AUSTRALIAN COMMISSION
ON **SAFETY** AND **QUALITY** IN **HEALTH CARE**

GUIDANCE
for health service organisations

Principles of environmental cleaning auditing

November 2023

Introduction

Facilities should develop and implement an environmental cleaning auditing plan/protocol in collaboration with its infection prevention and control (IPC) service. It should cover the local application of the seven key principles outlined in this document. Facilities with outsourced cleaning services should include the development and implementation of an auditing plan/protocol as part of contract negotiation.

Key Principles

1. When to audit

A risk-based approach should be taken regarding all aspects of the audit process. Auditing of environmental cleaning in patient care areas should include assessment of routine cleaning, discharge, and terminal cleaning. Auditing of environmental cleaning in non-patient care areas should be by visual inspection and at least annually.

2. Who should audit?

Individuals who are responsible for auditing should:

- Be trained in auditing of environmental cleaning
- Be provided with an orientation of the area that they are auditing
- Not be from the area that they are auditing
- Have a thorough knowledge of cleaning standards and processes required in the different areas that they are auditing.

The organisation should assess the need to use external auditors to undertake environmental auditing.

3. Where to audit

Environmental cleaning audits should be undertaken in patient care areas and general ward areas. The patient care area is the space dedicated to an individual patient for that patient's stay. This area may include, but is not limited to, inpatient bed areas including isolation rooms, patient bays, paediatric cots, neonatal incubators and/or cots, emergency department (where assessment or treatment is undertaken), theatres and outpatient clinics.

A general ward area is an area that adjoins the patient care area and where assessment or treatment of patients does not directly occur. These areas include, but are not limited to waiting areas, ward corridors, nurses' station, sterile stock rooms, equipment rooms and ward corridor toilets/showers/bathrooms.

4. Frequency of audits

The frequency of auditing for routine cleaning depends on the outcome of a risk assessment.[4,2] In general, higher risk areas require increased frequency of cleaning[5] and, in turn, environmental cleaning in these areas should be audited more frequently. Audit schedules should also include cleaning requirements associated with the following scenarios:

- Cleaning during outbreaks
- Cleaning for new department
- Building commissioning
- Special project cleaning.

Auditing schedules should be developed in consultation with environmental cleaning services and the local IPC team.

5. How to audit

Environmental cleaning audits should include a combination of visual inspection and objective methods of cleaning performance, such as fluorescent gel markers and Adenosine Triphosphate (ATP) bioluminescence. Visual inspection is not sensitive enough to assess bioburden and risk of infection.[6, 7] Visual inspection only measures the aspect of cleanliness that is apparent to patients and should be used to identify maintenance issues (e.g., surface degradation).[8]

6. What surfaces to audit

All surfaces should be included in environmental cleaning audits. Frequently touched surfaces in patient care areas should be cleaned more often due to an increased risk of contamination and should be audited using objective methods[5]. When using objective methods, a random selection of different sites (surfaces, equipment, and locations) in the patient care area should be observed at each audit. Minimally touched surfaces need to be audited by visual inspection.[5]

As a minimum, audit data for bathrooms and bedrooms should be reported separately. If an organisation wants to compare audit results for an individual surface over time (e.g., the same tap handle in the same room in the same ward), it is important to record what specific sites have been audited at each audit.

7. What to do with audit results

The results of environmental cleaning audits should be centrally collated. Environmental cleaning audit results, trends and issues should be regularly reviewed and discussed at the relevant governance and/or organisational

committee(s) (e.g., Infection Prevention and Control Committee, Clinical Governance Committee).

Results of individual environmental cleaning audits should always be fed back to cleaning, IPC and department staff members as well as management to support a local culture of accountability and knowledge of environmental cleaning. When providing this feedback, auditors should describe:

- The emergent issue, providing detail regarding location, time of day and how the issue was observed
- The expected cleaning standard.

Auditors should also work with cleaning staff, the clinical department and IPC service to develop an action plan to rectify the issues identified during the audit, including who will be responsible for each action and an appropriate timeframe for rectification. Any risks identified from the audit results should be managed according to an agreed risk management plan.

Audit tools and programs

There are several existing environmental cleaning audit tools already available in Australia that can be used, such as:

- Tasmanian Environmental Cleaning Assessment Program
- NSW Clinical Excellence Commission Template for External and for Internal Cleaning Audit
- SA Health Environmental Cleaning External Audit Tool.

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Table 1: Risk categories for environmental cleaning [4,3]

Risk category	Examples *These examples are inclusive of any adjoining areas, for example, bathrooms, corridors, storerooms, meeting rooms, offices, pan rooms and staff lounges*
Extreme	• Operating theatres • Day procedure areas • Medical imaging procedural areas • Intensive Care units • Clinical areas with patients in isolation or with patients who are immunosuppressed • Emergency Departments • Level 2 and 3 nurseries • Labour and delivery wards
High	• General wards • Level 2 nurseries • Pharmacy clean areas • Mortuaries, mortuary fridges and body holding rooms • Outpatient clinics and treatment rooms • Sterile stock storage (outside of central sterilising services departments and sterile supply areas) • Emergency ambulances and other rescue vehicles
Medium	• Day activity areas • Rehabilitation areas, including hydrotherapy • Outpatient clinics, including consulting rooms, ambulatory care • Residential accommodation • Offices in patient/clinical areas • Medical imaging • Pathology and other laboratories • General pharmacy • Kitchenette/pantry/other food preparation or storage areas • Main foyer • Cleaners room • Non-emergency patient transport vehicles • All ambulance operational support vehicles

Table 2: Where to audit using objective methods and visual inspection

	Objective methods	Visual inspection
Patient care area	• Frequently touched surfaces	• Minimally touched surfaces
General ward area	• Not routinely required • Risk assess if needed for outbreak situations	• Minimally touched surfaces

For more information on the recommended frequency of cleaning of different surfaces and equipment, see the Australian Guidelines for the Prevention and Control of Infection in Healthcare, Table A2.2.

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