PAS 5748:2014

Specification for the planning, application, measurement and review of cleanliness services in hospitals

bsi.

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Foreword

This PAS was sponsored by the Department of Health (DH). Its development was facilitated by BSI Standards Limited and it was published under licence from the British Standards Institution. It came into effect on 24 November 2014.

Acknowledgement is given to the following organizations that were involved in the development of this PAS as members of the steering group:

- Association of Healthcare Cleaning Professionals
- British Infection Association
- The British Institute of Cleaning Science
- The Business Services Association
- Department of Health
- East Leicestershire and Rutland Clinical Commissioning Group
- Health and Social Care Information Centre
- Health Estates and Facilities Management Association
- Healthcare Infection Society
- Infection Prevention Society
- NHS England
- The Rotherham NHS Foundation Trust
- Royal College of Nursing

Acknowledgement is also given to the members of a wider review panel who were consulted in the development of this PAS.

The PAS process enables a specification to be rapidly developed in order to fulfil an immediate need in industry. A PAS can be considered for further development as a British Standard, or constitute part of the UK input into the development of a European or International Standard.

Relationship with other publications

This PAS builds on the experience and content of *The national specifications for cleanliness in the NHS* (NSC), the most recent version of which was published by the National Patient Safety Agency in April 2007.

It does not replace the existing NSC; rather it will exist alongside it to provide an alternative means of demonstrating compliance with part of the registration requirements of the Care Quality Commission (CQC).

This PAS is expected to be used in conjunction with *The Revised Healthcare Cleaning Manual* [a], ownership of which was transferred to the Association of Healthcare Cleaning Professionals in April 2012. The purpose of this manual is to give general and specific guidance on how to operate the provision of cleaning services within a healthcare environment.

It is also consistent with BS EN 13549:2001, *Cleaning services – Basic requirements and recommendations for quality measuring systems*.

[a] Available from: http://www.ahcp.co.uk/images/stories/pdf-nat-manual/revised-healthcare-cleaning-manual-2009-06-v2.pdf

Use of this document

It has been assumed in the preparation of this PAS that the execution of its provisions will be entrusted to appropriately qualified and experienced people, for whose use it has been produced.

Presentational conventions

The provisions of this standard are presented in roman (i.e. upright) type. Its requirements are expressed in sentences in which the principal auxiliary verb is "shall".

Commentary, explanation and general informative material is indicated by *italics* and numbered endnotes presented at Annex A, and does not constitute a normative element. The word "should" is used to express recommendations, the word "may" is used to express permissibility and the word "can" is used to express possibility, e.g. a consequence of an action or an event.

Spelling conforms to The Shorter Oxford English Dictionary. If a word has more than one spelling, the first spelling in the dictionary is used.

Contractual and legal considerations

This publication does not purport to include all the necessary provisions of a contract. Users are responsible for its correct application.

Compliance with a PAS cannot confer immunity from legal obligations.

0 Introduction

"A well-run ward has very high standards of cleanliness and hygiene. Not only is a clean ward more likely to be a healthy one, it is an environment which will improve morale and confidence".

"It is not just the responsibility of cleaning staff to keep the ward spotlessly clean, but of all staff. Consultants and senior executives should be just as alert to picking up and disposing of waste on the floor as cleaning staff. All who detect something that needs cleaning should alert those responsible for taking action immediately".

The Mid Staffordshire NHS Foundation Trust Public Inquiry
Robert Francis QC
February 2013

0.1 General

The provision of a clean and safe healthcare environment remains a key priority for all healthcare organizations. It provides one of the key elements for effective infection prevention and control, and also promotes patient confidence and demonstrates the existence of a positive safety culture.

The absolute requirement to provide clean, safe healthcare is now written into a range of key legal processes and documents which govern the delivery of NHS-funded care.

NHS organizations in England that provide regulated activities must be registered with the CQC. They must meet the requirements specified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [b)] in order to be registered. Regulation 12 specifies requirements for cleanliness and infection control.

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, December 2010, contains guidance about demonstrating compliance with the CQC's registration requirements for cleanliness and infection control.

The *NHS Constitution* pledges that the NHS will commit to ensuring that "services are provided in a clean safe environment that is fit for purpose, based on national best practice". The Secretary of State for Health, all NHS bodies as well as private and voluntary sector providers supplying NHS services are required by law to take account of the *NHS Constitution* in their decisions and action.

0.2 Overview for NHS users

The DH has sponsored this revision of PAS 5748:2011 only in relation to its use in hospitals in the NHS in England. Any use of this PAS outside NHS hospitals in England is not a matter for the DH.

NHS hospitals are entirely free to choose whether or not to use this PAS. There are currently no central statutory or procedural requirements that they do so. Organizations might choose to adopt the PAS to provide evidence of an intention to comply with part of the CQC's registration requirements in relation to cleanliness and infection control.

[b)] New fundamental standards regulations – the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – are due to come into force for all providers on 1 April 2015, subject to Parliamentary process and approval.

This PAS is not a typical input or output specification in the sense that many staff working in the NHS might understand the term. Rather, it provides a governance framework for the planning, application, measurement and review of cleanliness services. In this revised form, it continues to reflect the increased autonomy of NHS organizations. Therefore any decisions about, for example, how clean the hospital should be or the frequency with which particular elements or functional areas should be cleaned are matters for local determination.

Throughout this PAS, reference is made to the concept of risk. This is because of the variety of problems that poor cleaning can cause. Clause **4** requires a comprehensive assessment to be undertaken of the risk posed by poor cleaning in relation to infection for patients and a poor public image and loss of confidence from patients and staff. The outcome of these assessments can be used, in conjunction with other service data, to determine and justify the cleaning frequencies required across the hospital.

The risk assessment clause (Clause **4**) now includes supportive material based on work carried out since the publication of PAS 5748:2011 by staff at The Rotherham NHS Foundation Trust together with staff from three professional bodies [c] representing cleaning, nursing and infection prevention and control staff.

This is represented as a completed risk assessment of all 50 scored elements (Annex C) as well as a range of typical functional areas likely to be found at all hospitals (Annex D). PAS users can choose to adopt this completed risk assessment (together with its professional provenance) or continue to undertake their own locally.

In addition to these provisions, this PAS continues to allow a more sophisticated risk assessment process to be implemented locally so long as compliance with the minimum requirements set out in Clause **4** is achieved.

This PAS supports the measurement of cleanliness through technical auditing and identifies 50 elements (Annex B) to be scored during a technical audit. These 50 scored elements are intended to be a **representative sample that reflects the range of risk associated with elements**, rather than the 50 elements that might pose the greatest infection or confidence risk. Not all scored elements will be present in all types of hospital. For example, mental health hospitals are unlikely to contain certain scored elements because of their patient profile. However, all functional areas within a hospital will contain a significant proportion of the scored elements and where a scored element is not present it can be identified as such.

This PAS is expected to be used in conjunction with *The Revised Healthcare Cleaning Manual*, ownership of which was transferred to the Association of Healthcare Cleaning Professionals in April 2012. The purpose of this manual is to give general and specific guidance on how to provide cleaning services within a healthcare environment.

It is also consistent with BS EN 13549:2001, *Cleaning Services – Basic requirements and recommendations for quality measuring systems*.

Any feedback received will be reviewed when developing future revisions of this document.

Also note that this PAS has been developed in such a way as to enable future revisions to accommodate other types of healthcare facilities.

[c] Association of Healthcare Cleaning Professionals (AHCP), Royal College of Nursing (RCN) and Infection Prevention Society (IPS).

1 Scope

This PAS specifies requirements for the planning, application, measurement and review of cleanliness services in acute, community and mental health hospitals.

It specifies requirements for:

a) governing cleanliness services (see Clause **3**);
b) assessing risk and categorizing elements and functional areas (see Clause **4**);
c) providing cleaning tasks (Clause **5**), including:
    1) identifying cleaning tasks;
    2) risk assessment of cleaning tasks;
    3) setting cleaning frequencies;
    4) providing method statements;
    5) setting work schedules;
    6) establishing competence;
    7) contingency planning;
d) measuring cleanliness on the basis of visual assessment (see Clause **6**);
e) implementing corrective action (see Clause **7**);
f) conducting performance analysis and implementing review and improvement actions (see Clause **8**);
g) providing a continuous service improvement plan (see Clause **9**); and
h) reporting cleanliness (see Clause **10**). [1)]

NOTE *The relationship between the requirements of this PAS and supporting figures and annexes is shown in Figure 1. In particular, attention is drawn to the detailed guidance on the provision of cleanliness given in* The Revised Healthcare Cleaning Manual *[1].*

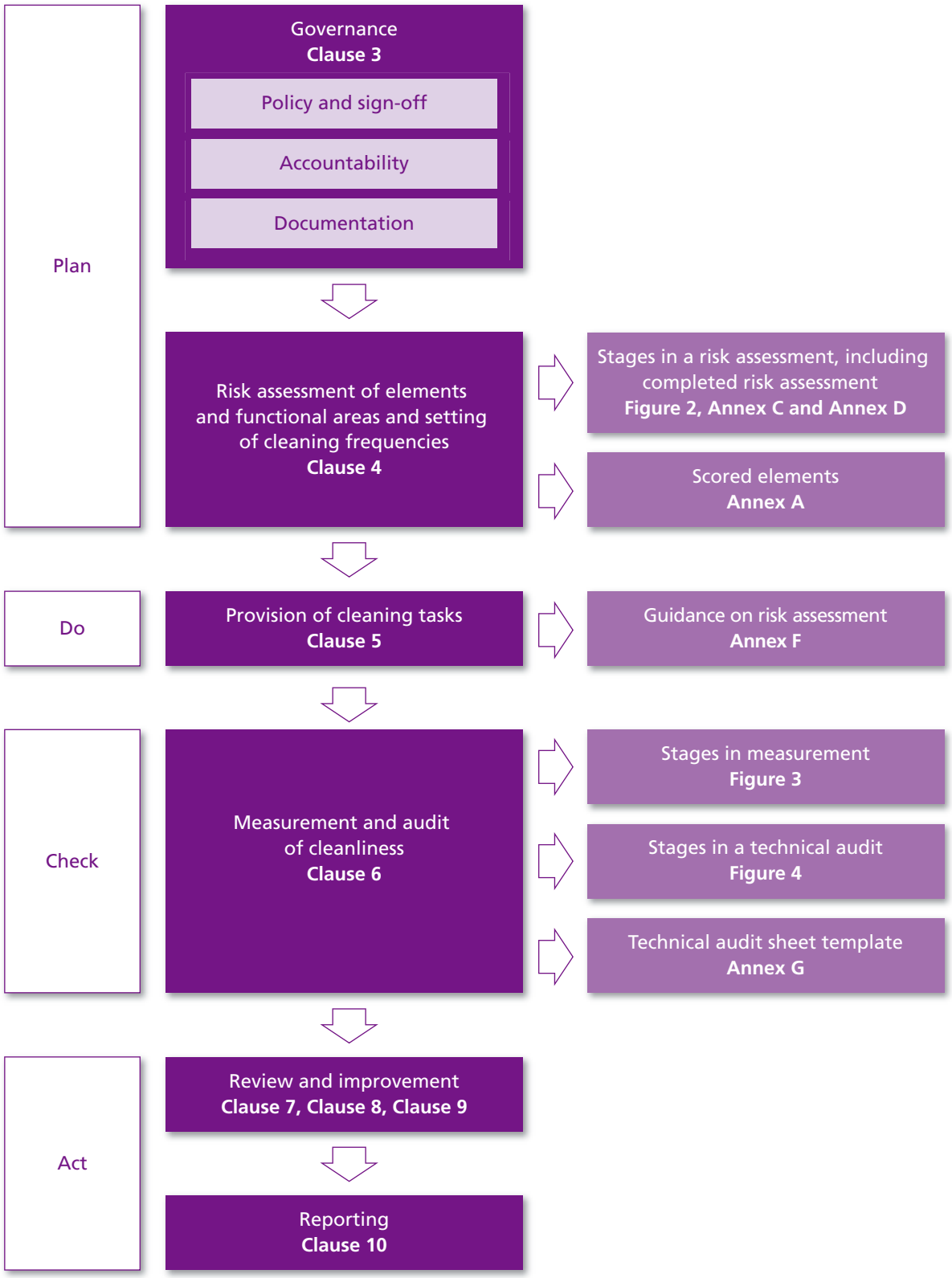
This PAS is designed to cover all functional areas in a hospital, including all clinical and non-clinical areas. However, catering facilities in a hospital that are covered by food hygiene legislation may be excluded from the provisions of this PAS, except where the catering facility forms an integral part of a functional area for which catering is not the primary purpose, such as a ward kitchen, beverage bay or staff room. It is a matter for local determination as to whether a large ward kitchen is deemed to constitute a functional area in its own right and hence be excluded from the provisions of this PAS.

