

Human Services



DEPARTMENT OF HUMAN SERVICES

CLEANING STANDARDS AUDIT PROJECT

November 2000 – May 2001



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REPORT OF THE CLEANING STANDARDS AUDIT PROJECT

EXECUTIVE SUMMARY

Introduction

This report describes the methodology and results of the Cleaning Standards Audits Project of Victorian Public Hospitals, commissioned in November 2000, and completed in May 2001.

Purpose

The fundamental purpose of this project was to conduct ‘a comprehensive audit of cleaning standards’ in Victorian Public Hospitals.¹ The reference used throughout this project was the Cleaning Standards for Victorian Public Hospitals – July 2000 (the *Cleaning Standards*).

Project Scope and Format

The approach taken by the audit team is described, including the procedures for contact with hospitals and the conduct of audits.

The scope of the project is demonstrated in the figures below:

- ❑ Hospitals audited: 56
- ❑ Functional areas visited: 610 (approx)
- ❑ Rooms inspected: 3,650
- ❑ Total audit days: 77

Conclusion

By the conclusion of the project, all hospitals audited met the *Cleaning Standards*. Of the 56 hospitals audited, 47 received ‘high achievement’ scores over 90%.

Many hospitals achieved very high scores across a range of risk groups and functional areas, demonstrating commendable levels of compliance with the *Cleaning Standards*.

Overall compliance scores generally increased as the size and complexity of hospitals decreased, that is, Groups D & E hospitals had higher average compliance scores than Group A. This is quite reasonably a matter of scale and degree of complexity of the task.

The results for Very High and High Risk functional areas (Operating Theatres, Special Care Nurseries, Intensive Care Units, Emergency Departments, Central Sterile Supply Departments) and Nursing Units, show average scores above 85% in all hospital groups. This clearly demonstrates compliance with the *Cleaning Standards*, in the areas most identified with clinical risk of infection.

It is evident from analysis by cleaning elements, that the lower average scores for doors, external features and windows, point to the cleaning elements which receive lower budget priority, and which are less critical from a risk point of view.

1 Advertisement of Tender No. T2148 – Acute Health Cleaning Standards Audit Project

Recommendations

Hospitals Reporting

Throughout the project, the audit team noted how the audits had raised interest in hospital cleaning standards generally. For this focus to be maintained, ongoing reporting and transparency of compliance with the *Cleaning Standards* will be required.

Recommendation: That hospitals be required to report external audit results of cleaning standards to DHS at least once per year.

Funding

The high level of compliance found in these audits, is attributable to many factors, including specific project funding for implementation of the *Cleaning Standards*. This practical financial support has contributed to hospitals' ability to meet and exceed the *Cleaning Standards*.

Recommendation: That funding to support maintenance of hospital cleaning standards be continued.

Review Of Standards

The *Cleaning Standards* have received much attention and discussion within the health sector. All the discussions between the audit team and hospital staff confirmed that the *Cleaning Standards* have become widely accepted. However several components of the *Cleaning Standards* have been identified as open to interpretation, such as:

- ❑ the complexity of scoring method and formula
- ❑ assignment of risk weightings,
- ❑ definition of functional areas, and
- ❑ risk weighting of rooms adjacent to Very High and High Risk areas, eg Storerooms.

All of these items can impact significantly on the overall scores and compliance outcomes.

Recommendation: When DHS conducts its planned review of the Cleaning Standards, inviting comment from hospitals and stakeholders generally, it should address issues that are currently open to interpretation.

1. INTRODUCTION

This report describes the methodology and results of the Cleaning Standards Audits Project of Victorian Public Hospitals, commissioned in November 2000, and completed in May 2001.

This audit project followed release of the Cleaning Standards for Victorian Public Hospitals (the *Cleaning Standards*) in July 2000 and specific project funding for hospitals to assist with implementation of the *Cleaning Standards*.

The report is divided into sections, namely Purpose, Project Tasks, Findings, Conclusion and Recommendations.

2. PURPOSE

The fundamental purpose of this project was to conduct ‘a comprehensive audit of cleaning standards’ in Victorian Public Hospitals.² The reference used throughout this project was the Cleaning Standards for Victorian Public Hospitals – July 2000 (the *Cleaning Standards*).

3. PROJECT TASKS

3.1 INTRODUCTION

This section describes how the audit team performed each of the project tasks set out in the project brief. In short, the tasks were:

- Develop an audit proforma
- Develop a standardized method for presentation of results
- Develop an audit program
- Provide the Department with an audit report for each facility audited.
- Provide the Department with a summary report of general trends and overall performance.

3.2 AUDIT PROFORMA

The project team were required to develop or have in place ‘... an audit proforma (survey tool) based on the *Cleaning Standards for Victorian Public Hospitals (July 2000)*.’³

Cogent had developed the CogentAudit System to collect and analyse data from cleaning audits, and this system was approved for use by DHS for the purposes of the audit. The system provides a database and handheld (Palm) software to collect information from cleaning audits, calculate scores and generate reports.

2 Advertisement of Tender No. T2148 – Acute Health Cleaning Standards Audit Project

3 Consultants’ Brief 3.1

3.2.1 Defining Risk For Weighted Scoring

Functional areas are grouped according to risk, as detailed in the *Cleaning Standards*, as follows:

- Very High, eg Operating Theatre;
- High, eg Emergency Department;
- Moderate, eg General Wards;
- Low, eg Administrative Areas; and
- Minimal Risk, eg Engineering Workshop

The following table from the *Cleaning Standards* shows how various risk levels are described and treated.

Excerpt from the *Cleaning Standards*, page 60

“When scoring compliance with the *Cleaning Standards*, each risk group receives a weighting to reflect its severity of risk and the timeframe for rectifying problems (not applicable for this project). There are four groups of weights as follows⁴:

Weighting	(Risk Group)		Timeframe for Rectifying Problems
7	A (Very High)	Constant, cleanliness critical	Immediate
6	B (High & Moderate)	Frequent, cleanliness important and requires maintaining	0-48 hours
4	C (Low)	Regular, on a less-frequent scheduled basis and as required in between	2-7 days
2	D (Minimal)	Infrequent, on a scheduled or project basis	1-4 weeks

The *Cleaning Standards* provides a matrix of these risk weightings, for each of the fourteen cleaning elements within each functional area⁵. The risk profiles from the matrix were built into the scoring and database used for assessing the results of audits.

To report detailed audit results clearly, every Audit Score Sheet showed the risk weighting for each of the fourteen cleaning elements, in the room or area, being reported.

This reporting of risk is carried through to the Audit Scores Summary for each hospital, which lists results scores for all of the rooms in all of the functional areas audited, together with the risk group of every functional area.

4 ibid Page 60

5 ibid Page 59

3.2.2 Selection Of Hospitals To Be Included In The Audit

All metropolitan acute hospitals and rural base hospitals were included in the audit. These comprise DHS groupings known as ‘Group A’ (Teaching Hospitals) and ‘Group B’ (Regional Base and Suburban Hospitals).

Other hospitals from rural areas were randomly selected, while retaining constant numbers for each grouping and within each region. These groups are ‘Group C’ (Regional General Hospitals), ‘Group D’ (Area Hospitals) and ‘Group E’ (Local Hospitals).

Constant numbers for each group, within each region, provides fair comparison when reporting across groups and regions.

3.2.3 Project Statistics

The scope of the audit visits and project breadth is demonstrated in the figures below:

- ❑ Hospitals audited: 56
- ❑ Functional areas visited: 610 (approx)
- ❑ Rooms inspected: 3,650
- ❑ Total audit days: 77

A list of the 56 hospitals included in this audit project is at Annex E.

3.3 PRESENTATION OF RESULTS

The Project Team were required to ... ‘Develop a standardised method for presentation of results and outcomes based on the *Cleaning Standards*, which allows for benchmarking and comparison between agencies, services and regions.’⁶

The format of reports to hospitals follows these criteria and comprised:

- ❑ Audit Score Sheet – one sheet for every room audited (example at Annex B). The score sheet generated by the CogentAudit System is based on the audit score sheet from the *Cleaning Standards*.⁷ It lists fourteen cleaning elements with space for scores and comments.
- ❑ Audit Scores Summary – for every hospital audited (example at Annex C). The Summary lists every room within all the functional areas audited, with its Risk Group, Demerit Points, Area Weight, Score and Weighted Score.
- ❑ Audit Scores Chart – for every hospital audited (example at Annex D). The chart shows percentage scores against the Acceptable Quality Level (AQL) level of 80% set in the *Cleaning Standards*. Scores for all areas audited, are included for the hospital as a whole (‘Hospital Score’) and grouped by risk weighting (‘A, B, C, D’).

6 Consultants’ Brief 3.2

7 Cleaning Standards for Victorian Public Hospitals – July 2000: page 64

3.4 AUDIT PROGRAM

The Project Team were required to ... 'Develop an audit program in conjunction with the Department and conduct a comprehensive audit of all acute Metropolitan Health Service sites, and a representational sample of rural hospitals and multipurpose centres'

3.4.1 Time Frames

This audit project comprised six phases in the period from November 2000 to May 2001. To maintain consistency, DHS agreed that audits would be suspended during Christmas and New Year period as hospital caseloads may vary and regular staff take leave during the holiday period.

Phase 1 (late November) – Verification, validation and training:

- ❑ discussions with DHS to agree audit and presentation formats, hospital selections and time lines.
- ❑ implement training package for auditors.

