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Cleaning Horizontal / Vertical Procedure for Healthcare

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1.0 PURPOSE

The purpose of this document is to aid facilities within the healthcare sector to establish Entity-specific, standardized Cleaning Procedures in compliance with industry standards and best practice. Guidance contained herein is designed for the Entity's Facility Management (FM) department, led by the Facility Manager. However, it should also be read and understood by third party Cleaning Service Providers (CSPs) such that cleaning levels reach the expectations of staff, patients, and visitors.

Applying this document across all cleaning operations shall enable the Entity to effectively implement, operate, maintain, and continuously improve its Cleaning Procedures. Also featured herein is the sector-specific guidance that focuses on infection control, cross-contamination, and prevention of healthcare associated hazards, the risk of which can be mitigated by a robust Cleaning Procedure.

2.0 SCOPE

The scope of this document covers all functional areas within healthcare facilities, including both clinical and non-clinical areas. However, catering facilities within the healthcare environment are covered by food hygiene laws and are not covered under the scope of this document, except where the catering facility forms an integral part of another functional area for which catering is not the primary purpose (e.g. ward kitchen, beverage bay, staff room). The Entity shall be responsible to determine whether the size of specific catering facilities shall be governed by guidance contained herein, or by regulations falling outside the scope of this document.

Topics covered within this document include:

- Functional risk area cleaning
- Infection control
- High-touch and Low-touch surfaces
- Spill management
- Laundry and linen
- Cleaning tools, equipment, and consumables
- Quality management and auditing
- Work instructions, also known as cleaning procedures or Standard Operating Procedures (SOPs)
- Health, Safety and Environmental (HSE) requirements
- Training

Guidance included in this document does not cover cleaning of internal parts of mechanical and electrical equipment. For example, cleaning interiors of Heating, Ventilation, and Air Conditioning (HVAC) systems, and lift shafts shall fall form part of Planned Preventative Maintenance (PPM) activities undertaken by Mechanical, Electrical, and Plumbing (MEP) staff. Further guidance can be found within the National Manual of Assets and Facility Management, Volume 6 (e.g. Mechanical System, HVAC Electrical System, Elevators and Escalators)

The Cleaning Service Provider (CSP) shall produce Cleaning Procedures that are presented in a checklist format. The same checklists serve a dual purpose for cleaning audits whereby cleaning levels are verified by the CSP or the Entity. Cleaning Procedures must be feasible, easy to read, and facility-specific.

For the purpose of this document, a Healthcare Facility has been defined as any location where healthcare is provided including, but not limited to:

- Hospitals
- Clinics
- Nursing homes
- Dental care facilities
- Psychiatric institutes/facilities

3.0 DEFINITIONS

Term	Definition
Consumables	Items such as: disinfectants, chemicals, paper towels, hand soap liquid and treatment agents that are used as part of maintenance tasks
Frequency	Time period under which repetition of a tasks shall be carried out to maintain the expected cleanliness at all times
Inspection	Visual observation of a stationary or operating asset
Job Hazard Analysis	A checklist referred to by operatives at the work location immediately before carrying out a task
Kentucky Mop	The traditional mop used in many facilities in the KSA. It has a head made of looped cotton that becomes heavy when wetted and is notorious for moving dirt from one area of a Facility to another rather than removing it
Microfiber	Used in cleaning extensively due to its characteristics, which include softness, toughness, absorption, water repellency. The use of washable microfiber cloths, as well as detachable and washable microfiber such as on mops and sweeping tools collect far more dirt than traditional cleaning equipment
Personal Digital Assistant	An electronic device that connects the Work Management Center (WMC) and other approved users to the Supervisor or operative
Point of Work Risk Assessment	A checklist referred to by operatives at the work location immediately before carrying out a task
Schedule	Cleaning activities and resource requirements presented in a tabular format against time
Tool	Manual or powered hand-held cleaning tools, implements used in the process of Cleaning the facilities
Unplanned Work	Any piece of work that requires emergency or urgent response, or that is prompted when a 'Quick Work' opportunity arises
Work Order	Formal, Uniquely Identifiable, Documented Instruction to Work
Abbreviations	
BICSc	British Institute of Cleaning Science
CBAHI	Saudi Central Board for Accreditation of Healthcare Institutions
CCU	Cardiac Care Unit
CMMS	Computerized Maintenance Management System
COSHH	Control of Substances Hazardous to Health
CSP	Cleaning Service Provider
FM	Facilities Management - Manager
HAI	Healthcare-Acquired Infection
HSE	Health, Safety and Environment
ICU	Intensive Care Unit
ISO	International Organization for Standardization
JHA	Job Hazard Analysis
KPI	Key Performance Indicator
KSA	Kingdom of Saudi Arabia
NHS	National Health Service (UK)
NMA&FM	National Manual of Assets and Facilities Management
OOH	Out of Hours
OPD	Out-patient Department
OSHA	Occupational Safety and Health Administration
PAPR	Powered Air Purifying Respirator
PDA	Personal Digital Assistant
POWRA	Point of Work Risk Assessment
PPE	Personal Protective Equipment
PTW	Permit to Work
RAMS	Risk Assessment and Method Statements
SDS	Safety Data Sheet
SLA	Service Level Agreement
SMW	Surgical Waste Management
WHSWR	The Workplace (Health, Safety and Welfare) Regulations 1992
WMC	Work Management Center
WO	Work Order

Table 1: Definitions

4.0 REFERENCES

- British Institute of Cleaning Science (BICSc)
- Cleaning Industry Management Standard (CIMS 3000:2008)
- Control of Substances Hazardous to Health (COSHH) Regulations (UK, 2002)
- Health Technical Memorandum (HTM 01-04) – Decontamination of Linen for Health and Social Care
- International Organization for Standardization (ISO 45001:2018) – Standard for Occupational Health and Safety
- International Organization for Standardization (ISO 9001:2015) – Quality Management System Certificate in UAE
- International Organization for (ISO 13485:2016) – Medical Devices – Quality Management Systems
- National Manual of Assets and Facilities Management (NMA&FM) Volume 14, Chapter 2 – Emergency Management Procedure - EOM-ZE0-PR-000001
- Press Ganey – www.pressganey.com/solutions/patient-experienceSaudi Central Board for Accreditation of Healthcare Institutions (CBAHI) – Second Edition 2011
- The Health & Safety at Work Act (1974
- The National Specifications for Cleanliness in the NHS (2007)
- The Personal Protective Equipment at Work Regulations (PPE) 1992 (as amended)
- The Work at Height Regulations (2005)
  US organization National Institute of Governmental Purchasing (NIGP) – Principles and Practices of Public Procurement Workplace (Health, Safety and Welfare) Regulations (WHSWR, 1992)

5.0 RESPONSIBILITIES

This section outlines the roles and associated responsibilities of all personnel directly or indirectly involved in successful establishment and delivery of Cleaning Procedures within healthcare facilities.

5.1 Entity Director

The Entity Director is a member of the Entity's senior leadership team who sponsors and enables the delivery of policies associated with maintaining a clean healthcare environment. The Entity Director holds overall accountability for the activities and staff associated with the cleaning that takes place in the healthcare facility.

Responsibilities associated with the role include:

- Securing and monitoring the facility's financial budget for cleaning activities sufficient to meet cleanliness standards within each Healthcare Facility based on inputs from the FM
- Reviewing and approving contractor performance reports and driving change across the Entity based on feedback from patients, staff, contractors, and visitors
- Approving budgets for resources (e.g. consumables, equipment, staffing) up to Entity-prescribed budgetary approval thresholds
- Overseeing the selection of facilities service providers with a proven track record in the Kingdom of Saudi Arabia (KSA) government sector and a demonstrable credibility of the service quality standards through a transparent procurement process

5.2 Medical/Clinical Director

The Entity Medical/Clinical Director is responsible for ensuring the alignment between the cleaning contractors cleaning activity and the day to day operation of the healthcare facility.

Responsibilities associated with this role include:

- Review and validation of the contractor's Cleaning Policies and Procedures
- Review of cleaning schedules to ensure no interruption in medical activity
- Review of audit output scores to identify any required follow-up action
- Ensure periodic review of the contractor's performance related to clinical activity

5.3 Infection Control Director

The Entity Infection Control Director is responsible for ensuring that the Cleaning Service Provider (CSP) cleaning activity conforms with and aligns with the Entity's Infection Control Policies and Procedures.

Responsibilities associated with this role include:

- Review and validation of the contractor's cleaning policies and procedures
- Accountability for ensuring the cleaning audit program is undertaken and actions are recorded and followed up
- Ensure periodic review of the contractor's performance related to infection control

5.4 Entity Facilities Manager

The FM is responsible for the successful management of the soft services cleaning services provider. The soft services cleaning provider should be appointed under a Service Level Agreement (SLA) and they are responsible for managing and operating cleaning services throughout the healthcare facility in compliance with Entity requirements. The Entity FM will oversee and manage the contractor's performance.

The FM at a healthcare facility shall ensure:

- Compliance with the requirements of statutory legislation, facility and appointed contractor local policies and procedures
- Staff are inducted and trained, whether directly employed or provided by subcontractor, including any site-specific training required by the Entity. This includes specific induction training
- Formal, written Risk Assessments and Method Statements (RAMS) are in place for all work activities
- Monitor the Cleaning Services Contractor to establish compliance with policies, procedures and Safe Systems of Work (SSOW)
- Cleaning budgets are prepared
- Cleaning related activity plans are maintained in accordance with latest standards and best practice including NHS 2007, Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI), and Entity-specific requirements
- Monitoring training, performance, and appraisals are completed

5.5 Cleaning Services Contract Manager

All cleaning tasks delegated by the Entity to a Cleaning Service Provider (CSP) shall fall under a Service Level Agreement (SLA) managed by the Cleaning Services Contract Manager.

They shall be responsible for ensuring that their organization conforms to the contracted requirements, service levels and Key Performance Indicators (KPIs). At a smaller facility, it is likely that the role of Contract Manager and Soft Services Manager is combined.

Responsibilities associated with this role include:

- Successful delivery of cleaning activities in line with contracted KPIs
- Delivering cleaning services to the satisfaction of the Entity's senior managers, clinicians, patients, staff, and visitors
- Ensure staff involved in delivering cleaning services have received the appropriate information, instruction, and training in order for them to undertake their work safely
- Record all training activity and ensure that any refresher training needed is undertaken at the specified frequency
- Identifying remedial works and areas of improvement
- Identifying staffing requirements and conducting interviews
- Leadership of Supervisors and defining objectives

Deliverables associated with the SLA may include, for example:

- An organization structure suitable to the needs of managing the delivery of cleaning in the Entity's facility
- RAMS and Job Hazard Analysis (JHA) covering all cleaning activities
- Task descriptions, work schedules, and Cleaning Plans
- Emergency Plans for cleaning activities

It is essential to hire professional cleaning contractors with extensive experience in the cleaning Industry, specifically in the healthcare sector who possess staff with adequate training and qualifications in the field.

