA), working in collaboration with other agencies including the Department of Health, and the Care Quality Commission (CQC), is providing a range of documents aimed at assisting providers to meet these responsibilities. We are grateful to Liverpool Primary Care Trust for their assistance in developing these specifications.

Purpose

These specifications have four main aims:

1 to assist providers in ensuring the infection risks posed by the delivery of services have been assessed;

2 to provide a framework through which cleaning services can be arranged to address those risks; and

3 to ensure that appropriate documentation showing how the above processes have been managed and implemented is available.

4 to emphasize that cleaning is a shared responsibility involving more than the cleaning team

It is recognised that initial implementation of the recommendations contained within these specifications will require time and staff resources. However, these are considered to be proportionate to the need to demonstrate that the premises are 'clean and safe'. Once implemented, further work will be limited to periodic review which should not prove onerous.

If adopted, the principles outlined will be valuable in helping primary care providers of all types set up simple, easy-to-follow processes which have proven effective in other areas of health care delivery.

Whilst these specifications are aimed primarily at NHS providers, they may equally be used as a benchmark standard by providers in the independent sector.

Given the wide range of sizes and configurations, it is not practical to produce a single document which meets the needs of all primary care practices. Accordingly no part of these specifications is mandatory and individual providers will need to take a view on the extent to which the processes set out are followed exactly or are adapted locally. When making such decisions, providers may wish to take into account, amongst other things, the size of premises and the number of staff involved in providing cleaning services. For example, where premises are small and/or only a single person is involved in providing cleaning, it may be decided that there is no need for a cleaning working group (Appendix 1, section 4) or for cleaning rotas. What is important is that the processes adopted make it clear that the issues around infection prevention and control and cleaning have been considered and taken into account when making decisions.

Where provision of cleaning services is contracted out, discussions should be had with the cleaning service provider on how best to reflect the recommendations contained in these specifications within the cleaning contract.

The appendices provided serve to act only as examples of what is required, and nothing contained within them should be taken as mandatory. So, for example, local decisions will need to be made on exact cleaning frequencies or the frequency of audits/ inspections. What is important is that these decisions are based on an assessment of the degree of risk which is attached to each item in its location, and take into account what is practicable and necessary to ensure that the determined standards of cleanliness are being met, and that there are clear mechanisms in place to show how this is verified.

How to use these specifications

These specifications have been based on similar documents already issued to hospitals and ambulance trusts. In the interests of proportionality they have been revised to ensure they reflect the differing composition of primary dental and medical settings.

These specifications do not provide advice or recommendations on the manner in which cleaning is undertaken, or the products used in the cleaning process. Rather they are aimed at ensuring providers can demonstrate how they ensure they meet the registration requirement to maintain appropriate standards. Where appropriate, advice and guidance on delivering cleaning services is contained within other documents, primarily the *Revised Healthcare Cleaning Manual* (Available at: www.nrls.npsa.nhs.uk/resources/?EntryId45=61830). Other useful sources of advice are listed in Appendix 10.

Similarly, it should be noted that these specifications apply to that area of cleaning activity which falls within the general definition of domestic cleaning, including non-invasive patient equipment. It does not apply to items of equipment the cleaning of which would be classed as decontamination. The term 'domestic cleaning' is intended to encompass cleaning undertaken by all staff groups who have responsibility in this area. Experience has shown that cleaning services are at their most effective when all staff groups work in a coordinated way, where individual roles and responsibilities are clearly defined, appropriately allocated and fully understood, and where appropriate training has been provided.

The specifications consists of 10 appendices, which provide a step-by-step process to ensure cleaning requirements are:

- identified;
- risk assessed;
- allocated to the appropriate person;
- meet the required standard;

They also help ensure that there are audit and inspection policies in place which ensure cleaning services are regularly monitored, any shortcomings identified, remedial actions taken, and that there is a clear and robust audit trail in place.

