# Cleaning policy template

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1. Introduction and statutory compliance

Ensuring that healthcare facilities are clean and safe is essential in the provision of effective healthcare. A clean and tidy environment helps prevent and/or control the spread of healthcare associated infections (HCAI), provides the right setting for the delivery of good patient care and is fundamental in helping patients to recover.

The absolute requirement to provide clean, safe healthcare is written into a range of key legal processes and documents governing the delivery of NHS-funded care; in particular, the NHS Constitution for England (DH, revised 2015), which pledges that “You have the right to be cared for in a clean, safe, secure and suitable environment”; The Health and Social Care Act 2022 (Regulated Activities); and Care Quality Commission Regulation 15: Premises and equipment.

The development and maintenance of a cleaning policy is important in demonstrating the organisation’s commitment to maintaining a clean and safe environment. The cleaning policy records the measures taken to ensure that:

* the accountabilities and responsibilities of the organisation’s officers and service partners are defined and understood
* all relevant parties are aware of the responsibilities for performance of cleaning tasks in each area
* teams are trained in cleaning methodology
* cleaning tasks are performed in a safe, efficient and consistent manner, in compliance with safety legislation
* cleanliness outcomes are closely and routinely monitored
* faults are rectified in a timely fashion, and star ratings are displayed with clearing scores regularly analysed
* efficacy audits are carried out to ensure the process of cleaning meets the requirements of the organisation and consistent cleaning standards are delivered
* steps are taken to ensure continuous improvement of cleanliness through analysis of scores and review of the functional risk (FR) ratings and cleaning frequencies, and cleanliness outcomes are regularly reported at Board level

Reviews, updates and amendments to the policy should be recorded in the document by its owner.

* 1. Purpose

This policy explains the principles of cleaning within healthcare environments and defines the responsibility and accountability of each member of staff in ensuring that those principles are adhered to, so that the organisation can be assured that its environmental cleaning measures are robust and appropriate.

The policy also aims to demonstrate how the organisation has implemented the National Standards of Healthcare Cleanliness 2025.

1. Aims

A clean environment is important to all staff and patients. While this is important from an aesthetic perspective, it is significant for minimising risks, including the incidence of HCAI.

The aims of this policy are therefore:

* to provide direction in maintaining and improving cleanliness standards across all hospital sites and premises, ensuring a clean, comfortable and safe environment for patients, service users, visitors, staff and members of the public
* to increase patient confidence while using the healthcare facilities in relation to environmental hygiene and the organisation’s commitment to reducing the incidence of HCAI
* to meet all the requirements of the National Standards of Healthcare Cleanliness 2025, The Health and Social Care Act 2022, the Code of Practice of the Prevention and Control of Infections and related guidance
* to provide good estate maintenance that supports effective cleaning and the promotion of an aesthetically pleasing environment. It must be recognised that as buildings and equipment age, they often become more difficult to keep clean and will eventually be beyond the scope of cleaning
* to improve the quality of healthcare services by ensuring risks involved in cleaning are identified and managed in an appropriate manner, including with appropriate funding
* to provide the procedures that are to be followed to achieve compliance in line with nationally recognised guidelines
* to provide a monitoring tool that is presented to the Board to provide assurance
1. Scope

This policy applies to all staff employed by the organisation, including contracted and agency staff, its contractors and any person who carries out cleaning procedures as part of their work. The policy embraces all cleaning activity within the organisation. This includes all general scheduled and reactive cleaning activities undertaken by the cleaning operatives as well as those undertaken by:

* clinical staff: for example, cleaning duties undertaken by nursing staff such as cleaning patient-related equipment; physio staff cleaning physio equipment; therapists or laboratory technicians cleaning equipment in their areas
* estates departments: for example, cleaning of air conditioning and/or ceiling vents
* catering departments
* porters: for example, cleaning medical gas trolleys or wheelchairs
* sub-contractors
* volunteers
* students
* residential accommodation cleaning operatives
* vehicle cleaning operatives
1. Responsibilities
	1. Chief Executive

The Chief Executive is the officer ultimately responsible in the organisation for maintaining and achieving the required standards of cleanliness and will:

* appoint a Director of Infection Prevention and Control (IPC) to ensure that infection control in the trust meets the required standards
* delegate responsibility for cleaning management to an executive director
* provide sufficient resources to deliver the service, and improve and maintain standards in the form of the commitment of time and financial resources
* ensure that employees receive training appropriate to their position and responsibilities
* ensure all employees are aware of their responsibilities for performance and assessment of cleaning tasks
* promote a positive culture in which the achievement of cleanliness is seen as everyone’s responsibility
* promote an organisational culture that demands identification of areas for improvement regarding cleanliness, and rectification of these issues in an appropriate timeframe
	1. Executive directors

Directors will have delegated responsibility for the dissemination and operation of the trust’s cleaning policy within their directorate and will:

* ensure all members of the organisation are aware of the Board’s expectations for the management of cleaning
* ensure all members of the organisation are aware of their individual responsibilities regarding cleaning
* provide adequate resources to achieve the required cleanliness standards in the form of the commitment of time and financial resources
* ensure appropriate monitoring systems are in place to determine the effectiveness of cleaning.
* share lessons learnt with colleagues and implement improvements

One Executive Board member will be the Director of IPC (DIPC) and have responsibility for assessing and ensuring the efficacy of cleaning as it relates to the prevention and control of infection. The DIPC will manage the Lead Nurse for IPC and the IPC team. The DIPC will liaise closely with the Director of Environment and the Head of Facilities on the management of cleaning services.