The methodology for the assessment of cleanliness is visual inspection. However, other methods of assessment, such as microbiological testing, which are not covered in this PAS, may be considered to complement visual inspection. Arrangements for this are for local determination in conjunction with the infection control team and the undertaking of a risk assessment.

This PAS does not cover the cleaning of internal parts of mechanical and electrical equipment, for example the interior parts of air handling systems and lift shafts. These would typically be managed by means of planned preventative maintenance.

This PAS does not cover hospital grounds or gardens.

Figure 1 – Overview of relationship between the requirements of this PAS and supporting figures and annexes



2 Terms and definitions

For the purposes of this PAS, the following terms and definitions apply.

2.1 board

top level of management responsible for an organization [2)]

2.2 catering facility

building or part of a building that houses the production, processing and storage of food

2.3 cleaning task

process required to clean an element

2.4 cleanliness criterion

description of visual appearance signifying cleanliness

2.5 agreed cleanliness performance level

minimum percentage of scored elements expected to conform to the cleanliness criterion averaged over a 12 month period

2.6 cleaning

process, which physically removes micro-organisms and organic matter but does not necessarily destroy infectious agents [3)]

2.7 cleaning schedule

plan for carrying out a cleaning process giving lists of intended tasks and times

2.8 cleanliness service

system through which a clean environment is provided

2.9 corrective action

action to rectify a lack of cleanliness identified during a technical audit

2.10 decontamination

process to render a product free from contamination and reduce number of micro-organisms

2.11 defined period

time span within which specified audit actions are to take place

2.12 dirt

matter adhering to or resting on an element, which is not part of that element [4)]

2.13 element

item or collection of items within a functional area, or any part of the fabric or fittings of a functional area, which requires cleaning [5)]

2.14 functional area

room or physically contiguous group of rooms/areas within a hospital deemed by a healthcare organization to constitute a discrete area of operational activity

2.15 hospital

institution for the reception and treatment of persons suffering from illness, any maternity unit, and any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation

[derived from National Health Service Act 1977 [2], section 128(1)]

2.16 hospital types

2.16.1 acute hospital

hospital for which a main purpose is the reception as inpatients, and treatment, of those requiring surgical or medical treatment, or maternity care

2.16.2 community hospital

hospital providing a range of healthcare services to a defined local community

2.16.3 mental health hospital

hospital for which the main purpose is the reception as inpatients, treatment and care of persons suffering from acute or chronic mental illness

2.17 improvement action

action to eliminate the cause of a lack of cleanliness

2.18 item

individual surface or article

2.19 leased area

room or physically contiguous group of rooms within a hospital in which activities are conducted by a different organization from that operating the majority of functional areas within that facility

2.20 method statement

description of the way in which a cleaning task is to be performed and the materials and equipment, including personal protective equipment, required to perform it

2.21 organization

company, corporation, firm, enterprise, authority or institution, or part or combination thereof, whether incorporated or not, public or private, that has its own functions and administration [6)]

[BS EN ISO 14001:2004, **3.16**]

2.22 room

part or division of a building enclosed by walls, floor and ceiling

2.23 scored element

one of 50 elements that form a representative selection for the measurement of cleanliness [7)]

2.24 stain

discolouration appearing on an element which is not caused by the natural aging of the element [8)]

2.25 sterilization

killing or removal of all viable microorganisms, including spores

2.26 technical audit

measurement of the cleanliness of elements against stated cleanliness criterion [9)]

2.27 unscored element

element, other than a scored element, which does not form part of the recorded measurement of cleanliness

2.28 work instruction

document that informs a staff member or staff group which cleaning tasks to perform and when to perform them

2.29 work schedule

plan of work for the performance of cleaning tasks in a functional area, describing each cleaning task, and indicating when it will be performed and how long it will take

3 Governance

This clause details all the documentation that is required to demonstrate effective governance and assurance of cleanliness services and sets out the supporting arrangements that are required to ensure the proper review and retention of that documentation.

Checklist 1 provides a summary of documentation required by this clause to demonstrate compliance.

3.1 Policy

The organization shall produce a signed-off documented cleanliness policy that details:

a) the name of the healthcare organization;

b) the name and type of all hospitals managed by the healthcare organization;

c) which hospitals are covered by the cleanliness policy;

d) which, if any, catering facilities within the hospital are covered by policies relating to compliance with food hygiene legislation instead of this cleanliness policy; [10)]

e) a commitment to plan, apply and measure cleanliness services in accordance with this PAS; and

f) a commitment to continuous service improvement.

The policy shall be signed off by the designated person, at Board level, with overall accountability for cleanliness. It shall be supported by a set of standard operating procedures and include a date for review.

3.2 Accountability

The organization shall produce a documented schedule of accountability for cleanliness identifying:

a) a designated person, at Board level, with overall accountability for cleanliness; [11)]

b) a designated person in each functional area with accountability for the cleanliness of that functional area; and [12)]

c) a designated person for each staff group identified in **5.1** with accountability for the cleaning services provided by that staff group. [13)]

3.3 Documentation

3.3.1 The organization shall produce a documented procedure for the management and retention of all the documentation established for the provision of cleaning in accordance with this PAS. [14)]

3.3.2 Where a procedure requires the production of any pro forma, the organization shall document the arrangements for controlling their issue and review. [15)]

3.3.3 Where a procedure requires the production of any documented information, the organization shall document the arrangements for controlling the issue and review of that documented information. [16)]

Checklist 1 – Governance documentation checklist

Document		Subclause	
1	Cleanliness policy	**3.1**	☐
2	Sign-off of cleanliness policy	**3.1**	☐
3	Schedule of accountability for cleanliness	**3.2**	☐
4	Procedure for the management and retention of all established cleaning documentation	**3.3.1**	☐
5	Arrangements for controlling the issue and review of pro formas	**3.3.2**	☐
6	Arrangements for controlling the issue and review of any documented information required by a procedure	**3.3.3**	☐

4 Risk assessment and setting of cleaning frequencies

Throughout this PAS, reference is made to the concept of risk. This is because of the variety of problems that poor cleaning can cause. Two types of risk are specifically identified:

- infection risk – the risk of infection for patients; and
- confidence risk – the risk of a poor public image and the loss of confidence from patients and staff in the organization's ability to provide a clean, safe environment for care.

Organizations choosing to adopt this PAS are required to undertake a risk assessment which combines the outcomes of individual assessments of both elements and functional areas.

Elements carry a certain risk, irrespective of where they are. A toilet for instance carries a high risk for both infection and confidence. A ceiling is a low risk for infection, but a high risk for confidence. Organizations are required to assess elements on a three point numeric scale for infection and confidence risk with the combined outcomes expressed as red, amber or green (RAG).

Likewise, for some parts of a hospital, the risk of poor standards of cleaning is greater than in others. A poorly cleaned main entrance carries a particular risk of damaging confidence. Functional areas are also risk assessed on a similar, three point numeric and then RAG-rated basis.

The PAS then requires that the risk assessment outcomes for both elements and functional areas are brought together to produce overall risk categories. This cross-referencing of both outcomes produces four overall risk categories (very high, high, medium and low) that can be used to inform decisions on:

- the frequency with which to undertake cleaning tasks;
- the frequency with which technical audits are conducted; and
- the consequent allocation of resources.

In its revised form, this PAS continues to reflect the increased autonomy of NHS organizations and supports the principle of local determination. This principle underpins this clause, which sets out requirements for hospitals undertaking their own risk assessments.

However, organizations may instead adopt the completed overall risk assessment of elements and typical functional areas as set out at Annex C and Annex D, and illustrated in the example of overall risk category outcomes at Annex E. This risk assessment is based on work led by The Rotherham NHS Foundation Trust with the involvement of staff from three professional organizations representing cleaning, nursing and infection prevention and control staff [d]. It was further reviewed by the steering group that participated in this PAS revision.

[d] AHCP, RCN and IPS.

4.1 General

4.1.1 The organization shall produce and document a procedure for the risk assessment of each element in each functional area within a hospital. It shall include, as a minimum:

a) the allocation of responsibility for the risk assessment in accordance with **4.2**;

b) the identification of functional areas and elements in accordance with **4.3**; [17)]

c) the risk categorization of elements in accordance with **4.4**; [18)]

d) the risk categorization of functional areas in accordance with **4.5**; [19)]

e) where the organization has decided to adopt the completed risk assessments at Annex C and Annex D, a record of this decision;

f) the provision of overall risk categories for elements in functional areas in accordance with **4.6**;

g) a description of how identified risks are used to determine cleaning frequencies for each element in each functional area;

h) a description of when the risk assessment is to be conducted; and

i) a description of when the risk assessment procedure is to be reviewed.