5.6 Soft Services Manager

At a larger healthcare facility, it is likely that the role of Soft Services Manager will report to the Cleaning Services Contract Manager. This is because they will have a large complement of staff and combining this with the overall contract management may be too onerous. It is likely that they will have an overall responsibility for the Operation and Management (O&M) of the laundry.

Responsibilities associated with this role include:

- Review and management of Supervisor performance
- Preparation of data for inclusion in reports
- Ensure cleaning schedules are prepared and approved in-line with the resource requirement of the facility
- Operatives' work activity is monitored to ensure that tasks are completed in the anticipated time
- Operatives' compliance to safe working procedures and adherence to the specified activities is compliant with the procedure
- Work Orders (WO) and work activity is closed on the Computerized Maintenance Management System (CMMS) in a timely manner
- Review of open and overdue WO
- Interview and selection of operatives
- Training and induction of operatives

5.7 Facilities Management Health Safety and Environment Representative

The Health Safety and Environment (HSE) Representative at a healthcare facility shall ensure that:

- Compliance with the requirements of statutory legislation, facility and appointed contractor local policies and procedures is reviewed and assured
- Appropriate Risk Assessment Method Statements (RAMS) and JHA are in place for all work activities being undertaken by operatives
- Regular reviews are undertaken regarding staff safety performance including use of Point of Work Risk Assessment (POWRA)
- Staff and contractors are operating in a safe manner in accordance with specified operating procedures
- Regular reviews of work equipment are undertaken to ensure safe performance of all the items of equipment
- Personal Protective Equipment (PPE) is issued to all operatives and is in a serviceable and safe condition for use
- Regular Toolbox Talks are undertaken to reinforce the importance of working safely
- Incidents, accidents, near misses or unsafe conditions are reported, recorded, investigated and reports on risk mitigation and control measures are acted on
- The healthcare facility safety performance is monitored by undertaking regular scheduled and unscheduled safety audits, setting safety targets and thresholds, and reporting and feedback to drive continuous safety performance improvement

5.8 Laundry Manager

If the Entity's healthcare facility incorporates a laundry, then it is also likely that this will operate 24/7 and will require both management and supervisory staff throughout its operation.

Responsibilities associated with this role include:

- Review and management of Supervisor performance
- Preparation of data for inclusion in reports
- Operatives' work activity is monitored to ensure that tasks are completed in the anticipated time
- Ensure operatives' compliance to safe working procedures and adherence to the specified activities is compliant with the procedure
- Interview and selection of operatives
- Training and induction of operatives
- Regular reviews of work equipment undertaken to ensure the safe performance of all items of equipment

- Ensure laundry operating schedules are prepared and approved in-line with the resource requirement of the facility
- Ensure the quantity of stock laundry items represents sufficient quantity to meet the needs of the facility

5.9 Laundry Supervisor

The Laundry Supervisor is responsible for ensuring the effective operation of laundry staff and the efficient use of their resources:

Responsibilities associated with this role include:

- Ensure operatives' work activity is monitored to ensure that tasks are completed in the anticipated time
- Ensure operatives' compliance to Safe Working Procedures and adherence to the specified activities is compliant with the Procedure
- Report, review, and where necessary, investigate any deficiencies in safety performance
- The allocation of resources to emergency Reactive Work Requests is sufficient to ensure Stakeholder satisfaction
- Ensure resources are available to meet the needs of work schedules and to plan coverage in the event of planned or unscheduled absences
- Ensure all equipment, plant and machinery is operational and safe to use
- Monitoring the qualitative output of Laundry to ensure that all pieces are washed to an agreed standard
- Ensure removal of damaged/stained or aged pieces of laundry from the laundry stock
- Ensure the storage of laundry in a safe, clean and serviceable condition

5.10 Supervisors

The Cleaning Supervisor is accountable for the actions of cleaning staff and holds overall responsibility for the implementation of Cleaning Plans and Procedures.

Supervisors shall ensure that:

- Cleaning schedules are prepared and approved in-line with the resource requirement of the facility
- Operatives' work activity is monitored to ensure that tasks are completed in the anticipated time
- Operatives' compliance to safe working procedures and adherence to the specified activities is compliant with the procedure
- Any deficiencies in safety performance are reported, reviewed, and where, necessary investigated
- The allocation of resources to emergency reactive work requests is sufficient to ensure stakeholder satisfaction
- Resources are available to meet the needs of work schedules and to plan coverage in the event of planned or unscheduled absences
- Ensure all equipment, plant and machinery is operational and safe to use

5.11 Operatives

Operatives are responsible for delivering cleaning activity that meets the guidance in this document and that complies with British Institute of Cleaning Science (BICSc) standards.

Core responsibilities include, but are not limited to:

- Cooperation with all reasonable instructions in relation to their work activity
- Following precisely the steps in RAMS and JHA
- Wear the appropriate PPE at all times for each work activity
- Report completed work activity to the WMC to enable the rapid closure of both planned and reactive work tasks
- Vertical and horizontal cleaning of fixed and portable assets
- Cleaning spillages
- Replenishing of consumables

5.12 All Entity Employees

Entity staff (Clinical and non-Clinical) have a responsibility to keep their workplace safe, clean, and tidy.

Staff shall, as a minimum:

- Support the aims and objectives of the Entity's cleaning procedures by employing behavioral best practice. For example, helping maintain in-patient room cleanliness by placing debris in the waste bin rather than leaving it to the cleaning personnel
- Never exhibit unsafe behavior
- At all times report unsafe practices, hazards, and near-miss incidents through the Entity's reporting protocols

5.13 Patients and Visitors

Patients and Visitors shall ensure that:

- They communicate and cooperate with the Entity and its contractors to ensure that their feedback is represented to the Entity
- Their use of the healthcare facility is undertaken in such a way as not to cause detriment or harm to the facility

6.0 PROCESS

This section outlines operational best practice, methods of cleaning, managing work tasks and activities, H&S and training requirements that help to maintain infection prevention, control, and to enhance cleanliness standards within a healthcare facility.

6.1 Developing and Implementing an Objective Healthcare Cleaning Procedure

The underpinning principles to the development and operation of this procedure is to formulate all the documentation in accordance with an approved quality maintenance procedure.

It is recommended that the system is developed based on the principles of ISO 9001:2015. Using the standard provides the Entity with a framework that governs all of their activities, both patient-facing and internal. This ensures that their service either meets or exceeds customers' requirements consistently, and that service quality is continually improved.

In the context of a healthcare environment, the use of such a quality management system as ISO 9001:2015 allows for the seamless integration of other healthcare related standards such as ISO 13485:2016 – Medical Devices.

The foundation principle of ISO 9001:2015 is that it is activity planned, tested, verified and provides actions for improvement. It is very simple but highly effective, and its adoption as a principle of operating a cleaning Procedure is highly recommended.
Planning the implementation of a healthcare cleaning procedure should be undertaken in-line with the process outlined in Figure 1 below. This document outlines all of the activities that an Entity needs to put in place to implement this procedure. The process flow below segregates that into discrete action phases. This includes a governance element that ensures that the procedure has received Entity executive sign-off, alongside a review phase to ensure that the outcomes are as anticipated.

The following diagram identifies the steps an Entity should consider in developing and implementing this healthcare cleaning procedure.

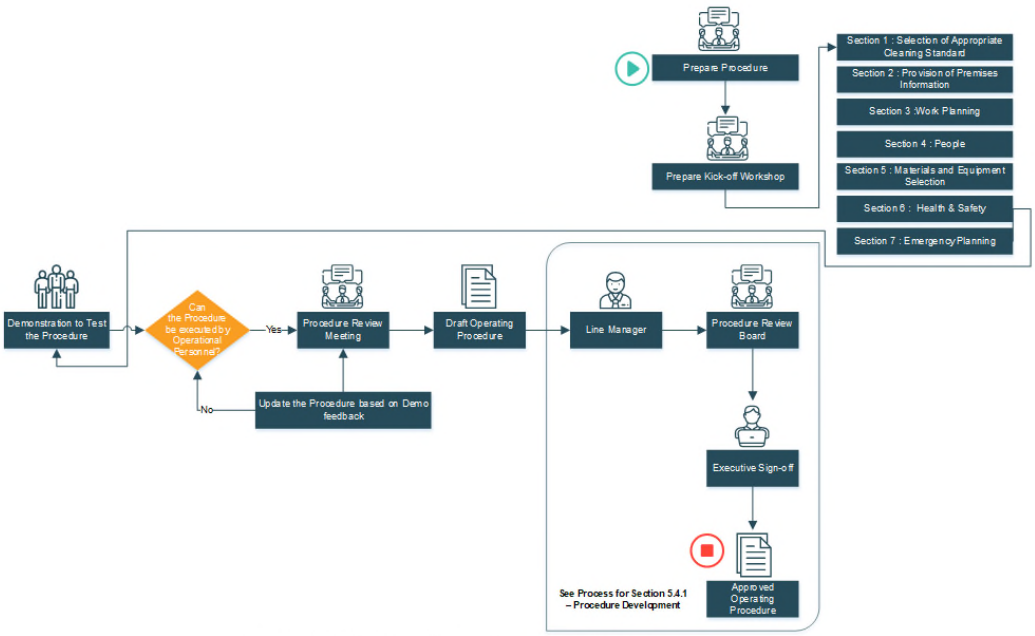

Figure 1: Effective Procedure Development

The process flow above provides the appropriate structure for developing and implementing a procedure. The subsequent sub-sections in **Section 6** of this document will provide the core elements that need to be considered in the development of this Procedure.