* 1. Board Lead for Cleanliness

The Director of Environment/Board Lead for Cleanliness has lead responsibility for cleanliness in the built environment and will:

* ensure provision of adequate resources to become compliant with best practice and to maintain this compliance
* ensure cleaning requirements and additional resources are factored into business cases for new builds or refurbishments of the estate
* ensure that instructions for cleaning items in new builds, including flooring, are included in building operation and maintenance manuals and are used to inform and/or modify cleaning method statements
* inform the Chief Executive of significant risks in relation to cleaning standards
* provide information to the Chief Executive and the trust Board on cleaning standards and issues, and recommend improvements
* champion cleaning at Board level and work collaboratively with the Director of Nursing in ensuring a seamless level of cleanliness across the clinical environment
	1. Director of Estates and Facilities/Associate Director of Estates and Facilities

The Director of Estates and Facilities/Associate Director of Estates and Facilities will ensure that the premises are fit for purpose, maintained and clean. They will:

* ensure regular monitoring of standards of cleanliness, reported at ward, departmental and Board level with actions to improve in areas of developing risk
* ensure provision of adequate resources to become compliant with legislation and to maintain this compliance
* ensure provision of adequate resources to become compliant with the National Standards of Healthcare Cleanliness and maintain this compliance
* ensure cleaning requirements, including clean/dirty storage, machine charging, laundry provision and additional labour resources, are factored into business cases for new builds or refurbishments of the estate
* ensure that instructions for cleaning items in new builds, including flooring, are included in building operation and maintenance manuals and are used to inform and/or modify cleaning method statements
* inform the Director of the Environment of significant risks in relation to cleaning standards
* ensure the trust has adequate resources to meet required levels of cleanliness
* delegate responsibility for the management of performance to the cleaning standards to the Head of Facilities
	1. Matrons and lead nursing staff

Matrons and lead nurses will:

* actively promote the importance of maintaining a clean and safe environment for patients, visitors and staff
* ensure that appropriate resources are provided in terms of time and financial resources within their area of responsibility
* ensure that cleaning tasks falling within the responsibility of nursing staff are performed consistently and in such a way as to produce the required cleanliness outcomes
* own the cleaning responsibilities framework and ensure that nursing staff complete actions arising from audits, including remedy of unsatisfactory cleanliness outcomes
* determine, in liaison with the IPC team, the method of cleaning required in vacated rooms, which will depend on the type of discharged patient; with an agreed process to differentiate between the type of cleans required using an organism-led process
	1. Ward and department managers

Ward and department managers have day-to-day responsibility for the operational activities within their areas of control and will:

* perform day-to-day informal monitoring of cleanliness and, where necessary, issue instructions for variation to usual cleaning practice to maintain high standards of environmental cleanliness in their ward or department
* ensure that work schedules are adhered to
* recognise cleaning staff for the important work they do and make them feel part of the ward/department team
* ensure that all cleaning tasks that should be performed by nursing staff in accordance with the cleaning responsibilities matrix are carried out consistently and effectively
* ensure that the cleaning responsibilities of Estates and other teams are met with rectifications managed within the agreed timescales
* participate in cleaning audits where possible, and sign-off all such audits or give written explanation of the grounds for not signing off
* ensure actions from audits are followed up within required timescales and defects are reported to Estates
* as part of the department local induction programme, ensure that new employees receive instruction on their roles and responsibilities regarding cleaning
* request confirmation from estates contractors that they have received authorisation from the relevant Estates office to work in the area and are carrying out works appropriately and without compromising cleaning or IPC standards
* decide, based on risk and in liaison with the IPC team, the method of cleaning required in each vacated bed
* ensure PPE is available to all facilities, contractor and estate teams to meet IPC standards
	1. Head of Facilities/Facilities Manager

The Head of Facilities has responsibility for promoting understanding of and compliance with the cleaning policy and will put in place an organisational framework for reporting that includes the monitoring of cleaning service provision.