4.1.2 The results of any risk assessment conducted in accordance with **4.1.1** shall be documented.

4.1.3 The risk assessment procedure in **4.1.1** and the results generated in **4.1.2** shall be approved by the Board and the approval documented. [20)]

*NOTE A flow chart representing the stages in a risk assessment specified in **4.2** to **4.6** is given in Figure 2.*

4.2 Responsibility

4.2.1 The organization shall establish a risk assessment group and document its membership. The group shall either:

a) undertake a risk assessment of all elements and functional areas within a hospital (as set out at **4.4** and **4.5**); or

b) adopt the completed risk assessments of elements and typical functional areas as provided at Annex C and Annex D.

4.2.2 A decision to adopt the completed risk assessments at Annex C and Annex D shall be documented by the group. [21)]

4.3 Identification of functional areas and elements

4.3.1 Every area within a hospital shall be assigned to a functional area.

4.3.2 All functional areas within a hospital, including leased areas, shall be defined and documented. [22), 23)]

4.3.3 Functional areas identified as catering facilities that are covered by policies relating to compliance with food hygiene legislation, instead of the cleanliness policy in **3.1**, shall be documented as such. [24)]

4.3.4 All rooms within a functional area shall be identified and documented.

4.3.5 All elements that are located, or might be used, within a hospital shall be identified and documented.

4.3.6 All elements that are located, or might be used, within each functional area shall be identified and documented.

4.3.7 Any element listed at Annex B shall be identified as a scored element and any other elements shall be identified as unscored elements. [25)]

4.4 Risk assessment of elements

4.4.1 Where the organization chooses to undertake a risk assessment of elements [see **4.2.1**a)], each element shall be assigned: [26), 27)]

a) an infection risk score using a three point scale, where 1 is low risk and 3 is high risk, which reflects the risk of a lack of cleanliness on infection prevention and control; and

b) a confidence risk score using a three point scale, where 1 is low risk and 3 is high risk, which reflects the risk of a lack of cleanliness on patient, public and staff confidence.

NOTE Guidance on assigning a risk score out of three for an element for both infection risk and confidence risk is given in Table 1. Scores should be assigned on the basis of the relative risk of the elements within a hospital and therefore elements should not, for example, all be assessed as "red" risk just because they are in a hospital.

Figure 2 – Stages in the risk assessment of elements in a functional area

4.4.2 Each element shall be assigned an element risk score of 1, 2, 3, 4, 6 (lower), 6 (upper) or 9 calculated in accordance with Table 2.

4.4.3 Each element shall be assigned to an element risk category in accordance with Table 2 on the basis of the element risk score.

4.4.4 Any element with an infection risk score of 3 shall be assigned to element risk category "red", irrespective of the total element risk score.

4.4.5 The element risk category assigned to each element shall be documented.

Table 1 – Guidance on assigning risk scores for elements

Infection risk	Infection risk score	Confidence risk	Confidence risk score
Elements with which patients, public and staff normally have infrequent and/or little contact with bare skin or which are unlikely to act as transmitters of infection.	1	Elements which, when seen in an unclean condition, are unlikely to lead to a loss of confidence in the ability to provide a clean, safe environment for care.	1
Elements with which patients, public and staff normally have a frequent and/or medium degree of contact with bare skin or which are likely to act as transmitters of infection.	2	Elements which, when seen in an unclean condition, are likely to lead to some loss of confidence in the ability to provide a clean, safe environment for care.	2
Elements with which patients, public and staff normally have very frequent and/or extensive contact with bare skin or which are certain to act as transmitters of infection.	3	Elements which, when seen in an unclean condition, will lead to a serious loss of confidence in the ability to provide a clean, safe environment for care.	3

Table 2 – Element risk scores and categories

Infection risk score	Confidence risk score	Element risk score	Element risk category
3	3	3 × 3 = 9	Red
3	2	3 × 2 = 6 (upper)	Red
3	1	3 × 1 = 3	Red
2	3	2 × 3 = 6 (lower)	Amber
2	2	2 × 2 = 4	Amber
1	3	1 × 3 = 3	Amber
2	1	2 × 1 = 2	Green
1	2	1 × 2 = 2	Green
1	1	1 × 1 = 1	Green

4.5 Risk assessment of functional areas

4.5.1 Where the organization chooses to undertake a risk assessment of functional areas, each functional area shall be assigned: [28), 29)]

a) an infection risk score using a three point scale, where 1 is low risk and 3 is high risk, which reflects the risk of a lack of cleanliness on infection prevention and control; and

b) a confidence risk score using a three point scale, where 1 is low risk and 3 is high risk, which reflects the risk of a lack of cleanliness on patient, public and staff confidence.

NOTE Guidance on assigning a risk score out of three for a functional area for both infection risk and confidence risk is given in Table 3.

4.5.2 Each functional area shall be assigned a functional area risk score of 1, 2, 3, 4, 6 (lower), 6 (upper) or 9 calculated in accordance with Table 4.

4.5.3 Each functional area shall be assigned to a functional area risk category in accordance with Table 5 on the basis of the functional area risk score.

4.5.4 Any functional area with an infection risk score of 3 shall be assigned to functional area risk category "red", irrespective of the total functional area risk score.

4.5.5 The functional area risk category assigned to each functional area shall be documented.

4.6 Overall risk assessment of each element in a functional area

4.6.1 An overall risk category shall be assigned to each element in each functional area.

4.6.2 The overall risk category for each element in a functional area shall be assigned in accordance with Table 5 using the element risk category determined in **4.4** and the functional area risk category in **4.5** or given in the completed risk assessments provided at Annex C (elements) and Annex D (functional areas).

4.6.3 The overall risk category assigned to each element in each functional area shall be documented.

Table 3 – Guidance on assigning risk scores for functional areas

Infection risk	Infection risk score	Confidence risk	Confidence risk score
Functional areas in which patients are not usually present.	1	Functional areas which, when seen in an unclean condition, are unlikely to lead to a loss of confidence in the ability to provide a clean, safe environment for care.	1
Functional areas in which patients, other than those undergoing high infection risk procedures or those who are critically ill, are present. Also functional areas through which patients and public regularly pass.	2	Functional areas which, when seen in an unclean condition, are likely to lead to a significant loss of confidence in the ability to provide a clean, safe environment for care.	2
Functional areas in which high infection risk procedures are performed or which house critically ill patients.	3	Functional areas which, when seen in an unclean condition, will lead to a serious loss of confidence in the ability to provide a clean environment for care.	3

Table 4 – Functional area risk scores and categories

Infection risk score	Confidence risk score	Functional area risk score	Functional area risk category
3	3	3 × 3 = 9	Red
3	2	3 × 2 = 6 (upper)	Red
3	1	3 × 1 = 3	Red
2	3	2 × 3 = 6 (lower)	Amber
2	2	2 × 2 = 4	Amber
1	3	1 × 3 = 3	Amber
2	1	2 × 1 = 2	Green
1	2	1 × 2 = 2	Green
1	1	1 × 1 = 1	Green

Table 5 – Overall risk categories

Element risk category (from Table 2)	Functional area risk category (From Table 4)	Overall risk category
Red	Red	Very high
Red	Amber	High
Red	Green	High
Amber	Red	High
Amber	Amber	Medium
Amber	Green	Medium
Green	Red	High
Green	Amber	Medium
Green	Green	Low

4.7 Frequencies

4.7.1 The organization shall determine and document the frequency with which to clean each of the elements in a functional area in accordance with the cleaning tasks identified in **5.2**. [30)]

4.7.2 The organization shall produce and document a procedure for reviewing the cleaning frequencies set in accordance with **4.7.1**. It shall include as a minimum a description of: [31)]

a) when frequencies can be changed;
b) who has the authority to change them;
c) how to document changes; and
d) how to document the time period over which the changes are valid.

4.7.3 The Board shall approve the frequencies determined in **4.7.1** and the review procedure produced in **4.7.2**. These approvals shall be documented. [32)]

Checklist 2 – Risk assessment documentation checklist

Document		Subclause	
1	Procedure for the risk assessment of each element in each functional area within a hospital	**4.1.1**	☐
2	Results of any risk assessment conducted in accordance with **4.1.1**	**4.1.2**	☐
3	Record of approval by the Board of risk assessment procedure and results	**4.1.3**	☐
4	Membership of risk assessment group	**4.2.1**	☐
5	Decision to adopt completed risk assessments provided at Annex C and Annex D	**4.2.2**	☐
6	Identification of all functional areas in a hospital	**4.3.2**	☐
7	Identification of functional areas covered by policies relating to food hygiene legislation	**4.3.3**	☐
8	Identification of all rooms within a functional area	**4.3.4**	☐
9	Identification of all elements that are located, or might be used, within a hospital	**4.3.5**	☐
10	Identification of all elements that are located, or might be used, within each functional area	**4.3.6**	☐
11	Element risk category assigned to each element	**4.4.5**	☐
12	Functional area risk category assigned to each functional area	**4.5.5**	☐
13	Overall risk category assigned to each element in each functional area	**4.6.3**	☐
14	Frequency with which to clean each of the elements in a functional area in accordance with the cleaning tasks identified in **5.2**	**4.7.1**	☐
15	Procedure for reviewing the cleaning frequencies set in accordance with **4.7.1**	**4.7.2**	☐
16	Approval of cleaning frequencies determined in **4.7.1** and review procedure produced in **4.7.2** by the Board	**4.7.3**	☐

5 Cleaning tasks

Cleanliness matters to patients who rightly expect hospitals to take care of them in an environment that is clean and safe. This clause describes the actions necessary to clean a hospital. It includes identifying what needs to be cleaned, whose responsibility it is to clean it, how clean it ought to be and what competencies are needed to conduct the cleaning. The criteria for assessing how clean an element has to be are given in Clause **6**, which deals with the measurement of cleanliness.

Checklist 3 provides a summary of documentation required by this clause to demonstrate compliance.

5.1 Responsibilities

5.1.1 The organization shall produce and make available a documented cleaning responsibility matrix that: [33), 34)]

a) lists all elements within a hospital that require cleaning, indicating which are scored elements as listed at Annex B;

b) assigns the responsibility for cleaning each element to a named staff group or groups; [35)] and

c) provides a definition and details of each of the staff groups referenced.

5.1.2 The organization shall establish a cleaning responsibilities group for the purpose of producing the matrix.

5.1.3 The organization shall document the membership and terms of reference of the cleaning responsibilities group. [36), 37)]

5.1.4 The Board shall approve the cleaning responsibility matrix. This approval shall be documented. [38)]

5.1.5 The matrix shall be communicated to Staff Group Managers (see definition at **3.2**).

5.1.6 The matrix shall be available on request from the person responsible for cleaning services as well as infection prevention and control.

5.1.7 The cleaning responsibility group shall review the matrix at least once every 12 months, or more frequently if there is a change in circumstances that might affect the matrix. The review of the matrix shall be approved by the Board.

5.2 Identification

Each Staff Group Manager shall identify and document all cleaning tasks relating to the cleanliness of elements assigned to them at **3.2**.

