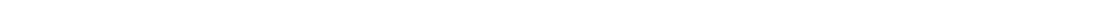


Cleaning standards for Victorian health facilities 2011



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2011



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The use of these standards is subject to the following:

- The standards are provided for information purposes only and do not constitute specific cleaning advice.
- It is up to individuals acting with appropriate professional advice to determine their applicability to particular situations.
- Each component should only be used for the purposes set out in the cleaning standards.
- In addition to the requirements in the cleaning standards, parties may be subject to various statutory, common law and contractual obligations. They should seek specific legal advice on the existence and scope of these obligations.

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Executive summary

In late 2010 the Department of Health (the department) updated the *Cleaning standards for Victorian health facilities 2009*. Changes were limited to correcting inconsistent terminology and the provision of information in areas where the content was seen as ambiguous. Consideration was also given to stakeholder comment resulting in the number of external audits being reviewed.

Since July 2010 public hospitals have been required to report to the department the results of three audits each financial year. All audits are to be undertaken by qualified Victorian cleaning standards auditors (QVCSA), that is, a person who has successfully completed the Victorian cleaning standards auditors' course. There is one audit that must be completed by a QVCSA who is outside the employ of the health service. The remaining two audits can be completed by a QVCSA employed by the health service and these are referred to as the non external audits.

In addition to these audits hospitals will continue to perform regular internal audits in all functional areas across all risk categories as part of their quality improvement and patient safety processes.

Participation in and reaching the acceptable quality level (AQL) in cleaning standards auditing is included in the Statement of Priorities for participating health services.

Background

This section has been preserved in part from the 2000, 2005 and 2009 cleaning standards and describes the underpinning concepts and developmental work.

In 2007 the Department of Health invited representatives from public hospitals and health services across metropolitan and rural regions to participate in a review of the cleaning standards for Victorian public hospitals.

The Victorian Cleaning Standards User Group (VCSUG) provided expert advice and feedback during the review process. Input from this forum, as well as from other relevant stakeholders, was used to inform the review, as well as the development of a cleaning standards auditor training program.

The VCSUG reported that generally the cleaning standards had been accepted enthusiastically by public health services although a number of issues relating to the need for further clarification, refinement or inclusion/exclusion of some content were identified.

Reporting and benchmarking formats for audit performance indicator data were also considered by the VCSUG, with a view to releasing statewide data publicly via the department's website. It was agreed that de-identified data would be released from April 2007. In March 2007 all public health services were notified of the introduction of an online electronic reporting format (the eForms) and the requirement for each health service to provide a generic email address for cleaning standards contact purposes.

The VCSUG reported large variances in the frequency of auditing undertaken across regions and health care services. It was agreed that a minimum of three external audits should be undertaken annually by all health services. However, it was also agreed that this should not occur until training opportunities to provide additional external cleaning standards auditors had been developed. In 2008, and in collaboration with key stakeholders, an accredited course in cleaning standards auditing was developed.

With regard to internal auditing, the VCSUG recommended that the United Kingdom's approach of determining frequency of auditing based on risk, with some modifications, should be adopted.

AQLs were considered in relation to cleaning standards audit scores. It was decided that AQLs would remain the same (85) except for the very high risk functional area category where the AQL will now be lifted from 85 to 90.

There are changes to both the content and format of the cleaning standards to provide updated or additional information or to provide clarification; for example, cleaning equipment and cleaning/cleaners' rooms have been added as a new element and a new functional area respectively.

These cleaning standards are a performance requirement of the department and are applicable to all Victorian health facilities, regardless of whether their cleaning service is contracted or performed in-house.

In August 1998 the department conducted an informal survey on infection control practices. The survey identified a need for outcome-focused cleaning standards that could be applied in all Victorian public health care facilities. Typically the health care facilities used their own internal manuals, guidelines and audit processes. Patient satisfaction surveys were frequently cited as a mechanism for evaluating cleaning services. The survey also found that approximately one-third of major metropolitan hospitals engaged external contractors to provide cleaning services.

In response to the need for standards, Eastern Health (then the Inner and Eastern Health Care Network) was commissioned to develop outcome-based cleaning standards for all Victorian public health facilities. Between May and November 1999 the cleaning standards were developed by drawing on and evaluating existing cleaning standards in the health care sector and in other industries and from evidence available in the general literature.

The 2000 cleaning standards were prepared following:

- an extensive literature review
- synthesis of review findings into a set of draft standards including an audit tool
- consultation with cleaning and other health professionals
- trials of the proposed standards in several health facilities.

Methodology

It was clear that for the cleaning standards to prove effective and meet the needs of all potential users and stakeholders, they would need to satisfy scrutiny from five different perspectives:

- clarity for cleaners and contractors
- effective aid to contract management
- clear outcome statements that can be used as performance indicators and benchmarking
- patient and customer focus.

Clarity for cleaners and contractors

The clarity of the cleaning standards is of paramount importance. Health care service staff and cleaning contractors need to have the same understanding of the standards and task requirements to ensure that they are working towards, and assessing, the same cleaning outcomes. At the same time, the cleaning standards must be realistically achievable. The cleaning standards should also ensure that cleaners are able to carry out their jobs safely and in a controlled environment.

Effective aid to contract management

The standards are structured to aid in the process of contract management and can be used as a guide for developing service specifications. They should be clear and unambiguous so that both parties to a contract, or indeed an in-house service provider, can clearly interpret the obligations that are imposed on them to meet the requirements of the hospital.

Clear outcome statements

The cleaning standards should reflect the outcomes required of a cleaning service wherever possible. They should avoid input and process measures and remain focused on the need to have a clean and safe environment. Most documents reviewed focused on cleaning methods rather than required outcomes.

Patient and customer focus

Clearly the cleaning standards must focus on the needs of patients, as they are the ultimate client of the health care service and their cleaning services. The needs of staff and visitors were also considered in the development of the 2000 cleaning standards.

Many service providers

In response to changes to the health care system, a range of cleaning service delivery models have been developed, including:

- cleaning services fully provided and managed in-house by health care service staff
- cleaning services completely purchased from an external provider
- hybrid models using a mix of the above models. The cleaning standards aim to improve quality health service provision by ensuring that all risks involving cleaning are identified and managed in an appropriate manner, irrespective of cleaning service provider arrangements.

Many stakeholders

Within each health care environment there are many interested stakeholders.

These include:

- patients
- general staff
- administrators
- the media
- clinical staff
- nursing staff
- the public
- government.

These stakeholders all scrutinised how clean individual health care services are. However, it became apparent that there was an absence of a uniform set of standards of cleanliness against which health care services could be assessed, or which could be used to demonstrate an adequate level of cleanliness.

The cleaning standards aim to provide stakeholders with a common understanding when they ask the question: 'How clean is this health care service?'

Using this guide

The cleaning standards are designed to be concise, flexible and easy to use. They are able to be used in several ways:

- as the basis for specifications if cleaning services are contracted out
- as a standard against which in-house services can be benchmarked
- as the framework for auditing cleaning services.

Outcome-focused targets

To encourage innovative and efficient cleaning practices, the cleaning standards focus on outcomes, not methods. This means that the suitability or unsuitability of different methods can be measured by assessing the outcomes of their use.

The cleaning standards are designed to focus users' attention on the outcome or output sought, rather than the method by which it is achieved.

Is this a cleaning manual?

The cleaning standards do not comprise a cleaning manual. Because cleaning outcomes can be achieved in different ways technically, the cleaning standards avoid prescribing inputs, equipment or processes. This is not because there is no place for input measures in achieving outcome standards, but because the outcomes are the focus of the quality cycle in maintaining a clean health care service environment.

The concept of risk

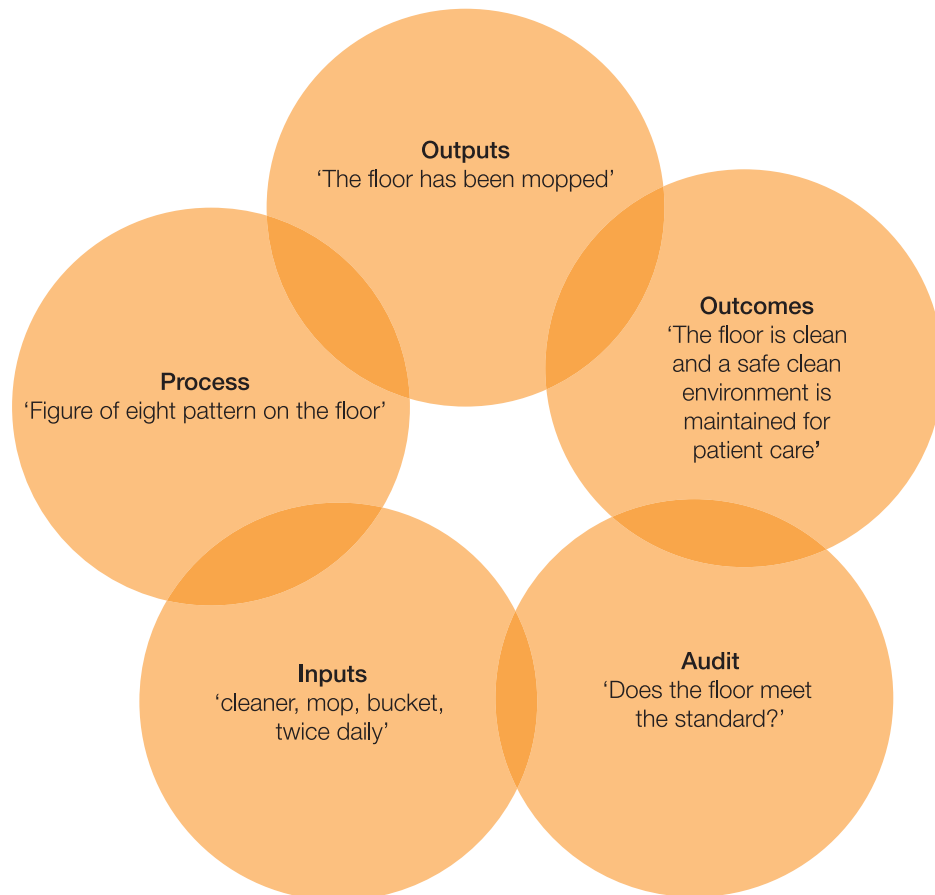
Throughout the cleaning standards the authors refer to the concept of risk. This approach was chosen because of the variety of problems that poor cleaning can cause within different areas of a health care service. Different types of risk include:

- the risk of infection for patients
- the risk of a poor public image for health care services and health authorities
- an occupational health and safety risk for health care service staff and the public
- the risk of a purchased cleaning service providing poor value for money.

The relationship of outcomes and inputs in the cleaning quality cycle

- Inputs – the resources used to produce and deliver outputs. Inputs may include staff, equipment and materials.
- Outputs – the actual product or service, for example, cleaning.
- Processes – the procedures, methods and activities that use the inputs to produce an output, for example, mopping a floor.
- Outcomes – the effect or consequence of the output; for example, cleaning produces a clean and safe environment for patient care.
- Quality systems – the organisational structure, procedures, resources and responsibilities required to implement quality management.

Figure 1 The cleanliness quality cycle



Achieving high standards

Whether provided in-house or externally, a cleaning service is a vital component in the development and maintenance of a health care service's quality systems. However, health care services also need to demonstrate a commitment to continuous quality improvement. It is essential that each facility participates in the Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program (EQulP) process and, where appropriate, ISO accreditation.

Important quality issues that must be addressed in managing and providing cleaning services include:

- accountability
- quality improvement and accreditation
- service specification
- training and education
- infection prevention and control
- infrastructure, maintenance and facility management
- auditing processes to measure outcomes.

Accountability

In-house responsibility: If cleaning services are provided in-house, the accountability for all aspects of cleaning and cleaning staff clearly lies with the management, that is, the CEO and the board of the health facility.

Contracted responsibility: Where the health facility purchases some or all of their cleaning service from an external provider, the roles, responsibilities and relationship between the purchaser and the provider become less clear. Defining these parameters at the start of the commercial relationship is essential to reduce the risk of later problems.

While a contractor may be responsible for providing cleaning services, the accountability relating to the cleaning service remains with the CEO and the board of the health facility. A well-defined relationship, with a delineation of roles and responsibilities between the purchasing health care service and the external cleaning service provider, is an essential component of any constructive working relationship.

Achieving good cleaning outcomes is important to minimise the risks associated with poor cleaning, such as cross-infection, media attention, patient dissatisfaction and occupational health and safety problems.

Risk management programs

A clearly defined relationship between a cleaning service provider and a health care service should form the foundation of a sound risk management program. It is vital that the relative risks and likelihood of occurrence of events associated with cleaning are identified, assessed and addressed. A common approach to, and understanding of, risk forms a sound basis for any purchaser – provider relationship. Health care services use (and specify that cleaning service providers also use) the approach to risk management detailed in the standard AS/NZS 4360:2004.

Quality improvement and accreditation

Accreditation became mandatory for all providers of acute health care services from 2000. Health care services may seek accreditation through the ACHS EQulP, the ISO 9000 Quality Management System or other equivalent programs. An 'equivalent program' must comply with specific criteria to be deemed suitable. Hospitals electing to use such programs and wishing to receive funding must seek prior approval from the Department of Health. A health care services' expectation regarding the contribution and accountability of an external cleaning service provider in the accreditation process needs to be addressed at the earliest stage of specification.

Involving appropriate cleaning managers and staff (internal, non external or external) in health care services quality processes, such as infection control committees, is one way of ensuring that the cleaning standards are met to the satisfaction of the accrediting body. Many cleaning service providers' own processes will mirror those undertaken by health care services and, where this synergy exists, the two organisations must coordinate their processes. A relevant professional within a health care service responsible for infection control should be involved in overseeing the outcome audits of cleaning services. This can be achieved through membership of a joint user – provider working group or some other mechanism that allows multidisciplinary input into how cleaning services are provided.

The ACHS summarises the responsibility for quality as follows:

Responsibility to rest on the provider for controlling the processes and methods for consistently procuring the specified product or service quality and for offering to the health care organisation for acceptance only those products and services verified by documented evidence to conform to contract requirements.

Responsibility to rest upon the health care organisation for ensuring that the contract requirements have been complied with before acceptance of the product or the service.

Service specification

To discharge the responsibilities defined above, both parties need a common understanding of cleaning service outcomes. The basis for this understanding is a well-constructed cleaning service specification. This is the critical element of contracts or cleaning service agreements signed by health care services and cleaning service providers. A quality cleaning service specification is essential if health care services are to obtain quality cleaning services from internal or external providers.

A succinct description of what service specifications must aim for is expressed by the ACHS:

A good contract is one in which the organisation knows what it wants and states it clearly. It contains quantitative and qualitative acceptance criteria for the service and provides thresholds for rejection.

When a cleaning service is well specified, the risk to health care services of poor cleaning outcomes will be reduced through sound contract management and monitoring.

Training and education

Where an external cleaning service provider employs cleaning staff, it is responsible for training them adequately and safely to meet the cleaning standards. This accountability includes the special training needed for health care settings, such as how to clean protective isolation areas.

The accountability for training needs to be clearly stated in the cleaning service specification and should include the type of person conducting training and education programs or the qualifications needed to be attained by cleaners or cleaning supervisors/managers. The recommended training standards have been the National competency standards for contract cleaning, developed by the Contract Cleaning Subcommittee of Property Services Training Australia.

Occupational health and safety responsibilities

A well-constructed training program also assists in ensuring that cleaning service providers meets occupational health and safety responsibilities. These include legislative requirements as well as a responsibility to adopt and follow infection control guidelines.

Infection prevention and control

Accountability for infection prevention and control always remains with health care services. Well-constructed cleaning specifications assist in ensuring that external providers play their part in minimising the risk of infection in health care settings. Cleaning service providers must comply with health service infection prevention and control practices and guidelines and demonstrate how infection control procedures are used in their practices.

As is the case for other quality improvement processes, the infection prevention and control processes of health care services and cleaning service providers should be coordinated and conducted in parallel to ensure complete infection prevention and control coverage. Australian infection control guidelines (Australian Guidelines for the Prevention and Control of Infection in Healthcare [2010] available from <http://www.nhmrc.gov.au/node/30290>) and guidelines released by the department, Victoria should be used as the basis of a shared understanding.

Infrastructure maintenance and facility management

As buildings and fixtures become old or are frequently used, they become more difficult to clean and maintain in an acceptable condition. Cleaning service providers are not generally expected to contribute to infrastructure maintenance or make capital expenditure on infrastructure.

This is particularly the case if the management of capital investments or facilities is wholly, or partly, provided externally.

The point of financial and management responsibility for utilities, consumables, workflow, scheduling, waste management, waste disposal and other facility issues peripheral to the core cleaning functions must be defined. This should be included as part of the cleaning service specification.

The line between cleaning and maintenance

Where cleaning ends and maintenance or engineering work begins is a common point of dispute. Cleaning specifications must be clear on this point.

In the case of an external cleaning service provider, it may be appropriate to undertake a baseline audit of health care facilities and document any problems with existing infrastructure that may make it difficult or impossible to fully meet the cleaning standards. It is recommended that such an audit be conducted jointly by the cleaning service provider and the nominated purchaser or contract manager of the health care service. The audit should note any floor surfaces that have broken down (for example, porous vinyl) and walls or ceilings that may require painting. Other areas that should be included in the audit may be air ducting (that is, the actual ducts as opposed to the outlets/vents) and areas where carpets and curtains are significantly stained. Action should be taken by the health care service to rectify problems that may have a considerable negative effect on the standard of cleanliness that can realistically be achieved.

In the case of in-house cleaning service provision, it is important that infrastructure problems affecting cleaning are reported to the appropriate person so that they may be rectified. Such problems may be identified by cleaners, supervisors or auditors. Infrastructure problems that impact on the cleaning standards should be dealt with by the appropriate person and should not reflect on the outcome of cleaning standards audits.

New equipment purchases

It is also recommended that issues associated with cleaning and maintenance be considered where new equipment is being purchased or where health care facilities are being modified, upgraded or built. For example, purchasing equipment with porous surfaces or surfaces that require

additional specialised cleaning techniques may lead to increased costs or risk of infection.