Whilst it is accepted that initial introduction of these specifications will require some time and effort, once completed maintenance will not be onerous and will be helpful to providers in their dealings with the CQC, commissioners and local performance management.

For each appendix there is a brief explanation of its purpose, followed where appropriate by an example. As noted earlier, these annexes are examples only, and the precise content is a local decision. The specifications and appendices are available to download from www.nrls.npsa.nhs.uk/resources/patient-safety-topics/environment/

Included in appendix 10 is a list of other guidance/documents which individuals may refer to for additional help.

Table of appendices

Appendix	Subject	Purpose	Resource
1	Cleaning Plan	Development of a general local policy setting out the strategy to be adopted to ensure the cleanliness of the premises meets required standards	A specimen cleaning plan which can act as a guide
2	Identification of functional areas and elements	To ensure all areas and key items which require cleaning are identified and listed	See appendices 4, 6 and 7
3	Risk assessment	To ensure that the degree of risk associated with identified functional areas and elements is identified	See appendix 5
4	Cleaning standard	To set a required standard of cleanliness for each element – key and non-key	Template element/ standard schedule
5	Cleaning frequency	To identify the frequency with which areas/ elements need to be cleaned to consistently meet the required standard	Template frequency schedule

Table of appendices *(continued)*

Appendix	Subject	Purpose	Resource
6	Cleaning responsibility	To ensure all cleaning tasks are allocated to the appropriate group/ individual	Template responsibility list
7	Routine and Managerial Audit	The regular process through which cleaning services are checked for efficacy	Interactive audit template
8	Timeframe for rectification of problems	Identification of the acceptable period between discovery of a cleaning related problem and its resolution	
9	Colour coding	A recommended process for the colour coding of equipment and materials used in the delivery of cleaning services to reduce the risks of cross-infection	Recommended coding
10	List of useful document	To provide a list of additional advice and guidance	

Appendix 1

Cleaning Plan

Setting out clear local policies and arrangements is best achieved through the production of a cleaning plan. This will also help healthcare providers meet the Care Quality Commission's requirements in terms of documentary evidence around the provision of cleaning services, and the relevant regulatory requirements.

There is no national standard for a cleaning plan, and it is for each health care provider to produce their own. However, this appendix provides an example which can act as a guide.

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 may include:

- the cleanliness standards to be achieved;
- the clear allocation of responsibility for cleaning all areas of, and items within, the premises;
- the member(s) of practice staff responsible for cleaning;
- cleaning schedules and frequencies;
- the systems to be used to measure outcomes;
- the reports required and the member(s) of practice staff 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;
- 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.

Appendix 1

[Insert name of premises]

Specimen Cleaning Plan

Version	Approved by	Date

Contents

Appendix 1

1. Introduction

The cleanliness of any health care environment is important to support infection prevention and control and ensure patient confidence. Cleaning staff play an important role in improving the quality of the care environment.

Cleanliness standards have been in place for acute and mental health care since publication of the *National standards for cleanliness in the NHS*, in 2001. This guidance was developed following consultation with experts and professionals in the fields of cleanliness and infection control in order to raise standards of cleanliness to an acceptable level throughout the NHS.

In 2010 the National Patient Safety Agency (NPSA) published *The national specifications for cleanliness in the NHS: A framework for setting and measuring performance outcomes in primary medical and dental care premises*. This guidance can be used in primary medical care (GP) and dental surgeries, clinics, walk-in centres and health centres. In 2009 the NPSA also published *The Revised Healthcare Cleaning Manual* which sets out technical information about the delivery of cleaning services.

[insert provider name here] has adopted this guidance where it is applicable to the services provided. Further detail is set out in this document.

2. The aims of this cleaning plan

- to assist primary medical and dental care providers in promoting confidence amongst patients, service users and staff that their facilities are clean and fit for purpose;
- to support good infection prevention and control practices;
- to provide assurance to their commissioners and regulators that the environments from which this provider delivers healthcare services are clean and fit for purpose.