5.3 Risk assessment of cleaning tasks

5.3.1 The organization shall produce a documented risk assessment for each cleaning task identified in **5.2**. The risk assessment shall identify and document the risks involved in performing the cleaning task and the actions to be implemented to mitigate these risks.

5.3.2 The organization shall document the date of completion of mitigating actions identified in **5.3.1**. [39)]

5.4 Method statements

5.4.1 The organization shall produce a documented method statement for each cleaning task identified at **5.2**.

5.4.2 The method statement for a cleaning task shall include a description of any mitigating actions or procedures identified for that cleaning task in the risk assessment undertaken in **5.3**. [40)]

5.5 Work schedules [41), 42), 43), 44)]

5.5.1 The organization shall produce and document work schedules for each functional area.

5.5.2 The Functional Area Manager (see **3.2**) shall approve each work schedule. This approval shall be documented. [45)]

5.5.3 The Board shall approve each work schedule. This approval shall be documented. [46)]

5.5.4 Work schedules for each functional area shall be available on request.

5.5.5 The organization shall review each work schedule every 12 months, or more frequently if there is a change in circumstances that might affect the work schedule.

5.6 Competence

5.6.1 Each cleaning task shall be conducted by persons who are competent to perform the task in accordance with the method statements in **5.4**.

5.6.2 The criteria by which a person conducting a cleaning task is deemed competent to do so shall be documented. [47), 48), 49)]

5.6.3 Evidence that a person conducting a cleaning task meets the criteria in **5.6.2** shall be documented.

5.6.4 The criteria by which a person delivering the training in **5.6.2** is deemed competent to do so shall be documented. [50)]

5.6.5 A documented training record shall be retained and shall record the completion of any training given in support of a person achieving the criteria in **5.6.2**. It shall include the date of completion and the signatures of both the trainer and trainee. [51)]

5.7 Contingency [52), 53)]

The organization shall produce a documented procedure for:

a) mitigating the effects of a temporary requirement for additional cleaning; and [54)]

b) mitigating the effects of a temporary unavailability of staff for the performance of cleaning tasks. [55)]

Checklist 3 – Cleaning tasks documentation checklist

Document		Subclause	
1	Cleaning responsibility matrix	**5.1.1**	☐
2	Membership and terms of reference of the cleaning responsibilities group	**5.1.3**	☐
3	Approval of the cleaning responsibility matrix by the Board	**5.1.4**	☐
4	Identification of all cleaning tasks relating to the cleanliness of elements assigned to each Staff Group Manager	**5.2**	☐
5	Risk assessment for each cleaning task identified in **5.2**	**5.3.1**	☐
6	Risks involved in performing each cleaning task and the actions to be implemented to mitigate these risks	**5.3.1**	☐
7	The date of completion of mitigating actions identified in **5.3.1**	**5.3.2**	☐
8	Method statement for each cleaning task identified at **5.2**	**5.4.1**	☐
9	Work schedules for each functional area	**5.5.1**	☐
10	Approval of each work schedule by the Functional Area Manager	**5.5.2**	☐
11	Approval of each work schedule by the Board	**5.5.3**	☐
12	Criteria by which a person conducting a cleaning task is deemed competent to do so	**5.6.2**	☐
13	Evidence that a person conducting a cleaning task meets the criteria in **5.6.2**	**5.6.3**	☐
14	Criteria by which a person delivering the training in **5.6.2** is deemed competent to do so	**5.6.4**	☐
15	Record of the completion of any training given in support of a person achieving the criteria in **5.6.2**	**5.6.5**	☐
16	Procedure for mitigating the effects of a temporary requirement for additional cleaning and a temporary unavailability of staff for the performance of cleaning tasks	**5.7**	☐

6 Measurement and audit [56)]

This clause specifies:

a) how clean elements are required to be;

b) how to set agreed cleanliness performance levels; and

c) how to audit cleanliness to determine whether these levels are being achieved.

Organizations need to demonstrate a robust audit process for identifying whether performance levels are being achieved as this is an essential part of providing assurance of the cleanliness of a hospital.

This clause also makes a distinction between scored and unscored elements. A scored element is one of 50 elements identified as forming part of a representative selection of elements for the measurement of cleanliness. An unscored element is an element other than a scored element which is not used in the recorded measurement of cleanliness but nevertheless needs to be clean and included in audit arrangements.

Checklist 4 provides a summary of documentation required by this clause to demonstrate compliance.

6.1 General [57)]

The organizations shall produce and document a procedure for measuring cleanliness in a hospital. It shall include, as a minimum:

a) the definition of cleanliness criterion in **6.2**;
b) agreed cleanliness performance levels set in accordance with **6.3**;
c) a description of how to conduct a technical audit in accordance with **6.4**;
d) a description of how to conduct a managerial audit in accordance with **6.5**;
e) a description of how to conduct a Board assurance visit in accordance with **6.6**; and
f) a description of how to conduct a system audit in accordance with **6.7**.

NOTE *A flow chart representing the stages in the measurement of cleanliness specified in **6.2** to **6.7** is given in Figure 3.*

6.2 Cleanliness criterion [58)]

An element shall be identified as clean if all parts of the element have the visual appearance of being free of dirt and stains.

NOTE *Definitions of dirt and stain are given in **2.12** and **2.24** respectively. Other methods of assessment, such as microbiological testing, which are not covered in this PAS, may be considered to complement visual inspection. Arrangements for this are for local determination in conjunction with the infection control team and the undertaking of a risk assessment.*

6.3 Agreed cleanliness performance level [59), 60)]

The organization shall set, justify and document an agreed cleanliness performance level for the hospital. This level shall be the minimum percentage of all scored elements in a hospital expected to conform to the cleanliness criterion in **6.2** averaged over a 12 month period.

6.4 Technical audit

6.4.1 General [61)]

The organization shall conduct technical audits to assess whether scored elements in each functional area conform to the cleanliness criterion in **6.2**.

NOTE *A flow chart representing the stages in a technical audit specified in **6.4.2** to **6.4.5** is given in Figure 4.*

Figure 3 – Stages in the measurement of cleanliness

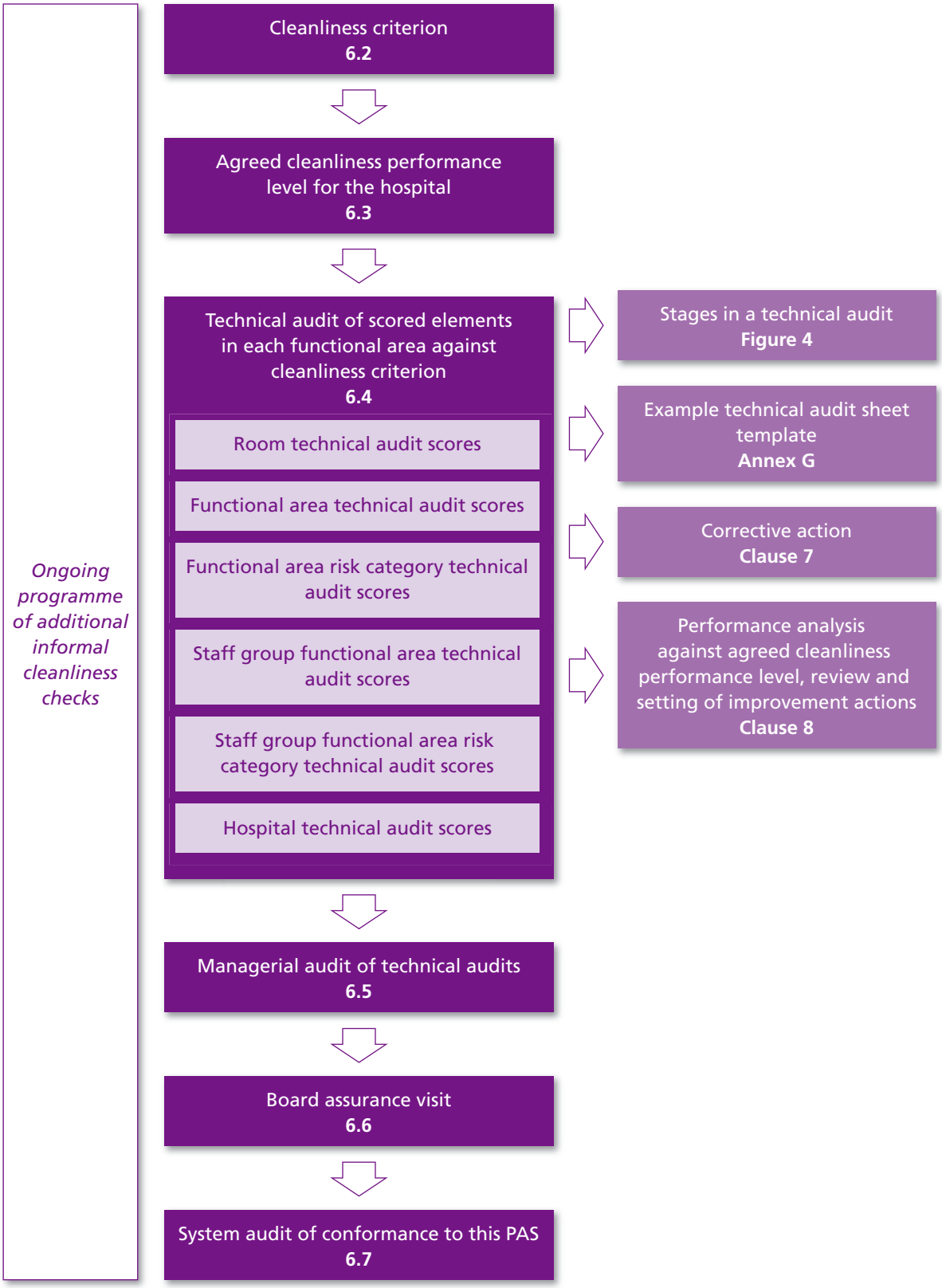


Figure 4 – Stages in a technical audit

6.4.2 Responsibilities [62), 63)]

The organization shall ensure that:

a) the criteria by which persons are permitted to undertake technical audits are deemed competent to do so are documented;

b) technical audits are conducted by persons permitted to do so; and

c) a record is kept of who has conducted each technical audit.

6.4.3 Sampling [64)]

Technical audits shall assess each scored element either in each room, or in each of a sample of rooms, within each functional area.

Where technical audits are conducted on the basis of a sample of rooms within a functional area, a method for doing this shall be documented and shall ensure that all rooms within a functional area are audited at least once within a defined period to be set and justified locally.

6.4.4 Frequency [65), 66)]

The organization shall determine and document the frequency with which technical audits are conducted. Changes to the frequency shall also be documented.

NOTE The frequency with which technical audits are conducted should be reflective of the functional area risk category. An example set of technical audit frequencies for technical audits that can be adopted for each functional area risk category is shown in Table 6.