Who should use this guide?

A clean health care service environment is of paramount importance to all staff and patients. Regardless of occupation, all personnel should be aware of the cleaning standards and, where necessary, should familiarise themselves with relevant components.

While all of the staff listed below do not necessarily perform cleaning tasks, they should all be aware of (and be involved in) the reporting and quality improvement process in their facility:

- cleaning staff and cleaning service providers
- general and support staff
- health care workers
- health care senior management and board of directors.

Checklist of expectations of service provider

Cleaning service providers should document and provide details of how cleaning services will be provided. These details should be included in contract requirements where a cleaning service is contracted out.

Service delivery procedures

Cleaning service delivery procedures should be documented, including details of how cleaning service providers intend to undertake the cleaning service. The procedures must include the following:

- Minimum cleaning frequencies and methods: The minimum cleaning frequencies should be indicative only. Cleaning service providers are required to provide cleaning services at whatever frequencies are deemed necessary in order to meet required standards.
- Staffing: including rosters for full-time, part-time and relief staffing numbers, as well as for management and supervisory positions.
- Equipment: including provision of consumable items (such as cleaning fluids and toilet paper) and facilities to be used to deliver each cleaning service.
- Management of the cleaning service: how the cleaning services will be managed and controlled at the service level, including specific details of the on-site management functions.

Organisation chart

An organisational chart should be provided showing:

- function reporting lines
- organisation reporting lines
- the relationship between units within the cleaning service, including the role of any subcontractors
- details of any other personnel responsibilities.

Arrangements for managing the cleaning service must also be provided, including the roles and responsibilities of the service managers and details of the support that will be provided to cleaning service managers by contracting health care services.

Skills and qualifications

A summary of the skills and qualifications profile that will apply to the personnel employed to deliver cleaning services should address all levels including management, supervision, and operational staff.

Training

Details of staff training programs should be included for all levels of staff (covering details of courses undertaken), for example, course type and level, course objectives, course provider details, length of course and the frequency of training. Information should also cover induction courses and training in addition to in-service and other training provided to staff.

Staffing levels

Details of staffing levels that are applied to each area, ward or department should be provided, indicating whether such staff will be employed on a full-time, part-time or casual basis. This should include details and strategies for multi-skilling and how such personnel would be managed and supervised to ensure there is no degradation of service performance.

Peak loads and contingency planning

Cleaning service providers should have arrangements in place to meet peak loads. Cleaning service providers should also have contingency plans in place in the event of industrial action, utility failure or other events that may cause cleaning services to be compromised. A risk management strategy should provide details of how identified risks will be managed.

Performance standards

Details of the systems and procedures that will be used to monitor and maintain the continuing achievement of agreed performance standards should be provided, including:

- how performance standards for each cleaning service will be maintained and monitored
- an outline of quality systems and plans that are used, including continuous improvement processes
- arrangements attaining and maintaining formal quality certifications, for example, ISO accreditation
- key performance indicators and standards specific to the nature of cleaning services
- details of the strategies to be implemented to ensure that cleaning service delivery is customer-focused, taking into account patients' rights and the nature of the core services of health care service
- details of arrangements to resolve issues, for example, complaints or disputes arising from cleaning service delivery.

Industrial relations strategy

Details of an industrial relations strategy to be applied by cleaning service providers should include employee consultation arrangements, details of any existing or potential enterprise agreements (where applicable) with potential coverage of health care service sites and industrial relations dispute resolution procedures.

Occupational health and safety strategy

Cleaning service providers should provide details about how they will achieve, monitor and maintain compliance with applicable occupational health and safety regulations. This includes proof of current WorkCover insurance policies and details and procedures for maintaining insurance policies and procedures for compliance with all aspects of the Occupational Health and Safety Act 1985, the Dangerous Goods Act 1985, the Accident Compensation Act 1985 (and subsequent amending legislation), together with all regulations and codes of practice supporting the Acts.

Subcontracting arrangements

Where a part of a cleaning service is subcontracted, for example, window cleaning or drape cleaning, the cleaning service provider should have clearly documented procedures for managing the subcontractor, including details of proposed cleaning services to be subcontracted and how the responsibility for subcontractors will be managed. This includes procedures for resolving problems and disputes as well as details of subcontractors' compliance with relevant Australian standards, occupational, health and safety requirements, accreditation and other regulatory or legislative requirements.

Insurance arrangements

Details of cleaning service providers' insurance arrangements (workers compensation, public and products liability, plant and equipment and, where relevant, professional indemnity insurance) should be provided.

The cleaning standards

The cleaning standards are designed to simplify cleaning assessments with reference to:

- the surface, article or fixture being cleaned (the element)
- the area in which cleaning occurs (the functional area)
- the relative importance of the cleanliness of the element or area (using the cross-reference charts).

Elements

An element refers to an item such as a surface, article or fixture to be cleaned. Fifteen elements related to the health care service context are described in the current cleaning standards and can be found under one of four major groups: building elements, fixture elements, equipment elements and environmental elements.

Regardless of where an element is located within the health care service, it should be cleaned as the requirements specify. Weighting of each element is only applied when the location of the element is also considered (that is, the element's location within one of the four functional area risk categories as described on pages 31-34). Weighting helps determine the frequency and intensity of cleaning needed for each element within a functional area. Further information about weighting can be found in the Key under the cross-reference heading below and in the final section of this document that gives an overview of auditing (page 39).

Functional areas

A functional area refers to an area in which cleaning occurs, for example, a hospital ward or operating theatre. Thirty functional areas within a health care service have been identified.

Functional areas have been grouped under four risk categories: very high risk, high risk, moderate risk and low risk. The four risk categories reflect the level of frequency and intensity of cleaning needed to meet the required standards. Some functional areas, such as the engineer's workshop for example, do not require the same level of frequency or intensity of cleaning when compared with other functional areas such as the intensive care unit (ICU) or operating suite.

In addition to weighting individual elements within functional areas, weighting has also been applied to each of the four functional area risk categories. Health care services are free to increase the weighting applied to a particular functional area if patients in that area are considered to be at increased risk. However, no functional area should have its weighting reduced.

The intensity and frequency of cleaning needed for each of the four functional area risk categories is described under four corresponding headings: critically important, highly important, very important and important.

The cross-reference charts

The cross-reference charts link elements, functional areas and weightings. Element-based cross-reference charts are given for each group of elements. For example, there is a building elements cross-reference chart. The element-based cross-reference charts consider each element within all four functional area risk categories and weightings are applied. The health facility cross-reference chart is a large cross-reference chart, where all elements are considered and weighted within all locations.

Managing and reporting on cleaning standards

Each health care service should identify how the cleaning standards audit data will be reported within their management structures. For example, reports on cleanliness will be relevant to the infection control committee/team, the infection control executive sponsor, the quality manager, the contract manager and the board of management. Reports should detail variances and action plans where appropriate.

User group

A cleaning standards user group may be of benefit to a health service. This may include representatives from management, nursing, infection control, the health care service's contract manager and cleaning service provider.

The user group should discuss audit results and agree on actions and timeframes when needed. In the case of smaller health services, a regional user group may be of benefit to facilitate learning from similar health services, benchmarking and developing a regional support network.

Contracted or in-house providers?

The cleaning standards are designed for use regardless of whether health care services employ an in-house cleaning service or a contracted cleaning service. The cleaning standards assist health care services to assess the adequacy of in-house or contracted cleaning service procedures and processes and to develop contract specifications and performance evaluation.

It is strongly recommended that, regardless of whether a cleaning service is provided by an in-house or contracted cleaning service provider, specifications incorporating the cleaning standards underpin contract agreements.

Reporting to the Department of Health

Publicly funded health care services are required to hold a generic cleaning services emailing address and to submit cleaning standards audit results electronically as required by the department. (See <http://www.health.vic.gov.au/cleaningstandards/submissions.htm>)

All reporting requirements for publicly funded health facilities, together with the associated online reporting forms, published statewide reports and additional information can be found at <http://www.health.vic.gov.au/infectionprevention/>

Elements

Fifteen items to be cleaned within a health care service (surfaces, articles or fixtures) have been grouped under four major headings: building elements, fixture elements, equipment elements and environmental elements. Regardless of where an element is located within the health care service, it should be cleaned as the following required standards specify. The numbering of the elements in the following tables corresponds to the numbering of the elements in the element-based cross-reference charts found in a later section (page 31-34).

Building elements

(Seven elements)

	Building elements	Required cleaning standard
1	External features, fire exits and stairwells Handrails are clean and free of stains	Landings, ramps, stairwells, fire exists, steps, entrances, porches, patios, balconies, eaves and external light fittings are free of dust, grit, dirt, leaves, cobwebs, rubbish, cigarette butts and bird excreta. Garden furniture is clean and operational.
2	Walls, skirtings and ceilings	Internal and external walls and ceilings are free of dust, grit, dirt, lint, soil, film and cobwebs. Walls and ceilings are free of marks caused by furniture, equipment or staff. Light switches are free of fingerprints, scuffs and any other marks. Light covers and diffusers are free of dust, grit, dirt, lint and cobwebs. Polished surfaces are of a uniform lustre.
3	Windows (internal)	Surfaces of glass are clear of all streaks, spots and marks, including fingerprints and smudges. Window frames, tracks and ledges are clear and free of dust, dirt, grit, marks, spots and cobwebs.
4	Doors	Internal and external doors and doorframes are free of dust, grit, dirt, lint, soil, film, fingerprints and cobwebs. Doors and door frames are free of marks caused by furniture, equipment or staff. Air vents, relief grilles and other ventilation outlets are kept unblocked and free of dust, grit, dirt, soil, film, cobwebs, scuffs and any other marks. Door tracks and door jambs are free of grit, dirt and other debris. Polished surfaces are of a uniform lustre.