Phase 2 (early December) – Selected regional and metropolitan audits:

- ❑ audits in Barwon, Northern Metropolitan and Bayside hospitals
- ❑ deliver Phase 2 Audit Reports to DHS

Phase 3 (mid December to early January) – Holiday period audits:

- ❑ audits in Gippsland and Northern Health hospitals
- ❑ deliver Phase 3 Audit Reports to DHS

Phase 4 (mid January to mid February) – Southern Metropolitan, Grampians and Hume audits:

- ❑ remainder of Southern Metropolitan hospitals
- ❑ Hume and Grampians hospitals
- ❑ deliver Phase 4 audit reports to DHS

Phase 5 (February) – Loddon Mallee and Metropolitan Audits

- ❑ Loddon Mallee hospitals
- ❑ Remainder of Western Metropolitan Hospitals
- ❑ deliver Phase 5 audit reports to DHS

Phase 6 (March to early May) – Eastern Metropolitan Audits and Summary Reports

- ❑ Eastern Metropolitan Hospitals
- ❑ deliver Phase 6 audit reports
- ❑ draft Final Summary Report
- ❑ deliver Final Report

3.4.2 'Audits Without Notice' and Hospital Contacts

The Consultant's Brief for this project stated that the audits '...are to be conducted without notice.'

Practical considerations of access to Very High and High Risk areas dictate some warning of the auditor's arrival. It would be clumsy, time wasting and unnecessarily disruptive to expect a hospital to respond "without notice" to an auditor arriving unannounced at the Reception Desk. Such a strategy also runs the risk that staff who can assist the auditor may be away or engaged on other duties. Clearly, hospitals do need to be aware of personnel who are accessing hospital departments, particularly those identified as Very High and High Risk Areas.

These issues were considered carefully in arriving at the agreed procedure, which was that Hospitals would nominate a representative who would be contacted by the auditor in the afternoon of the business day before the audit. These initial phone call contacts were used to agree the start time for the audit, and arrange access to Very High and High Risk areas, without forecasting the areas to be audited.

3.4.3 Compiling The Audit Samples

The task of compiling audit samples required close adherence to the *Cleaning Standards*' parameters for:

- ❑ mix of risk areas within the audit sample, and
- ❑ size of sample (number of functional areas) based on bed numbers.

Hospitals provided copies of internal telephone directories and building layouts, from which audit samples were compiled. Estimated acute bed numbers were provided by DHS.

Phone directories and building plans showed the range and type of departments within each hospital, so risk ratings could be applied accurately.

The audit team held strongly to the view that for the audit to be of benefit to hospitals, local names and references (departments, buildings, rooms) must be used in reporting back of results. Without such accurate local references, a report is almost useless for feedback and quality improvement.

The duration and size of audits according to hospital sizes is shown below:

Number of Beds	Duration of Audit	Number of Functional Areas to be Audited
<300	1 day or less	10
300-500	2 days	14-18
>500	3 days	20-24

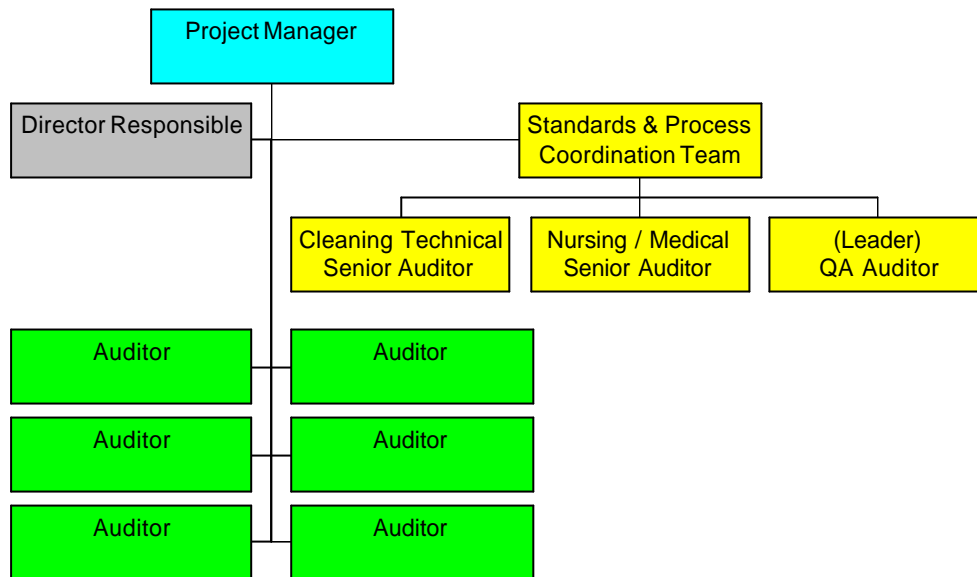
Those compiling the audit samples had no detailed knowledge of subject hospitals, which is appropriate for the random sampling used in compiling the functional areas for audit.

3.4.4 Hospital Site Guides

Hospitals were requested to nominate a Site Guide to accompany the auditor. This could be any staff member who knew the hospital geography, and need not necessarily be a member of senior management. Site Guides assisted the auditors in finding directions and gaining access to all areas in the audit sample.

3.4.5 Audit Team and Preparation

The Cogent Team organisation is shown in the chart below.



At project commencement the auditors were brought together for:

- ❑ Orientation into the project plan and audit program;
- ❑ Practice audit sessions to establish consistency in assessment of cleaning conditions; and
- ❑ Training on the Palm-based *CogentAudit* System, to have auditors reach a level of competence and confidence with the software and handhelds, before embarking on hospital visits.

Auditors were accompanied by a Standards and Process Coordination Team-member on a hospital visit, at least once, to provide constructive feedback to the auditor and maintain consistency in auditor appraisals.

3.4.6 Audit Format

Initial Contact: The auditor contacted the primary hospital representative on the afternoon before the audit, to advise that the audit would take place the next day and to arrange a convenient time to commence the visit in the hospital's Very High Risk areas, such as Operating Theatre Suite or ICU. In most instances, audits were scheduled to start 30 minutes before the theatre list, usually between 6:00 – 7:00 am.

Entry Meeting: As early as possible in the visit, the auditor conducted a brief entry meeting to introduce the audit and meet hospital representatives. At this meeting the auditor followed a checklist of points, as follows:

- ❑ Define the scope of the audit.
- ❑ Outline the audit plan and schedule.
- ❑ Seek guidance (on hospital layout, timings etc.)
- ❑ Confirm any environmental management documentation provided by hospital is accurate
- ❑ Reminder that auditor is seeking evidence of conformance – once obtained, will proceed to next criteria
- ❑ Reminder that it is the system being audited, not the performance of individuals
- ❑ Ask for brief description of hospital's auditing program
- ❑ Confirm site guide is available
- ❑ Determine time and location for Exit meeting. Confirm attendees.
- ❑ Outline the purpose of Exit meeting.
- ❑ Confirm any local requirements, eg access
- ❑ Confirm all communications will be conducted through the Department of Human Services.
- ❑ Invite and answer any questions about the audit.

Conduct Audit: Then the auditor proceeded to visit the functional areas shown in the audit sample on the Palm handheld (accompanied by the site guide), and record assessments plus supporting comments.

Exit Meeting: When all functional areas had been visited, an Exit meeting was conducted with hospital stakeholders. The auditor followed a checklist of points as follows:

- ❑ Discuss Category 1 (Immediate Rectification) or Category 2 (Early Reporting for Rectification) non-conformances, if any.
- ❑ Reminder that the audit report will be sent from DHS within 28 days.
- ❑ Reminder that you (the auditor) do not know the audit scores.
- ❑ Comment on two or three strengths observed in the cleaning services.
- ❑ Comment on two or three weaknesses observed in the cleaning services.
- ❑ Ask if the hospital representatives have issues to raise about the conduct of the audit.
- ❑ Mention that a member of the Quality Team (Standards and Process Coordination Team) will be phoning the principal contact person for a review of the audit process.
- ❑ Thank people for their cooperation and assistance.

Data transfer & report: Palm handheld and notes taken at Entry and Exit meetings were returned to Project Manager for downloading into the main software and report generation.

3.4.7 Quality Assurance Processes

All aspects of the audit program were reviewed by Cogent's Standards and Process Coordination Team (Quality Team). These reviews included initial briefing of auditors, practice audit sessions, hospital audit profiles, reporting formats and consistency of audit appraisals.

Repeat audits

To test and verify consistency of audit appraisals and scoring, three repeat audits were conducted by members of the Standards and Process Coordination Team. These included rural and metropolitan sites.

Phone follow up after audits

Forty-nine hospitals' contact persons were telephoned and asked to respond to questions about the conduct of the audits, as follows:

- ❑ Audit Arrangements – reasonable notice / other.
- ❑ Auditor – attitude/demeanour; timeliness; presentation; knowledge/professionalism
- ❑ Entry & Exit Meetings – suitable; presentation useful; covered necessary points
- ❑ Overall rating – 'good audit'; 'no issues of note'; 'not acceptable'.

Generally, there was a positive response to the audits methodology, with no specific issues raised about the conduct of the audits.

The most frequent comments concerned the positive educative aspect of the audits. People had learned from the auditors, or gained a different perspective. Some commented that auditors had noticed points of cleaning that they had not, or should have, noticed.