Table 6 – Example technical audit frequencies

Functional area risk category	Frequency
Green	Quarterly or half-yearly
Amber	Monthly
Red	Weekly

6.4.5 Scoring

Technical audits shall assign an element technical audit score of 0 or 1 to each scored element in each room, or in each of a sample of rooms, in accordance with Table 7.

The cleanliness of each scored element shall be assessed as it appears on first inspection. If the element does not conform to the cleanliness criterion in **6.2**, it shall be scored 0, irrespective of whether it is immediately cleaned thereafter.

Table 7 – Criteria for assigning an element technical audit score to a scored element

Element technical audit score	Criteria
0	Element does not conform to the cleanliness criterion in **6.2**
1	Element conforms to the cleanliness criterion in **6.2**

The element technical audit scores shall be recorded and used to calculate the technical audit scores in Table 8 for all rooms, functional areas, functional area risk categories and hospitals covered by the cleanliness policy in **3.1** and staff groups. [67)]

Where a scored element is not present in a room, this shall be recorded and the element shall not be included in the calculation of technical audit scores in Table 8.

Where the cleaning of a scored element is the responsibility of more than one staff group, as determined in **5.1**, the element technical audit score achieved for that element shall apply to all staff groups when calculating the staff group scores in Table 8.

6.5 Managerial audit

6.5.1 The organization shall undertake a managerial audit by validating a sample of technical audit methodologies at least once a quarter. This shall determine whether technical audits are being conducted in accordance with **6.4** and shall be conducted in accordance with a documented procedure. [68)]

6.5.2 The organization shall document the criteria by which the persons permitted to undertake managerial audits are deemed competent to do so. [69)]

6.5.3 The organization shall document the names of persons permitted to undertake management audits.

Table 8 – Technical audit scores

Category	Name	Description	Unit
Room	Room technical audit score	Total of all element technical audit scores achieved by all scored elements present in a room as a percentage of the maximum achievable total for that room	%
Functional area	Functional area technical audit score	Average (mean) of all room technical audit scores achieved by a functional area	%
	Quarterly functional area technical audit score	Average (mean) of all functional area technical audit scores achieved in technical audits by a functional area over 13 weeks	%
	Annual functional area technical audit score	Average (mean) of all functional area technical audit scores achieved in technical audits by a functional area over one year	%
Functional area risk category	Functional area risk category technical audit score	Average (mean) of all functional area technical audit scores achieved by all functional areas in a functional area risk category	%
	Quarterly functional area risk category technical audit score	Average (mean) of all functional area technical audit scores achieved in technical audits by all functional areas in a functional area risk category over 13 weeks	%
	Annual functional area risk category technical audit score	Average (mean) of all functional area technical audit scores achieved in technical audits by all functional areas in a functional area risk category over one year	%
Hospital	Hospital technical audit score	Average (mean) of all functional area risk category technical audit scores achieved by a hospital	%
	Quarterly hospital technical audit score	Average (mean) of all functional area risk category technical audit scores achieved in technical audits by a hospital over 13 weeks	%
	Annual hospital technical audit score	Average (mean) of all functional area risk category technical audit scores achieved in technical audits by a hospital over one year	%
Staff group	Staff group functional area technical audit score	Total of all element technical audit scores achieved by all scored elements that a staff group is responsible for in a functional area as a percentage of the maximum achievable total for that staff group in that functional area	%
	Staff group functional area risk category technical audit score	Average (mean) of all staff group functional area technical audit scores achieved by a staff group in all functional areas in a functional area risk category	%
NOTE *Variance around the mean can also be determined to provide extra information on performance.*			

6.6 Board assurance visit

6.6.1 The organization shall produce and document a procedure for conducting a Board assurance visit. It shall define as a minimum:

a) the terms of reference of Board assurance visits;

b) the activities to be undertaken during a Board assurance visit; and

c) the frequency with which, and locations in which, Board assurance visits are to be conducted. [70)]

6.6.2 A Board assurance visit shall be conducted by a Board member. [71)]

6.6.3 The outcomes of a Board assurance visit shall be documented.

6.7 System audit

6.7.1 The organization shall conduct internal audits at defined intervals to determine whether the provision of cleanliness conforms to the requirements of this PAS.

6.7.2 System audit programmes shall be planned, established, implemented and maintained by the organization, taking into consideration the importance of the operations concerned and the results of previous audits.

6.7.3 Audit procedures shall be established, implemented and maintained that address:

a) the responsibilities and requirements for planning and conducting audits, reporting results and retaining associated records; and

b) the determination of system audit criteria, scope, frequency and methods.

6.7.4 There shall be a documented description of how the selection of auditors and the conduct of audits ensures objectivity and impartiality in the audit process.

Checklist 4 – Measurement documentation checklist

Document		Subclause	
1	Procedure for measuring cleanliness in a hospital	**6.1**	☐
2	Agreed cleanliness performance level for the hospital	**6.3**	☐
3	Criteria by which persons are permitted to undertake technical audits are deemed competent to do so	**6.4.2**	☐
4	Record of who has conducted each technical audit	**6.4.2**	☐
5	Method for conducting technical audits on the basis of a sample of rooms within a functional area	**6.4.3**	☐
6	The determined frequency with which technical audits are conducted	**6.4.4**	☐
7	The criteria by which the persons permitted to undertake managerial audits are deemed competent to do so	**6.5.2**	☐
8	Names of the persons permitted to undertake management audits	**6.5.3**	☐
9	Procedure for conducting a Board assurance visit	**6.6.1**	☐
10	Outcomes of a Board assurance visit	**6.6.3**	☐
11	Description of how the selection of auditors and the conduct of audits ensures objectivity and impartiality in the audit process	**6.7.4**	☐

7 Corrective action[72)]

When audits demonstrate a shortfall in cleaning, corrective action needs to be timely and thorough. This clause defines a mechanism for planning and recording corrective actions. It requires organizations to declare their target timescales for completion of corrective actions. Such targets are set and justified locally.

Checklist 5 provides a summary of documentation required by this clause to demonstrate compliance.

7.1 Any scored element in any room that receives an element technical audit score of 0 in accordance with **6.4** shall be assigned a corrective action by the person conducting the technical audit.

7.2 Any unscored element that does not conform to the cleanliness criterion in **6.2** shall also be assigned a corrective action by the person conducting the technical audit, even though it does not contribute to technical audit scores.[73), 74)]

7.3 The organization shall document the target timescales for the completion of corrective actions.[75), 76), 77)]

7.4 Corrective actions and target timescales for their completion shall be passed to the Staff Group Manager.[78)]

7.5 The organization shall document the completion of corrective actions and the actual timescales for their completion.

Checklist 5 – Corrective action documentation checklist

Document		Subclause	
1	Target timescales for the completion of corrected actions	**7.3**	☐
2	Record of the completion of corrective actions and the actual timescales for their completion	**7.5**	☐

8 Performance analysis, review and improvement action

This clause requires that the results of technical audits are analysed and actions assigned to prevent recurrence of identified issues.

Checklist 6 provides a summary of documentation required by this clause to demonstrate compliance.

8.1 The organization shall produce documented procedures for:

a) analysing the results of technical audits and addressing identified issues;

b) analysing timescales for the completion of corrective actions and addressing identified issues; and

c) receiving, investigating, addressing and recording reports of a lack of cleanliness.

8.2 The procedures in **8.1** shall include as a minimum:

a) the recording of improvement actions assigned to address identified issues and a target timescale for completion;

b) the recording of the actual timescale for the completion of each improvement action; and

c) whether the improvement action had resolved the identified issue. [79)]

Checklist 6 – Performance analysis and improvement documentation checklist

Document		Subclause	
1	Procedure for analysing the results of technical audits and addressing identified issues	**8.1**	☐
2	Procedure for analysing timescales for the completion of corrective actions and addressing identified issues	**8.1**	☐
3	Procedure for receiving, investigating, addressing and recording reports of a lack of cleanliness	**8.1**	☐

9 Continuous service improvement

This PAS requires a commitment to continuous service improvement. This clause embeds this principle.

Checklist 7 provides a summary of documentation required by this clause to demonstrate compliance.

The organization shall produce and maintain a documented plan to promote continuous service improvement relating to the provision of cleanliness. [80)]

Checklist 7 – Continuous service improvement documentation checklist

Document		Subclause	
1	Plan to promote continuous service improvement relating to the provision of cleanliness	**9**	☐

10 Reporting

This PAS requires organizations to make information available on request. A positive safety culture at front-line level can be evidenced by a number of factors including thorough and thoughtful information for patients. Such generic information should include a list of standards patients can expect to experience on the ward, such as those in relation to cleanliness and hygiene.

To support proper governance and assurance of all the procedures relating to cleaning, this PAS also requires the submission of quarterly performance reports to the Board.

Checklist 8 provides a summary of documentation required by this clause to demonstrate compliance.

10.1 Functional areas

10.1.1 The most recent functional area technical audit score for any functional area, as determined in accordance with **6.4**, shall be available on request.

10.1.2 The most recent quarterly and annual functional area technical audit scores, as determined in accordance with **6.4**, shall be available on request.

10.1.3 A trend chart showing the ten most recent functional area technical audit scores for any functional area shall be available on request.

10.2 Hospital

10.2.1 The agreed cleanliness performance level for the hospital determined in accordance with **6.3** shall be available on request.

10.2.2 The annual hospital technical audit score, as determined in accordance with **6.4**, shall be available on request.

10.3 Board [81), 82)]

The Director with Responsibility for Cleanliness (see **3.2**) shall make a quarterly documented report to the Board.

Checklist 8 – Reporting documentation checklist

Document		Subclause	
1	Quarterly report to the Board by the Director with Responsibility for Cleanliness	**10.3.1**	☐

Annex A (informative)
Commentary to Clause 1 to Clause 10

A.1 Scope

1) The relationship between the requirements of this PAS and supporting figures and annexes is shown in Figure 1. In particular, attention is drawn to the detailed guidance on the provision of cleanliness given in *The Revised Healthcare Cleaning Manual* [1].

A.2 Terms and definitions

2) Within the NHS this would be the Trust Board (or Board of Directors for Foundation Trusts).

3) Cleaning is not:
   a) decontamination; or
   b) sterilization.

4) Dirt can include, for example:
   a) adhesive tape;
   b) blood;
   c) body substances;
   d) cobwebs;
   e) dead animals, birds or insects;
   f) dust;
   g) food debris;
   h) graffiti;
   i) grease;
   j) limescale;
   k) litter;
   l) scum;
   m) smears; and
   n) spillages of liquids or powders.

5) For example, a bed or a ceiling.

6) For organizations with more than one operating unit, a single operating unit may be defined as an organization.

7) The 50 scored elements are listed at Annex B.

8) A stain can be attributed to, for example:
   a) rust;
   b) food and drink;
   c) dyes; and
   d) watermarks.

9) A technical audit is not necessarily identical to contract monitoring.