3. The objectives of this cleaning plan

- to identify the cleaning requirements of the facilities as identified in *The national specifications for cleanliness*;
- to set out and implement a plan that meets the cleaning requirements of the facilities;
- to identify and allocate resources efficiently and effectively;
- to set out and implement a quality assurance process by which this organisation can monitor progress;
- to ensure that the standards of cleanliness achieved meet the expectations of the public.

4. Cleanliness working group

In order to focus on the delivery of the national cleaning standards, a cleanliness group was established within the organisation. This group has the specific objective of implementing *The national specifications for cleanliness* within the organisations.

Membership: [suggested – to be determined locally]
- Practice/Centre Manager;
- Cleaning Manager (where not the above);
- A member of staff with expertise in infection control;
- GP/DP Partner.

Terms of reference:
- to take ownership of the standards of cleanliness within the organisation;
- to develop and maintain the cleaning plan;
- to oversee the implementation of the national cleaning specifications;
- to be responsible for maintaining acceptable standards of cleanliness and to produce reports on performance against standards;
- to ensure failures in the provision of cleaning services are swiftly rectified;
- to ensure cleaning staff receive training in the appropriate cleaning processes and equipment and in the importance of infection control, and that training needs are regularly reviewed and additional/remedial training provided.

5. Cleaning resources

The following cleaning resources have been allocated:
[add name of cleaner(s) and times of cleaning]

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
AM							
PM							
Evening							

Appendix 1

6. Principles

The key principles which underpin this cleaning plan are:-

Clarity for all staff undertaking cleaning activities
The clarity of cleanliness standards is of paramount importance. It is essential that all staff undertaking cleaning activities have a clear understanding of the specifications and task requirements to ensure they are working towards and assessing the same cleanliness outcomes. The standards are to be realistic and achievable and staff must be able to carry out their jobs safely and in a controlled environment.

Infection control
Setting out clear arrangements, following advice from infection control professionals, for ensuring the premises are clean and safe.

Monitoring and performance
To make sure standards of cleanliness stay high, and that any variation is recognised and corrected.

Resources
To ensure that the appropriate levels of resource, which are essential in delivering and maintaining the standards, are provided. This includes ensuring sufficient trained staff are always available, and that effective and efficient methods and adequate and modern equipment is used.[1]

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

- an up-to-date cleaning manual that gives written guidance on how to complete each task;[2]
- comprehensive risk assessments undertaken to ensure working methods and staff are as safe as possible. In many cases the standard workplace risk assessment may suffice, but where specific cleaning materials or equipment are used, there should be procedures in place to ensure that any specific risk which may arise from their use is considered;
- where the number of staff involved in delivering cleaning warrants it, a staff rota system to ensure appropriately trained staff are available and deployed as necessary.

Identifying risk
Ensuring that the infection risks have been assessed and built in to the provision of cleaning services.

7. Supporting documentation

This cleaning plan is supported by further documentation which:

- details the risk assessment process undertaken (see also appendix 3);
- details the areas and elements (items) which require cleaning;
- sets out the required standard of cleanliness for each element;
- sets out the frequency with which cleaning will be undertaken;
- sets out the member of staff responsible for cleaning each item or area;
- details the audit process to be followed
- provides advice on cleaning methods (it is recommended that the *Revised Healthcare Cleaning Manual* is used for this purpose, available from www.nrls.npsa.nhs.uk/resources/?EntryId45=61830).

8. Review

This plan will be subject to regular, and at least annual, review and updated through the cleanliness group.

[1] For further information visit www.nhssupplychain.nhs.uk

[2] Content should be derived from the *Revised Healthcare Cleaning Manual*, which is available to download from www.nrls.npsa.nhs.uk/resources/?EntryId45=61830

Appendix 2

Identification of functional areas and key elements

One of the key steps in producing a local version of this document is the identification and cataloguing of the rooms which comprise the premises, e.g. waiting room, treatment room, kitchen (known as 'Functional Areas') and the items in these areas which require cleaning (known as 'Elements'). These elements are split into two categories – key and non-key.