3.5 AUDIT REPORTS

The project team was required to ... 'Provide the Department with an audit report for each facility audited ...'

3.5.1 Audit Reports and Scores Security

This audit project collected data via Palm handheld units, which were loaded with the audit sample, before each hospital visit. After each audit, the results were downloaded to the main database for scores and reports to be generated.

Only the project manager and individual auditor could access the audit data on the Palm, via the auditor's PIN.

Auditors tick boxes on the Palm to record their assessments, but do not have access to the score for the audit, because the score is compiled after the data is downloaded to the main database.

These arrangements provided a high level of security for audit data and ensured that scores could not be modified, accidentally or intentionally.

3.5.2 Reporting

Reports were provided for every hospital audited, in the format approved by DHS, as described in 3.3 Presentation of Results. The Cogent Project Manager prepared these reports by directly generating the scores and comments from each audit, via the project database. The reports

contained the auditor's scores and comments, as an independent assessment of each hospital's conformance to the *Cleaning Standards*.

4. FINDINGS

4.1 PERFORMANCE BANDS

All Victorian Public Hospitals audited were assessed as meeting the Acceptable Quality Level (80%) in the *Cleaning Standards*.

Instances where individual rooms or particular areas within a hospital did not meet the *Cleaning Standards* are shown in detail in each hospital's audit report.

The table below lists hospitals' overall performance against the *Cleaning Standards* within the performance bands of:

- 'High Achievement', being a hospital score above 90%;
- 'Meets *Cleaning Standards*', being a hospital score of 80% - 90%; and
- 'Improvement Required', being a hospital score below 80%.

PERFORMANCE BANDS BY HOSPITAL GROUP

	High Achievement >90%	Meets <i>Cleaning Standards</i> 80% - 90%	Improvement Required < 80%	Totals
Group A (Teaching Hospitals)	Number of Hospitals	12	Number of Hospitals	6
	Score Range	90.5%-98.7%	Score Range	80.0%-89.6%
	Mercy Public Hospital - E Melb Campus Mercy Public Hospital - Werribee Campus Monash Medical Centre Northern Hospital Peter MacCallum Cancer Institute Royal Melbourne Hospital Royal Women's Hospital St. Vincents Hospital Sunshine Hospital The Alfred The Royal Victorian Eye & Ear Hospital Western Hospital	Austin & Repatriation Medical Centre Barwon Health - The Geelong Hospital Box Hill Hospital Dandenong Hospital Frankston Hospital Royal Children's Hospital		
Group B (Regional Base & Suburban Hospitals)	Number of Hospitals	17	Number of Hospitals	2
	Score Range	90.4%-97.9%		
	Anqliss Health Services Bairnsdale Regional Health Service Ballarat Health Services Bendigo Health Care Group Central Gippsland Health Service Echuca Regional Health Goulburn Valley Health LaTrobe Regional Hospital Mildura Base Hospital Sandringham & District Memorial Hospital South West Healthcare - Warrnambool Swan Hill District Hospital West Gippsland Healthcare Group Western District Health Service - Hamilton Williamstown Hospital Wimmera Health Care Group Wodonga Regional Health Service	Maroondah Hospital Wangaratta District Base Hospital		
Group C (Regional General Hospitals)	Number of Hospitals	10	Number of Hospitals	1
	Score Range	90.1%-97.9%		
	Colac Community Health Services Djerriwarrh Health Services Gippsland Southern Health Service Kyabram & District Memorial Community Maryborough District Health Service Portland & District Hospital Rosebud Hospital Stawell District Hospital Wonthaggi & District Hospital Yarra Ranges Health Service	Benalla & District Memorial Hospital		
Groups D&E (Area and Local Hospitals)	Number of Hospitals	8	-	-
	Score Range	94.0%-99.3%		8
	Beaufort & Skipton Health Services Hepburn Health Service Hesse Rural Health Service Kooweerup Regional Health Service Rochester & Elmore District Health Service Seymour & District Memorial Hospital Tallangatta Health Service Terang & Mortlake Health Service			
Totals	47		9	56

4.2 RE-AUDITS

Within the time frame of the audit project, one hospital did not meet the *Cleaning Standards* and was re-audited after a period was allowed for improvement work to be undertaken. The hospital met the *Cleaning Standards* at the second audit.

One other hospital was assessed as just meeting the *Cleaning Standards* AQL, and subsequently Very High and High Risk functional areas were scheduled for re-audit.

4.3 ANALYSIS CHARTS

The summary charts that follow comprise the three types of analysis of the audit results:

- ❑ **Area Risk** charts show average scores ‘Hospital Overall’ and for each risk area (A, B & C weightings), within each DHS Hospital Group.
- ❑ **Functional Area** charts show the average compliance scores for selected functional areas within each DHS Hospital Group. The functional areas are CSSD, Emergency Departments, Intensive Care Units, Nursing Units, Operating Theatres and Special Care Nurseries.
- ❑ **Cleaning Elements** charts show the percentage compliance for each of the fourteen cleaning elements, for each DHS Hospital Group. Note that the scores for cleaning elements charts are **not risk weighted**.

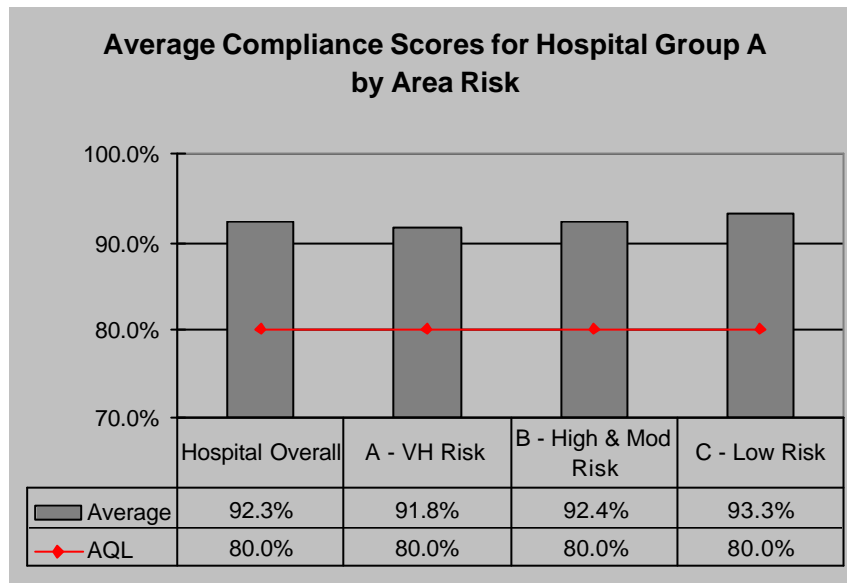
4.3.1 Hospital Group by Area Risk

The Area Risk charts below, are produced in the same format used for hospital reports. The Acceptable Quality Level (AQL) from the *Cleaning Standards* is shown in red on the 80% gridline. Scores are shown for each risk weighting level, within each DHS Hospital Group.

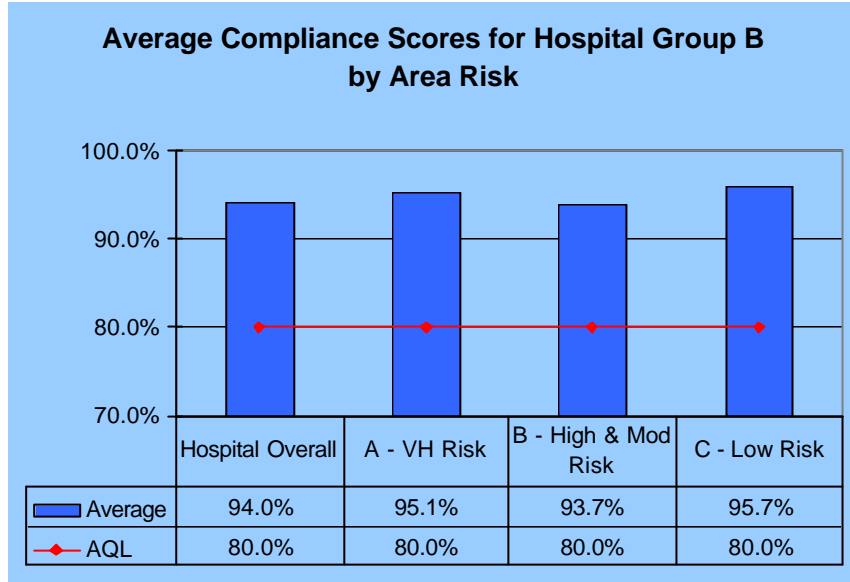
Overall Results

All hospitals audited have scored well with averages exceeding 90% for all hospital groups. This indicates strong performance in complying with the *Cleaning Standards*.