	Building elements	Required cleaning standard
5	Hard floors	<p>The floor is free of dust, grit, dirt, litter, marks and spots, water or other liquids.</p> <p>The floor is free of polish or other build-up at the edges and corners or in traffic lanes.</p> <p>The floor is free of spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.</p> <p>Inaccessible areas (edges, corners and around furniture) are free of dust, grit, dirt, lint and spots.</p> <p>Polished or buffed floors are of a uniform lustre.</p> <p>Appropriate signage and precautions are taken regarding pedestrian safety near newly cleaned or wet floors.</p>
6	Soft floors	<p>the floor is free of dust, grit, dirt, litter, marks and spots, water or other liquids.</p> <p>The floor is free of stains, spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.</p> <p>Inaccessible areas (edges, corners and around furniture) are free of dust, grit, dirt, lint and spots.</p> <p>Where carpets are vacuumed/cleaned, this is done in accordance with section 5 of Australian Standard No 3733.</p>
7	Ducts, grills and vents	<p>All ventilation outlets are kept unblocked and free of dust, grit, dirt, soil, film, cobwebs, scuffs and any other marks.</p> <p>All ventilation outlets are kept clean and uncluttered following cleaning.</p>

Fixture elements

(Four elements)

	Fixture element	Required cleaning standard
1	Electrical fixtures and appliances	<p>Electrical fixtures and appliances are free of grease, dirt, dust, encrustations, marks, stains and cob webs.</p> <p>Electrical fixtures and appliances are kept free from signs of use or non-use.</p> <p>Hygiene standards are satisfied where the fixture or appliance is used in food preparation.</p> <p>Range hoods (interior and exterior) and exhaust filters are free of grease and dirt on inner and outer surfaces.</p> <p>Motor vents etc. are clean and free of dust, dirt and lint.</p> <p>Drinking fountains are clean and free of stains and mineral build-up.</p> <p>Insect killing devices are free of dead insects, and are clean and functional.</p>
2	Furnishings and fixtures	<p>Hard surface furniture is free of spots, soil, film, dust, dirt, fingerprints and spillages.</p> <p>Soft surface furniture is free from stains, soil, dirt, film and dust.</p> <p>Furniture legs, wheels and castors are free from mop strings, soil, dirt, film, dust and cobwebs.</p> <p>Inaccessible areas (edges, corners, folds and crevices) are free of dust, grit, dirt, lint and spots.</p> <p>All high surfaces are free from dust, dirt and cobwebs.</p> <p>Curtains, blinds and drapes are free from stains, dust, dirt, cobwebs, lint and signs of use or non-use.</p> <p>Equipment is free of tapes/plastic etc that may compromise cleaning.</p> <p>Furniture has no odour that is distasteful or unpleasant.</p> <p>Shelves, bench tops, cupboards and wardrobes/lockers are clean inside and out and free of dust, dirt and litter or stains.</p> <p>Internal plants are free of dust, dirt and litter.</p> <p>Waste/rubbish bins or containers are clean inside and out, free of stains and mechanically intact.</p> <p>Fire extinguishers and fire alarms are free of dust, grit, dirt and cobwebs.</p>

	Fixture element	Required cleaning standard
3	Pantry fixtures and appliances	<p>Fixtures, surfaces and appliances are free of grease, dirt, dust, encrustations, marks, stains and cobwebs.</p> <p>Electrical and cooking fixtures and appliances are kept free from signs of use or non-use.</p> <p>Motor vents etc are clean and free of dust, dirt and lint.</p> <p>Refrigerators/freezers are clean and free of ice build-up.</p> <p>Notes: This cleaning standard refers to small, ward based pantries. Larger kitchens where a facility's food is stored, prepared and cooked are not included in the cleaning standards. Such kitchens are audited as part of the Food Safety Act 1994 and related food safety codes.</p>
4	Toilets and bathroom fixtures	<p>Porcelain and plastic surfaces are free from smudges, smears, body fats, soap build-up and mineral deposits.</p> <p>Metal surfaces, shower screens and mirrors are free from streaks, soil, dirt, smudges, soap build-up and oxide deposits.</p> <p>Wall tiles and wall fixtures (including soap and cream dispensers and towel holders) are free of dust, grit, dirt, smudges/streaks, mould, soap build-up and mineral deposits.</p> <p>Shower curtains and bath mats are free from stains, smudges, smears, odours, mould and body fats.</p> <p>Plumbing fixtures are free of smudges, dust, dirt, soap build-up and mineral deposits.</p> <p>Bathroom fixtures are free from odours that are distasteful or unpleasant.</p> <p>Polished surfaces are of a uniform lustre.</p> <p>Sanitary disposal units are clean and functional.</p> <p>Consumable items are in sufficient supply.</p>

Equipment elements

(Two elements)

	Equipment element	Required cleaning standard
1	Patient equipment	<p>Equipment is free from soil including blood or body fluids, smudge, dust, dirt, fingerprints, grease and spillages.</p> <p>Equipment is free of tapes/plastics etc that may compromise cleaning.</p> <p>Equipment legs, wheels and castors are free from mop strings, soil, film, dust, dirt and cobwebs.</p> <p>Equipment has no odour that is distasteful or unpleasant.</p> <p>Equipment is free from signs of non-use.</p>
2	Cleaning equipment	<p>Electrical appliances (and filters), wet and dry vacuum cleaners and burnishes/buffing machines are stored free of grease, dirt, dust, encrustations, marks, stains and cobwebs.</p> <p>Electrical and battery operated appliances have visible, current tags displaying safety check, service and inspection information.</p> <p>Battery-operated equipment (auto scrubber, carpet extractor) is stored free of dirt, dust, marks, stains and cobwebs.</p> <p>Legs, handles, wheels and castors on cleaning equipment are free from stains, soil, dirt, film, cotton, fluff, cobwebs and dust.</p> <p>Cleaning equipment using water is stored clean and dry.</p> <p>Vacuum head and hose are free from dust and blockages and vacuum bags are in good condition and not over full.</p> <p>Annual review and risk assessment of cleaning equipment is documented and current.</p> <p>Cleaning trolleys are free from spillages, dirt and dust.</p> <p>Use of cleaning chemicals complies with chemical safety data sheets, dilution and storage instructions.</p>

Environmental elements

(Two elements)

	Environmental element	Required cleaning standard
1	General tidiness	<p>The area appears tidy and uncluttered</p> <p>Floor space is clear, only occupied by furniture and fittings designed to sit on the floor.</p> <p>Furniture is maintained in a way that allows for cleaning.</p> <p>Fire access and exit doors are left clean and unhindered.</p>
2	Odour control	<p>The area smells fresh.</p> <p>There is no odour that is distasteful or unpleasant.</p> <p>Room deodorisers are clean and functional.</p>

Functional area risk categories

Functional areas

Thirty areas to be cleaned within a health care service (for example, an operating theatre, a general ward, or an outpatients' clinic) have been identified and are known as functional areas. The 30 functional areas have been grouped according to risk. Some functional areas, such as the engineer's workshop, do not require the same level of frequency or intensity of cleaning when compared with other functional areas such as the intensive care unit (ICU) or operating suite.

Functional areas have been grouped into four risk categories reflecting the level of cleaning frequency and intensity needed based on the risks associated with inadequate cleaning in each risk level. The denotation of categories from A to D corresponds to the denotations in the element-based and health facility cross-reference charts (pages 31-35).

Very high risk category A

Required standard of cleanliness – critically important

The standard of cleanliness for functional areas in the very high risk category is of critical importance. Within these functional areas there is a very high risk of transmission of infection because patients are very susceptible and/or undergo procedures that can be highly invasive. Cleaning outcomes must be achieved through the highest level of intensity and frequency of cleaning. Processes and protocols for cleaning should be clearly defined and strictly adhered to.

Functional areas included in this risk category (six functional areas)

- Operating theatres: This may include procedure areas in other departments where significant invasive procedures are performed and patients are at a very high risk of infection.
- Invasive procedure areas: endoscopy and catheter laboratories should routinely be included in this risk category
- Intensive care unit (ICU)
- Level 2 and level 3 nurseries
- Special needs patient/area: areas with patients who are immuno-suppressed, such as burns units and infectious disease units
- Central sterilising department (CSD)

Additional internal areas

Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to very high risk functional areas it is essential that they are also weighted accordingly and receive the most intensive and frequent level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.

High risk category B

Required standard of cleanliness – highly important

The standard of cleanliness for functional areas in the high risk category is of high importance. Within these functional areas there is a high risk of transmission of infection because patients are very susceptible and/or undergo procedures that can be highly invasive, or because surgical equipment and other supplies must be processed and/or stored to the highest of standards. Cleaning outcomes must be maintained by frequent scheduled cleaning and a capacity to spot clean as required.