6.1.1 Key Considerations

Key considerations for an Entity for operational procedure development include, but are not limited to:

- **Using an Established Standard** (Refer Section 6.2)
- **Premises Information** (Refer Section 6.3)
  - Building plans
  - Premises information
  - Accurately coded locations and assets
- **Work Planning and Control (**Refer Section 6.4)
  - Work Management Centre (WMC)
  - AMS/Work planning tool
  - Coded locations and assets input and networked PDAs
  - Published work schedules
- **Resourcing and Training (**Refer Section 6.52)
  - Organization chart
  - Availability of trained and experienced cleaning personnel
  - Training materials
  - Induction
  - Communication tools
- **Materials and Equipment Selection (**Refer Section 6.6)
  - Choice of cleaning equipment (Refer Section 6.2.7)
  - Choice of cleaning chemicals (Refer Section 6.2.7)
  - Cleaning audit tools (Refer Section 6.2.7))
- **Health & Safety** *(Refer Section 6.7)*
  - RAMS
  - Control of Substances Hazardous to Health (COSHH) Assessments
  - PPE
  - Safety training
- **Emergency Planning** (Refer Section 6.8)

6.2 Using an Established Cleaning Standard and Cleaning Activities

This Cleaning Procedure strongly recommends that the Entity uses a formal internationally recognized standard to underpin their healthcare procedure and embedded cleaning standards. The standard selected is the *2007 National Specification for Cleanliness in the NHS* (an update for which is due to be issued during 2020)

The reason for selecting this standard is two-fold:

- It uses an objective audit mechanism that drives improving standards

- It is an approach rooted in risk management that has been successful in improving overall standards of cleanliness, delivering a demonstrable reduction in healthcare facility acquired infections since its introduction, and maintaining infection control in general at the highest level in the UK

It is important to understand that this provides a foundation for an Entity to apply whatever cleaning frequencies and methods they choose. The healthcare systems in KSA and UK are very different, for example, the publicly funded UK model is aimed at maximum infection elimination and control, but is less concerned with absolute aesthetics, whereas the ‘touch, smell and look tests’ that are applied in the KSA are not used in the UK.

However, the approach used has provided infection control results of the highest order. These infection control results are published and available for patients and visitors to see, and this increased transparency drives healthcare facilities to deliver continually improving results.

It is important to understand that the use of the word ‘Audit’ in these functional risk areas does not mean a visual inspection, which can and should be undertaken at whatever frequency the Entity determines, but

rather an objective audit, using calibrated measuring equipment that demonstrates levels of clinical cleanliness and enables the Entity to be certain about levels of infection in all risk areas.

6.2.1 Cleaning Activity Terminology

Furthermore, the standards and frequencies described below are the minimum that an Entity should seek to uphold, to maintain and enforce standards of clinical cleanliness and infection control. It is important to distinguish between different types of cleaning activity terminology, and to be accurate and consistent in their usage to ensure that cleaning standards are not adversely affected by misused terminology.

The following terms are used in this Procedure:

6.2.1.1 Discharge Clean

A Discharge Clean is undertaken when a non-infectious patient has been present in an area (e.g., Operating Theater (OT), cubicle, room).

6.2.1.2 Periodic Terminal Clean

A Periodic Terminal Clean is undertaken when an infectious patient has been present in an area (e.g., OT, cubicle, room).

6.2.1.3 Deep Clean

A Deep Clean is a general periodic frequency clean undertaken to any area (e.g., ward, patient room, Out Patient Department (OPD)) where equipment and furniture is removed to leave a clear area for a deep clean. Patients shall never be present when this activity is undertaken.

The frequency at which this activity is undertaken is based on the specific requirements of an Entity. A 'Deep Clean' should **not** be confused with the levels of diligent, and thorough cleaning, associated with general functional risk area cleaning, discharge or periodic terminal cleans.

6.2.1.4 Reactive Clean

The table below offers guidance on the service levels an Entity should consider for Reactive Cleaning at their healthcare facility. It shall be for the Entity to determine suitable response and completion times. The Entity should be wary of making response and completion times too onerous in all categories. This is because the outcome will be that the service provider takes on more labor hours than is actually required to service the facility in order to avoid the contingent risk of service failure penalties. Although this provides a pool of responsive labor, it is at a price of appropriate levels of labor utilization and productivity.

Priority Category	Response Time	Completion/Rectification	Example of work
Emergency	10 minutes	15 minutes to 30 Minutes	Spillages
			Burst water or sewage pipes
Urgent	20 Minutes	30 minutes to 01 Hour	Cleaning of broken glass
			Discharge of patient room
			Toilet blockage
Important	1 hour	24 Hours	Overfull waste bin
			Public area spillage
Routine	4 hours	48 Hours	General public area floor cleaning
			Cleaning lightly-stained carpet

Table 2: Exemplar Response Times

6.2.2 Cleanliness and Customer Perception

In KSA, because healthcare is largely either self-funded or insurance company-funded, the marketplace for healthcare delivery is significantly different from that of the UK. Patients can choose their healthcare provider based on a number of factors including location, reputation, facilities offered, age and condition of the facility, cleanliness appearance of the facility and many other disparate reasons.

However, by adding infection control performance, through the use of the activities prescribed in '2007 National Specification for Cleanliness' in the NHS, as a further KPI for a healthcare facility to demonstrate to its patients and visitors that will empower patients with a further essential measure of healthcare facility performance and drive improved patient safety and infection control standards.

6.2.3 Measuring Customer Perception

It is recommended that as part of their Cleaning Procedure an Entity selects a means of formally measuring customer feedback and perception to inform their decision making.

Many healthcare facilities in the KSA and across the GCC use the 'Press Ganey Patient Experience Tool' to identify patient and visitor feedback on their healthcare facility. Please refer to **Section 4** for website details. This survey focuses on all aspects of the patient journey, from clinician performance to Out Patient Department (OPD) Waiting Times and from ease of car parking to facility cleanliness including general circulation areas, departments, and in-patient areas.

There are over 60 questions with a percentile scoring mechanism and the facilities are ranked against their peers for an overall position in each category, as well as having individual scores per category for their performance.

This survey provides a useful snapshot to an Entity of the public perception of their facility, and where patients and visitors perceive improvements can be made. However, cleanliness is in the perception of a patient or visitor that is usually based on the 'touch, smell, and look tests', and can never incorporate infection control results.

By using the *2007 National Specification for Cleanliness in the NHS*, the Entity can use an objective demonstrable measure of clinical cleanliness, and overlay the results of this with the subjective customer perception provided by Press Ganey or similar.

6.2.4 Acceptable Cleaning Outcomes

Agreeing and verifying acceptable cleaning outcomes is an activity undertaken independently of the formal cleaning audit process and the two activities should not be conflated.

Achieving acceptable cleaning outcomes is a process of Entity and service provider's vsual inspections, at agreed frequencies, producing action plans for rectifying any service failures.

The table below gives guidance on the standards that an Entity should be expecting following a cleaning activity in terms of visual appearance only. The Entity shall agree to the service levels with service provider having achievement benchmarks that allow the service provider to succeed without receiving a 100% outcome score.

Cleaning Tasks	Acceptable Levels
Buffing or Burnishing	After buffing or burnishing, an area shall be free from dust and dirt. There shall be no muddying or rippling effect caused by over spraying. The floor shall present an overall appearance of cleanliness. Skirting boards and equipment should be free of residue
Damp Mopping	After wet mopping, an area should be clear of surface stains and without a streaked finish. Walls, skirting boards and other surfaces should be free of watermarks. Water should not have been allowed to collect under furniture legs and cabinets. Areas shall be left dry

Cleaning Tasks	Acceptable Levels
Dispensers	All dispensers shall be cleaned replenished with adequate and appropriate consumables
Dusting	After dusting, surfaces should be free from dust, finger marks and stains. Corners and crevices should be free from dust. Dusting should result in a clean surface
Dust Mopping	After dust mopping, an area should be free from dirt, waste materials or other matter. Attention should be paid to corners, areas under furnishings, behind doors, and other generally accessible areas
Glass Cleaning	After glass cleaning, the surface should be visibly free from streaks/smears or unwashed places on the glass surface and any associated frame. For glazed windows there should be no water residue following the cleaning
Polishing	After polishing, items should be clean and polished to a sheen finish, but, if a floor surface, not unsafe to walk on (slip free)
Replacing Hand Towels, Tissues & Toilet Tissue	Areas provided with Hand towels, tissues and toilet tissues shall be replenished as required
Rubbish	Internal waste bins should be allowed to become no more than 70% full before they are emptied
Sanitaryware Cleaning	Sanitaryware fixtures should be free of stains, soap build up, dust and mold including areas around floor and wall fixings
Scraping	Scraping a surface shall mean that a blade shall be used to remove all adherents to that surface without damaging the surface itself
Scrubbing	After scrubbing or stripping an area, there should be no wax or finish build up on the stripped floor surface following the operation. The furniture should be moved for complete floor coverage. Walls, skirting boards and other surfaces should be free of watermarks and the second party lashing
Shampooing	After shampooing, an item should be left damp but not wet and should look visibly clean and free from general dirt and stains insofar as is possible
Toilet Fixture Cleaning	After cleaning, toilet fixtures should be free from dust, hand marks, water streaks, mop marks and fittings shall be free from mold including areas around floor and wall fixings
Toilet Floors	Toilet floors shall be mopped at a frequency suitable for their use, with particular attention being given at or around prayer times. Where water has been used for prayer preparation the floor shall be mopped dry at each clean/inspection
Vacuuming	After vacuuming carpets, barrier mats and rugs should be visibly free from dust or dirt
Washing	After washing, an item or area may have had a cleaning solution applied and the residue created by that application should be removed. The item or area shall then be dried and left free from residual marks
Wiping	After wiping, surfaces should be free of finger marks, smudges and other defacing marks. Wiping should result in a visibly clean surface

Table 3: Acceptable Cleaning Outcomes

6.2.5 Functional Risk Area Cleaning and Auditing

Under the *2007 National Specification for Cleanliness in the NHS*, healthcare facilities are functionally divided into risk areas. These risk areas are defined by the activities that are undertaken in each location and this in turn defines the minimum cleaning frequencies that these areas should receive.

All functional areas should be assigned one of the following four risk categories:

- Very High
- High
- Significant
- Low

Risk categories are used to set service level standards and provide a context for measuring audit outcomes. Auditing of cleanliness standards should take place at the time of cleaning, or as close as possible to that time. This will ensure that the measurement is not contaminated by subsequent activity in the location.

Locations should also be subject to regular informal audit and review if audit outcomes have given rise to concerns for the general cleanliness of the location.

6.2.5.1 Very High Risk Functional Areas

Very High Risk functional areas may include, but are not limited to:

- OT
- Intensive Care Units (ICUs) and other critical care units
- Cardiac Care Units (CCU)
- Accident and Emergency (A&E) departments
- Burns units
- Delivery and labor rooms
- Departments where invasive procedures are performed or where immuno-compromised patients are receiving care
- Internal areas such as bathrooms, toilets, staff lounges, offices, and any other areas adjoining very high risk functional areas should be treated as having the same risk category

Consistently high standards of clinical cleanliness must be maintained, and these outcomes will only be achieved through intensive and frequent cleaning activity. Formal auditing of outcome standards should take place continuously on an ongoing basis. Additionally, all areas allocated a ‘Very High Risk’ rating should be audited weekly until the required standards are met, after which the frequency can be reduced to monthly.

6.2.5.2 High Risk Functional Areas

High Risk functional areas required regular and frequent cleaning with ‘spot cleaning’ in-between. Formal auditing of outcome standards should take place continuously on an ongoing basis. Additionally, all areas allocated a ‘high risk’ rating should be audited monthly until the required standards are met, after which the frequency can be reduced to twice a month.