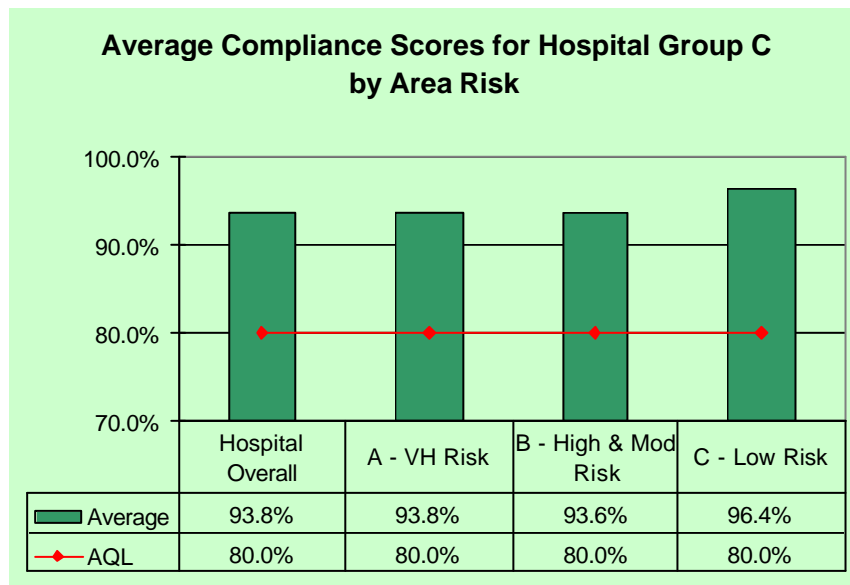
COMPLIANCE BY AREA RISK – GROUP A (TEACHING HOSPITALS)



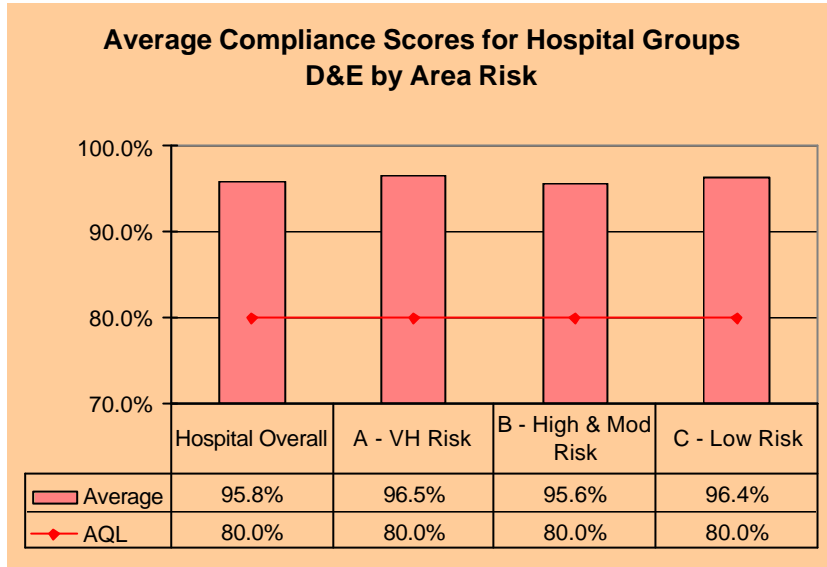
COMPLIANCE BY AREA RISK – GROUP B (REGIONAL BASE & SUBURBAN HOSPITALS)



COMPLIANCE BY AREA RISK – GROUP C (REGIONAL GENERAL HOSPITALS)



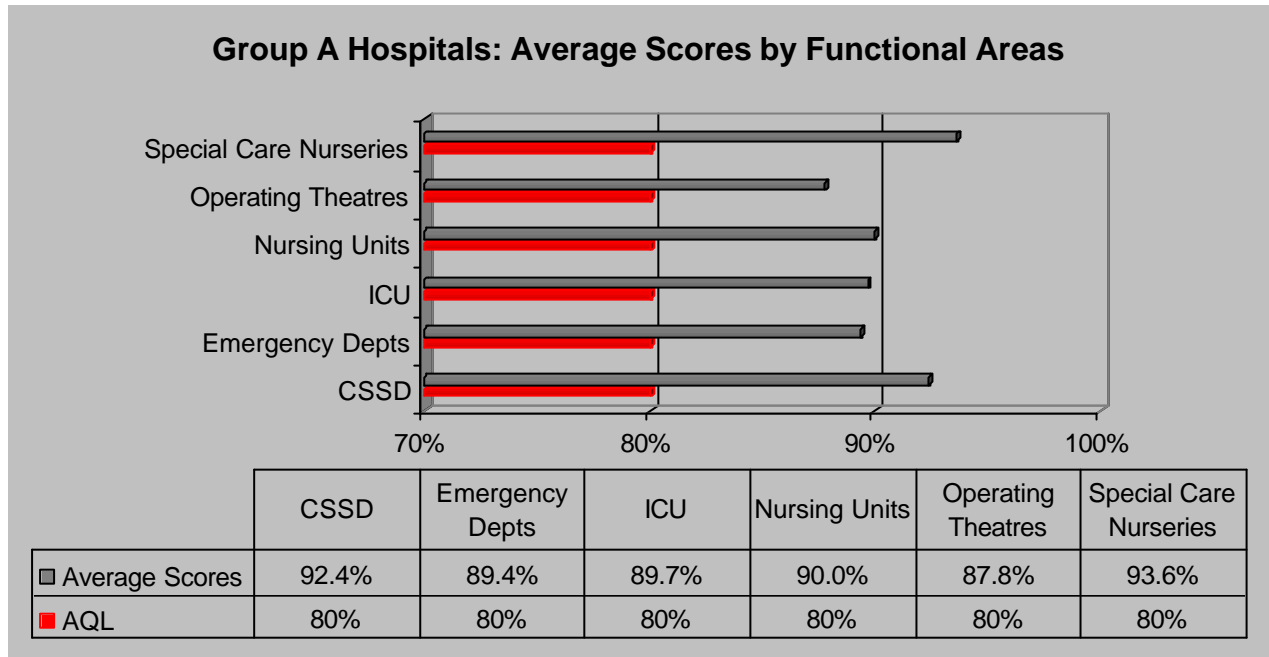
COMPLIANCE BY AREA RISK – GROUP D (AREA HOSPITALS) AND GROUP E (LOCAL HOSPITALS)



4.3.2 Hospital Group by Functional Areas

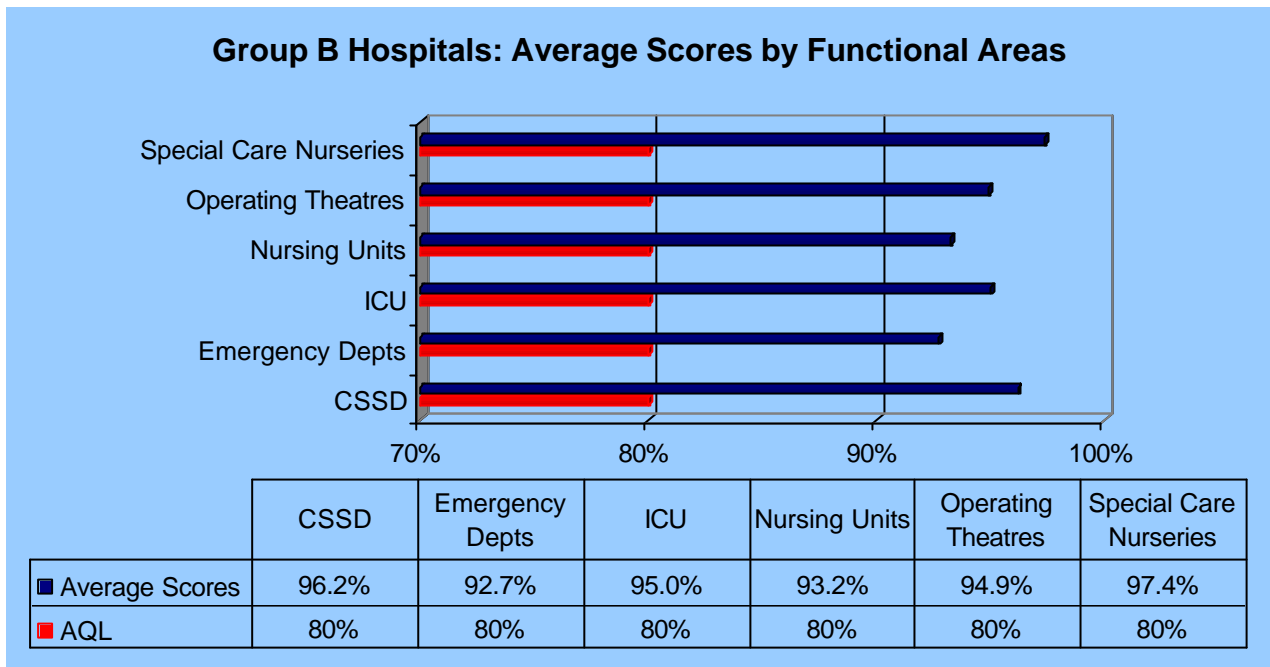
This series of charts shows the average compliance scores for selected functional areas within each DHS Hospital Group. The functional areas are CSSD, Emergency Departments, Intensive Care Units, Nursing Units, Operating Theatres and Special Care Nurseries, all being Very High or High Risk areas, except Nursing Units, which are Moderate Risk areas.

Overall Results - These areas show a very high level of compliance with the *Cleaning Standards*.