A.3 Governance

10) Catering facilities in a hospital that are covered by food hygiene legislation may be excluded from the provisions of this PAS, except where the catering facility forms an integral part of a functional area for which catering is not the primary purpose, such as a ward kitchen, beverage bay and staff room. It is a matter for local determination as to whether a large ward kitchen is deemed to constitute a functional area in its own right and hence be excluded from the provisions of this PAS.

11) This role is referred to in this PAS as the Director with Responsibility for Cleanliness. It can be performed by the Director of Infection Prevention and Control, the Director of Nursing, the Director of Facilities or by another named Board member.

12) This role is referred to in this PAS as the Functional Area Manager.

13) This role is referred to in this PAS as the Staff Group Manager.

14) Documentation can be retained in any format, including paper or electronic formats.

15) Examples of pro forma include technical audit sheets and corrective action sheets.

16) Examples of documented information include work schedules and technical audit scores.

A.4 Risk assessment and setting of cleaning frequencies

17) The organization may use the completed risk assessment of elements and typical functional areas as given at Annex C and Annex D to meet the requirements of **4.3**.

18) The organization may use the completed risk assessment of elements as given at Annex C to meet the requirements of **4.4**.

19) The organization may use the completed risk assessment of typical functional areas as given at Annex D to meet the requirements of **4.5**.

20) A flow chart representing the stages in a risk assessment specified in **4.2** to **4.6** is given in Figure 2.

21) The risk assessment group should include Functional Area Managers (see **3.2**), Staff Group Managers (see **3.2**) and a representative with expertise in infection prevention and control. The risk assessment group could be the same as the cleaning responsibilities group (see **5.1.2**).

22) A functional area is a discrete area of operational activity (see **2.14**), that is defined as such because, for example:
   a) it is the location for different clinical activity from neighbouring areas;
   b) it is differently managed from neighbouring areas; or
   c) it exhibits a level of risk that differs from neighbouring areas.

   Typical examples of functional areas in a hospital include a ward, a department, a suite of offices and a set of corridors including associated lifts and stairwells.

23) Where the risk assessment group find that a discrete area within a defined functional area would have a different risk rating from the rest of the functional area, e.g. a part of an imaging department where invasive procedures are conducted, the discrete area may be defined as a functional area in its own right.

24) Catering facilities in a hospital that are covered by food hygiene legislation may be excluded from the provisions of this PAS, except where the catering facility forms an integral part of a functional area for which catering is not the primary purpose, such as a ward kitchen, beverage bay and staff room. It is a matter for local determination as to whether a large ward kitchen is deemed to constitute a functional area in its own right and hence be excluded from the provisions of this PAS.

25) Scored elements are identified separately because they will be used in the measurement of cleanliness in Clause **6**.

26) The organization may use the completed risk assessments of elements and typical functional areas as given at Annex C and Annex D to meet the requirements of **4.4** and **4.5**.

27) Guidance on assigning a risk score out of three for an element for both infection risk and confidence risk is given in Table 1. Scores should be assigned on the basis of the relative risk of the elements within a hospital and therefore elements should not, for example, all be assessed as "red" risk just because they are in a hospital.

28) The organization may use the completed risk assessments of elements and typical functional areas as given at Annex C and Annex D to meet the requirements of **4.4** and **4.5**.

29) Guidance on assigning a risk score out of three for a functional area for both infection risk and confidence risk is given in Table 3.

30) In the determination of cleaning frequencies a number of factors can be considered, including:
   a) the outcome of the risk assessment in Clause **4**;
   b) the days and hours of use of the functional area; and
   c) the likely rate of resoiling of an element, which can depend on how and how often it is used and moved.

31) A review of cleaning frequencies can be conducted, for example, as a part of a regular review, as a result of an identified lack of cleanliness or as a result of a change in risk. For example, higher cleaning frequencies can be implemented when there is a heightened risk of infection, i.e. an outbreak situation.

32) The frequencies determined in **4.7.1** and the review procedure produced in **4.7.2** will normally be presented to the Board as part of a Board report summarizing its contents.

A.5 Cleaning tasks

33) The 50 scored elements should be listed, in the order in which they are listed at Annex B, at the top of the cleaning responsibilities matrix. All unscored elements should be listed below these, in any order. The 50 scored elements cover most elements within a functional area, however there are other elements specific to certain locations that are not scored but which are equally important and should be kept clean. These unscored elements should be identified in the organization's cleaning policy with details of who is responsible for cleaning them. There should also be a cleaning frequency attached to these elements which should also be documented and a corrective action response time attached.

34) Typically, cleaning tasks are assigned to the following three staff groups.
   a) Cleaning staff. In most hospitals, the majority of cleaning tasks are undertaken by a dedicated cleaning service. The dedicated cleaning service may be provided directly by the healthcare organization, or may be outsourced either to a neighbouring

healthcare organization under a service level agreement (SLA) or to a commercial provider under a standard contract or as part of a private finance initiative (PFI) agreement.

b) Clinical or departmental staff. Some cleaning tasks are undertaken by those staffing the functional area in which the cleaning tasks are to be undertaken. For example, nurses in wards and pharmacy and physiotherapy staff in their respective departments. This staffing group is usually employed directly by the healthcare organization they serve.

c) Estates staff. A small minority of cleaning tasks are undertaken by the healthcare organization's estates service. These may be either directly employed by the healthcare organization they serve or under another contractual arrangement.

In addition to these three main staff groups, cleaning tasks can also be identified as being the responsibility of other staff groups, such as porters.

35) For some elements, there may be a clearly-defined dual responsibility for cleanliness. In this case, a description of the responsibility of each staff group should be given in the cleaning responsibilities matrix. For example, baths are cleaned after each use by nursing staff, then once per day by cleaning staff. The identification of dual responsibilities is particularly important for elements that are shared by, and/or moved between, functional areas.

36) The cleaning responsibilities group is likely to have to make decisions that have significant financial and labour resource implications. Therefore, the group should be made up of senior individuals and given a place in a healthcare organization's governance structure that allows it to make these decisions.

For example, a cleaning responsibilities group should include representation from:

- infection prevention and control;
- facilities management;
- nursing; and
- finance.

This should include at least one Director at Board level (usually the Director with Responsibility for Cleanliness where only one Director is involved), Functional Area Managers, Staff Group Managers, at least one experienced cleaning staff member and, if employed, dedicated auditors, usually known as Monitoring Officers or Compliance Officers.

37) The cleaning responsibilities group's terms of reference should be to:

- identify all elements in a hospital;
- identify existing arrangements for cleaning these elements;
- identify areas of a lack of clarity, non-performance or inconsistent performance;
- develop, define and review competence levels required to complete cleaning tasks;
- own, and if necessary create, a cleaning responsibilities matrix allocating the responsibility for cleaning each element to a staff group;
- ensure that adequate resource is available for the cleaning of all elements;
- ensure that the cleaning responsibilities matrix is clearly understood by all parties, and is accurately reflected in work planning, work schedules and team briefs; and
- review the cleaning responsibilities matrix.

38) The cleaning responsibility matrix will normally be presented to the Board as part of a Board report summarizing its contents.

39) Further guidance on a selection of health and safety aspects that are considered in the risk assessment of cleaning tasks is given at Annex F.

40) Method statements should be written with the aim of achieving the cleanliness criterion in **6.2**. They should give full instruction in the performance of a cleaning task and list all equipment required for it. Instructions common to all cleaning tasks, or applicable to most cleaning tasks, may be contained in a separate section added to the start of each method statement. Further guidance on producing method statements is given in *The Revised Healthcare Cleaning Manual* [1].

41) The review of a work schedule should take into account the result of technical audits for that functional area conducted in accordance with Clause **6**.

42) Different work schedules for each functional area may be produced for different staff groups, allowing the work schedule to perform a secondary function as a work instruction. For example, there may be two work schedules for a typical hospital ward, one detailing the cleaning tasks performed by dedicated cleaning staff and another detailing the cleaning tasks performed by the nursing staff.

43) Some cleaning tasks are typically performed less frequently than once per week, but require regular performance at defined intervals, which may range from fortnightly to six-monthly or even annually. Examples of such tasks include carpet shampooing, curtain changing, floor stripping and application of polish or sealant, cleaning of ventilation grilles, and window cleaning.

The performance of these tasks should be planned in advance every year and documented in a periodic work schedule.

A periodic work schedule usually covers more than one functional area and therefore one periodic work schedule can be used to form part of the work schedule for each of several functional areas.

44) Further guidance on producing work schedules is given in *The Revised Healthcare Cleaning Manual* [1].

45) Work schedules will normally be agreed between the Functional Area Manager and the Staff Group Manager.

46) Work schedules will normally be presented to the Board as part of a Board report summarizing their contents.

47) The criteria should include evidence of training in:
   a) how to perform the cleaning task in accordance with the method statements in **5.4**;
   b) site orientation;
   c) infection prevention and control;
   d) fire safety;
   e) manual handling; and
   f) health and safety.

48) Training in how to conduct a cleaning task should consist of instruction, demonstration, questioning and observation of performance. Training should be repeated until the trainee is observed as conducting the cleaning task in accordance with the instructions given.

49) The provision of training towards achieving formal national qualifications, such as National Vocational Qualifications (NVQs), should be considered, as should the provision of apprenticeships.

50) Training may be delivered directly by employees of the healthcare organization responsible for the hospital or by contracted trainers.

51) Further guidance on training records is given in *The Revised Healthcare Cleaning Manual* [1].

52) Guidance on contingency planning for the provision of cleaning tasks is given in *The Revised Healthcare Cleaning Manual* [1].

53) Contingency planning for the provision of cleaning tasks forms part of a wider need for business continuity management within a healthcare organization.

54) For example, an infection outbreak will require additional resource for a defined period of time. This need might suddenly become apparent and require immediate action.

55) For example a number of staff might suddenly be affected by an outbreak of sickness and not report to work.

A.6 Measurement and audit

56) The audits and Board assurance visits in Clause **6** are not intended to represent the totality of auditing performed. An ongoing programme of additional informal checks should be in place in each functional area to identify issues as they occur.

Further guidance on the measurement of cleanliness, including guidance on additional informal checks, is given in *The Revised Healthcare Cleaning Manual* [1].

57) A flow chart representing the stages in the measurement of cleanliness specified in **6.2** to **6.7** is given in Figure 3.

58) Definitions of dirt and stain are given in **2.12** and **2.24** respectively. Other methods of assessment, such as microbiological testing, which are not covered in this PAS, may be considered to complement visual inspection. Arrangements for this are for local determination in conjunction with the infection control team and the undertaking of a risk assessment.

59) There are no national performance levels defined within this PAS. The organization should set an agreed cleanliness performance level ordinarily in collaboration with healthcare commissioning bodies and this can be included within formal contracts. Any performance level agreed should be realistic, achievable, challenging and regularly reviewed to ensure it contributes to an ethos of continuous improvement.