To assist in this process, a list of 33 elements identified as key is provided in this appendix. Local decisions will need to be taken on whether to use this list or to create a version specific to the premises.

Items identified as key should be entered into a template, as per appendix 4, and all other items identified as non-key should be entered into a template as per appendix 5.

Functional areas	Key elements
For example, consulting rooms, treatment rooms, reception areas, kitchens	01 Weighing scales, manual handling equipment 02 Medical equipment e.g. blood pressure monitor, ECG machine 03 Medical gas equipment 04 Consultation room/treatment room/ examination couch 05 Dressings/minor operations trolley
	06 Switches, sockets and data points 07 Walls 08 Ceiling 09 All doors including handles 10 All internal glazing, including partitions and mirrors 11 All external glazing 12 Radiators 13 Ventilation grilles - extractor and inlets
	14 Floor - hard 15 Floor - soft
	16 Electrical items including computer equipment and waiting room televisions/radio 17 Cleaning equipment
	18 Low surfaces e.g. skirting boards 19 High surfaces e.g. curtain rails, top of door frames 20 Chairs 21 Tables/desks 22 Hand wash containers/hand rub dispensers 23 Waste receptacles 24 Curtains & blinds 25 Toys
	26 Dishwashers 27 Fridges and freezers 28 Hot water boilers 29 Kitchen cupboards 30 Microwaves
	31. Toilets 32. Sinks 33. Baby changing areas

Appendix 3

Risk assessment

This is an important step since the element of risk will be used to determine the frequency with which cleaning should take place within areas and/or for elements.

The 'risk' under consideration is the degree of infection risk which would be posed to patients and staff from inadequate cleaning – either in terms of frequency or efficacy and should be based on the type of activity being undertaken in a room.

Once Functional Areas have been identified, an assessment of the degree of risk to be allocated to each area should be made. It is recommended that this be based on three risk categories:

High risk functional areas

Required service level

Only consistently high cleaning standards will ensure the required outcomes. To achieve this, cleaning must be both intensive and frequent. Since this category includes areas where invasive procedures may be undertaken there is a need for very high standards of cleaning.

Medium risk functional areas

Required service level

In these areas, good standards of cleanliness are required for both hygiene and aesthetic reasons, but they will not require the same levels of intensity or frequency as very high/high risk areas. Regular cleaning with the capacity for 'spot cleaning' when necessary should be sufficient to maintain standards in these areas.

Low-risk functional areas

Required service level

In these areas the risks posed to patient safety will have been judged to be minimal and therefore cleaning is more for aesthetic reasons and to provide reassurance to patients and the public that the importance of cleaning is recognised. Cleaning in such areas would be less frequent than for medium risk areas though still to a regular schedule and there should be the ability to undertake minor 'spot cleaning' as and when required.

For example, if a Functional Area is designated as high risk (e.g. endoscopy suite, minor surgery room), then it is likely cleaning will need to be undertaken more frequently than it would be in an area designated medium risk. Further, the same element (e.g. a door handle) may be considered to pose a greater degree of risk in a practice treatment room than in a reception area.

There are, therefore, two possible approaches:

- clean all elements within a Functional Area to the same frequency (in this scenario the determined cleaning frequency of the highest risk element would determine the frequency of cleaning of all elements within the area); or
- determine cleaning frequencies for each element in each Functional Area.

The latter option will inevitably require greater initial work, but would bring the benefit that cleaning resources could be more focused on those areas where the risk factor is deemed the highest.

It will be essential that infection control advice be sought when making these decisions. Providers are advised to approach their PCT for advice on this issue.

The results of this process should be carried forward to appendix 5.

Appendix 4

Cleaning standards

Once the steps identified in appendices 2 and 3 have been carried out, decisions should be made on the standards expected from the cleaning services. These should be clear and unambiguous so that those delivering cleaning services know exactly what is required of them.