Functional areas included in this category (four functional areas)

- Sterile stock storage
- Emergency department
- Pharmacy – clean area
- General wards: This includes level 1 nursery and CCU, oncology and dialysis units, delivery and birthing suites, and non-invasive treatment and procedure rooms

Additional internal areas

Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to high risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.

Moderate risk category C

Required standard of cleanliness – very important

The standard of cleanliness for functional areas in the moderate risk category is very important. Functional areas in this category represent areas where the risk of transmission of infection must be minimised. Cleaning outcomes should be maintained through regular cleaning on a scheduled basis, with the capacity to spot clean in between.

Functional areas included in this category (14 functional areas)

- Day activity area
- Residential accommodation
- General pharmacy
- Laboratories
- Medical imaging (non-invasive)
- Cleaning equipment room
- Cafeteria
- Rehabilitation area
- Pathology
- Kitchenette/pantry
- Mortuary
- Outpatient clinic
- Waiting room
- Public areas

Additional internal areas

Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to moderate risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However if direct access does not occur then the adjoining areas listed above may not need to be weighted in the same way.

Low risk category D

Required standard of cleanliness – important

The standard of cleanliness for functional areas in the low or minimal risk category remains important for maintaining good hygiene and confidence in the health care aesthetic generally. Cleaning outcomes should be achieved through regular cleaning on a scheduled or project basis, with a capacity to spot clean in between.

Functional areas included in this category (six functional areas)

- Administrative areas
- Non-sterile supply
- Record storage
- Engineering workshops
- Plant rooms
- External surrounds

Additional areas

Areas adjoining low risk functional areas should also receive the same level of cleaning. These include balconies, bathrooms, corridors, elevators, lecture/ meeting rooms, pantry/ kitchenette, offices, staff lounges, storerooms and loading docks.

Cross-reference charts

There are five cross-reference charts. Four element-based cross-reference charts are given for each group of elements:

- building elements
- fixture elements
- equipment elements
- environmental elements.

These four, element-based, cross-reference charts consider each element within all four functional area risk categories. A key at the top of each cross-reference chart lists all the elements in the grouping. For example, the building elements cross-reference chart lists the building elements from 1 to 7. This numbering corresponds with the listing of the seven building elements described earlier in the cleaning standards for elements: building elements (page 21-22).

The required standard of cleanliness for each functional area risk category is also given.

There are four required standards of cleanliness:

- critically important
- highly important
- very important
- important.

These four standards of cleanliness correspond to the four functional area risk categories and are fully described in each of the four element-based cross-reference charts (pages 31-36).

The cross-reference charts use a system of weighting that has been applied to both elements and to functional area risk categories (A, B, C or D). More information on weighting and scoring can be found in the next section 'An overview of auditing' (page 37).

In addition to the four element-based cross-reference charts, there is a health facility cross-reference chart. This chart gives weightings (A, B, C or D) for all 15 elements within all 30 functional areas.

The weightings in the health facility cross-reference chart are the same as those given in each of the smaller, element-based cross-reference charts.

Building elements cross-reference chart

Key: 1 = external features, fire exits and stairwells 2 = walls, skirtings and ceilings 3 = windows 4 = doors
5 = hard floors 6 = soft floors 7 = ducts, grills and vents

Required standard of cleanliness of functional area risk category	Functional area risk	Functional area	Weighting of seven building elements						
			1	2	3	4	5	6	7
<p>Critically important</p> <p>The standard of cleanliness is of critical importance. Cleaning outcomes must be achieved through the highest level of intensity and frequency of cleaning. Processes and protocols for cleaning should be clearly defined and strictly adhered to.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to very high risk functional areas it is essential that they are also weighted accordingly and receive the most intensive and frequent level of cleaning. However, if direct access does not occur then the adjoining areas do not need to be weighted in the same way.</p>	Very high risk A	Operating theatre	C	A	A	A	A	A	A
		Invasive procedure area	C	A	A	A	A	A	A
		ICU	C	A	A	A	A	A	A
		L2 or L3 nursery	C	A	A	A	A	A	A
		Special needs patient/ area	C	A	A	A	A	A	A
		CSD	C	A	A	A	A	A	A
<p>Highly important</p> <p>The standard of cleanliness is of high importance. Cleaning outcomes must be maintained by frequent scheduled cleaning and a capacity to spot clean as required.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to high risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.</p>	High risk B	Sterile stock storage	C	B	B	B	B	B	A
		Emergency department	C	B	B	B	B	B	A
		Pharmacy clean area	C	B	B	B	B	B	A
		General ward	C	B	B	B	B	B	A
<p>Very important</p> <p>The standard of cleanliness for functional areas in the moderate risk category is very important. Functional areas in this category represent areas where the risk of transmission of infection must be minimised. Cleaning outcomes should be maintained through regular cleaning on a scheduled basis, with the capacity to spot clean in between.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to moderate risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above may not need to be weighted in the same way.</p>	Moderate risk C	Day activity	C	B	B	B	B	B	B
		Rehabilitation area	C	B	B	B	B	B	B
		Residential area	C	B	B	B	B	B	B
		Pathology	C	B	B	B	B	B	B
		General pharmacy	C	C	C	C	C	C	B
		Kitchenette/pantry	C	B	B	B	B	B	B
		Laboratory	C	C	C	C	C	C	B
		Mortuary	C	C	C	C	C	C	B
		Medical imaging (non Invasive)	C	B	B	B	B	B	B
		Outpatient clinic	C	B	B	B	B	B	B
		Waiting room	C	C	C	C	C	C	C
		Cafeteria	C	B	C	B	B	B	B
		Public area	C	B	C	B	B	B	C
Cleaning equipment room	C	B	C	B	B	B	B		
<p>Important</p> <p>The standard of cleanliness of functional areas in the low or minimal risk category remains important for maintaining good hygiene and confidence in the health care aesthetic generally. Cleaning outcomes should be achieved through regular cleaning on a scheduled or project basis, with a capacity to spot clean in between.</p> <p>Areas adjoining low risk functional areas should also receive the same level of cleaning. These include balconies, bathrooms, corridors, elevators, lecture/meeting rooms, pantry/kitchenette, offices, staff lounges, storerooms and loading docks.</p>	Low risk D	Administration area	C	C	C	C	C	C	C
		Non-sterile supply area	C	D	D	D	C	C	C
		Record storage	C	D	D	D	D	D	D
		Engineering workshop	D	D	D	D	D	D	D
		Plant room	D	D	D	D	D	D	D
		External surrounds	C	D	D	D	C	\	D

Fixture elements cross-reference chart

Key: 1 = electrical fixtures and appliances 2 = furnishings and fixtures
 3 = pantry fixtures and appliances 4 = toilets and bathroom fixtures

Required standard of cleanliness for functional area risk category	Functional area risk category	Functional area	Weighting			
			1	2	3	4
<p>Critically important</p> <p>The standard of cleanliness is of critical importance. Cleaning outcomes must be achieved through the highest level of intensity and frequency of cleaning. Processes and protocols for cleaning should be clearly defined and strictly adhered to.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to very high risk functional areas it is essential that they are also weighted accordingly and receive the most intensive and frequent level of cleaning. However, if direct access does not occur then the adjoining areas do not need to be weighted in the same way.</p>	Very high risk A	Operating theatre	A	A	B	A
		Invasive procedure area	A	A	B	A
		ICU	A	A	B	A
		L2 or L3 nursery	A	A	B	A
		Special needs patient/area	A	A	B	A
		CSD	A	A	B	A
<p>Highly important</p> <p>The standard of cleanliness is of high importance. Cleaning outcomes must be maintained by frequent scheduled cleaning and a capacity to spot clean as required.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to high risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.</p>	High risk B	Sterile stock storage	B	B	B	B
		Emergency department	B	B	B	B
		Pharmacy clean area	B	B	B	B
		General ward	B	B	B	B
<p>Very important</p> <p>The standard of cleanliness for functional areas in the moderate risk category is very important. Functional areas in this category represent areas where the risk of transmission of infection must be minimised. Cleaning outcomes should be maintained through regular cleaning on a scheduled basis, with the capacity to spot clean in between.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to moderate risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above may not need to be weighted in the same way.</p>	Moderate risk C	Day activity	B	B	B	B
		Rehabilitation area	B	B	B	B
		Residential area	B	B	B	B
		Pathology	B	B	B	C
		General pharmacy	C	C	B	C
		Kitchenette/pantry	B	B	B	B
		Laboratory	C	C	B	C
		Mortuary	C	C	\	C
		Medical imaging (non Invasive)	B	C	B	B
		Outpatient clinic	B	B	B	B
		Waiting room	C	C	C	B
		Cafeteria	B	B	B	B
		Public area	C	B	\	B
		Cleaning equipment room	B	B	\	\
<p>Important</p> <p>The standard of cleanliness of functional areas in the low or minimal risk category remains important for maintaining good hygiene and confidence in the health care aesthetic generally. Cleaning outcomes should be achieved through regular cleaning on a scheduled or project basis, with a capacity to spot clean in between.</p> <p>Areas adjoining low risk functional areas should also receive the same level of cleaning. These include balconies, bathrooms, corridors, elevators, lecture/meeting rooms, pantry/kitchenette, offices, staff lounges, storerooms and loading docks.</p>	Low risk D	Administration area	C	C	C	C
		Non-sterile supply area	D	D	\	C
		Record storage	D	D	\	C
		Engineering workshop	D	D	\	C
		Plant room	D	D	\	C
		External surrounds	D	D	\	C