60) Agreed cleanliness performance levels may also be set for each of the four functional area risk

categories in Table 5 (green, red and amber). These can be used to determine the agreed cleanliness performance level for the hospital. For example, where 30% of the functional areas are assessed as low risk with an agreed cleanliness performance level of 60%, 50% are assessed as medium risk with an agreed cleanliness performance level of 80% and 20% are assessed as high risk with an agreed cleanliness performance level of 100%, the agreed cleanliness performance level for the hospital could be calculated as (60% × 30) + (80% × 50) + (100% × 20) = 78%.

61) A flow chart representing the stages in a technical audit specified in **6.4.2** to **6.4.5** is given in Figure 4.

62) Technical audits can be undertaken as a joint exercise by:
   a) the Functional Area Manager (see **3.2**);
   b) the Staff Group Manager (see **3.2**);
   c) Infection Prevention and Control Team members; and
   d) other interested persons, if any, such as patient and public representatives and dedicated auditors, usually known as Monitoring Officers or Compliance Officers and staff representatives (for example cleaning staff).

63) Where there is more than one auditor, a lead auditor should be nominated for each technical audit of a functional area.

64) Further requirements and recommendations on sampling are given in BS EN 13549.

65) The frequency with which technical audits are conducted should be reflective of the functional area risk category. An example set of technical audit frequencies for technical audits that can be adopted for each functional area risk category is shown in Table 6.

66) Technical audit frequencies may be reviewed in light of technical audit scores. For example, if a functional area is consistently achieving agreed cleanliness performance levels, consideration can be given to reducing the frequency of conducting the technical audit frequencies.

67) The results of technical audits can be recorded on paper or electronically. An example technical audit sheet template is given at Annex G.

68) A managerial audit is a vital part of the overall assurance process and allows managers within a hospital to obtain assurance that technical audits are being conducted correctly.

69) The persons conducting the managerial audits should be different from those who carried out the technical audit.

70) The purpose of the Board assurance visit is to allow the Board to form an impression of the cleanliness of the hospital and the satisfaction of its users. It is not intended that any formal assessment of cleanliness should be made in the course of a Board assurance visit. However, if the visit identifies a need for improvement, this should be communicated to the Functional Area Manager and the Staff Group Manager and an additional technical audit should be conducted.

71) Board assurance visits will usually be conducted by the Director with Responsibility for Cleanliness.

A.7 Corrective action

72) The corrective actions identified, recorded and implemented in accordance with Clause **7** are not intended to represent the totality of corrective action performed. Additional corrective actions should be conducted in each functional area to rectify issues as they occur.

   Further guidance on corrective actions, such as setting completions timescales, producing records and maintaining an ongoing programme of additional informal corrective actions is given in *The Revised Healthcare Cleaning Manual* [1].

73) The 50 scored elements will cover most elements within a functional area, however there will be other elements specific to certain locations that are not scored but which are equally important and should be kept clean. These unscored elements should be identified in the organization's cleaning policy with details of who is responsible for cleaning them. There should also be a cleaning frequency attached to these elements which should also be documented and a corrective action response time attached.

74) A corrective action normally demands the performance of a specific cleaning task, for example "perform high dusting to top of curtain rail in room 15".

   Occasionally, a corrective action may require a non-cleaning action in addition to a cleaning task, for example, "remove stored archives to allow cleaning of the hard flooring in room 15" or "an element is worn or damaged and needs replacing".

A corrective action should not take the form of a general comment on the cleanliness of a room or functional area, e.g. "room 15 dusty".

75) Target timescales for the completion of corrective actions should be driven by the risk level/status of the element and/or functional area.

76) Further guidance on setting corrective action timescales is given in *The Revised Healthcare Cleaning Manual* [1].

77) Where this does not delay the process, elements requiring corrective action should be corrected in order of element risk category (i.e. red, amber, green).

78) These should be passed to the Staff Group Manager without delay.

A.8 Performance analysis, review and improvement action

79) Issues identified can, for example, be addressed by:
   a) changing cleaning frequencies;
   b) changing agreed cleanliness performance levels;
   c) changing method statements; and
   d) providing training.

   Further advice on dealing with underperformance over time, including the setting of improvement actions is given in *The Healthcare Cleaning Manual* [1].

A.9 Continuous service improvement

80) Guidance on continuous service improvement is given in *The Revised Healthcare Cleaning Manual* [1].

   In summary, the commitment to continuous service improvement, which is detailed in the cleanliness policy in **3.1**, does not necessarily imply additional service cost, and may indeed produce savings. Measures to promote continuous service improvement may include:
   a) more efficient use of labour;
   b) better working or supervisory practices;
   c) schemes to regularly and meaningfully engage with staff, raise staff morale and reduce sickness absence and staff turnover; and
   d) implementation of, or increased use of, technological advances.

   Commercial cleaning, nursing, departmental or estates contracts should be let on the basis that there will be an ongoing commitment to innovation and improvement in cleaning.

   All cleaning service managers and other managers responsible for the delivery of cleaning services should consider joining a professional association, in order to ensure that they keep abreast of new developments, innovations and evolving best practice.

A.10 Reporting

81) The documented report should include:
   a) the agreed cleanliness performance level for the hospital determined in **6.3**;
   b) a summary of all the technical audit scores described in Table 8 for the period up to the end of this 13 week reporting period;
   c) a summary of the findings of managerial audits undertaken in accordance with **6.5** during the reporting period;
   d) a summary of the findings of any Board assurance visits undertaken in accordance with **6.6** during the reporting period;
   e) a summary of the number of corrective actions and target and actual timescales for their completion as determined in Clause **7**;
   f) a summary of the results of system audits conducted in accordance with **6.7**;
   g) a summary of the improvement actions and target and actual timescales for their completion as determined in Clause **8**; and
   h) a continuous improvement plan completed in accordance with Clause **9**.

82) The report may contain other information relevant to hospital cleanliness and may form part of a wider Board report. An example report is given in *The Revised Healthcare Cleaning Manual* [1].

Annex B (normative)
Scored elements

The 50 elements listed in Table B.1 shall be identified as scored elements.

*NOTE These 50 scored elements are intended to be a **representative sample that reflects the range of risk associated with elements**, rather than the 50 elements that might pose the greatest infection or confidence risk. Not all scored elements will be present in all types of hospital, for example, certain mental health hospitals are unlikely to contain certain scored elements because of their patient profile. However, all functional areas within a hospital will contain a significant proportion of the scored elements and where a scored element is not present it can be identified as such.*

Table B.1 – Scored elements

No.	Element name
1	Commode
2	Bed pan and bed pan holder
3	Macerator and bed pan washer
4	Manual handling equipment
5	Catheter stand
6	IV stand
7	Patient washbowl
8	Medical equipment not connected to a patient, e.g. X-ray machine
9	Medical equipment connected to a patient, e.g. infusion pump and blood pressure cuffs
10	Medical gas and suction equipment including gas cylinder holder
11	Patient fan
12	Notes and drugs trolley
13	Resuscitation trolley
14	Telephones and fax machines
15	Nurse call bell
16	Wall fixture, e.g. switch, socket and data point, and cord pull
17	Wall surfaces including skirting and bumper boards
18	Ceiling
19	Door including frame
20	Door furniture including handles and door plates
21	Internal glass, including partitions and vision panels, the interior surface of external facing windows and mirrors
22	Computer equipment, including keyboard, mouse, monitor, printer, stand and photocopier
23	TV including earpiece for bedside entertainment system and public area information touch screen
24	Radiator including the space between radiator plates

Table B.1 – Scored elements *(continued)*

No.	Element name
25	Hard floor
26	Soft floor
27	Toys and games
28	Lighting including overhead, bedside, wall mounted and free standing
29	Cleaning equipment, including cleaning trolley
30	High surface, e.g. curtain rail, picture frame, top of cupboard and vending machine
31	Patient chair, including dining chair and easy chair, and settee
32	Bed, cot and patient trolley, including bed frame, bed rail, wheels and castors, and bed controls
33	Clinical workstations
34	Locker and wardrobes including wheels and castors
35	Over-bed/dining table including legs and feet
36	Hand hygiene equipment, e.g. soap dispenser, alcohol gel dispenser and towel dispenser
37	Waste receptacle including lid and pedal
38	Curtain, blind and screen, excluding shower curtain
39	Dishwasher
40	Fridge and freezer
41	Ice machine, hot water boiler and drinking water dispenser
42	Ward kitchen cupboard
43	Microwave and cooker
44	Bath and/or shower including shower head, wall-attached shower chair, shower screen and shower curtain
45	Toilet, raised toilet seat and bidet
46	Toilet brush
47	Sink and wash hand basin including taps
48	Ventilation grille
49	Wheelchair
50	CCTV equipment

Annex C (informative)
Completed risk assessment of elements

A completed risk assessment of elements is given in Table C.1.

NOTE Table C.1 is based on work led by The Rotherham NHS Foundation Trust with the involvement of staff from three professional bodies representing cleaning, nursing and infection prevention and control staff [e].

It was further reviewed by the steering group that participated in this PAS revision. It delivers a completed risk assessment of all the scored elements detailed at Annex B as per the requirement at ***4.4****.*

[e] AHCP, RCN and IPS.

Table C.1 – Completed risk assessment of elements

No.	Element name	Infection risk score	Confidence risk score	Element risk score	Element risk category
1	Commode	3	3	9	Red
2	Bed pan and bed pan holder	3	3	9	Red
3	Macerator and bed pan washer	3	2	6 upper	Red
4	Manual handling equipment	3	2	6 upper	Red
5	Catheter stand	2	2	4	Amber
6	IV stand	2	2	4	Amber
7	Patient washbowl	2	2	4	Amber
8	Medical equipment not connected to a patient, e.g. X-ray machine	1	2	2	Green
9	Medical equipment connected to a patient, e.g. infusion pump and blood pressure cuffs	3	3	9	Red
10	Medical gas and suction equipment including gas cylinder holder	1	1	1	Green
11	Patient fan	2	2	4	Amber
12	Notes and drugs trolley	1	2	2	Green
13	Resuscitation trolley	2	2	4	Amber
14	Telephones and fax machines	2	2	4	Amber
15	Nurse call bell	3	2	6 upper	Red

Table C.1 – Completed risk assessment of elements *(continued)*

No.	Element name	Infection risk score	Confidence risk score	Element risk score	Element risk category
16	Wall fixture, e.g. switch, socket and data point, and cord pull	2	2	4	Amber
17	Wall surfaces including skirting and bumper boards	1	2	2	Green
18	Ceiling	1	2	2	Green
19	Door including frame	1	2	2	Green
20	Door furniture including handles and door plates	2	2	4	Amber
21	Internal glass, including partitions and vision panels, the interior surface of external facing windows and mirrors	1	2	2	Green
22	Computer equipment, including keyboard, mouse, monitor, printer, stand and photocopier	2	2	4	Amber
23	TV including earpiece for bedside entertainment system and public area information touch screen	2	3	6 lower	Amber
24	Radiator including the space between radiator plates	1	2	2	Green
25	Hard floor	1	3	3	Amber
26	Soft floor	1	3	3	Amber
27	Toys and games	2	3	6 lower	Amber
28	Lighting including overhead, bedside, wall mounted and free standing	1	3	3	Amber
29	Cleaning equipment, including cleaning trolley	3	3	9	Red
30	High surface, e.g. curtain rail, picture frame, top of cupboard and vending machine	1	3	3	Amber
31	Patient chair, including dining chair and easy chair, and settee	3	3	9	Red