They will:

* ensure cleanliness outcomes are audited by staff suitably qualified to conduct such audits; such staff may be direct trust employees or employees of an outsourced cleaning contractor working to the specified requirement
* ensure verification of remedial cleaning undertaken because of audit. Remedial cleaning will be undertaken by the staff group responsible for the performance of the specific task at fault, in accordance with the cleaning responsibilities matrix
* ensure assessment of response to requests for ad-hoc cleaning task performance
* ensure reporting of cleaning service performance via a formal monthly report to the trust Board, based on the report generated by the audit regimen to the Environmental Cleanliness Group
* ensure management of performance of the cleaning service
* liaise with the Estates Manager and with matrons on performance of the cleaning service where the responsibility for performance of tasks lies with the Estates service and nursing staff, respectively
* support the Facilities Manager on each site in the provision of cleaning services
* liaise with the Estates Manager in maintaining a safe, clean and well-maintained environment that can be cleaned
* liaise with the Lead Nurse for IPC on cleaning elements of the overall response to outbreaks of infection, choice of disinfectant/cleaning products, and methods of barrier and terminal cleaning
* direct cleaning input into preparations for PLACE (patient-led assessment of the care environment)
* liaise with and provision of expert advice to Capital Planning and the Estates Department
* act as a key member of all cleanliness groups, and play a key role in each group’s determination of cleaning responsibilities, specification of cleaning services and evaluation of tenders from contractors
	1. Facilities/Hotel Services Lead

The Facilities/Hotel Services Lead will monitor compliance with this policy and investigate any non-compliance, ensuring that corrective action is taken to continually improve. They will co-ordinate audits throughout the organisation and the dissemination of results, including by providing regular reports on cleaning standards and associated actions to the environment cleanliness groups.

* 1. Hotel services/facilities managers/service providers/contractors

They will:

* provide expert advice on cleaning, consumables, equipment and methodology of cleaning, working closely with the IPC and Health and Safety teams
* develop cleaning schedules for all areas of the trust
* ensure sufficient trained staff and resources are available to deliver the cleaning service, including by delivering specialist and enhanced cleaning requirements in line with the organisation’s policy
* ensure compliance with service level agreements, and delivery of high standards of cleanliness and value for money
* regularly liaise with the Facilities Manager and IPC team
* maintain records to evidence service delivery, audits, rectification and ad-hoc cleaning requests
* establish a spirit of collaborative team working with service users
	1. Lead Nurse for IPC

The Lead Nurse for IPC will:

* advise the Head of Facilities of any need to vary delivery of cleaning services in response to outbreaks of infection
* determine, in liaison with the Head of Facilities, the methods to be used for barrier and discharge cleaning of rooms
* authorise, in liaison with the Head of Facilities, the disinfectant/cleaning products to be used in the organisation
* act as a key member of the Environmental Cleanliness Group, and play a key role in that group’s determination of cleaning responsibilities, specification of cleaning services and evaluation of tenders
	1. Estates managers

They will:

* liaise with the Head of Facilities in maintaining a safe, clean and well-maintained environment
* ensure that site Estates teams complete repairs and actions arising from environmental cleaning audits and other inspections
* ensure that all Estates jobs, including those fulfilled by sub-contractors, are completed with a clean to restore sites to the cleanliness standards, such as removing handprints, excess material and debris
* ensure that cleaning tasks falling within the responsibility of Estates in accordance with the cleaning responsibility matrix are performed consistently and effectively to achieve the required cleanliness outcomes
* ensure planned works are carried out without compromising cleaning and IPC standards and that completion records are recorded
	1. Facilities managers

The facilities managers will support the managers within their area of responsibility to ensure appropriate delivery of services at all organisation sites.

They will:

* provide and facilitate core and statutory training for facilities staff
* ensure that sufficient trained staff, consumables and equipment are available to deliver the cleaning service and that any electrical devices used are safe to use and in good working order
* the facilities managers/facilities support manager will also perform competency assessments and observations of practice, and co-ordinate efficacy checks to ensure the process of cleaning is being complied with and any issues identified
	1. Facilities supervisors

They will:

* provide operational supervision of cleaning operatives in line with the cleaning policy and other relevant organisation policies
* co-ordinate and supervise specialist cleaning services including enhanced cleaning and cleaning with hydrogen peroxide
* ensuring that the national colour coding is always adhered to
* audit compliance with the cleaning standards and ensure any remedial actions are undertaken and communicated
* provide day-to-day advice in relation to cleaning requirements
	1. Trust and contractor staff

All trust employees have a personal responsibility for contributing effectively to the achievement of the required cleanliness outcomes throughout the organisation. In relation to this responsibility employees must:

* perform cleaning tasks that they are required to do effectively, in accordance with their training and with the frequency required
* attend all relevant training sessions
* note and remedy or report any failure of cleaning
* ensure that they are aware of health and safety precautions for their work activities and always work safely
* promote a culture where cleaning is seen as everyone’s responsibility
	1. Third-party users

Third-party users of the organisation’s owned premises will:

* take all reasonable steps to ensure that the required cleanliness standards are achieved in their areas
* observe the terms of their leases or other terms of occupation regarding cleaning
* provide the organisation’s cleaning contractor and/or in-house service providers with familiarisation training, so they understand the functional requirement
* where contractors are appointed by third-party users, they will be responsible for the performance of cleaning tasks, always act in strict accordance with the requirements and terms of their contracts, and meet the requirements detailed in the organisation’s policies relating to cleanliness

### 4.16 Board and committee responsibilities

The Environmental Cleanliness Group should be chaired by the Head of Facilities, and its membership should ideally include:

* the Hotel Services/Facilities Lead
* IPC representation
* facilities managers from the Domestic Services, Catering Services and Waste Management teams
* matrons and/or senior nurse representation
* Estates Manager
* a senior procurement/category manager

The group will have responsibility for:

* + - agreeing the responsibility for the cleaning of each item present on the organisation’s premises and publishing its decision in the form of a cleaning responsibility matrix within the cleaning policy and in the cleaning specification
		- allocating risk categories to functional areas
		- agreeing the content of the cleaning policy including required cleanliness outcomes, key performance indicators, cleaning auditing, reporting requirements, including IPC audits, estates issues and waste
		- any issues deemed essential to the Environment Group that need discussing

4.17 Infection Control Taskforce

The Infection Control Taskforce will review and determine changes to cleaning practice, cleaning chemicals, PPE and frequency appropriate to types of infection outbreak, and to specific problems identified.

4.18 Capital Infrastructure and Environment Group

The Capital Infrastructure and Environment Group will review and approve the cleaning policy and propose inclusions specifically relating to refurbishments and new builds to the policy owner. Estates will ensure cleanliness and infection control considerations are detailed and accounted for and that cleaning managers are informed and consulted, and their recommendations given due consideration.

The Capital Infrastructure and Environment Group will receive the monthly Environmental Cleanliness Group minutes from the Head of Facilities.

1. Key objectives
	1. Taking cleanliness seriously

Ensure high standards of cleanliness are maintained across the organisation to ensure patients receive treatment in an environment that is clean, safe and welcoming.

* Cleaning managers, Estates and Facilities, and contractors should work in partnership with matrons, ward managers, clinical managers and department managers to develop procedures for their individual areas of activity.
* Setting clear local standards (reflecting the National Standards of Healthcare Cleanliness 2025 and associated policies) and keeping cleanliness high on the organisational agenda.
* Cleaning routines should be clear, agreed and well publicised. Cleaning activity should be part of the ward routine, not an intrusion into it.
* Cleaning routines must be flexible to respond to the changing needs of an area or ward.
* Cleaning operatives must be treated as fully integrated members of the team for the area they work in.
* Ensuring a Commitment to Cleanliness Charter is in place for each ward or department.
	1. Listening to patients and patient involvement

Cleaning services work in partnership with patients and/or their representatives to ensure that consistently high standards of cleanliness are achieved and maintained across every healthcare organisation premises. Also see section 7: Patient involvement.

* 1. Infection prevention and control

The IPC team should work closely with Estates and Facilities on the development, implementation and monitoring of policies, protocols and procedures. Refer to local IPC policy.

1. Activities and responsibilities
	1. Implementing the National Standards of Healthcare Cleanliness 2025

The flowchart below shows the steps required to support the introduction of the standards:



1. Patient involvement

Cleaning services must work in partnership with patients and/or their representatives to ensure that consistently high standards of cleanliness are achieved and maintained across every healthcare environment.

Patients and/or their representatives should be involved in the following ways:

* patient and/or public involvement will form part of annual PLACE inspections
* patient views will be sought through routine satisfaction surveys and patient exit surveys, and the feedback from these will be reported back through the organisation’s hierarchy or Communication Department
* formal and informal complaints and comments from patients, service users or their representatives relating to cleanliness will be acted on via formal and informal complaints
1. Education, training and development

Cleaning is a vital part of the overall IPC process, which aims to provide a clinically clean and safe environment for delivering patient care. Areas that are not cleaned properly could aid the transfer of harmful organisms in a healthcare environment, potentially causing infection. For this reason, the importance of robust training is paramount. Cleaning regimens should be underpinned by standard operating procedures and any other national guidance.

All levels of the cleaning team, as well as anybody else undertaking cleaning tasks, should be clear about their roles and responsibilities, and cleaning training should be delivered using the NHS England method statements as a template. This should be supported by:

* job chats/ward briefing
* additional training in IPC
* health and safety training
* chemical training, including dilution and safe use
* risk management
* patient integration and information governance

Everyone who is required to clean as part of their role must have the specific cleaning requirement detailed in their job description.

### 8.1 Monitoring

Healthcare organisations need to provide assurance at all levels that their establishments are meeting and maintaining safe standards of cleanliness, and be able to demonstrate to patients, staff and the public that cleanliness meets the required standards. This supports IPC good practice by ensuring patients, staff and the public are confident that both visual and efficacy audits are providing assurance that safe standards of cleaning are met.