Equipment elements cross-reference chart

Key: 1 = patient equipment 2 = cleaning equipment

Required standard of cleanliness for functional area risk category	Functional area risk category	Functional area	Weighting	
			1	2
<p>Critically important</p> <p>The standard of cleanliness is of critical importance. Cleaning outcomes must be achieved through the highest level of intensity and frequency of cleaning. Processes and protocols for cleaning should be clearly defined and strictly adhered to.</p>	Very high risk A			
		Operating theatre	A	A
		Invasive procedure area	A	A
		ICU	A	A
		L2 or L3 nursery	A	A
		Special needs patient/area		
		CSD	A	A
<p>Highly important</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to very high risk functional areas it is essential that they are also weighted accordingly and receive the most intensive and frequent level of cleaning. However, if direct access does not occur then the adjoining areas do not need to be weighted in the same way.</p> <p>The standard of cleanliness is of high importance. Cleaning outcomes must be maintained by frequent scheduled cleaning and a capacity to spot clean as required.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to high risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.</p>	High risk B	Sterile stock storage	B	B
		Emergency department	B	B
		Pharmacy clean area	B	B
		General ward	B	B
<p>Very important</p> <p>The standard of cleanliness for functional areas in the moderate risk category is very important. Functional areas in this category represent areas where the risk of transmission of infection must be minimised. Cleaning outcomes should be maintained through regular cleaning on a scheduled basis, with the capacity to spot clean in between.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to moderate risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above may not need to be weighted in the same way.</p>	Moderate risk C	Day activity	B	B
		Rehabilitation area	B	B
		Residential area	B	B
		Pathology	B	B
		General pharmacy	B	B
		Kitchenette/pantry	\	B
		Laboratory	B	B
		Mortuary	C	C
		Medical imaging (non Invasive)	B	B
		Outpatient clinic	B	B
		Waiting room	B	B
		Cafeteria	\	B
		Public area	\	B
		Cleaning equipment room	\	B
<p>Important</p> <p>The standard of cleanliness of functional areas in the low or minimal risk category remains important for maintaining good hygiene and confidence in the health care aesthetic generally. Cleaning outcomes should be achieved through regular cleaning on a scheduled or project basis, with a capacity to spot clean in between.</p> <p>Areas adjoining low risk functional areas should also receive the same level of cleaning. These include balconies, bathrooms, corridors, elevators, lecture/meeting rooms, pantry/kitchenette, offices, staff lounges, storerooms and loading docks.</p>	Low risk D	Administration area	\	C
		Non-sterile supply area	C	C
		Record storage	\	C
		Engineering workshop	\	C
		Plant room	\	C
		External surrounds	\	C

Environmental elements cross-reference chart

Key: 1 = general tidiness 2 = odour control

Required standard of cleanliness for functional area risk category	Functional area risk category	Functional area	Required standard of cleanliness for functional area risk category	
			1	2
<p>Critically important</p> <p>The standard of cleanliness is of critical importance. Cleaning outcomes must be achieved through the highest level of intensity and frequency of cleaning. Processes and protocols for cleaning should be clearly defined and strictly adhered to.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to very high risk functional areas it is essential that they are also weighted accordingly and receive the most intensive and frequent level of cleaning. However, if direct access does not occur then the adjoining areas do not need to be weighted in the same way.</p>	Very high risk A	Operating theatre	B	B
		Invasive procedure area	B	B
		ICU	B	B
		L2 or L3 nursery	B	B
		Special needs patient/area	B	B
		CSD	B	B
<p>Highly important</p> <p>The standard of cleanliness is of high importance. Cleaning outcomes must be maintained by frequent scheduled cleaning and a capacity to spot clean as required.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to high risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above do not need to be weighted in the same way.</p>	High risk B	Sterile stock storage	B	B
		Emergency department	B	B
		Pharmacy clean area	C	B
		General ward	B	B
<p>Very important</p> <p>The standard of cleanliness for functional areas in the moderate risk category is very important. Functional areas in this category represent areas where the risk of transmission of infection must be minimised. Cleaning outcomes should be maintained through regular cleaning on a scheduled basis, with the capacity to spot clean in between.</p> <p>Where bathrooms, corridors, storerooms, lecture/meeting rooms, offices, pan rooms and staff lounges provide direct access to moderate risk areas it is essential that they are also weighted accordingly and receive the same level of cleaning. However, if direct access does not occur then the adjoining areas listed above may not need to be weighted in the same way.</p>	Moderate risk C	Day activity	B	C
		Rehabilitation area	B	C
		Residential area	B	C
		Pathology	C	C
		General pharmacy	C	C
		Kitchenette/pantry	B	C
		Laboratory	C	C
		Mortuary	B	C
		Medical imaging (non Invasive)	B	C
		Outpatient clinic	B	C
		Waiting room	B	C
		Cafeteria	B	C
		Public area	B	C
		Cleaning equipment room	B	C
<p>Important</p> <p>The standard of cleanliness of functional areas in the low or minimal risk category remains important for maintaining good hygiene and confidence in the health care aesthetic generally. Cleaning outcomes should be achieved through regular cleaning on a scheduled or project basis, with a capacity to spot clean in between.</p> <p>Areas adjoining low risk functional areas should also receive the same level of cleaning. These include balconies, bathrooms, corridors, elevators, lecture/meeting rooms, pantry/kitchenette, offices, staff lounges, storerooms and loading docks.</p>	Low risk D	Administration area	D	C
		Non-sterile supply area	D	C
		Record storage	D	C
		Engineering workshop	D	D
		Plant room	D	D
		External surrounds	\	C

An overview of auditing

This section provides an overview of important processes and principles to consider when undertaking a cleaning standards audit. The department specifies the frequency of auditing that is required and the acceptable quality level (AQL) for each functional area risk category.

Types of audits

Internal audits

As part of quality improvement and patient safety processes, public hospitals require a comprehensive, continuous, systemic approach to monitoring cleaning outcomes within their facilities. Internal audits should be performed in all functional areas across all functional area risk categories. A systemic program of internal auditing, as well as the results of all internal audits undertaken, should be clearly documented.

Cleaning audit scores should be equal to, or higher than, the specified AQL for each functional area risk category. The frequency with which any particular functional area should be audited depends on what functional area risk category it falls under. The table below provides the specified frequency of internal auditing and AQLs for each risk category:

Required frequency of internal auditing and AQLs for each functional area risk category

Functional area risk category	Example of a functional area in that category	Required frequency of auditing	AQL
Very high risk (category A)	Intensive care unit	Over a period of one month 50% of rooms within a very high risk (category A) functional area should be audited at least once	90
High risk (category B)	General ward	Over a period of one month 50% of rooms within a high risk (category B) functional area should be audited at least once	85
Moderate risk (category C)	Rehabilitation area	Over a period of three months 50% of rooms within a moderate risk (category C) functional area should be audited at least once	85
Low risk (category D)	Administrative building	Over a period of 12 months all rooms within a low risk (category D) functional area should be audited at least once	85

Feedback should be provided to staff in individual functional areas and results of audits should be tabled at appropriate meetings – for example, infection control, quality and risk – and included in public hospital quality reports.

Non external audits

Non external audits are to be conducted by accredited auditors who are either employed by the public hospital or external auditors contracted by the public hospital.

There is no difference between an external cleaning audit and a non external cleaning audit – the auditing processes are the same. The only difference is “who” conducts the audit.

External audits

In addition to an ongoing internal and non external cleaning standards auditing program, facility-wide cleaning standards audits, undertaken by an external auditor, are required. As is the case for internal and non external audits, external cleaning audit scores should be equal to, or higher than, the specified AQL for each functional area risk category.

Results of non external and external audits are to be reported to the department.

An external cleaning standards audit includes the examination of a public hospital's internal auditing program and the results for all internal audits. A public hospital must be able to demonstrate or produce the following:

- a comprehensive mapping, or catalogue, of all rooms within the public hospital with accompanying risk profile (this is sometimes referred to as a 'tree' or 'network map' and may show the public hospital, then each facility within the public hospital, then the buildings comprising each facility, followed by the functional areas within each building and finally the individual rooms within each of the functional areas. Some mapping also indicates floors or levels within buildings as a navigational aid for auditors)
- an auditing frequency schedule, diary or timetable based on the specified frequencies for functional area risk categories
- reports of all audits undertaken, including variance reports complete with any required rectification and re-auditing of functional areas
- reporting and feedback processes as required within the public hospital.

Following Australian Standards in sampling procedures for inspection by attributes, an external audit should include approximately a fifth of the total health facility. However, the external audit should include an appropriate sample of rooms from all functional areas in the very high risk functional area category A, at least 75 per cent of functional areas in the high risk functional area category B and 50 per cent of areas in a medium functional risk area category C. The Low risk area category D is not included in an external audit.