The results of this, and the process described in appendix 2 for the identification of elements, should then be listed on a template which shows the required standard for each element requiring cleaning – see the following specimen. For ease of management, it may be best to produce two such documents, one for key elements and one for non-key elements.

Cleaning standards – Primary Care

Element	Standard
01 Weighing scales, manual handling equipment	All parts (including underneath) should be visibly clean, with no blood or body substances, dust, dirt, debris or spillages.
02 Medical equipment e.g. blood pressure monitor, ECG machine	All parts (including underneath) should be visibly clean, with no blood or body substances, dust, dirt, debris or spillages.
03 Medical gas equipment	All parts (including underneath) should be visibly clean, with no blood or body substances, dust, dirt, debris or spillages.
04 Consultation room/treatment room/ examination couch	All parts (including wheels/castors and underneath) should be visibly clean, with no blood or body substances, dust, dirt, debris or spillages.
05 Dressings/minor operations trolley	All parts (including wheels/castors and underneath) should be visibly clean, with no blood or body substances, dust, dirt, debris or spillages.

Appendix 4

Fixed assets

Element	Standard
06 Switches, sockets and data points	All wall fixtures e.g. switches/sockets/ data points should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
07 Walls	All wall surfaces (including skirting) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
08 Ceiling	All ceiling surfaces should be visibly clean with no blood or body substances, dust, dirt, debris or spillages.
09 All doors including handles	All parts of the door structure should be visibly clean so that all door surfaces, vents, frames and jambs have no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
10 All internal glazing, including partitions and mirrors	All internal glazed surfaces should be visibly clean and smear free with no blood or body substances, dust, dirt, debris, adhesive tape or spillages and should have a uniform shine appearance.
11 All external glazing	All external glazed surfaces should be clean.
12 Radiators	All part of the radiator (including between panels) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
13 Ventilation grilles - extractor and inlets	The external part of the ventilation grille should be visibly clean with no blood or body substances, dust, dirt, debris or cobwebs.

Floors

Element	Standard
14 Floor - hard	The complete floor (including all edges, corners and main floor spaces) should have a uniform finish or shine and be visibly clean with no blood or body substances, dust, dirt, debris, spillages or scuff marks.
15 Floor - soft	The complete floor (including all edges and corners) should be visibly clean with no blood or body substances, dust, dirt, debris or spillages. Floors should have a uniform appearance and an even colour with no stains or watermarks.

Fixtures - Electrical fixtures and appliances

Element	Standard
16 Electrical items including computer equipment, telephones and waiting room televisions/radio	The casing of any electrical item should be visibly clean with no blood or body substances, dust, dirt, debris or adhesive tape.
17 Cleaning equipment	Cleaning equipment should be visibly clean with no blood or body substances, dust, dirt, debris or moisture.

Appendix 4

Furnishings and fixtures

Element	Standard
18 Low surfaces	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
19 High surfaces	All surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages.
20 Chairs	All parts of the furniture should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape, stains or spillages.
21 Tables/desks	All parts of the table (including wheels/ castors and underneath) should be visibly clean with no blood or body substances, dust, dirt, debris, stains, adhesive tape or spillages.
22 Hand wash containers/ hand rub dispensers	All part of the surfaces of hand soap/ paper towel containers should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. Dispensers should be kept stocked.
23 Waste receptacles	The waste receptacle should be visibly clean (including lid and pedal) with no blood or body substances, dust, dirt, debris, stains or spillages.
24 Curtains & blinds	Curtains/blinds should be visibly clean with no blood or body substances, dust, dirt, debris, stains or spillages.
25 Toys	Toys should be visibly clean with no dirt, dust debris adhesive or body substances.