Auditing in all types of healthcare setting should provide clear evidence that cleanliness standards are being met safely and responsibly, and where they are not, detail any service deficiencies and areas for improvement.

The organisation must implement a monitoring and audit process that meets the requirements of the National Standards of Healthcare Cleanliness 2025.

The policy must detail the audit frequency for each functional risk (FR) category. If the frequencies differ from those in the standards, the reason for this must be detailed in the organisation’s cleaning policy.

### 8.2 Principles

The audit principles for the national standards (see section 8.2 of the National Standards of Healthcare Cleanliness 2025) provide a national approach to auditing healthcare cleanliness in all types of healthcare settings. The overarching aim is to encourage safe standards of cleanliness in all healthcare environments, and the audit process (see section 9 of the National Standards of Healthcare Cleanliness 2025) is designed to be easy to use and adaptable to local requirements.

Cleaning and IPC are intrinsically linked. It is therefore essential to demonstrate cleaning efficacy by auditing both the outcome of cleaning and the process by which the cleaning standards are achieved. To meet safe standards, the efficacy of the cleaning process is as important as the technical outcomes of cleaning, which is why it is an area of focus.

Providing assurance that cleanliness has been delivered is critical; therefore, displaying the overall cleanliness result is an important part of the audit process.

1. Classifying risk and frequencies

All wards and departments should pose a minimal risk to patients, staff and visitors. However, different functional areas represent different degrees of risk, and therefore require different cleaning frequencies. All areas have been categorised into 1 of 6 levels, otherwise known as functional risk (FR) categories.

1. National colour coding scheme

The trust will implement the national colour coding scheme for cleaning. All equipment, cleaning materials and PPE should be identifiable as follows:

Red – Bathrooms, washrooms, toilets

Blue – General areas, public areas

Green – Catering areas, ward kitchens, patient food areas

Yellow – Isolation, infected cleans

Theatres and specialist units may have their own cleaning equipment to use between patients. This colour coding for such dedicated equipment must be agreed locally and added to your trust colour coding chart.

1. Methodology

Cleaning should always be carried out using the correct equipment and that equipment should be correctly colour coded. The correct cleaning methodology for each element should be followed, as well as the organisation’s discharge cleaning process, which will comply with the organisation’s IPC policies.

The organisation will maintain a set of method statements and risk assessments relating to every cleaning task performed by cleaning services.

Reference will be made to the methodologies, videos and posters contained in the NHS England cleaning manual.

All staff who have cleaning responsibilities, including clinical and estates and facilities staff, will have auditable training records verifying that they are competent in the effective and safe performance of the cleaning tasks.

* 1. Infection prevention and control cleaning definitions

Additional cleaning or cleaning using a disinfectant solution may be required where patients have certain infections. The IPC team will advise the ward manager when and where an infection control clean is required.

Records should be retained to confirm:

1. originator of the request to clean
2. date, time
3. location
4. type of clean
5. known infection or outbreak
6. cleaning completed by
7. completion of the task
	1. Isolation or barrier cleaning

A barrier (or ‘isolation’) cleaning regimen will be implemented for a named room or rooms. Barrier cleaning will be required daily where a patient has a known infection that requires different cleaning procedures or there is a suspected or active outbreak (local IPC procedures in conjunction with the NHS England National IPC Manual should be referred to). It will be carried out in the same way as routine cleaning but using a prescribed disinfectant solution.

* 1. Discharge clean

Following a patient’s discharge their room will receive a discharge clean, even if the patient is only discharged temporarily: for example, for home leave. The category of clean will be determined following an agreed process (with IPC) and this clean, including the approved decontamination process, should be carried out within an agreed timescale.

Curtains will be changed in line with trust policy and type of organism.

* 1. Rapid response cleaning

Where rapid or reactive cleaning is required, the domestic staff or the rapid response team member on duty should be informed and asked to respond to the request within an agreed timeframe, which will depend on the urgency of the request. Patient safety, health and safety, and infection control related issues should be prioritised for a speedy response.

Requests for reactive cleaning services should be responded to in a timely manner. The appropriate response time will be agreed with the Estates and Facilities management team and the unit/service manager, with interruption to service delivery the minimum possible.

* 1. Beyond the scope of cleaning

When an item or surface has become damaged to the point where cleaning is not viable – for example, rips or tears in chairs or mattresses that would allow ingression, or peeling paint on walls – this should be raised through the audit process and via IPC and Estates teams to ensure replacement or repair of the item or area.

1. Cleaning products

All cleaning product containers will be correctly labelled with the details of their contents, and kept in safe, dedicated and lockable areas (or the containers themselves should be lockable), to ensure they are used for their intended purpose only.

All cleaning chemicals should be diluted as agreed with the IPC teams. Diluted chemicals should be disposed of daily to avoid contamination and to maintain product effectiveness, and records kept demonstrating compliance.