High Risk Functional Areas may include but are not limited to:

- General Wards (e.g., acute, non-acute, mental Health)
- Sterile supplies
- Public thoroughfares and public toilets
- Internal areas such as bathrooms, toilets, staff lounges, offices and any other areas adjoining high risk functional areas should be treated as having the same risk category

6.2.5.3 Significant Risk Functional Areas

Service levels in these areas are important for reasons of both cleanliness and appearance. Outcomes should be achieved and maintained by regular and frequent cleaning with 'spot cleaning' in-between. Formal auditing of outcome standards should take place continuously on an ongoing basis, and all areas allocated a 'Significant Risk' rating should be audited at least once every three months until the required standards are met, after which the frequency can be reduced to twice a month.

Significant Risk functional areas may include, but are not limited to:

- Pathology
- OPDs
- Laboratories
- Mortuaries
- Internal areas such as bathrooms, toilets, staff lounges, offices and any other areas adjoining significant risk functional areas should be treated as having the same risk category

6.2.5.4 Low Risk Functional Areas

Service levels in these areas are important for reasons of cleanliness, appearance and to a lesser extent, hygiene. Outcomes should be achieved, maintained regularly, and frequent cleaned with 'spot cleaning' in-between. Formal auditing of outcome standards should take place continuously on an ongoing basis. Similarly, all areas allocated a 'Low Risk' rating should be audited at least once every six months until the required standards are met, after which the frequency can be reduced, if desired.

Low Risk functional areas may include, but are not limited to:

- Administrative areas
- Non-sterile supply areas
- Record storage and archives
- Internal areas such as bathrooms, toilets, staff lounges, offices, and any other areas adjoining significant risk functional areas should be treated as having the same risk category

The auditor should also take into account the physical condition of the infrastructure when making the assessment. For example, it may not be possible to obtain a uniform luster on a damaged floor surface. However, poorly maintained buildings are no excuse for low cleaning standards and auditors should not be overly generous with their discretion in most of these situations.

6.2.6 High-Touch and Low-Touch Surfaces

Cleaning activity in a healthcare facility is divided into 'high-touch' and 'low-touch' surfaces. The determination of the cleaning activity under *2007 National Specification for Cleanliness in the NHS* identifies the frequency with which the various surfaces should receive cleaning attention.

Surfaces that are subject to a high frequency of human contact are known as "high-touch", while those that experience comparatively less human contact are known as "low-touch". The frequency of cleaning and the use of disinfectants on surfaces depends on the frequency with which surfaces within the healthcare facility are subject to human contact.

6.2.6.1 High-Touch Surfaces

High-touch surfaces include, but are not limited to:

- Beds
- Mattress covers
- Bedside tables
- Bedrails
- Over-bed tables
- Visual display components on touch-screen electronic devices
- Control knobs of monitors and ventilators

- Infusion pumps
- Bed control buttons and nurse call buttons
- IV stands
- TV remote controls
- Trolley handles
- Door handles
- Light switches
- Computer keyboards
- Telephones
- Patient files
- Toys in pediatric wards
- Drawer and cupboard handles
- Sanitary fittings (e.g., toilet handles, toilet grab bars, sinks, basins, baths, taps)

High-touch surfaces carry a greater risk of transmitting microorganisms than low-touch surfaces. Therefore, surfaces such as those mentioned in the list above shall be cleaned more frequently than Low-touch surfaces. For example, minimum once per day at peak times, or immediately when such a surface becomes visibly soiled. Such surfaces should be wiped down with disinfectant after cleaning.

6.2.6.2 Low-Touch Surfaces

Low-touch surfaces include, but are not limited to:

- Floors
- Walls
- Ceilings
- Windows (e.g., ledges, glass panes, frames)
- Luminaires
- High shelves
- Furnishings

Low-touch surfaces experience minimal contact with infectious micro-organisms. Therefore, such surfaces feature low levels of pathogen contamination typically found within healthcare facilities. As a result, non-airborne infections have a lower risk of cross-infection from such surfaces.

Low-touch surfaces can be cleaned with detergent and water only on a daily basis. However, spot-cleaning must be performed immediately when one of these surfaces become visibly soiled.

6.2.7 Location-Specific Cleaning Recommendations

6.2.7.1 Operating Theatres (OT)

OT cleaning should be undertaken both in between patients and overnight. The cleaning staff shall work in collaboration with the nursing staff to clean the area and prepare it for the next patient. The OT shall have a dedicated cleaning team with dedicated carts, cleaning tools, vacuums, and floor machines such as high- speed scrubbers and buffing machines.

The OT Cleaning Procedure shall include the following components:

Overnight Cleaning

- Using a lint-free cloth moistened with disinfectant, wipe down overhead luminaires and diffusers, the operating table, and medical equipment in the specific OT
- Use floor cleaning machines to maintain the cleanliness and standards of the floor surface as required
- Vacuum and mop the floors with a disinfectant solution
- The use of 'I am Clean' stickers and labels are recommended to demonstrate that items have been left in a clean state prior to work starting the following morning

Cleaning between Patients

- Soiled linen is appropriately bagged and stored in the Dirty Utility Area for collection
- Hazardous and general waste is appropriately bagged and removed to the dirty utility area for collection

6.2.7.2 Delivery Rooms

All labor and delivery rooms shall feature 'Labor Room Kits' for managing body fluid and blood spills. Kits should be replenished as required and inventory maintained by the Facilities Manager.

Chlorine solution should be prepared at least three (3) times in a day to control cross-contamination of the cleaning equipment after each use.

The following shall be processed in-line with the guidance outlined within NMA&FM – Waste Management Procedure for Healthcare – EOM-ZO0-PR-000077:

- Hazardous medical waste (e.g. disposable pads soaked with urine, fecal matter, blood)
- Body parts and human remains
- Deceased persons

All waste shall be removed between procedures or at a minimum of every 3 hours, during cleaning activities, or at the request of medical staff.

The Cleaning procedure for labor and delivery rooms shall, as a minimum, follow the procedures for very high risk functional area cleaning:

- Daily routine cleaning and disinfection
- Cleaning between delivery cases
- Thorough clean after the last case of the day using disinfectant and microfiber cloths
- Periodic cleaning in compliance with 'as a minimum', follow the procedures for Very High Risk functional area cleaning

6.2.7.3 Emergency Room/Accident & Emergency (A&E)

The Cleaning Procedure for the emergency room/A&E shall, as a minimum, follow the procedures for Very High Risk functional area cleaning:

- Daily routine cleaning and disinfection
- Cleaning of cubicles/consultation rooms/bays in between patients – with the types of clean selected based on whether the patient is or is not infectious
- Thorough clean after the last case of the day using disinfectant and microfiber cloths
- Periodic cleaning in compliance with 'as a minimum', follow the procedures for very high risk functional area cleaning

The Emergency Room Cleaning Procedure shall include the following components:

- Wipe down cleaning trolleys and disinfect high-touch surfaces with the alcohol-free wipes between each patient
- Carry out daily dusting with microfiber
- Carry out wet and dry microfiber mopping
- Treatment room turnover cleaning shall be done using alcohol-free wipes, with the exception of high-touch medical equipment such as cardiac leads, which shall be cleaned with anti-microbial wipes
- For clean surfaces, disinfect surface using a second wet-wipe and allow to dry for three minutes
- Change curtains in between patients. If curtains are washable rather than disposable, then they should be placed among the dirty laundry in the Dirty Utility Area and replaced with the clean ones
- Thoroughly clean walls, ceilings, fixtures, windows, floors and upholstery weekly or as needed/requested by clinicians

6.2.7.4 Patient Transport – Ambulance and Medical Aircraft

The cleaning procedure for the emergency room/A&E shall, as a minimum, follow the procedures for Very High Risk functional area cleaning:
The Patient Transport Cleaning Procedure shall include the following components:

- The vehicle shall have the ignition switched off and be parked with the on handbrake prior to cleaning commencement
- Non-fixed medical equipment shall be removed and cleaned
- High-touch medical equipment such as cardiac leads, which shall be cleaned with anti-microbial wipes
- All fixed equipment and surfaces shall be dusted cleaned and disinfected with a damp microfiber cloth. Cleaning staff shall ensure that no water enters the equipment and causes damage during the cleaning process
- Curtains (if used) shall be removed and laundered (if non-disposable) in line with the procedure for curtains outlined above. Washable curtains should be placed in the appropriate laundry bag and either taken to the nearest Dirty Utility Room for storage and collection or directly to the laundry
- Body fluid spills shall be cleaned using tissue paper or paper towels, to blot the area. Further absorbent paper towels should be placed over the spill, and the area cleaned with anti-microbial wipes, followed by a chlorine-based detergent, after which it should be allowed to dry
- The floor of the vehicle should be dry mopped followed by a clean damp mopping with a microfiber mop
- Thoroughly clean walls, ceilings, fixtures, windows, floors and upholstery weekly or as needed/requested by clinicians and replenish consumables e.g., hand sanitizer, wipes.

The Entity should determine the cleaning frequencies based on the specific requirements of their facility. Taking into account the standards expected by their patients and visitors, the general expectations of visual cleanliness of healthcare facilities in the KSA, the age of the premises and any other factor that may contribute to their Entity-specific requirements for cleanliness and appearance.

6.2.8 Audit

An Audit is the key means of demonstrating objective clinical as opposed to visual cleanliness. However, clean a facility may look from a visual inspection, there is no substitute for an auditable verification of the lack of infection. It should be the aim of Entity's Cleaning Procedure to be able to demonstrate cleanliness through both visual inspection and objective auditing. This will provide the most visually appealing and clinically clean environment for their patients and visitors.

This Procedure makes no recommendation as to the specific tools that should be used to create an audit function for the Entity. However whichever product is elected, it should be calibrated to incorporate the requirements of *2007 National Specification for Cleanliness in the NHS.*

The examples presented below are of different products that all meet the requirements of managing audit activity and all will have varied components that should include the following:

- Cleaning Audit score sheets
- Management information including SLA trends
- Audit reports
- Actions reports
- Dashboard illustrating key data e.g. failure reasons, and element failure trends
- Export data to PDF, Excel, Word, CSV, and Email formats
- Meet reporting objectives/proof of best practice
- Cloud-based recording and back up of data

The key essential is to ensure that the system selected, and the process followed, is executed on a continuing basis. It also provides demonstrable evidence of compliance to the *2007 National Specification for Cleanliness in the NHS.* This will allow reporting to be undertaken at the frequencies required to enable report production that demonstrate improvement over time.