Kitchen fixtures and appliances

Element	Standard
26 Dishwashers	Dishwashers should be visibly clean with no blood or body substances, dust, dirt, debris, stains, spillages or food debris.
27 Fridges and freezers	Fridges and/or freezers should be visibly clean with no blood or body substances, dust, dirt, debris, spillages, food debris or build up of ice.
28 Ice machines and hot water boilers	Ice machines and/or hot water boilers should be visibly clean with no blood or body substances, dust, dirt, debris or spillages.
29 Kitchen cupboards	Kitchen cupboards should be visibly clean with no blood or body substances, dust, dirt, debris, stains, spillages or food debris.
30 Microwaves	All microwave surfaces should be visibly clean with no blood or body substances, dust, dirt, debris, spillages or food debris.

Appendix 4

Toilets, sinks, wash hand basins and bathroom fixtures

Element	Standard
31. Toilets	The toilet and bidet should be visibly clean with no blood or body substances, scum, dust, removable lime scale, stains, deposits or smears.
32. Sinks	The sink (and such equipment as wall attached dispensers, etc.) should be visibly clean with no blood or body substances, dust, dirt, debris, lime scale, stains or spillages. Plugholes and overflow should be free from build-up.
33. Baby changing areas	All parts should be visibly clean with no body substances, dust, dirt, debris stains or spillages. Restraints should be capable of being removed for cleaning. Cleaning materials should be made available for cleaning between use.

Further advice and information can be found in the *Revised Healthcare Manual* (www.nrls.npsa.nhs.uk/resources/?EntryId45=61830)

Appendix 5

Cleaning frequencies

Once areas and elements have been identified, and the required standard determined, it will then be necessary to determine the frequency with which cleaning needs to happen in order to reach and maintain the required standard.

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 healthcare provider'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 code of practice and to identify the resources needed to keep the premises clean, and therefore demonstrate to the Care Quality Commission that sufficient resources are being allocated. The precise allocation of resources, and the actual frequency of cleaning, varies according to locally determined need.

This appendix therefore includes suggested cleaning frequencies, recognising that it will be for individual providers to determine the precise frequencies that best meet their own identified needs. However, it is recommended good practice that the frequencies take into account the identified risk associated with the area/element in question. The following gives an example:

Category 1 - Low - Elements with which patients and the public have little or no direct contact and which are unlikely to act as reservoirs of infection (may include e.g. mirrors, internal glass, fridges, microwaves).

Category 2 - Medium - Elements with which patients and the public normally have a moderate degree of direct contact and which are unlikely to act as reservoirs of infection (may include e.g. high and low surfaces, chairs, curtains).

Category 3 - High - Elements with which patients and the public have extensive and frequent contact or which are certain to act as reservoirs of infection (may include e.g. toilets, commodes, medical equipment attached to a patient).

Appendix 5

Cleaning frequencies – Primary Care

These suggested cleaning frequencies are offered by way of a guide. Providers should use the information contained within the table below as a starting point and make adjustments based on the local assessment of risk. Frequencies can either be increased or decreased based on local circumstances. All spills and body fluids contamination must be cleaned immediately regardless of suggested frequencies.

Element	Frequency
01 Weighing scales, manual handling equipment	Clean contact points between patient use. One full clean weekly.
02 Medical equipment e.g. blood pressure monitor, ECG machine	Clean contact points between patient use. One full clean weekly.
03 Medical gas equipment	Clean between patient use and one full clean weekly.
04 Consultation room/treatment room/ examination couch	Two full cleans daily with additional 'spot cleaning' as required.
05 Dressings/minor operations trolley	One full clean between each procedure.

Fixed assets

Element	Frequency
06 Switches, sockets and data points	One full clean weekly.
07 Walls	Dust weekly. Full wash yearly.
08 Ceiling	Dust weekly. Full wash yearly.
09 All doors including handles	Clean handles and push plates daily. One full clean weekly.
10 All internal glazing, including partitions and mirrors	One full clean monthly.
11 All external glazing	One full clean 6 monthly.
12 Radiators	One full clean weekly.
13 Ventilation grilles - extractor and inlets	Dust weekly. Full wash yearly.