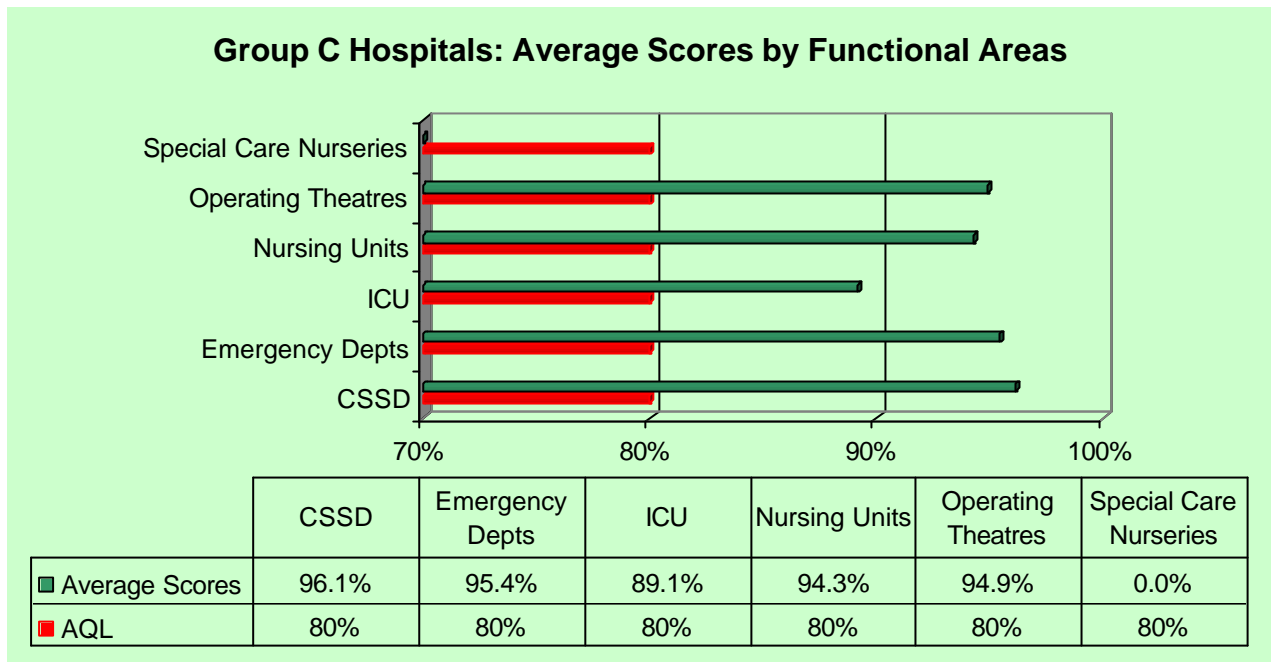
Analysis – Group A Hospitals

- ❑ Overall strong performance.
- ❑ All scores within a 6% band grouped around the 90% line.
- ❑ The lower score for Operating Theatres is not significant, given that the AQL was met.
- ❑ Special Care Nurseries high scores reflect strong compliance with cleaning requirements for Very High Risk functional areas in the *Cleaning Standards*.



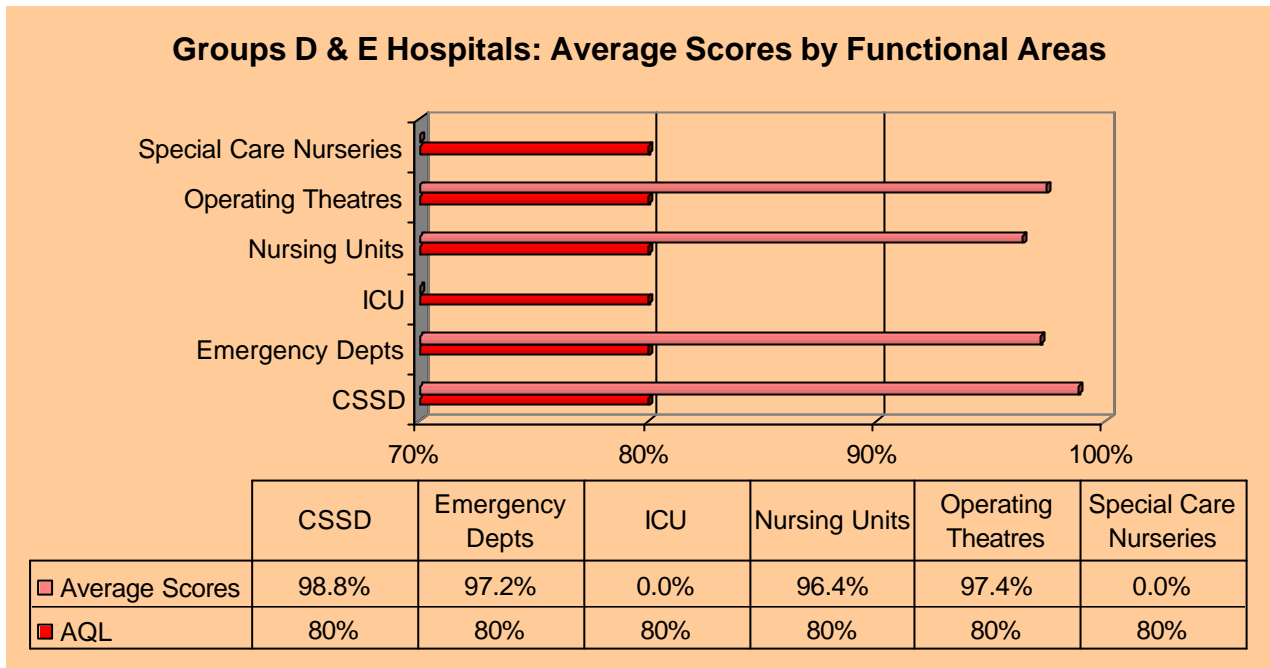
Analysis – Group B Hospitals

- Overall very strong achievement in all areas.
- Special Care Nurseries and CSSD scores exceed 95%, which shows very strong compliance with the cleaning requirements for Very High Risk functional areas in the *Cleaning Standards*.
- Remaining functional area average scores exceed 90%, indicating a consistent high level of compliance with the *Cleaning Standards* across various Very High and High Risk areas.



Analysis – Group C Hospitals

- Overall strong achievement in all areas
- There are no Special Care Nurseries in this group of hospitals.
- The lower score for ICU is not significant, given that it exceeds the AQL and almost reaches 90%.
- The remaining average scores are grouped within a percentage point of 95%, indicating very high compliance with the *Cleaning Standards* across various differing functional areas.



Analysis – Groups D & E Hospitals

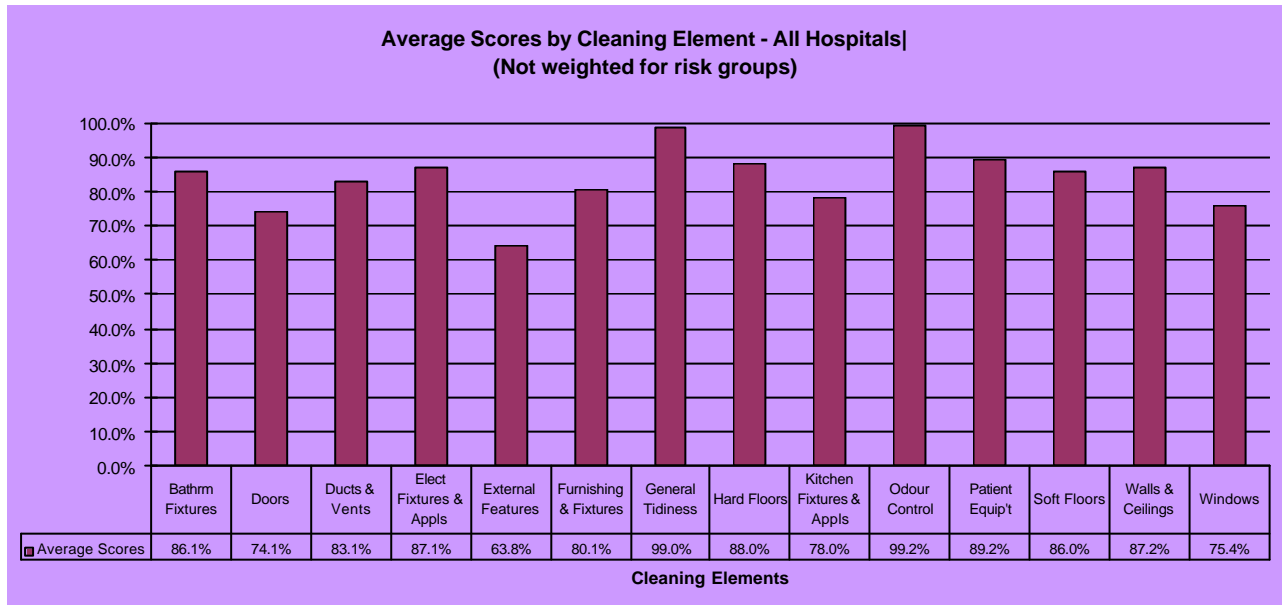
- Overall very strong performance in all areas
- There are no Special Care Nurseries or ICU in this group of hospitals.
- Average scores for all four functional areas exceed 95%, indicating very high compliance with the *Cleaning Standards* across a range of Very High, High and Moderate Risk areas.

4.3.3 Hospital Group by Cleaning Elements

This series of charts shows percentage compliance with *Cleaning Standards* of the fourteen cleaning elements **without risk weightings**, within each DHS Hospital Group.

Note these scores are calculated outside the demerit scoring system of the *Cleaning Standards* and are not risk weighted. As a result the 80% AQL is not applicable.