It is important to recognize that clinical cleanliness cannot be expected either immediately or every time a swab takes place, because circumstances can change in an instant. The admission of an infected patient, the transmission of an infection from a visitor to a patient or a healthcare professional can change the environmental circumstances.

The continued use of this process will (if outcomes from audits are enacted into cleaning activity)deliver a continuous improvement to the reduction of infection in healthcare facilities.

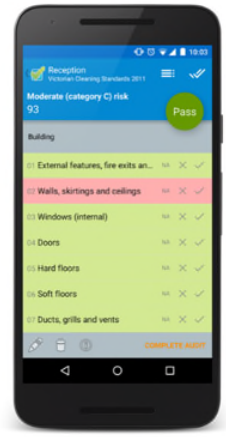

Figure 2: Example Audit Tool – *courtesy of TopCat*

Figure 3: Example Adenosine Triphosphate (ATP) Swabbing Tool *– courtesy of About Cleaning*

6.2.9 Infection Prevention & Control

Control and prevention of infection, contamination, and cross-contamination is the primary aim of implementing and managing cleaning procedures in a healthcare facility.

Each healthcare facility in KSA shall have an established and effective Infection Prevention & Control Program. It shall be designed by specialists and optimized for the specific facility to which it is applied. All staff (medical and non-medical) shall be trained and be competent in Infection Prevention Procedures.

Key components of the Infection Prevention & Control Program include:

- RAMS that enable mitigating measures (e.g. prevention, detection, treatment) for infection control and Hospital Acquired Infection (HAI)
- Compliance with relevant standards associated with cleaning and hygiene for healthcare facilities and cleaning equipment
- Continuous review of Cleaning Procedures against the latest standards and best practice
- Ensuring the establishment and compliance with hand hygiene procedure in line with Infection Prevention and Control Guidelines
- Appropriate use of PPE e.g., gloves, gown, apron, mask, eye protection, in-line with the outcome of a task specific risk assessment
- Appropriate handling and disposal of sharps, waste, and linen
- Ensure the effective establishment and implementation of priority zoning, based on risk assessment
- Risk based Isolation Cleaning Procedures

6.2.10 Isolation Cleaning Procedures

Infectious micro-organisms are transmitted from various sources and via several mediums. Such mediums include, but are not limited to:

- Airborne
- Contact
- Droplet

This section describes basic precautions that shall be taken by cleaning staff to prevent the transmission of infectious micro-organisms through the media. Some precautions undertaken by all cleaning staff are applicable regardless of the medium within which the infectious micro-organism is being transmitted. For example, although cleaning is scheduled around planned medical activities such as daily rounds and staff shift handovers, cleaning staff must check with medical staff before entering an area.

6.2.10.1 Airborne

Airborne transmission occurs by dissemination into the air of tiny droplet nuclei or dust particles containing the infectious agent, over a distance greater than one meter. Examples of infectious agents include measles, chickenpox, and tuberculosis.

Before entering an area where airborne infectious agents are known to have been present, cleaning staff shall check signage that indicates the presence of infection and the demarcation of an infected area. In such cases, cleaning teams shall wait 1 hour after patient discharges (or moves), before entering a room. Each cleaner shall wear a Powered Air-Purifying Respirator (PAPR) – N95. In such infected areas, routine cleaning with a neutral detergent shall be undertaken in-line with Infection Prevention & Control Procedures.

6.2.10.2 Contact

Contact transmission occurs when infectious micro-organisms are transferred from person-to-person or surface-to-person, for example, when a person comes into contact with medical instruments or infected bed linen. Examples of infectious agents include Methicillin-Resistant Staphylococcus Aureus (MRSA), bedbugs, lice, and scabies.

Prior to entry into the area by cleaning staff, medical staff shall ensure that medical equipment that have been in an area where contact infectious agents are known to have been present, is disinfected in-line with infection prevention & control procedures. Where possible, medical equipment shall be completely removed, if the patient has been discharged or moved from the area.

Before entering an area where contact-infectious agents are known to have been present. Cleaning staff shall check signage that indicates the presence of infection and indicates the demarcation of an area. In such a situation a virucidal disinfectant cleaning product shall be employed for floor cleaning.

6.2.10.3 Droplet

This form of transmission occurs when droplets containing infectious micro-organisms come into contact with the eyes, nose, or mouth of a susceptible person. The source of droplet infectious agents typically includes sneezing or coughing. Examples of infections agents include common cold, influenza, and some forms of respiratory illness.

Before entering an area where droplet infectious agents are known to have been present. Cleaning staff shall check signage that indicates the presence of infection and indicates the demarcation of an area. In such areas, routine cleaning with a neutral detergent or water shall be undertaken in line with Infection Prevention & Control Procedures.

6.2.11 Spill Management

This section offers guidance to the Entity on addressing spills that commonly occur within healthcare facilities. Each spill must be cleaned immediately, and each type of spill must be managed based upon the risk that it presents to people and assets.

6.2.11.1 Bio-Hazardous Spills

Bio-hazardous spills (i.e. spills containing body fluids), are potentially infectious. Given that some infectious microorganisms can survive in the environment for an extended period, spillages that are hours or even days old shall be approached with the same precautionary measures as those that are fresh.

There are three distinct steps in the approach to addressing bio-hazardous spills:

- **Contain the Spill**: Isolate the spill and evacuate the area to an extent that is required in order to protect people. The Cleaning Supervisor shall demarcate the area and erect safety warning sign boards

- **Clear Up the Spill**: Cleaning must precede disinfection. Absorb excess fluid with paper towels, or other absorbent material. As applicable, apply chemicals that solidify the moisture. Once most of the moisture has been absorbed, deposit solids into Bio-hazardous waste bags, and wash the area thoroughly with detergent and water to remove the visible soil and organic material
- **Disinfect the Contaminated Area**: Use appropriate disinfectant in the appropriate dilution ratio as per manufacturer's Instructions (for example: a water dilution of 1:10 sodium hypochlorite). The area is deemed safe when the disinfectant solution has completely dried

A chlorine-releasing agent should be applied as a disinfectant on all spillages. Except for urine and vomit, it is recommended to use cellulose paper towels.

Medical staff shall be responsible for removal of body parts from the spill area. Whilst cleaning staff shall be responsible for the removal of body fluids, cleaning, and disinfecting surfaces that have been affected by the body fluids.

Adequate training and appropriate PPE is essential in successful execution of Cleaning Procedures, specifically for bio-hazardous spills.

To enable effective cleaning of surfaces, all finishing such as those applicable to walls, floors, and furnishings shall be:

- Smooth
- Non-porous
- Durable (able to withstand frequent cleaning procedures including cleaning with chlorine-based agents)
- Continuous (i.e. without acute corners or edges)
- Use of carpets should be avoided in all areas of the healthcare facility designed for patient use

6.2.11.2 Acid Spills

Acid spills should be effectively neutralized by sodium bi-carbonate, sodium carbonate, or calcium carbonate.

The cleaner shall first encompass the spill (e.g. by use of cleaning equipment or consumables), then evenly sprinkle powder such as (Na_2CO_3) Sodium Carbonate over the spill, starting from the outside and working in towards the nucleus of spill. Acid is neutralized if effervescence ceases in the presence of excess bicarbonate.

The risk of inhaling fine power and dissolved gas shall be suitably mitigated through distance, and if applicable, through the use of appropriate PPE.

6.2.11.3 Alkali Spills

Alkali spills shall be effectively neutralized by sodium bi-sulfite, boric acid or oxalic acid, and sodium carbonate.

The cleaner shall first encompass the spills (e.g. by use of cleaning equipment or consumables), then evenly sprinkle powder such as (Na_2CO_3) Sodium Carbonate over the spill, starting from the outside and working in toward the nucleus of the spill. Acid is neutralized if effervescence ceases in the presence of excess bicarbonate.

Alkalis are hazardous for humans and carry a high risk of causing burns to skin and eyes. Cleaners shall approach alkali spills with extreme caution based entirely on adequate training, extensive experience in cleaning alkali spills, and appropriate PPE. The JHA associated with alkali spills shall include mitigating measures such as adequate ventilation and elimination of all sources of ignition.

6.2.11.4 Mercury Spills

Mercury spills typically occur as a result of damage to instrumentation equipment. In the event of a mercury spillage, all patients, staff, and visitors shall be evacuated from the affected area. The area shall be isolated by means of barriers to prevent accidental ingress, HVAC systems shall be turned off, and windows(if possible) and external doors/windows shall be opened to promote airflow.

- A vacuum cleaner shall never be used to clean up mercury, because the vacuum will put mercury into the air and increase the risk of exposure
- A broom shall never be used to clean up mercury, because it will break the mercury into smaller droplets, spread them, and increase the risk of exposure
- Mercury shall never be disposed of by pouring it into a sink or drain, because it may lodge in the plumbing system or cause pollution if discharged
- Clothing and footwear that may be contaminated with mercury, shall be disposed of in a sealed plastic bag

The equipment required to contain and clean up a mercury spillage is:

- Eyedropper or teat pipette
- Zip locking plastic bags
- Bags for final disposal
- Rubber, nitrile, or latex gloves
- Paper towels
- Cardboard
- Duct tape

- Task light
- Powdered sulfur to bind the mercury droplets

Mercury Spill Clean Up Instructions

- Put on gloves
- Collect pieces of glass or sharp objects and place these on a dampened paper towel
- Fold the paper towel and place in a zip locking bag
- Secure the bag for subsequent disposal
- Locate visible mercury beads. Gently and carefully use the cardboard to gather mercury beads into small manageable balls of mercury
- Mercury moves erratically, so use gentle 'sweeping' motions to keep mercury from becoming uncontrollable
- Use the flashlight by holding it close to the floor level and with the lights off identify additional mercury that may have been missed
- The whole room/area should be carefully examined because mercury can spread easily and widely on a flat surface
- The eyedropper or teat pipette should be used to collect the mercury beads
- Once collected, the beads should be ejected on to a dampened paper towel and the paper towel should be placed in a zip lock bag for subsequent disposal
- Duct tape should be used to collect smaller glass fragments and tiny mercury particles. All should be placed in a zip lock bag for subsequent disposal
- Powdered sulfur can also be used to collect mercury because it binds the mercury together. If used, it is essential that the COSHH data, SDS, and associated RAMS are followed by the operative
- Keep the area well-ventilated for at least 24 hours and monitor the area for the presence of mercury vapors
- Children or vulnerable individuals should be prevented from re-entering the area for a minimum of 24 hours
- Dispose of the waste products following the NMA&FM – Waste Management Procedure for Healthcare - EOM-ZO0-PR-000077, or as the Entity's own waste management procedure dictates

6.2.12 Laundry and Linen Management

The management of linen and laundry has a dual purpose:

- To keep clean linen infection free
- To prevent cross-contamination or the spread of pathogens from dirty linen

It is mandatory that the Procedure for Linen Management maintains an absolute separation between clean and dirty linen. Dirty linen can take the following forms:

- **Used Linen:** Not visibly dirty. The patient who came into contact with the linen was not known to carry an infectious illness
- **Contaminated Linen:** Visibly contaminated with blood, body fluids, secretions, or excretions
- **Infectious Linen:** Used for a patient carrying a communicable illness. In such cases, contamination may not be visible, but the risk profile is high and should be treated with caution

- **Infested Linen:** Used by a patient known to have parasites, such as: lice, fleas, bedbugs, or scabies.