Care should be taken not to mix chemicals and only chemicals that the IPC team agrees to should be used in the provision of cleaning services.

Manufacturer’s instructions should always be followed, including contact time. Up to date manufacturers’ safety data sheets (MSDS) and risk assessments for all cleaning chemicals will be available in each functional area of work.

COSHH (Control of Substances Hazardous to Health) legislation must be complied with.

The number and type of cleaning products should be kept to a minimum to reduce risk of misuse. Where possible, environmentally friendly products and packaging are used.

All staff should be fully trained in the correct use of chemicals and equipment.

1. Cleaning schedules and allocation of work

Each functional area within the healthcare organisation will have a Commitment to Cleanliness Charter detailing all the items to be cleaned and who is responsible for cleaning each one.

The Commitment to Cleanliness Charters will be kept up to date.

Cleaning teams will be routinely allocated to the same functional area to ensure consistency of cleaning standards, drive ownership and foster relationships between facilities and clinical teams. Allocation should be based on the level of training in cleaning specific elements and functional areas, to ensure cleaning teams can meet any specialist requirements of the area and/or elements within it.

1. Auditing and performance monitoring

14.1 Committee and board reporting

Committee/board papers should include a report on cleaning performance for each functional area. Reports should detail:

* cleanliness audit scores and trends, and any areas where remedial action is required
* details of any areas that have failed to achieve a 5-star or 4-star rating and the actions taken to improve cleaning in these areas
* efficacy audit plan and scores against the plan, with any areas of concern identified
* any recommended strategic changes for agreement by the committee/board, including the resource implications of changes
* assurance that star ratings are correctly displayed and updated
* assurance that cleaning frequencies are displayed in accordance with the Commitment to Cleanliness Charter
* assurance that efficacy audits are carried out, and that they meet agreed standards, and remedial action is taken to rectify any non-conformance
* confirmation that an annual external audit is undertaken to assure the quality and methodology adopted by the healthcare organisation

14.2 Audit risk categories and star ratings

The audit target score, audit frequency and star rating should be identified for each FR category, with justifications provided for any changes to the audit frequency detailed in the National Specification of Healthcare Cleanliness 2025.

**Healthcare specific target audit score and audit frequency by functional area**

|  |  |  |
| --- | --- | --- |
| **Functional risk category**  | **Audit target score**  | **Audit frequency** |
| FR1  | 98% and above  | Weekly |
| FR2  | 95% and above  | Monthly |
| FR3  | 90% and above  | Every 2 months |
| FR4  | 85% and above  | Every 3 months |
| FR5  | 80% and above  | Every 6 months |
| FR6  | 75% and above  | Every 12 months |

Organisations can use blended functional area options and should detail the specific areas where these have been adopted, and the functional risk categories and overall audit frequency for each room within the blended functional area and the star rating for the overall functional area.

Audit scores will be displayed in each FR area.

Star ratings should be displayed in the functional area in a prominent position where they will be visible to staff, patients and the public, such as at the entrance to each ward and department and in public areas. They should be displayed as soon as practicably possible after an audit has been completed, include an expiry date and be kept up to date, changing as and when there is a change in the area’s star rating.

14.3 Audit rectification

Audit rectification is carried out as per the table below (change as required locally).

|  |  |
| --- | --- |
| **Priority of rectification**  | **Maximum timeframe for rectifying cleaning problems**  |
| **Rapid response items** –all areas regardless of their FR rating where there is a health and safety, patient safety or IPC issue  | Task should be assessed within 20 minutes and completed in under 1 hour Cleaning these items should be recognised as a team responsibility. Where necessary and cleaning staff are unavailable, for example at night, the task should be the responsibility of other ward or department staff. It is important that all tasks are clearly outlined and that all staff understand their responsibilities and the methods of cleaning, including what the appropriate cleaning equipment and materials are kept |
| **FR1**  | Assessment within 20 minutes and task completed at the next scheduled clean or within 2 hours (if the area is accessible), whichever is soonest  |
| **FR2**  | Assessment within 20 minutes and task completed at the next scheduled clean or within 4 hours (if the area is accessible), whichever is soonest  |
| **FR3**  | Assessment within 1 hour and task completed at the next scheduled clean or within 12 hours (if the area is accessible), whichever is soonest  |
| **FR4**  | Assessment within 1 hour and task completed at the next scheduled clean or within 72 hours, whichever is soonest  |
| **FR5**  | Assessment within 24 hours and task completed at the next scheduled clean or within 96 hours, whichever is soonest  |
| **FR6**  | Assessment within 24 hours and task completed at the next scheduled clean or within 120 hours, whichever is soonest  |
| **FRB (blended functional area)**  | The above rectification times should be used depending on the FR for the room concerned  |

14.4 Efficacy audit

The efficacy audit will be completed monthly by a multidisciplinary team (MDT) including representation from the IPC team, the Estates and Facilities Cleaning Manager and a matron or ward manager.