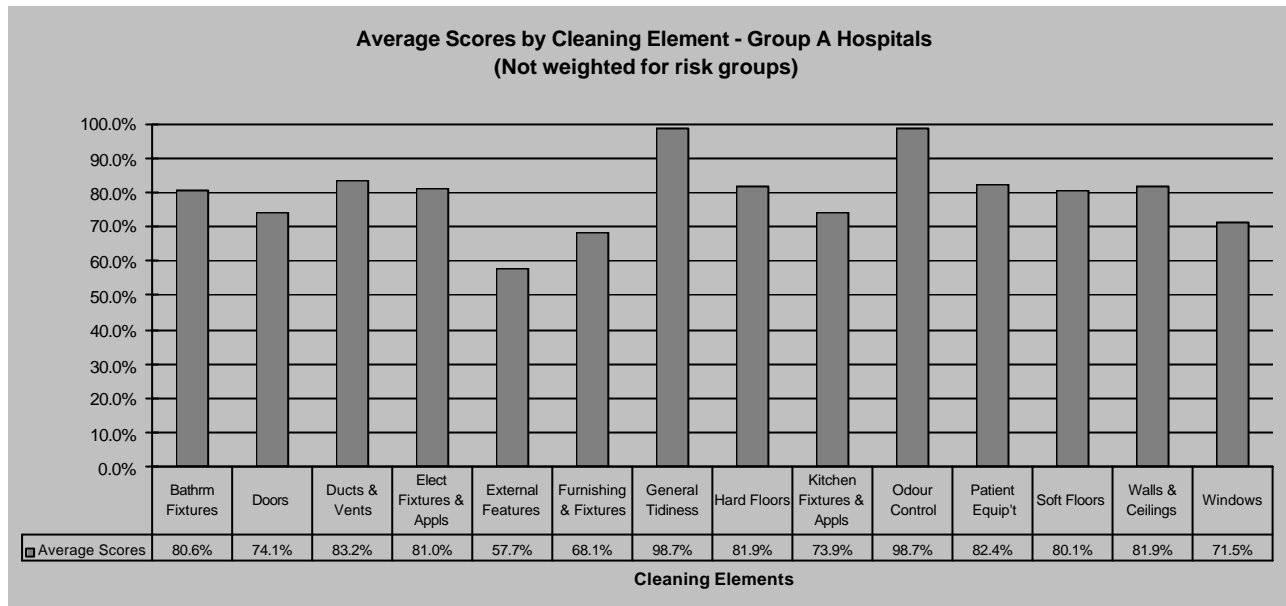
CLEANING ELEMENTS – ALL HOSPITALS



Analysis – All Hospitals

- ❑ The highest compliance scores were for General Tidiness and Odour Control.
- ❑ Bathroom Fixtures, Ducts & Vents, Electrical Fixtures & Appliances, Furnishing & Fixtures, Hard Floors (eg vinyl), Patient Equipment, Soft Floors (eg carpet) and Walls & Ceilings scores make up the middle range.
- ❑ Doors, External Features, Kitchen Fixtures & Appliances and Windows received the lowest scores.
- ❑ The Kitchen element refers to pantries and kitchen-like facilities found in many functional areas, such as Nursing Units, but **not main hospital kitchens**.
- ❑ The Doors element includes handles, push-plates, hinges, closers and door vents. Door closers and door vents frequently received demerits on hospital score sheets.
- ❑ The External Features element includes fire exits and stairwells.
- ❑ The Windows element includes internal and external surface of glass in windows, and internal glass such as mirrors.

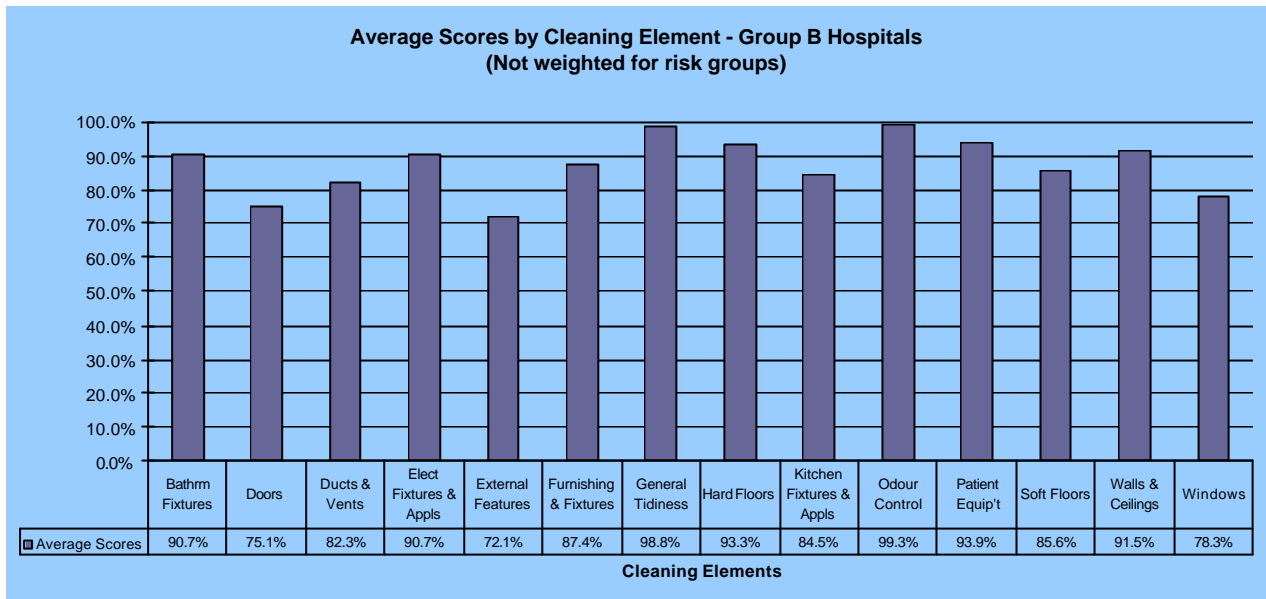
CLEANING ELEMENTS – GROUP A (TEACHING HOSPITALS)



Analysis – Group A Hospitals

- ❑ General Tidiness and Odour Control received outstanding scores.
- ❑ Bathroom Fixtures, Ducts & Vents, Electrical Fixtures & Appliances, Hard Floors (eg vinyl), Patient Equipment, Soft Floors (eg carpet) and Walls & Ceilings scores make up the middle range.
- ❑ Areas noted for improvement are Doors, External Features, Furnishing & Fixtures, Kitchen Fixtures & Appliances (note: not main kitchens) and Windows.
- ❑ Group A Hospitals showed a similar profile of results to Group B Hospitals, but with slightly higher scores. This may well reflect budgetary priorities, and hospital's focus of effort into higher risk functional areas.

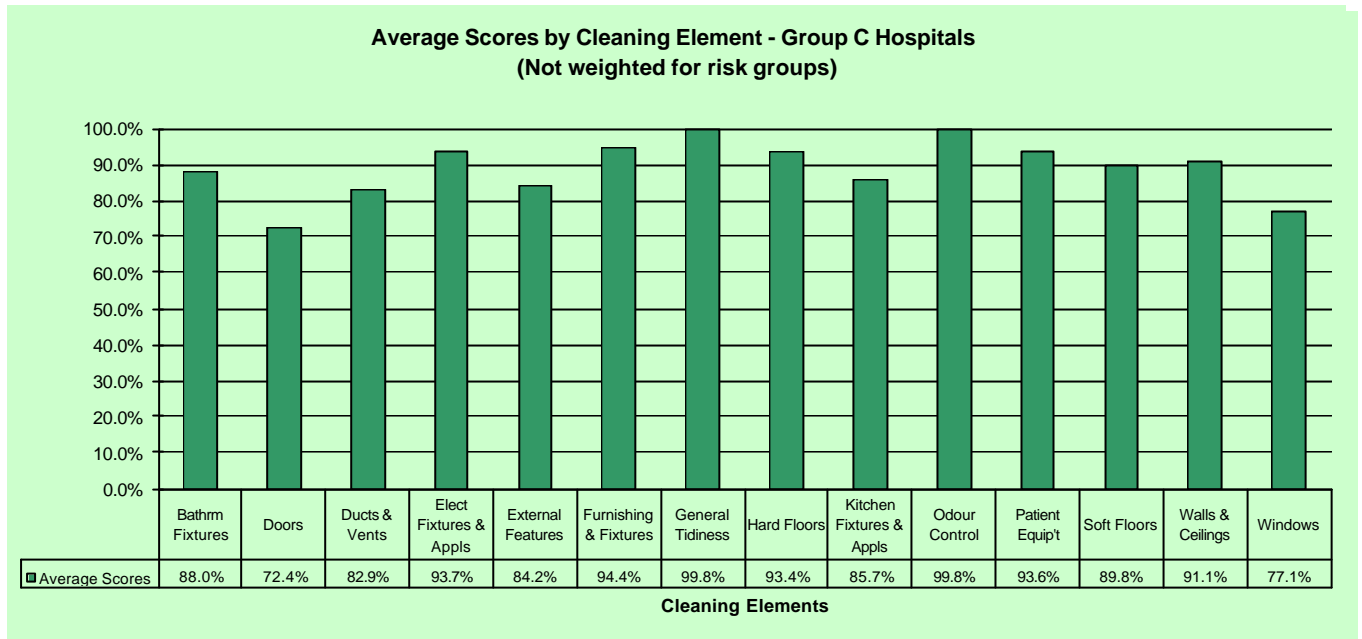
CLEANING ELEMENTS – GROUP B (REGIONAL BASE & SUBURBAN HOSPITALS)



Analysis – Group B Hospitals

- General Tidiness and Odour Control again received outstanding average scores.
- The majority of cleaning elements make up the middle range scores, ie Bathroom Fixtures, Ducts & Vents, Electrical Fixtures & Appliances, Furnishings & Fixtures, Hard Floors (eg vinyl), Kitchen Fixtures & Appliances (note: not main kitchens), Patient Equipment, Soft Floors (eg carpet) and Walls & Ceilings.
- Doors, External Features and Windows are areas noted for improvement.
- Group B Hospitals show a similar profile of results to Group A, but with higher average compliance with the *Cleaning Standards*.