Please refer to Figure 4 below, showing a complete cycle of Linen and Laundry Management in a healthcare facility.

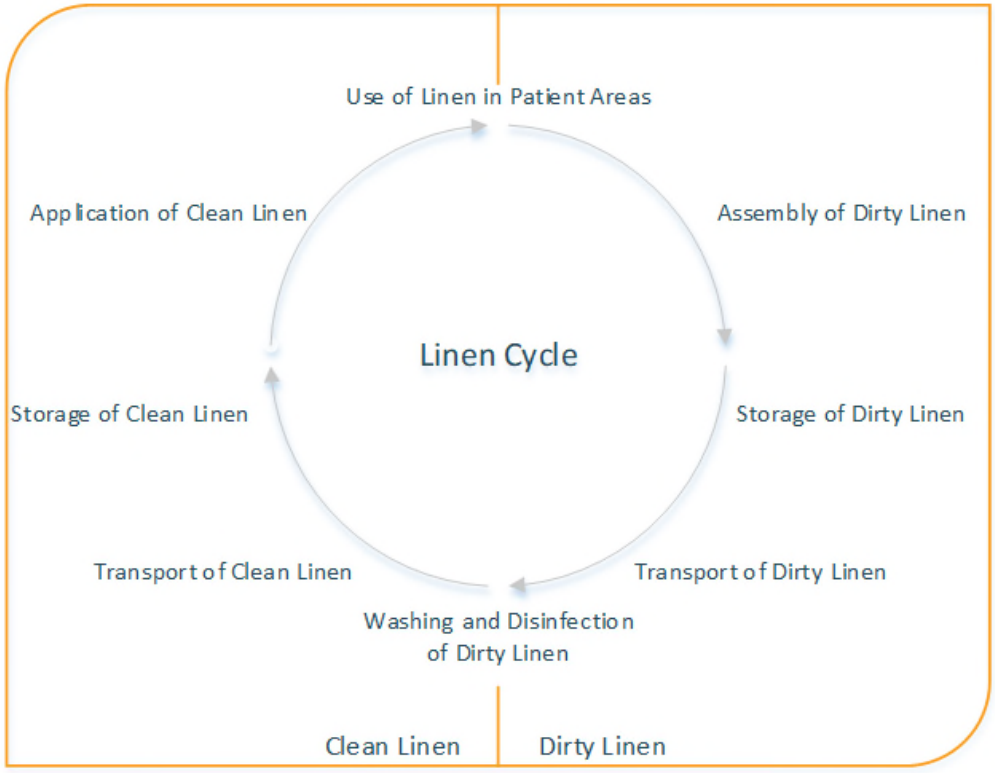

Figure 4: Linen and Laundry Management Cycle

6.2.12.1 Transportation, Use and Storage of Clean and Unused Linen in Patient Areas

Clean linen shall be transported from the laundry to departments, wards, and patient areas in a clean and closed Clean Linen Cart or in sealed Linen Bags.

Clean Linen Carts containing clean linen should deliver to the designated area at a frequency determined by the use of linen in that area. It also should not remain after the delivery has been made, to preclude the risk of cross-contamination.

- Clean (unused) linen shall be stored above floor level, in a designated location
- Clean (unused) linen shall be stored in plastic bags to avoid contamination or cross-infection risks and to protect the linen pieces
- The location should either have a door, preferably lockable to ensure security and cross-contamination risks are avoided. If no linen cupboard is available, the linen should be stored in a designated ‘Clean Linen’ trolley, covered to avoid contamination or cross-infection risks
- Clean linen shall never be stored in a bathroom, toilet, or sluice area
- Any clean linen taken into an isolation area must be treated as contaminated regardless of whether it is used and follow the process below in Figure 5
- Damaged clean linen should be removed from service, segregated from other pieces and brought to the attention of the Laundry Manager for disposal
- Linen storage areas should be cleaned in line with the periodic frequency identified by the risk category of the location
- Linen storage facilities shall not be used for storage of other items

6.2.12.2 Assembly, Storage and Transportation of Dirty Linen

The assembly, storage, and transportation of soiled linen should follow the process below. All linen, whether contaminated or not, shall be placed in an impermeable bag sealed with a tie tag, and have a label attached confirming the status of the contents.

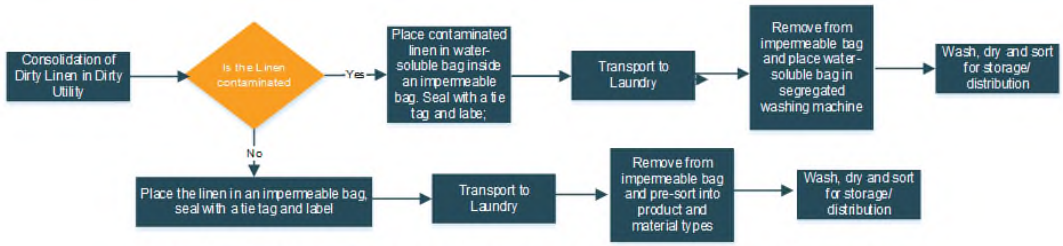

Figure 5 - Assembly, Storage, Transportation and Washing of Soiled Linen

Dirty linen should be consolidated in a separate Dirty Utility Area, in covered trolleys that are only used for the transportation of dirty linen. The trolleys should be removed as required, based on the amount of dirty linen generated, either by laundry workers or porters. The trolley should never be allowed to become over full. The trolleys shall be fully decontaminated on a frequency determined by the facility's Infection Control Director.

The picture below in Figure 6 shows a water-soluble contaminated linen bag. All contaminated linen must be placed into such a bag prior to being placed inside another impermeable bag and only then shall it be placed in the dirty laundry trolley.

Figure 6: Water-soluble Contaminated Linen Bag – *Source CLH Healthcare*

Best practice is that staff uniforms should be washed daily to minimize the risk of cross-contamination. Damage or permanent staining to staff uniforms should be avoided and the article replaced.

6.2.12.3 Sorting Linen

Figure 5 above identifies the end-to-end process of consolidation, transportation and washing of all linen. The healthcare facility laundry shall have an area for sorting soiled linen.

A laundry shall be designed to ensure a flow from dirty to clean. Dirty linen shall never be in the Clean Linen Area.

Operatives working within the Laundry Sorting Area shall be provided with appropriate PPE, comprising:

- Disposable apron
- Disposable gloves
- Disposable face mask
- Hair protection

- Disposable shoe covers
- Optionally eye protection can also be provided

Every time an operative leaves the Sorting Area, the PPE shall be disposed of in accordance with the Entity's Waste Management Policy. No operative shall enter the Laundry Sorting Area without wearing PPE.

The sorting process shall consist of the removal of linen from the impermeable bag, identification, and segregation of soiled linen into types. For example, bed linen (sheets, pillowcases, comforters), towels, blankets, patient gowns, clinicians' scrubs, uniforms, dressing gowns, and similar products are to be washed collectively.

Contaminated linen shall have been placed in a water-soluble bag and then placed inside a separate impermeable bag. **Under no circumstances** shall the contaminated linen be removed from the water-soluble bag. The bag and its contents shall be placed in a permanently segregated discrete washing machine to ensure the risk of cross-contamination is minimized. The provision of PPE to protect laundry sorting operatives is not, **under any circumstances**, considered to be a suitable and sufficient protection from the hazards of exposure by individuals to contaminated linen.

6.2.12.4 Washing Linen

Decontamination of laundry is achieved through washing with water and use of laundry detergent. However, further decontamination is achieved by the temperature of the wash water, laundry additives, as well as the drying and ironing/steaming process.

The wash cycle temperature and duration applicable to typical loads of dirty linen shall be at least 71°C for a minimum of twenty-five (25) minutes. These parameters shall be used to guide the Entity, in conjunction with the manufacturer's instructions for the washing machine.

6.2.12.5 Washing Staff Uniforms

- Clinical uniforms shall be changed daily and, if the facility provides the service, should be sent to the laundry
- If a uniform is contaminated with blood or body fluids, it must be changed for a clean one immediately
- The contaminated item shall be placed in a soluble bag and sent to the laundry
- If washed at an employee's home in a domestic washing machine, they shall be washed separately from all other items and shall be washed either at 71° C (for not less than three (3) minutes) or 65°C (for not less than ten (10) minutes)

6.2.12.6 Washing Microfiber Cleaning Materials

A separate washing machine should be made available for the laundering of microfiber mopheads, cloths, and the like. Used microfiber should be placed in a tagged and tied 'contaminated' soluble bag, consolidated in the Dirty Utility Area and transported to the laundry.

All microfiber items shall be washed daily, and the Entity shall ensure there are sufficient pieces in circulation to allow for spare capacity, especially in the circumstances of laundry unavailability.

6.3 Provision of Premises Information

Accurate premises information is key to the successful implementation and ongoing management of a cleaning procedure.

The Entity should have detailed plans, either electronically or in hard copy of the healthcare facility. Changes to a healthcare facility are frequent and these detailed plans should be updated as every reconfiguration or change occurs and be reflective of the current 'as is' position.

Building plans such as these should be a prerequisite for a successful handover to the O&M phase after construction of a new facility, but they are even more important for an existing facility. In many cases

accurate 'as built' drawings are either incomplete or missing altogether. Worse, the key information is only available from the memory of long-serving members of staff.

In order to implement ***2007 National Specification for Cleanliness in the NHS*** successfully, the Entity will need to have clearly-defined locations on building plans defining:

- Very High Risk locations
- High Risk Locations
- Significant Risk locations
- Low Risk Locations

Each location/room should also be provided with a unique bar code or RFID tag to identify it. This is important for two reasons:

- When issuing Reactive Cleaning instructions, especially for a spillage that is in urgent need of rectification. The precise location can be accurately recorded through the WMC (see Section 6.4)

- The location can have details of planned cleaning activity, scheduled deep cleaning activity as well as reactive responses to cleaning requests recorded through the WMC. This is vital for generating audit activity and recording outcomes. It can also identify if there are issues associated with specific locations. For example, repeat audit failures, manpower shortages at busy times, and frequency of recorded reactive cleaning requests.