Who can audit?

There are no restrictions on who can perform internal cleaning standards audits; however, a thorough knowledge of the cleaning standards and an understanding of health facilities processes are required.

Auditors should have appropriate communication and interpersonal skills including cultural sensitivity, conflict resolution and problem solving skills. Auditors should also possess organisational, planning and time management skills as well as the observation, analytical, numeracy and technology skills needed to conduct and report on auditing activities.

In response to the 2007 review of the cleaning standards, the department commissioned the development and accreditation of a course in cleaning standards auditing. Those conducting non external and external cleaning standards audits for Victorian health facilities must have completed the appropriate training at a registered training organisation.

Auditors conducting external audits are required to be qualified cleaning standards auditors and can not be an employee of the public hospital.

Those auditors conducting non external audits must also be QVCSA having completed the appropriate training at a registered training organisation; however these auditors can also be an employee of the public hospital or a contracted external auditor.

Further information can be found at <http://www.health.vic.gov.au/cleaningstandards/auditors.htm>

Weighting and scoring

Weighting is widely used in all fields including health care. Common examples from the field of health care include using WIES (Weighted Inlier Equivalent Separation) units in determining government health care funding, and weighted health status where morbidity and mortality rates are weighted according to the cost effectiveness of addressing various medical conditions.

Weighting within the current cleaning standards refers to an aspect of the auditing and scoring process that reflects the importance of various elements within different functional area risk categories.

Although each element should be cleaned to the required standard regardless of where it is located, door handles in a record storage area pose less of an infection risk than door handles in an ICU and are therefore weighted accordingly when audited. Likewise the required cleaning standards are important in low risk functional areas such as an administrative area but critically important in very high risk functional areas such as an ICU. Therefore functional areas are risk categorised and weighted accordingly when audited.

Weighting also addresses the urgency for rectifying identified problems within each functional area risk category. Weighting is expressed numerically for the purposes of scoring cleaning standards audits. Both the timeframe for addressing problems and the numerical expressions are linked to the concept of risk and required levels of cleaning frequency and intensity.

The following table demonstrates the relationship between numerical weighting of functional area risk categories, the level of cleaning frequency and intensity needed to meet the required standard, and the timeframe for rectifying and re-auditing any problems identified through the cleaning standards auditing process.

Numerical Weighting	Functional area risk category weighting	Required level of cleaning frequency and intensity	Timeframe for rectifying identified problems and re-auditing
7	Very high risk category A	Critically important: constant	Immediate
6	High risk category B	Highly important: frequent	0 - 48 hours
4	Moderate risk category C	Very important: regular scheduled basis and as required in between	2 - 7 days
2	Low risk category D	Important: infrequent on a scheduled or project basis	1 - 4 weeks

An audit score sheet is provided on page 44 of this document. A separate audit sheet should be used for every room within a functional area; this provides a more comprehensive method of documenting the variances. Following the inspection of all rooms in each functional area, the scores are totalled then averaged for that functional area.

Examples of a functional area include:

- a general ward area comprising a number of rooms including toilets, bathrooms and showers, sterile and non sterile stock storage areas, utility rooms, day room, pantry and a nurses station
- an operating theatre complex or department comprising recovery, operating theatres, sterile storage area, scrub rooms, anaesthetic areas, toilets and other rooms
- an outpatients area comprising a number of treatment rooms, office area and utility rooms
- a department such as a physiotherapy department comprising a number of treatment rooms, rehabilitation area and offices. Sampling within a functional area should ensure that all types of rooms are audited (for example, bathrooms, toilets, offices, bedrooms and pantries) and that approximately 20 per cent of the functional area (by square metre area) is audited.

The 20 per cent sampling within clinical functional areas should be biased towards clinical and patient areas, and not towards offices and non-clinical rooms within the functional area.

Where a room or area is used for a number of different purposes with different risk weightings, the purpose with the highest risk weighting should be applied when auditing. For example, a treatment room may be used for performing invasive procedures (very high risk category A) on some days as well as for outpatients' consultation on other days (moderate risk category C). In this example, regardless of the purpose the treatment room is being used for on the actual day of the audit, the treatment room would be audited as a very high risk category A area.

Where there are offices, tearooms and storerooms attached to very high risk category A areas, the design and layout on the area may influence what category these areas should be audited as (see 'The cleaning standards for functional area risk categories' section of this document on pages 27-29; *Additional internal areas.*)

For general internal, non external and external audits, all 15 elements relevant to a functional area should be assessed. Every element should be assessed as either acceptable or unacceptable based on the cleaning standard for each element (refer to 'The cleaning standards for elements' of this document on pages 21-26).

Auditors need to exercise discretion and commonsense when making judgements about the acceptability or unacceptability of an element, taking into account the degree of associated risk. For example, one or two scuff marks on a floor, or an isolated smudge on a window does not indicate that that element should fail. To be recorded as unacceptable, the element must consistently fail across the room or functional area; for example, smudges would need to occur on several windows of a room or within a functional area for that element to fail. However, in the case of a blood or bodily fluid spill, the element would automatically fail if this was evident once in a room or functional area.

A demerit-based system is used for scoring. A functional area starts with 100 points and points are deducted when an element within the functional area fails. The weighting given to each element within different functional area risk categories distinguishes the relative importance and risk. The process of scoring is the same for internal, non external and external audits.

Scoring a functional area

Using the audit score sheet on page 44, the auditor(s) record the functional area under audit (for example, ICU), the date and their names. The auditor(s) assess and score each element within the functional area; an element scores zero (0) if it is acceptable resulting in no points being deducted from 100. An element scores one point (1) if it is unacceptable. A complete list of all 30 functional areas can be found under their respective functional risk categories on pages 27-29 of this document.

When the audit of a functional area has been completed weightings are applied to the elements that scored 1. The cross-reference charts are used to determine the actual demerit points for each unacceptable element. For example, if the functional area is the ICU and an element that scored 1 (unacceptable) was the 'patient equipment' element, the actual demerit points that would be recorded in column D would be 7. If an element that scored 1 (unacceptable) was the 'pantry fixtures and appliances' element, the actual demerit points that would be recorded in column D would be 6. All the demerit points recorded in column D are added up and the total is subtracted from 100.

Example: Functional area is the ICU

Element	Comments	0, 1 or N/A	D	Action time frame	Action taken (Y/N)
External features, fire exits, stairwells		0			
Walls, skirtings and ceilings		0			
Windows		0			
Doors		0			
Hard floors		0			
Soft floors		0			
Ducts, grills and vents		0			
Electrical fixtures and appliances		0			
Pantry fixtures and appliances		1	6	0 - 48 hours	✓
Toilets and bathroom fixtures		1	7	Immediate	✓
Patient equipment		1	7	Immediate	✓
Cleaning equipment		0			
Furnishings and fixtures		0			
Odour control		0			
General tidiness		0			
Total demerit points (add column D)			20		
Score: (subtract the total of column D from 100)			80		

In the example above the ICU scored 80

Where individual score sheets are used to score each room audited within a particular functional area, add the score for each room then divide the total score for all rooms by the number of rooms audited for that functional area, for example ICU.

Scoring a functional area risk category

Once all functional areas have been scored, an average score for each functional area risk category should be obtained for internal, non-external and external audits of a health facility.

There are four functional area risk categories and these are fully described on pages 27-29.

To obtain an average score for each risk category the auditor should add the scores for all functional areas in a risk category together and divide the total by the number of functional areas that were audited.

Example: Functional area risk category is high risk category B

Functional area	Score
Coronary care unit	100
Level 1 nursery	90
Dialysis unit	90
Birth suite	72
Medical ward south	86
Surgical ward west	86
Surgical ward south	82
Sterile stock storage	94
Emergency department	83
Pharmacy clean area	90
Total score of all functional areas	873
Number of functional areas audited	10
Functional area risk category score:	87.3
(Divide the total score of all functional areas by the number of functional areas audited)	

In the above example the health facility scored 87 in their high risk functional area category

Scoring a public hospital with multiple campuses – Reporting to the Department of Health

The department requires the results of one external audit (August) and two non external audits (March and November) to be reported to the Quality, Safety and Patient Experience Branch. The report to the department is by risk category – very high risk, high risk and moderate risk areas.

Whilst public hospitals with multiple campuses are expected to conduct cleaning standards audits at a campus level and compare and benchmark results within the public hospital, for the purposes of reporting to the department they are required to report by public hospital only (see example below).

Once an average score for each risk area within each campus has been calculated a public hospital score must be obtained.

Example: Multicampus public hospital

Risk area	Campus	Score	Public hospital Score
Very High Risk	A	93	(reported to DH)
	B	99	
	C	100	
	D	96	
			$A+B+C+D = 388/4 = 97$
High Risk	A	87	
	B	95	
	C	96	
	D	85	
			$A+B+C+D = 363/4 = 90.75$
Etc			

Audit score sheet

Room Functional Area:	Element weighting	Action timeframe
Audit date:	A = 7	Immediate
Auditor 1:	B = 6	0 - 48 hours
Auditor 2:	C = 4	2 - 7 days
	D = 2	1 - 4 weeks

Key: Acceptable (0)
 Unacceptable (1)
 Not Applicable (N/A)
 Column D = number of demerit points after weighting the unacceptable element.