The audit will be scored, remedial action carried out and results included in the report to the Environmental Cleanliness Group.

The efficacy audit questions will be reviewed and amended to reflect ongoing cleaning-related areas of focus, and continually developed for continuous improvement.

14.5 External annual audit

Consideration will be given to introducing an external annual audit to review documentation, carry out a mock audit, and review systems and processes to validate the score or recommend remedial action to meet the standards.

1. Scheduled periodic and deep cleaning

The National Standards of Healthcare Cleanliness 2025 describe the periodic cleaning required to maintain the cleaning standards.

A periodic cleaning matrix should be developed and maintained for the deep and periodic cleaning that is required on an annual, bi-annual or 3-yearly basis.

The deep cleaning schedule should be based on FR category and developed in conjunction with the IPC and Facilities teams.

An MDT within the organisation should agree a programme for deep cleaning rooms or areas following the discharge of patients who had an infection or following an outbreak; this team should comprise as a minimum head of facilities, cleaning supervisors, IPC representation, head of estates and clinical/nursing representation. Deep cleaning is a full clean of all elements within the room, including wall washing, and curtain changing. Disinfectant will be required. Where decontamination equipment is to be used following the deep clean, this should be detailed in the cleaning policy.

The periodic cleaning schedule should detail those cleaning tasks that are required to be performed monthly or less frequently.

Progress against the deep cleaning and periodic cleaning schedules will be reported through the organisation’s hierarchy in the monthly report.

1. Discharge cleaning/infected rooms/pandemic definitions

In addition to the scheduled cleaning tasks, unscheduled cleans can be necessary. A record of the clean should always be made, including date, time, location, infection and the domestic who cleaned area.

The NHS England cleaning manual should also be followed when carrying out the following cleans:

* a discharge clean: a full clean of a bed space or side room after a patient is transferred or discharged
* an infected clean: a clean of a bed space, bay, ward or area due to an infection or infestation

During a pandemic or outbreak an area may be segregated and cleaned separately to the main hospital/healthcare area. The trust will give those involved in cleaning these areas specific cleaning instruction. Refer to national guidance.

1. Decontamination using hydrogen peroxide vapour, ultraviolet C (UVC) and steam

This section should cover the technological decontamination processes to be used in the organisation. (Sub-sections can be deleted if they are not applicable.)

Decontamination using technological processes may be required to augment cleaning processes where specific organisms are present or to support deep cleaning and the reduction of the environmental load of organisms within specific areas. All decontamination processes should be followed to ensure the clean is validated and a technological process should never be considered a substitute for a manual clean.

Rooms should be prepared for technological decontamination to allow maximum penetration of the vapour, light or steam into all areas of the room, as instructed by the machine supplier.

Organisations should detail an organism-specific decontamination programme within their discharge and deep cleaning programme. Include:

* how, who and when will the method be used
* referral to estates policy for isolating/reinstating power, alarms, etc
* referral to the helpdesk process for management of calls
* when using an external contractor, procedure and policy for compliance

17.1 Hydrogen peroxide

Hydrogen peroxide vapour (HPV) is a highly effective environmental decontaminant used to clean areas that may have been contaminated with microbiological organisms that may present a risk of infection to susceptible patients: for example, Clostridium difficile, MRSA and resistant Gram-negative organisms.

HPV machines must only be used in unoccupied rooms/bays and by staff specifically trained to use them.

HPV must be sealed in a dispenser, as it will be absorbed by and damage all absorbent material, such as bedding, curtains and paper consumables. These materials should be removed before decontamination with HPV. HPV is not suitable for use in carpeted rooms.

17.2 Ultraviolet C

Ultraviolet C (UVC) is another highly effective environmental decontaminant used for the same indication as HPV. Again, UVC must only be used in unoccupied rooms/bays and by staff specifically trained to use it.

UVC works in the line of sight and the room will need to be prepared such that the harder to reach areas that are normally in shadow can be decontaminated.

* 1. Steam

Steam can support decontamination and its use where suitable for the type of contamination or clean required should always be consistent with the standard operating procedure for steam cleaning agreed with the IPC team. Incorrect use can aerosolise organisms into the environment, spreading the source of infection.

Steam cleaning should only be undertaken by trained staff in a well-ventilated area, away from patients and other staff.

1. Waste collection and disposal

Waste must be handled with care and separated in accordance with the trust’s waste management policy and recycling policy.

Waste should be disposed of in the following manner:

* orange sacks for the disposal of infectious and potentially infectious waste: for example, dressings from known infected wounds and other items that have been in contact with infectious body fluids
* tiger sacks (yellow and black stripped) for the disposal of offensive waste: for example, gloves, aprons, feminine hygiene products, nappies and dressings from non-infected wounds
* all clinical waste bags must be tied securely with an identity tag, not overfilled and only stored in a clinical waste bin or designated disposal area prior to disposal
* blue rigid containers for the disposal of pharmaceutical waste, including all giving sets and blister packs
* yellow rigid containers for the disposal of pharmaceutically contaminated infectious waste
* clear plastic bags for the disposal of recyclable products such as paper, hand towels, metal, plastics and card
* black bags for the disposal of non-clinical, or domestic, waste must be disposed of in black bags: for example, flowers, crisp packs and polystyrene

It is a mandatory requirement that clinical waste bins are kept locked at all times.