Floors

Element	Frequency
14 Floor - hard	Vacuum and mop daily.
15 Floor - soft	Vacuum daily Full wash 6 monthly or if significantly stained.

Appendix 5

Fixtures - Electrical fixtures and appliances

Element	Frequency
16 Electrical items including computer equipment and waiting room televisions/radio. Telephones.	Dust daily. Phones and keyboards cleaned with detergent wipe or equivalent daily.
17 Cleaning equipment	Full clean after each use.

Furnishings and fixtures

Element	Frequency
18 Low surfaces	One full clean daily.
19 High surfaces	Dust weekly. One full clean monthly.
20 Chairs	One full clean daily.
21 Tables/desks	One full clean daily.
22 Hand wash containers/ hand rub dispensers	One full clean daily.
23 Waste receptacles	One full clean daily.
24 Curtains & blinds	Change 6 monthly.
25 Toys	One full clean daily or when contaminated with body fluids.

Element

Appendix 6

Cleaning responsibility

The provision of health care takes place in settings that vary enormously, and the range of equipment that requires cleaning will differ. It is also the case that responsibility for cleaning can also vary and experience suggests that without careful consideration the opportunities for particular items to 'fall through the gaps' is increased.

Whilst it recognised that this will be less of an issue for smaller premises, good practice suggests that the responsibility for cleaning particular elements should be clear and unambiguous. It is therefore recommended that a template as per that which follows be completed.

The framework form should be completed by:

1. Inputting the elements determined in accordance with appendix 2 and assigning the responsibility for cleaning them to a staff group. Where two staff groups have some responsibility for the cleaning of an element this needs to be recorded. Thus, in the example given below, the healthcare provider has decided that domestic staff are responsible for cleaning the treatment couches daily, but clinical staff will additionally clean between patient use.

2. identifying any additional items requiring cleaning which are not covered by the 33 elements, assigning responsibility for cleaning each of them to a staff group, and inputting them into the framework.

Element	Frequency	Responsibility
01 Weighing scales, manual handling equipment		
02 Medical equipment e.g. blood pressure monitor, ECG machine		
03 Medical gas equipment		
04 Consultation room/ treatment room/ examination couch		
05 Dressings/minor operations trolley		

Fixed assets

Element	Frequency	Responsibility
06 Switches, sockets and data points		
07 Walls		
08 Ceiling		
09 All doors including handles		
10 All internal glazing, including partitions and mirrors		
11 All external glazing		
12 Radiators		
13 Ventilation grilles - extractor and inlets		

Floors

Element	Frequency	Responsibility
14 Floor - hard		
15 Floor - soft		

Appendix 6

Fixtures - Electrical fixtures and appliances

Element	Frequency	Responsibility
16 Electrical items including computer equipment and waiting room televisions/radio		
17 Cleaning equipment		

Furnishings and fixtures

Element	Frequency	Responsibility
18 Low surfaces		
19 High surfaces		
20 Chairs		
21 Tables/desks		
22 Hand wash containers/ hand rub dispensers		
23 Waste receptacles		
24 Curtains & blinds		
25 Toys		

Kitchen fixtures and appliances

Element	Frequency	Responsibility
26 Dishwashers		
27 Fridges and freezers		
28 Hot water boilers		
29 Kitchen cupboards		
30 Microwaves		

Toilets, sinks, wash hand basins and bathroom fixtures

Element	Frequency	Responsibility
31. Toilets		
32. Sinks		
33. Baby changing areas		

Appendix 7

Routine and managerial audits

A key aspect of this process is the methodology by which the actual standards being achieved by the cleaning service are measured in a way which allows for the retention of a documented audit trail. It may also be beneficial to have a system which allows for weekly/monthly/quarterly/annual comparisons to be made to monitor progress.