Table C.1 – Completed risk assessment of elements *(continued)*

No.	Element name	Infection risk score	Confidence risk score	Element risk score	Element risk category
32	Bed, cot and patient trolley, including bed frame, bed rail, wheels and castors, and bed controls	3	3	9	Red
33	Clinical workstations	2	3	6 lower	Amber
34	Locker and wardrobes including wheels and castors	2	3	6 lower	Amber
35	Over-bed/dining table including legs and feet	3	2	6 upper	Red
36	Hand hygiene equipment, e.g. soap dispenser, alcohol gel dispenser and towel dispenser	1	3	3	Amber
37	Waste receptacle including lid and pedal	1	3	3	Amber
38	Curtain, blind and screen, excluding shower curtain	3	3	9	Red
39	Dishwasher	1	2	2	Green
40	Fridge and freezer	1	2	2	Green
41	Ice machine, hot water boiler and drinking water dispenser	1	3	3	Amber
42	Ward kitchen cupboard	1	2	2	Green
43	Microwave and cooker	1	2	2	Green
44	Bath and/or shower including shower head, wall-attached shower chair, shower screen and shower curtain	3	3	9	Red
45	Toilet, raised toilet seat and bidet	3	3	9	Red
46	Toilet brush	1	3	3	Amber
47	Sink and wash hand basin including taps	3	3	9	Red
48	Ventilation grille	1	2	2	Green
49	Wheelchair	3	3	9	Red
50	CCTV equipment	1	1	1	Green

Annex D (informative)
Completed risk assessment of typical functional areas

A completed risk assessment of typical functional areas is given in Table D.1.

*NOTE Table D.1 is based on work led by The Rotherham NHS Foundation Trust with the involvement of staff from three professional bodies representing cleaning, nursing and infection prevention and control staff [f]. It was further reviewed by the steering group that participated in this PAS revision. It delivers a completed risk assessment of a range of typical functional areas likely to be found at all hospitals as per **4.5**.*

[f] AHCP, RCN and IPS.

Table D.1 – Completed risk assessment of typical functional areas

Functional area group	Infection risk score	Confidence risk score	Functional area risk score	Functional area risk category
Operating theatres (includes associated clinical spaces such as anaesthetic rooms and recovery, all associated administrative space and general circulation areas)	3	3	9	Red
Invasive treatment or diagnostic departments (includes catheter labs, renal dialysis units, endoscopy units, all associated administrative space and general circulation areas)	3	3	9	Red
Critical care (includes intensive care units, coronary care, neonatal units, all associated administrative space and general circulation areas)	3	3	9	Red
Accident and emergency departments (includes minor injuries units, all associated administrative space and general circulation areas)	3	3	9	Red
Pharmacies with aseptic suite	3	2	6 upper	Red
Dispensing pharmacies	1	2	2	Green
Laboratories	1	1	1	Green
Wards (includes all general and specialist wards, e.g. medical, surgical, elderly care, maternity, all associated administrative space and general circulation areas, does NOT include critical care wards)	2	3	6 lower	Amber

Table D.1 – Completed risk assessment of typical functional areas *(continued)*

Functional area group	Infection risk score	Confidence risk score	Functional area risk score	Functional area risk category
Non-invasive treatment and diagnostic departments (includes radiology, ultrasound, physiotherapy, occupational therapy, all associated administrative space and general circulation areas)	2	2	4	Amber
Reception and entrances (includes main receptions and internal receptions areas within departments)	1	3	3	Amber
Outpatient departments (includes all clinics and treatment areas, all associated administrative space and general circulation areas)	2	2	4	Amber
Administrative space (non-clinical areas) (includes all offices, records departments, libraries, lecture theatres etc.)	1	2	2	Green
General circulation areas (non-clinical areas) (includes corridors, lifts and stairwells)	1	2	2	Green
Plant rooms and semi-outdoor areas (e.g. garages, loading bays) (includes restricted access areas)	1	1	1	Green
Residencies	1	2	2	Green
Cafes, restaurants, retail outlets	1	3	3	Amber

Annex E (informative)
Example of overall risk category outcomes

NOTE An example of the outcome of the overall risk category process (see Table 5) for ten of the 50 scored elements is shown in Figure E.1 as a means of demonstrating how NHS trusts might combine risk assessments of elements and typical functional areas as one factor in determining cleaning frequencies.

Figure E.1 – Example of overall risk category outcomes

Elements (Clause 4, Tables 1 and 2)	Functional area groups (Annex D)															
	Red					Amber						Green				
	Operating theatres	Invasive treatment or diagnostic departments	Critical care	Accident and emergency departments	Pharmacies with aseptic suite	Dispensing pharmacies	Wards	Non-invasive treatment and diagnostic departments	Reception and entrances	Outpatient departments	Cafes, restaurants, retail outlets	Laboratories	Admin space (non-clinical areas)	General circulation areas (non-clinical areas)	Plant rooms and semi-outdoor areas (e.g. garages, loading bays)	Residencies
Commode		VH	VH	VH			H	H								
Bed, cot and patient trolley, including bed frame, bed rails, wheels and castors and bed controls	VH	VH	VH	VH			H	H								
Curtain, blind and screen, excluding shower curtain	VH	VH	VH	VH			H	H		H						
Manual handling equipment	VH	VH	VH	VH			H	H	H	H						
Computer equipment, including keyboard, mouse, monitor, printer, stand and photocopier	H	H	H	H	H		M	M	M	M			M	M		M
Toys and games		H	H	H			M	M	M	M	M					
Lighting including overhead, bedside, wall mounted and free standing	H	H	H	H	H		M	M	M	M	M		M	M		M
Toilet brush	H	H	H	H	H		M	M	M	M	M		M	M		M
Wall surfaces including skirting and bumper boards	H	H	H	H	H		M	M	M	M	M		M	M		M
Dishwasher			H	H	H		M	M								L

Key to overall risk categories from Clause 4, Table 5

VH Very high

H High

M Medium

L Low

Not present

Annex F (informative)
Risk assessment of cleaning tasks

F.1 General

An overview of some of the health and safety risks associated with the provision of cleaning tasks is given in **F.2**, **F.3** and **F.4**. However, note this does not purport to be an exhaustive description of all the factors that need consideration when conducting a risk assessment of cleaning tasks.

F.2 Health and safety at work

It is the responsibility of employers, under the Health and Safety at Work etc Act 1974 [3], to undertake risk assessments of all activities, tasks and procedures carried out by its employees and, if necessary, to take measures to eliminate or reduce risk to patients, public and staff.

Guidance on risk assessment is available from the Health and Safety Executive (HSE). The HSE's *Five-step process to risk assessment* [4] should be followed. The five steps include:

- identifying the hazard;
- deciding who might be harmed and how;
- evaluating the risks and deciding on precautions;
- recording findings and implementing them; and
- reviewing the assessment and updating if necessary.

The specific precautionary measures taken to mitigate the risks associated with cleaning tasks are incorporated into cleaning task method statements and associated training modules.

F.3 Control of substances hazardous to health

Employers are required, under The Control of Substances Hazardous to Health Regulations 2002 (COSHH) [5], to protect employees and others who may be exposed to substances potentially hazardous to health, including cleaning agents.

COSHH sets out eight basic measures which employers must take. These are to:

- assess the risks;
- decide what precautions are necessary;
- prevent or adequately control exposure;
- ensure that control measures are used and maintained;
- monitor the exposure;
- carry out appropriate health surveillance;
- prepare plans and procedures to deal with accidents, incidents and emergencies; and
- ensure employees are properly informed, trained and supervised.

Further guidance can be found in the HSE guidance leaflet, *Working with substances hazardous to health – What you need to know about COSHH* [6].

Typical actions arising out of the COSHH risk assessment of cleaning tasks include:

- the maintenance and issue of up-to-date COSHH sheets relating to each product used, including actions to be taken in the event of an accident;
- insistence on wearing appropriate personal protective equipment (PPE);
- the labelling of chemical containers;
- the storage of chemical products in a secure area;
- recorded health and safety training; and
- regular inspection of the use and storage of chemicals.

F.4 Personal protective equipment

The issue and use of personal protective equipment (PPE) is governed by The Personal Protective Equipment at Work Regulations 1992 [7].

The regulations define PPE as all equipment, including clothing affording protection against the weather, which is intended to be worn or held by a person at work and which protects the person against one or more risks to their health and safety.

PPE is required to be supplied and used at work whenever there are risks to health and safety that cannot be adequately controlled in any other way. No charge, not even a refundable deposit, may be made for the supply of PPE.

PPE is also required to be:

- properly assessed before use to ensure that it is suitable;
- maintained and stored properly;
- provided with instructions on how to use it safely; and
- used correctly by employees.

All PPE used is required to bear the CE mark.

Further guidance is available in the HSE's *A Short Guide to the Personal Protective Equipment at Work Regulations 1992* [8] and *Personal Protective Equipment at Work Regulations – Personal Protective Equipment at Work Regulations 1992 (as amended) – Guidance on Regulations* [9].

Annex G (informative)
Example of a technical audit sheet template

An example of a technical audit sheet template is given in Figure G.1. This example template represents one possible method of recording technical audit scores, however, other methods can be used such as those that make use of software tools.

Figure G.1 – Example technical audit sheet template

Functional area		**Auditors**		**Audit date**	

Scored element		**Staff groups responsible** [A]	**Element technical audit score** [B], [C], [D]							
			Room 1	Room 2	Room 3	Room 4	Room 5	Room 6	Room 7	Room 8
1	Commode	N								
2	Bed pan and bed pan holder	C, N [B]								
3	Macerator and bed pan washer	E								
4	Manual handling equipment	N								
5	Catheter stand	C								
6	IV stand	E								
7	Patient washbowl	N								
Total										
Maximum achievable total										
Room technical audit score %										

Functional area technical audit score %	**Staff group functional area technical audit scores %**		
	C =	E =	N =

[A] Staff groups are represented with a "C" for cleaning services, "E" for estates staff and "N" for nursing staff.

[B] Where more than one staff group is responsible for cleaning a particular element, the element technical audit score achieved for that element counts towards the staff group functional area technical audit score for each staff group identified as responsible.

[C] Element technical audit scores are assigned as 0 or 1 in accordance with Table 7.

[D] Where an element is not present in a room, the entry for that element in that room is marked not present (NP).

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