1. Dress code

All staff should dress in accordance with the organisation’s uniform policy and adhere to the following:

* only minimal jewellery worn:
* rings should be plain with no stones and no more than one worn
* earrings should be small hoop and only 1 pair worn
* necklaces should be discrete and removed when visiting control areas
* facial piercing (1 only) must be covered or removed in control areas
* shoes should:
* have a low heel height (below 2 inches)
* be fully enclosed (sandals not suitable)
* rubber or slip resistant soles preferred
* **in clinical areas, bare below the elbow** with no watches or bracelets
* nails should be short and clean – **no** nail polish (including clear), false nails or wraps
* hair should be clean, and long hair should be tied back
* beards need to be clean and tidy
* tattoos and body piercings that could be deemed offensive must be concealed
1. Personal protective equipment

Personal protective equipment (PPE) is the last control in the hierarchy of risk assessment and when specified should be worn as instructed and detailed in the IPC policy and task risk assessment.

20.1 Gloves

Disposable gloves must be worn when cleaning an area occupied by an infectious patient, including for the cleaning of sanitary ware and side rooms as per the isolation policy. To help prevent infection, injury and cross-contamination, gloves should be worn for all wet cleaning tasks and within all sanitary or infected areas. Gloves should also be worn when using hypochlorite solution.

All gloves should be colour coded where possible and disposable.

Gloves should be changed between each patient bed space and between tasks (as appropriate) and removed when a task is finished or interrupted.

The use of gloves does not replace the need for proper hand washing.

20.2 Aprons

Staff who are at risk of clothing contamination should wear colour-coded disposable plastic aprons to create a waterproof barrier. If contamination by large amounts of fluid is anticipated, local protocol should be followed. This should be established by a COSHH/risk assessment.

Aprons should be changed after cleaning an area occupied by an infectious patient, for each patient zone and between tasks (as appropriate), and removed when a task is finished or interrupted.

20.3 Goggles, masks or visors

Staff who perform procedures that risk their faces being splashed with fluid should wear goggles, masks or visors to protect their eyes, nose and mouth.

Goggles must be worn when diluting cleaning chemicals, including hypochlorite solution. Masks must be worn for airborne precaution isolation ensuring that chemicals and vapours are not inhaled.

1. Record keeping

Keeping cleaning records is mandatory and these must be available for inspection and to answer any requests for information, always. Reporting on performance against the standards will also be required for organisational budget setting and financial strategy. Specific reports will be generated on a regular basis.

Every month, the cleaning audit scores will be reported at the following groups (this list is not exhaustive and should be revised as appropriate):

* Environmental Cleanliness Group
* Estates and Facilities monthly dashboard
* Hotel Services Performance Committee

Every quarter, the cleaning audit scores, trend analysis, accidents and near miss incidents will be reported to the following (this is not an exhaustive list and should be revised as necessary):

* IPC Management Committee
* Patient Catering Committee
* Health and Safety Committee

Annually, the cleaning audit scores, overview of the 12 months service delivery and proposed innovation will be reported to the organisation’s Management Board.

1. Laundry process (cleaning cloths/mops)
	1. Laundry logistics
* Ensure mops and cloths for each area are counted in and out of the laundry, and that the allocation process for mops and cloths provides the shift with enough of each to clean the functional area.
* Arrange for the transport of the clean microfibre and the return of the used microfibre, ensuring that the used products cannot cross-contaminate the clean ones.
* Dirty laundry should be laundered as soon as practicable to reduce risk of infection spread.
* Provide a wheeled method of transporting linen around the buildings to avoid manual handling of linen and laundry.
	1. Laundry room – handling chemicals
* Provide recommended PPE: gloves and safety glasses, approved for use as protection against chemicals if there is a danger of splashing.
* Ensure the manufacturers’ safety data sheets (MSDS) and COSHH assessment are in place in the laundry room.
* Ensure any leaks/damaged containers are promptly reported and repaired.
* Only approved chemicals should be used.
* Chemicals should not be mixed.

22.3 Cross-infection procedures

* PPE should be worn as directed.
* Used laundry should be handled wearing gloves and an apron.
* All cuts/scratches should be covered with waterproof plasters.
* All exposed skin should be covered.
* Uniforms worn in the laundry should be laundered at 600C or above.
* Eating or drinking within the laundry is prohibited.
* Hands should be washed frequently, and always between handling soiled and clean microfibre, and when leaving the laundry.
* Clean and dirty laundry should be kept segregated.