The precise frequency of such audits should be determined locally, but it is recommended that some consideration be given to ensuring that the frequency takes the identified element of risk into consideration so that high risk areas/elements would be audited more frequently that others. It is also recommended that the audit process ensures that all areas/elements are audited to a specified frequency so, for example, if there are four 'Functional Areas' each might be audited in one week so that over a four week period all areas have been audited.

The following process is therefore of necessity technical in nature, but efforts have been made to keep it as simple as possible.

An interactive spreadsheet which will allow the results of the audit process to be recorded is available from www.nrls.npsa.nhs.uk/resources/patient-safety-topics/environment/

Process

The auditor must decide the cleanliness of each element in a room using the required standard (determined in accordance with appendix 4) using acceptable (score 1) or unacceptable (score 0). Each room must first be reviewed for those elements not present and these should be discounted on the audit score sheet as not applicable.

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

Thereafter, each element should be scored in accordance with the principles set out above. 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 should be entered in the record.

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 reception area had a maximum of 12 elements, and 10 were acceptable, the overall percentage would be calculated as 10/12 or 83 per cent. The functional area score is calculated by taking an average of the individual room scores as shown in the following example:

Surgery – lower ground	
Reception	70%
GP Room 1	80%
GP Room 2	90%
Minor Ops Room	100%
Toilet	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 would necessarily be scored as unacceptable.

Managerial audits

Ultimate responsibility for ensuring that health care premises meet required standards of cleanliness, and that the risks associated with health care associated infections have been addressed and are managed, rests not with those delivering cleaning, but with senior member(s) of practice staff.

It is therefore recommended that ad hoc audits should be undertaken to verify outcomes of routine technical audits and identify areas for improvement. The precise make up of such audits should be determined locally.

Personnel

Audits should not be the sole responsibility of the cleaning staff. The task should be shared amongst all of the relevant stakeholders in the health care facility. The member(s) of practice staff undertaking audits should:

- have a detailed knowledge of health care 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.

A suggested formation of an audit team would be:
Practice Manager
Cleaning manager (if not the above)
Infection control adviser
General/dental practice manager

Appendix 8

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. These should 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 having regard to both the location and the nature of the incident, so for example spillage of blood or vomit in a low-risk area should be dealt with as a very high risk incident.

Broadly, the timescale for rectification should mirror the three risk categories set out in appendix 3.

The table below provides example timeframes that health care providers may wish to use to base a local policy on.

	Timeframe for rectifying problems
A. Constant Cleaning critical *High risk*	Immediately or as soon as is practically possible.
B. Frequent Cleaning important and requires maintaining *Medium risk*	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.
C. Regular Cleaning on a less frequent scheduled basis, and as required in-between cleans *Low-risk*	These responsibilities should be clearly set out and understood. 0-3 hours for patient areas (to be rectified by daily scheduled cleaning service for non-patient areas). 0-48 hours.

Appendix 9

Colour Coding

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 health care 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.

This appendix sets out suggested colour coding systems for cleaning materials. Providers should consider ensuring its equipment conforms to these. The poster can be downloaded at **www.nrls.npsa.nhs.uk/cleaningspecificationsprimarycare**.

National colour coding scheme

For cleaning materials and equipment in primary care medical and dental premises
All practices are recommended to adopt the colour code below for cleaning materials. All cleaning items, for example, cloths (re-usable and disposable), mops, buckets, aprons and gloves, should be colour coded.

Red	Blue
Sanitary areas including sinks in sanitary areas	General areas, e.g. waiting rooms and consulting rooms (including sinks in general areas)

Green	Yellow
Kitchens	Treatment and minor operation rooms

Appendix 10

Useful information

- Department of Health. (2009). *The Health and Social Care Act 2008*.
- Department of Health. (2009). *The Health and Social Care Act 2008 - Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.
- National Patient Safety Agency. (2009). *The Revised Healthcare Cleaning Manual*.
- Department of Health. (2009). *Decontamination in dental practices – HTM 01-05*.

National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

T 020 7927 9531

Reference: 1181

www.npsa.nhs.uk