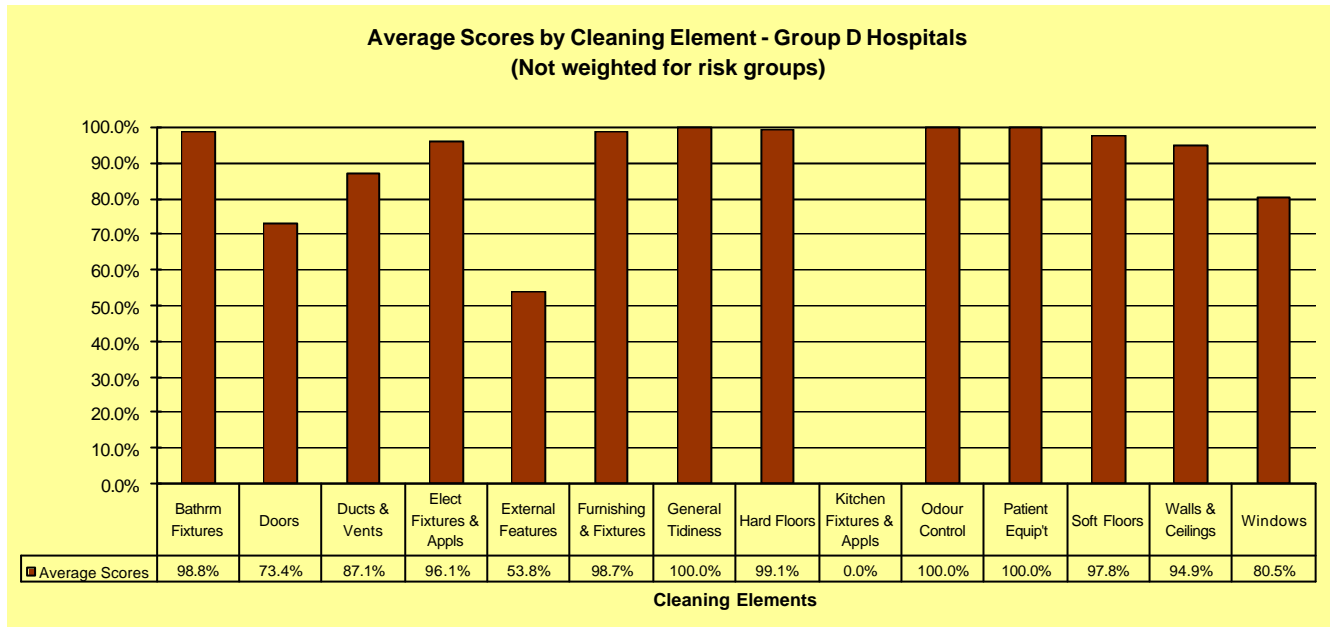
CLEANING ELEMENTS – GROUP C (REGIONAL GENERAL HOSPITALS)



Analysis – Group C Hospitals

- General Tidiness and Odour Control scores are approaching 100%.
- The middle range scores apply to Bathroom Fixtures, Ducts & Vents, Electrical Fixtures & Appliances, External Features, Furnishings & Fixtures, Hard Floors (eg vinyl), Kitchen Fixtures & Appliances (note: not main kitchens), Patient Equipment, Soft Floors (eg carpet) and Walls & Ceilings.
- External Features scores average over 80% in this Group only.
- Doors and Windows are areas noted for improvement.
- Group C Hospitals show some similarity in scores profile to Groups A and B, but with higher average compliance with the *Cleaning Standards*.

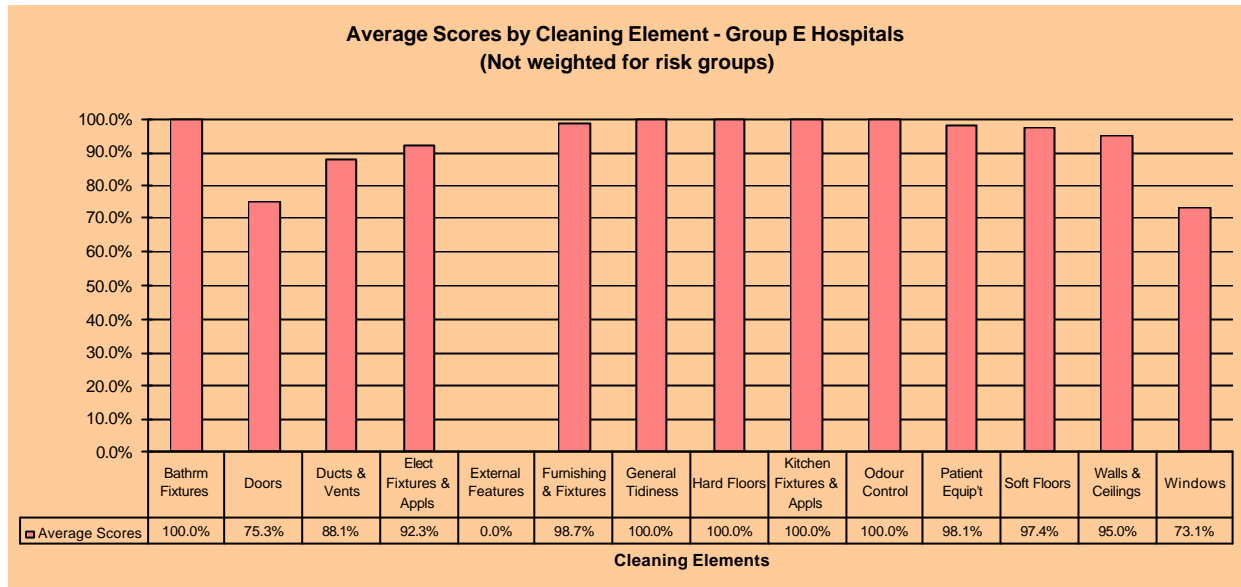
CLEANING ELEMENTS – GROUP D (AREA HOSPITALS)



Analysis – Group D Hospitals

- ❑ Group D Hospitals show very strong average scores on most cleaning elements indicating high compliance with the *Cleaning Standards*.
- ❑ General Tidiness and Odour Control scores achieve 100% compliance.
- ❑ Average scores over 90% are noted for Bathroom Fixtures, Electrical Fixtures & Appliances, Furnishings & Fixtures, Hard Floors (eg vinyl), Patient Equipment, Soft Floors (eg carpet) and Walls & Ceilings.
- ❑ Windows average score exceeds 80% in this Group only.
- ❑ Doors and External Features are again the areas noted for improvement.
- ❑ Group D had insufficient scores for the pantry (Kitchen Fixtures & Appliances) element to have meaning.

CLEANING ELEMENTS – GROUP E (LOCAL HOSPITALS)



Analysis – Group E Facilities

- ❑ Group E Facilities show most average scores exceeding 90% indicating very high compliance with the *Cleaning Standards*.
- ❑ Bathroom Fixtures, General Tidiness, Hard Floors (eg vinyl), Kitchen Fixtures and Appliances (note: not main kitchens), Odour Control scores achieve 100% compliance.
- ❑ Ducts & Vents and Electrical Fixtures & Appliances show moderate average scores.
- ❑ Doors and Windows are again the areas noted for improvement.
- ❑ Group D had insufficient scores for the External Features element to have meaning.

5. CONCLUSION

5.1 PROJECT SUMMARY

By the conclusion of the project, all hospitals audited met the *Cleaning Standards*. Of the 56 hospitals audited, 47 received 'high achievement' scores over 90%.

Many hospitals achieved very high scores across a range of risk groups and functional areas, demonstrating commendable levels of compliance with the *Cleaning Standards*.

Overall compliance scores generally increased as the size and complexity of hospitals decreased, that is, Groups D & E hospitals had higher average compliance scores than Group A. This is quite reasonably a matter of scale and degree of complexity of the task.

The results for Very High and High Risk functional areas (Operating Theatres, Special Care Nurseries, Intensive Care Units, Emergency Departments, Central Sterile Supply Departments) and Nursing Units, show average scores above 85% in all hospital groups. This clearly demonstrates compliance with the *Cleaning Standards*, in the areas most identified with clinical risk of infection.

It is evident from analysis by cleaning elements, that the lower average scores for doors, external features and windows, point to the cleaning elements which receive lower budget priority, and which are less critical from a risk point of view.

5.2 PROJECT METHODOLOGY

The project tasks were completed as set out in the project documents. From the favourable comments received during review of audit methodology with hospital contact staff, the audit team concludes that its approach to the execution of the project received general acceptance.