Cleaning Supervisors should be provided with hand-held equipment that enables them to see all planned and reactive work requests in their area of responsibility and its completion status to enable them to monitor operative utilization.

- Is the work being completed in the anticipated time?
- Is the standard of cleaning acceptable to a visual inspection and clinical cleanliness?
- Is the area demonstrably clean using ATP swabbing?

6.4 Work Planning and Control

This section is based on NMA&FM Volume 7 Chapter 2 – Requesting, Prioritizing, Planning and Scheduling Work Procedure -EOM-ZW0-PR-000001. For more detailed information about work management, the Entity should consult this document.

Work Control is an office-based activity that includes planning and scheduling of work, directing the workforce to successfully complete all work, and managing immediate, short, medium and long term inquiries.

Work Control involves:

- Receiving inquiries and instructions
- Clarifying and confirming requirements
- Assessing contractual obligations of work
- Assigning priorities to work
- Estimating available and required resources
- Arranging permissions and resources
- Instructing work to commence and managing until complete
- Continually adjusting work following new inquiries and instructions

Work control can either be centrally controlled or delegated to supervisors and operatives. Best practice should be that the work control decision making is centrally controlled by a work control team and not delegated directly to operatives.

6.4.1 Work Planning

Work planning involves understanding of the requirements, arranging for all the resources, and permissions to be identified and provisionally arranged so that the work can be scheduled once authorization has been granted.

Work planning is a combination of technical, logistical, and administrative activities that ensure everything is in place for the work to be started, progressed, and completed according to plan. Work scheduling is the activity of identifying the best time period in which to carry out the planned work.

Adoption of electronic technology extending to Personal Digital Assistants (PDAs) for service delivery can streamline the assignment of emergency or urgent work. The Help Desk Operator can electronically assign tasks to the Supervisor, who in turn can 'accept' the instructions via the PDA and allocate the work to an operative.

This transfer of information and process of acquiring approval from the relevant stakeholders is best managed through a workflow function within a CMMS, because timing and communications can easily be tracked through the life of the WO.

6.4.2 Requesting Work

The advice presented here on requesting work resides within the context of several related documents within NMA&FM Volume 7.

The request initiation should be directed and monitored at an authorized and recognized center within the organization such as a Help Desk within a WMC. Requests made via informal routes should not be received or processed.

Requesting work comes from a variety of sources, including the Entity client, occupants, users, H&S audits, external audits and remedies arising from inspections and audit.

It is necessary to have the appropriate communication methods available for each level of expected urgency. From building custodians and duty managers, and from healthcare facility staff to senior leaders, this requires awareness training for those likely to make these types of requests (e.g., work requests that are considered emergencies are best reported by telephone).

6.4.3 Prioritizing Work

Prioritizing work refers to the activity of deciding whether the work is an emergency, urgent, or routine in nature, and responding to and processing the request to the next valid step. Emergency and urgent work is usually categorized as 'unplanned work' because it disrupts or displaces work that is planned, and already in progress.

Urgent work may not necessarily be motivated by risk of injury to personnel or damage to the facility but be made urgent by other factors such as the seniority of the requestor or risk to reputation that the work or fault presents. The contractor needs to balance the pressure put on them while reacting to such work requests because this can displace work that is more urgent.

6.4.3.1 Factors Affecting Work Prioritization

Prioritizing work is influenced by several factors including, but not limited to:

- Safety
- Regulations
- Customer deadline
- Environmental impact
- Performance improvements
- Customer/user experience, reputation, public image
- Contractual targets

Priorities are usually defined in the contract, both in terms of categories and timescale. The most commonly used categories are ‘Emergency’, ‘Urgent’ and ‘Routine’. These categories also need to have a timescale for response or resolution.

6.4.3.2 Emergency and Urgent Work (i.e., ‘Unplanned/Disruptive Work’)

Unplanned work is usually the work for which processing via planning and scheduling process should be prioritized (cannot or should not be delayed or postponed). The unplanned/disruptive work process defines the sequence of events that takes place to ensure that the correct and complete response is implemented when a potential emergency or urgent situation is identified.

This will confirm the urgency of the work, resolve any immediate emergencies, and ensure that work is responded to in the most appropriate manner.

A high-level summary of the prioritization route that urgent/emergency work follows is illustrated in Figure 7 below:

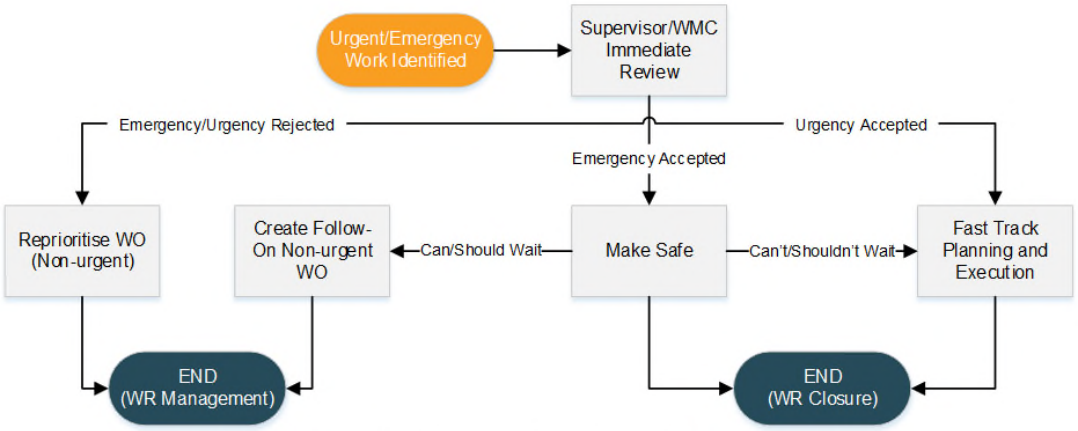

Figure 7: Prioritizing Urgent/Emergency Work Process Flow

Also note that some emergency or urgent work requests need to be responded Out of Hours (OOH). This may require OOH escalation and contact with decision-makers,

6.4.4 Work Scheduling

Work scheduling is only performed on approved Work Requests (i.e. WO). Work scheduling is influenced by several factors, including:

- Information gathering
- Availability of resources including skilled resources
- Contractual targets

6.5 Resourcing and Training

The CSP must have an organizational structure with sufficient staff, clearly defined roles responsibilities, and competencies to oversee, monitor, and deliver the cleaning at the facility.

The CSP will be responsible for the provision of an adequate number of resources to undertake the totality of cleaning required at the Entity’s facility. This should take into account seasonal variations for irregular tasks that will inevitably run concurrently with other, more regular, routine tasks. The Entity should satisfy themselves that the contractor has sufficient resources throughout the year.

The CSP should provide the Entity with information that demonstrates effective resource management and operative utilization. It has been historically the case in KSA that contracts frequently operated on a provision of labor, with no risk to the contractor about the effectiveness and the management of that labor.

Increasingly Entity's should be expecting the contractor to review the extent of the tasks and plan manpower accordingly.

6.5.1 Training

The CSP will be responsible for the provision of trained and competent staff, equipped with appropriate equipment, to deliver the cleaning service for the Entity.

The Entity should ensure that they regularly review and sample the training records of the contractor's staff to ensure that all staff employed are suitably trained to carry out their work activity.

Training will include, but not be limited to the following:

- Induction training
- Task-based training for general cleaning activities e.g., mopping, sweeping, window cleaning
- Training on the requirements of *The National Specifications for Cleanliness in the NHS (2007)*
- Cooperation between the Cleaning Service Provider and departments, for department-specific training, e.g. OTs, emergency departments, labor and delivery rooms
- Food safety (where required)
- Training for powered cleaning equipment
- Safe use of chemicals
- Manual handling
- Working at height

The Cleaning Service Provider must give suitable and sufficient training to ensure their staff are competent to deliver the services for which they are employed.

In delivering the cleaning service, the Cleaning Service Provider shall:

- Ensure operatives and all other staff are trained and skilled to carry out their work
- Have a continuous development and learning plan
- Train Supervisors and management to competent levels
- Carry out 'Toolbox Talks'
- Record training and attendance

Service-specific training will include the following:

- Health and Safety
- Cleaning process and delivery methodology
- Chemical dilution protocol
- Control of infection
- Facility user privacy
- Waste management, including recycling
- Spillages
- Helpdesk and Reception, where applicable
- Emergency procedures;
- Reactive request management
- Equipment and tools management

6.5.2 Healthcare User Education

Healthcare users are provided with basic information to guide them on the cleaning service and the activities that are undertaken.

For visitors to the healthcare facility, information is usually provided via displays and information packs. This will provide the necessary and relevant information to educate visitors on common cleaning activity that may be encountered at the facility.

Additionally, the Cleaning Service Supervisors and Managers should liaise with healthcare staff and identify their satisfaction with the service received. This is to enable the development of strategies to achieve continuous improvement. It is for the Entity to collaborate with the CSP in the development of an agreed training program that is monitored by both parties and managed by the CSP.

6.6 Materials and Equipment Selection

An essential component of delivering high quality cleaning outcomes is the selection of quality cleaning equipment. The following images identify the variety of products required to deliver these outcomes. The products shown are courtesy of Vermop but this Procedure makes no recommendation as to manufacturer, rather to the standard of quality build and versatility of use. This particular product range is distributed in the KSA and is used in both healthcare and non-healthcare facilities.

6.6.1 Typical Cleaning Equipment

Figure 8 : Large 'Twixter' Cleaning Trolley

Figure 9: 'Shopster' Cleaning Trolley

Figure 10: Large 'Equipe' Cleaning Trolley

Figure 11:'Shopster' Stair Climbing Cleaning Trolley

Figure 12: 'Variant' Cleaning Trolley

Figure 13: 'Twixter' Wet and Dry Microfiber Mop

Figure 14: - 'Lock Head' Window Wiper

Figure 15: 'Top Lock' Telescopic Stick

Figure 16: 'Glassman' Safety Scraper

6.7Typical Cleaning Consumables

Figure 17: Universal Sanitizing Wipes – Image source Clinell

Figure 18: 'Color Coded Microfiber Cloths

Figure 19: Multi-Purpose Cleaning Products – Example Ecolab 'Oasis – *Image source Ecolab*

Figure 20: Multi-Purpose Cleaning Product Dispenser – Example Ecolab 'Oasis – *Image source Ecolab*

Best practice cleaning solutions now use washable microfiber because of its superior capability in lifting dirt from surfaces, thereby improving cleaning outcomes and control of the infection. Mopheads are soaked in a disinfectant solution and carried on cleaning trolleys, used and then added to the dirty laundry for overnight washing.