Element	Comments	0, 1 or N/A	D	Action time frame	Action taken (Y/N)
External features, fire exits, stairwells					
Walls, skirtings and ceilings					
Windows					
Doors					
Hard floors					
Soft floors					
Ducts, grills and vents					
Electrical fixtures and appliances					
Pantry fixtures and appliances					
Toilets and bathroom fixtures					
Patient equipment					
cleaning equipment					
Furnishings and fixtures					
Odour control					
General tidiness					
Total demerit points (add column D)					
Score: (subtract the total of column D from 100)					

Auditor 1 signature:

Auditor 2 signature:

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Frequently asked questions (FAQs)

1. Which health facilities are required to complete the external and non external cleaning standards audits and report results to the department?

All public hospitals are required to report their cleaning standards data. Community health services and residential aged care services are excluded.

2. How do public hospitals submit cleaning audit data?

The eForms for submitting cleaning audit data are available on the Department of Health Cleaning Standards website approximately two weeks prior to the submission date. The web site is <<http://www.health.vic.gov.au/cleaningstandards/submissions.htm>>

3. What is the difference between an external cleaning audit and a non external cleaning audit?

The auditing processes for non external cleaning audits are the same as external cleaning audits. The only difference is 'who' conducts the audit. Refer to Q 4 and Q5.

4. Who is able to perform the external audit?

The external audit is to be performed by a person/s who is a qualified Victorian cleaning standards auditor (QVCSA), having completed the appropriate training at a registered training organisation (RTO). This person cannot be an employee of the public hospital.

5. Who is able to perform the non-external audits?

Non external audits are to be conducted by a QVCSA, having completed the appropriate training at a RTO. This person can be an employee of the public hospital or a contracted external auditor.

6. Who is able to perform routine internal audits (i.e. those not reported to the department)?

There are no restrictions on who can perform internal cleaning standard audits; however, a thorough knowledge of the cleaning standards and an understanding of health facility processes are required.

7. Who is a qualified auditor?

A qualified auditor is a person that has successfully completed a Victorian Cleaning Standards Auditors course at a RTO.

A list of QVCSAs is available on the Department of Health website <<http://www.health.vic.gov.au/cleaningstandards/auditors.htm>>. Please note that this list is not a complete list of all QVCSAs and public hospitals may engage a QVCSA that is not listed.

8. What if we do not have a qualified auditor in our organisation?

The options are to nominate a person to become a qualified auditor by undertaking the accredited course through a RTO. This person can then conduct the two non-external audits per year. Alternatively, the non external audits can be contracted to a qualified external auditor.

A list of trained QVCSAs is available at the Auditors' page.

<<http://www.health.vic.gov.au/cleaningstandards/>>

9. To assist with resource issues, when public hospitals are arranging for external cleaning standards audits, are they able to 'swap' staff?

Yes, swapping of QVCSA staff may occur as long as it is not the same person undertaking the audit every year.

While all auditors can be expected to act professionally and objectively, using the same 'swapped' auditor all the time may pose a risk. The risk is that, over time, some objectivity may be lost as there is never any 'outside' comparison with assessment and scoring.

Due to this it is recommended that a different external auditor is used each time. For non external audits public hospitals may chose to swap accredited staff at campus or organisational level.

10. Do public hospitals have to audit the entire health facility for an external or non external audit?

No, a sample of areas from 20% of the total health care facility should be included in the audits.

11. The standard says that "an external cleaning standard audit should include all functional areas in the very high risk functional area category A and at least 75 per cent of functional areas in the high risk functional area category B – does this mean every room in the very high risk functional area is to be audited?"

No, it means a sample of the rooms in every very high risk functional area category A and a sample of rooms in at least 75% of high risk functional areas category B should be audited. A sample should be equal to 20% of the functional area.

12. In the months of the three reporting audits (one external, two non external) do we need to conduct the scheduled internal audits?

Yes, for those three months internal audits should be undertaken to maintain a level of quality assurance. However, areas audited in the external and non external audits may be added to the internal audit results for example, instead of 50% of areas to be internally audited, do 30% and add the 20% from the external or non external audits.

13. Can QVCSAs deduct points for chipped paint, or is it a maintenance issue?

No, chipped paint is a maintenance issue and points should not be deducted for any maintenance issue. However a maintenance request ensuring the problem is repaired should be lodged in accordance with the hospital's policy.

14. Do I have to report each campus of my public hospital on an individual eForm?

No, one report for a public hospital is required. You are required to calculate the average of each risk category and report the public hospital score (see example below).

15. How do I calculate the scores for each category at my public hospital which is comprised of three campuses?

An example is:

A public hospital has three campuses – each campus has a functional category A area. To determine the overall score for Category A, each overall campus score is added together then divided by the number of campuses.

Category A results for:

Campus X	94
Campus Y	90
Campus Z	99
Total for X, Y + Z = 283/3 = 94.3	94.3

The total score of 283 is divided by 3 (being the number of campuses) providing an overall public hospital score of 94. This is the score to be entered into the department's data submission form.

16. Do public hospitals that achieve >90% AQL in very high risk functional areas category A, >85% AQL in high risk functional areas category B and >85% AQL in moderate risk area category C pass the cleaning audit?

Not necessarily, even though the AQL was achieved, from 2010 public hospitals must also be able to provide evidence supporting internal audits, for example, cleaning schedules and mapping in addition to the AQL to pass the audit.

17. What happens if the public hospital fails the AQL in a functional category?

When a public hospital fails a functional area category, the rooms that have failed to achieve the acceptable quality level (AQL) should be cleaned immediately. Public hospitals included in the Statement of Priorities are obligated to reaudit the rooms that failed the AQL within sixty (60) days.

Glossary of terms and abbreviations

Term/Abbreviation	Definition
ACHS	Australian Council on Healthcare Standards
AQL	Acceptable quality level
Audit	An examination or inspection. A procedure for investigating or assessing. Cleaning standards audits can be internal, non external or external (see definitions below)
Auditor	A person who undertakes audits
CCU	Coronary care unit
CEO	Chief executive officer
Clean	Free from dirt, impurities, marks, stains, blemishes, odours and contamination
Cleaning service provider	An organisation or group that employs staff and supplies cleaning services to a health care service and employs staff and cleaners. Cleaning service providers can be in-house or contracted.
Cleaning standard	See 'Standard of cleanliness'
Contract manager	A person(s) handling the contract between a health care service and a contracted cleaning services provider. A contract manager may also be known as a 'purchaser'
Contracted cleaning services provider	A team or group that is employed by an external agency and provides cleaning services to a health care service. A health care service contracts an external agency whose employees are not directly employed by that health care service. Contracted cleaning service providers have responsibility for their employees and cleaning service provision.
Cross-reference charts (element based)	Four reference charts giving the required standard of cleanliness for functional area risk categories, functional areas and elements.
Cross reference chart (health facility)	A reference chart showing weighting for all 15 elements across all 30 functional areas.
CSD	Central sterilising department
The department	Victorian Government Department of Health
Element	An item to be cleaned, such as a surface, article or fixture. Fifteen elements related to the health care service context can be found under one of four major groups: building, fixtures, equipment and environment.
EQulP	Evaluation and Quality Improvement Program
External audit	A cleaning standards audit of a health care service performed by a QVCSA who is not a staff member of that health care service.
Functional area	An area in which cleaning occurs, for example, a public hospital ward or an operating theatre. 30 functional areas related to the health care service context can be found in one of four categories.

Term/Abbreviation	Definition
Functional area risk category	30 functional areas have been categorised according to risk to reflect the level of intensity and frequency of cleaning needed. The four categories are: very high risk, high risk, moderate risk and low risk.
ICU	Intensive care unit
In-house cleaning services provider	A team or group that provides cleaning services to a health care service and is employed by that health care service. In-house cleaning services and employees are the responsibility of the health care service.
Internal audit	A cleaning standards audit of a functional area, a functional area risk category or a health care facility performed by in-house staff.
ISO accreditation	This refers to the ISO 9000 Series Quality Management System
L2 or L3 nursery	Level 2 or level 3 nursery
Non external audit	Non external audits are the same as external audits; however they can be conducted by a qualified auditor who has completed the appropriate training at a RTO. This person can be an employee of the public hospital or a contracted external auditor.
Public Hospitals	A public hospital, or a denominational hospital, or a public health services, or a privately operated health service as set out in the <i>Health Services Act 1988</i> .
Qualified Victorian cleaning standards auditor (QVCSA)	A qualified auditor is a person who has successfully completed a Victorian Cleaning Standards Auditors course at a RTO.
Required standard of cleanliness	See 'Standard of cleanliness'
RTO	Registered training organisation
Standard of cleanliness	There are four standards of cleanliness described in the element based cross-reference charts under the headings: Critically important, Highly important, Very important, and Important. The four standards of cleanliness correspond to the four functional area risk categories.
To clean	To make clean by removing dirt, filth or unwanted substances from an object or area.
VCSUG	Victorian Cleaning Standards User Group
Weight, weighted, weighting	An aspect of the cleaning standards auditing and scoring process that reflects the importance of various elements within different functional area risk categories