This avoids the use of 'Kentucky mops', which although popular and well-priced in the KSA are inimical to high-quality infection control based cleaning. This is because they have a tendency to retain dirt and pathogens in the 'spaghetti string' head and frequently reposition dirt in a new location, while microfiber removes and retains the dirt due to its technical construction.

Figure 21 – Traditional 'Kentucky' Mop

Occupational Health & Safety

6.6.2 Inoculation

Vaccination of healthcare professionals, including housekeeping staff, or anyone who may come into close contact with vulnerable patients is a key factor in infection control. Not only to protect them from transmissible agents, but also to prevent them from transmitting pathogens to patients and visitors in the healthcare facility.

Key immunizations for healthcare workers include but are not limited to:

- Hepatitis B
- Seasonal influenza
- Varicella (also known as chicken pox)
- Measles, Mumps, and Rubella (MMR)
- Meningococcal meningitis (for microbiology workers)

6.6.3 Risk Assessments and Method Statements (RAMS)

RISK MATRIX						
5	10	15	20	25	Almost certain	Likelihood
4	9	14	19	24	Likely	
3	8	13	18	23	Possible	
2	7	12	17	22	Unlikely	
1	6	11	16	21	Rare	
A	B	C	D	E		
Impact						

Figure 22: Risk Matrix

The Risk management plan will define how priorities will be established based on the risk categories defined, and it will define the level of risk management interventi

on that will be required for risks in different priority categories. This is illustrated in the following example:

	Level of Risk Exposure			
	Red Priority 1	Amber Priority 2	Yellow Priority 3	Green Priority 4
Risk Tolerance	Risks that significantly exceed the risk tolerance threshold	Risks that exceed the risk tolerance threshold	Risks that lie on the risk tolerability threshold	Risks that are below the risk tolerability threshold
Risk Response	Requires urgent and immediate attention	Requires proactive management	Requires active monitoring	Do not require active management

Figure 23: Level of Risk Assessment

Almost certain	5	10	15	20	25
Likely	4	9	14	19	24
Possible	3	8	13	18	23
Unlikely	2	7	12	17	22
Rare	1	6	11	16	21
Cost Impact (*)	< SAR 1M	SAR 1-2.5M	SAR 2.5-5M	SAR 5–10M	> SAR 10M
Schedule Impact (*)	< 1 week	1- 2 weeks	2-4 weeks	1– 2 months	> 2 months
Impact Category	A	B	C	D	E

Figure 24: Risk/Cost Matrix

A suite of risk assessments and corresponding method statements for each task must be developed and implemented to ensure a safe working environment for operatives, patients, and visitors. Using the risk management tools illustrated above enables an objective measurement of true risk to be undertaken, and as with all risk mitigation, the outcome should be driven by safety rather than cost considerations. Risk assessments should always be 'suitable and sufficient' and if there is a better way to protect individuals from hazards that does not have a significantly disproportionate cost, then this should be the method selected.

It is essential that all operatives are given information, instruction, and training in the use of the risk assessments and method statements to ensure their understanding, paying particular attention to the potential language barriers posed by immigrant workers.

An example of this in a cleaning context would be the use of chemical dispensers, rather than hand diluting cleaning chemicals. The cost difference of the chemicals and the dispensers is not significant when set against the hazards associated with skin or eye damage to the individual.

6.6.4 PPE

PPE should always be selected as the last resort to protect an individual. Removal of the risk or modification of the process is a far better and less hazardous approach to undertaking the task. However, the use of PPE is still important and can be combined with other risk management activity to improve the safety of operatives.

Cleaning involves a number of hazards that can cause harm. These can include the use of chemical substances, equipment, and machinery including but not limited to:

- Sharp-edged tools (scrapers)
- Mechanically powered equipment e.g. scrubber driers or street sweepers

PPE must be worn by all operatives where the RAMS determine it as a requirement. If it is not provided the operative should not undertake the task until it is available.

The Contract Manager/H&S Manager are responsible for ensuring that a suitable and sufficient risk assessment is in place for all tasks, and that resources are available to provide appropriate PPE for all operatives.

- **Goggles**: Operatives must wear goggles when undertaking such activities as dispensing chemicals or the like, to prevent the hazard of sight damage
- **Safety Footwear**: Operatives must wear safety footwear with a steel toecap, to prevent the hazard of impact on the foot by moving machinery or equipment, such as a scrubber drier
- **Arm and Leg Protection**: Appropriate clothing should be worn to protect the arms and legs, especially to prevent the hazard of injuries while using powered equipment. Torn or damaged clothing shall not be allowed to be worn because there is a hazard of it being entangled in machinery
- **Gloves**: Gloves must be worn to protect the hand and wrist, both to reduce the hazard of skin irritation and also to minimize the risk of cuts and abrasions. Gloves should be suitable to the task being performed, with nitrile gloves or equivalent being used to dispense chemicals and protective gauntlets when using powered cleaning equipment
- **Dust Masks or Respiratory Protection:** – These should be worn by operatives carrying out a range of activities, including sweeping or any activity likely to produce airborne debris
- **Ear Defenders:** These should be provided to any operative using noisy, powered equipment that has the potential to cause hearing damage. Ear defenders should be selected on the basis of the noise they exclude. Cheap ear defenders are available but should be avoided because they frequently don't provide adequate, certified protection from noise
- **Anti-Vibration Gauntlets:** These should be worn with machinery that is known to generate high levels of vibration if used. Operatives using this kind of equipment for extended periods, e.g. powered cleaning equipment should be provided either with adequate protection or have their exposure limited

6.6.5 Exposure Limits

- **Chemicals:** Chemicals and fertilizers are provided with an SDS. This will provide guidance on the length of time and the concentration levels to which operatives should be exposed. The hazard of 'over-exposure' can be avoided by following these instructions and minimizing harm to employees. The SDS will also identify guidance about how to deal with spillages or human contact
- **Noise**: Noise at work can cause significant harm to operatives. Those exposed to consistently high levels of noise should be routinely tested to ensure no lasting damage to their hearing and be removed from such tasks if their hearing is demonstrably damaged
- **Vibration:** Vibration at work can cause significant harm to operatives. Those exposed to consistently high levels of vibration through the use of powered equipment should be routinely tested to ensure no lasting damage to their bodies and be removed from such tasks if they are demonstrably damaged
  Temperature: Working outside in KSA can expose operatives to extremes in temperature. In order to ensure that these are all used safely it is of vital importance that safety considerations are taken into account when designing work procedures.
  - Summer **–** The risk of dehydration when working, especially energetically, in the summer heat is high and the hazards associated with dehydration can be significant and, in some cases, severe. Care should be taken to ensure that regular rest and refreshment breaks are given to ensure that operatives working externally do not dehydrate. Water replenishes the water that has been sweated by the body as a result of physical outdoor activity

    Care should be taken to ensure that staff are monitored when they are working in extreme heat. Suitable outdoor clothing should also be selected, including head and neck protection e.g., wide-brimmed sunhats, and Ultra Violet (UV) clothing that contains minerals like zinc and titanium, which protect the wearer from the worst effects of sun. Operatives should also be provided with high UV factor sunscreen to protect exposed areas of skin

- Winter **–** In areas of KSA where the winter temperatures can reduce significantly from their summer highs, operatives should be provided with clothing to retain the heat and ward off the cold. These can be lightweight fabrics that do not constrict the wearer, which provide protection from the cold by trapping warm air in the fabric close to the skin of the wearer

6.7 Emergency Planning

NMA&FM Volume 14, Chapter 2 **–** Emergency Management Plan for Healthcare Facilities, provides the Entity with detailed arrangements for emergency planning in a healthcare facility, detailing the process to be followed for planning to cope with the effects of a major disruption to 'business as usual'.

This can be a violent climatic condition, such as a flood or a debilitating sandstorm, a serious incident, for example a major fire with significant casualties, significant road traffic incident with multiple vehicles involved, or dealing with the consequent effects of power failure/back up power supply malfunction.

This is an essential feature of any Healthcare Cleaning Procedure, because in almost every case, there will be a significant impact on the cleaning provider and their operatives. The resilience of their operation will be severely tested in such circumstances, and the Entity should be sure that their contingency planning is robust enough to cope.

7.0 ATTACHMENTS

Attachment 1 – EOM-ZO0-TP-000211 – Safe Work Instruction for Healthcare - Terminal Cleaning Isolation Room

Attachment 1 – EOM-ZO0-TP-000211 – Safe Work Instruction for Healthcare - Terminal Cleaning Isolation Room

SAFE WORK INSTRUCTION	
Proposed Actions	**Details**
Description of Task Give brief description of activity (Floor, fittings and fixtures)	**Terminal Cleaning of Isolation Room**
Description of Location Name of contract, building and floor level	
Manager/ Supervisor in Charge Person in charge of project with overall responsibility	Qualified Department trainer or Certified Trainer with BICSc License is recommended.
Minimum competence level of Operative Minimum Training requirements of operative (date of training and by whom)	No assumptions are made that the candidate has any prior experience. Trainer to check before undertaking any form of training.
Pre Site Preparation Does work area need any associated safety documentation or special procedures before task is undertaken	Where applicable, COSHH data, and any special instruction should be obtained where the trainer is unfamiliar with equipment and materials refer Infection control Manual
Equipment required	Trainer to check against task code list in assessment kit Bin liner Bucket Spray bottle Cleaning agent(s) Cloths of appropriate color COSHH data sheets Hand buckets Measuring apparatus Non - abrasive pad PPE (Personal Protective Equipment) Refuse sack - appropriate color Risk Assessment Spray bottle Supply of soaps/paper towels (where used) Toilet brush Warning signs Any other equipment as per Infection Control Department
Method of work Step by step task procedure	1. Remove window and privacy curtains and place in dirty laundry bags. Close the bags before removing them from the room. Label the bags as "infectious linen". 2. Clean medical and other equipment (thermometer, oxygen saturation monitor, blood pressure apparatus, stethoscope, procedure trolley, other monitors, and electric cords of equipment by wiping them down with a soapy cloth and then a rinsed cloth. Pay special attention to frequently-touched surfaces such as monitor controls, IV pump controls, and ventilator control panel. 3. Use a wash bowl, cloth, and soapy water to wash down the furniture, shelves, cupboards and other flat surfaces in the room. Wash the room first and then the bathroom (if attached). 4. Work from top to bottom and from clean to dirty. Pay special attention to frequently-touched areas: Beds, mattress covers, bedside tables, bedrails, over-bed tables, touch surfaces of electronic devices close to the patient beds (including the control knobs of monitors and ventilators, infusion pumps, bed control buttons and nurse call buttons), IV stands, trolley handles, door handles, light switches, computer keyboards, telephones, patient files, toys, pagers, drawer and cupboard handles, and sanitary fittings (including toilet handles, toilet grab bars, sinks, basins, baths and taps, dispose washroom door mats if