6. RECOMMENDATIONS

6.1 HOSPITALS REPORTING

Throughout the project, the audit team noted how the audits had raised interest in hospital cleaning standards generally. For this focus to be maintained, ongoing reporting and transparency of compliance with the *Cleaning Standards* will be required.

Recommendation: That hospitals be required to report external audit results of cleaning standards to DHS at least once per year.

6.2 FUNDING

The high level of compliance found in these audits, is attributable to many factors, including specific project funding for implementation of the *Cleaning Standards*. This practical financial support has contributed to hospitals' ability to meet and exceed the *Cleaning Standards*.

Recommendation: That funding to support maintenance of hospital cleaning standards be continued.

6.3 REVIEW OF STANDARDS

The *Cleaning Standards* have received much attention and discussion within the health sector. All the discussions between the audit team and hospital staff confirmed that the *Cleaning Standards* have become widely accepted. However several components of the *Cleaning Standards* have been identified as open to interpretation, such as:

- ❑ the complexity of scoring method and formula
- ❑ assignment of risk weightings,
- ❑ definition of functional areas, and
- ❑ risk weighting of rooms adjacent to Very High and High Risk areas, eg Storerooms.

All of these items can impact significantly on the overall scores and compliance outcomes.

Recommendation: When DHS conducts its planned review of the *Cleaning Standards*, inviting comment from hospitals and stakeholders generally, it should address issues that are currently open to interpretation.

ANNEXES

- A. Glossary
- B. Audit Score Sheet (example)
- C. Audit Scores Summary (example)
- D. Audit Scores Chart (example)
- E. List of Hospitals Audited

GLOSSARY OF TERMS

<u>Term or Abbreviation</u>	<u>Meaning or Usage</u>
AQL	Acceptable Quality Level
'the <i>Cleaning Standards</i> '	Cleaning Standards for Victorian Public Hospitals – Acute Health Division – July 2000
Cogent	Cogent Business Solutions Pty. Ltd.
CogentAudit System	Database and Palm (handheld) software which collects cleaning audit information, calculates scores and generates reports.
CSSD	Central Sterile Supply Department
DHS	Department of Human Services – Acute Health Division
Functional Area	(from the <i>Cleaning Standards</i> 2.4.4) 'Functional Area is the area in which the cleaning occurs, for example, a ward or operating theatre. The area of the hospital which has been defined as having a particular risk associated with it is a Functional Area.'
High Risk	In the functional areas designated High Risk, the required standards are of high importance and must be maintained by frequent scheduled cleaning, and a capacity to spot clean.
Hospital Groups (DHS)	A - Teaching Hospitals B - Regional Base and Suburban Hospitals C - Regional General Facilities D - Area Hospitals E - Local Hospitals
ICU	Intensive Care Unit
Low Risk	In the functional areas designated Low Risk, the required cleaning standards are important for aesthetic, and to a lesser extent hygiene reasons. The outcomes should be achieved through regular cleaning on a scheduled basis, with a capacity to spot clean in between.
Minimal Risk	In the functional areas designated as Minimal Risk, the required standards can be met in these areas through infrequent cleans on a scheduled or project basis.
Moderate Risk	In the functional areas designated Moderate Risk, the required standards are important for both hygiene and aesthetic reasons. The outcomes should be maintained through regular cleaning on a scheduled basis, with a capacity to spot clean in between.
Palm	Handheld computer for collecting information. Information is later transferred to a desktop computer.
PIN	Personal Identification Number

<u>Term or Abbreviation</u>	<u>Meaning or Usage</u>
SCN	Special Care Nursery
Very High Risk	In the functional areas designated Very High Risk, the required cleaning standards are of critical importance. The outcomes must be achieved through the highest level of intensity and frequency of cleaning.

ANNEX B:
AUDIT SCORE SHEET

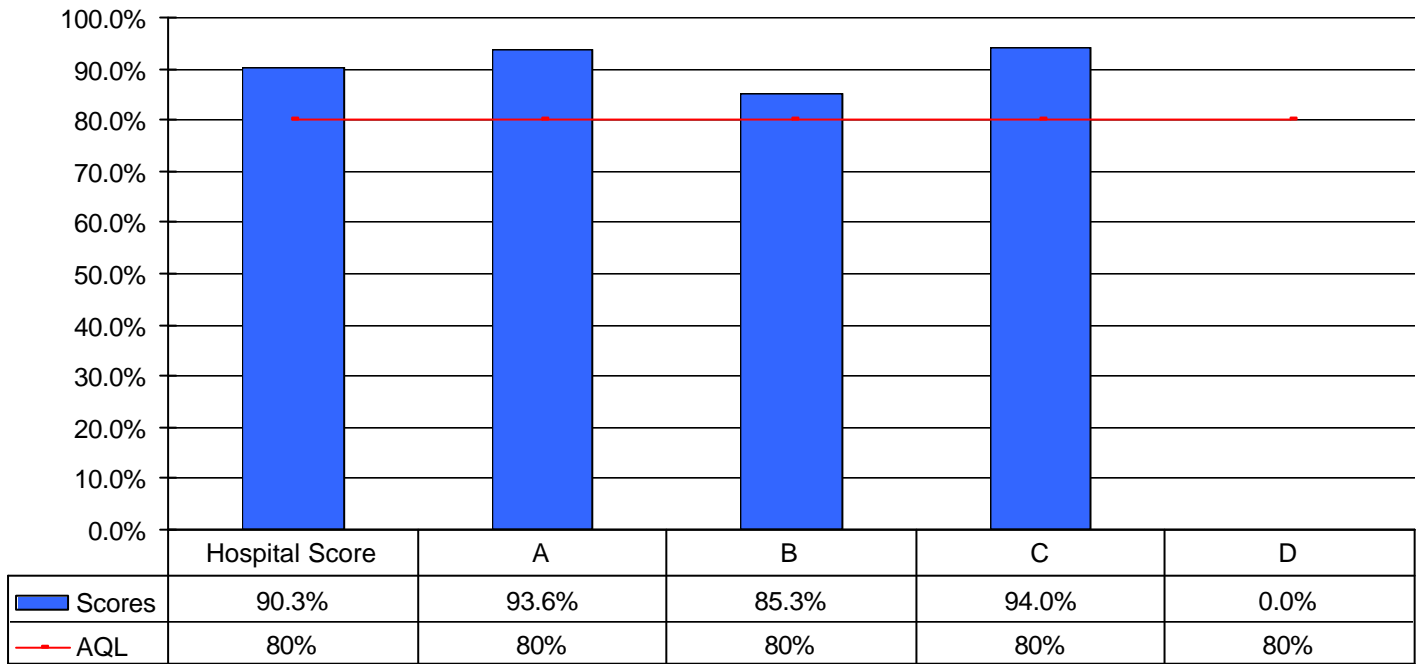
Audit Score Sheet																
Functional Area:	00 Ward 2 East			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Weighting</th> <th>Suggested Action</th> </tr> <tr> <td>A = 7</td> <td>Immediate</td> </tr> <tr> <td>B = 6</td> <td>0-48 Hours</td> </tr> <tr> <td>C = 4</td> <td>2-7 Days</td> </tr> <tr> <td>D = 2</td> <td>1-4 Weeks</td> </tr> </table>			Weighting	Suggested Action	A = 7	Immediate	B = 6	0-48 Hours	C = 4	2-7 Days	D = 2	1-4 Weeks
Weighting	Suggested Action															
A = 7	Immediate															
B = 6	0-48 Hours															
C = 4	2-7 Days															
D = 2	1-4 Weeks															
Auditor:	Sample Only															
Audit Date:	09-Mar-01															
Cluster Audited	Utility Rms & Pantry															
Elements	Pass Fail N/A	Comments	Risk Group	Demerit Points	Action Timeframe	Action Taken										
External features & stairwells	N/A		C		2-7 Days	<input type="text"/>										
Walls, skirtings & ceiling	Fail	Stains on wall Near benches	B	6	0-48 Hours	<input type="text"/>										
Windows	N/A		B		0-48 Hours	<input type="text"/>										
Doors	Fail	Top of door frame is dusty One door	B	6	0-48 Hours	<input type="text"/>										
Hard floors	Pass		B		0-48 Hours	<input type="text"/>										
Soft floors	N/A		B		0-48 Hours	<input type="text"/>										
Ducts & vents	Pass		B		0-48 Hours	<input type="text"/>										
Electrical fixtures & appliances	N/A		B		0-48 Hours	<input type="text"/>										
Kitchen fixtures & appliances	Fail	Fridge needs defrost and clean	B	6	0-48 Hours	<input type="text"/>										
Bathroom fixtures	N/A		B		0-48 Hours	<input type="text"/>										
Patient equipment	N/A		B		0-48 Hours	<input type="text"/>										
Furnishings & fixtures	Fail	Shelves dusty/dirty	B	6	0-48 Hours	<input type="text"/>										
Odour control	Pass		C		2-7 Days	<input type="text"/>										
General tidiness	Pass		B		0-48 Hours	<input type="text"/>										
Total Demerit Points				24												
Score (Formula: subtract total demerit points from 100)				76												
_____ AUDITOR		_____ DATE		_____ DEPARTMENT HEAD												
Wednesday, May 02, 2001																

ANNEX C:
AUDIT SCORES
SUMMARY

Audit Scores Summary						
					No. areas audited	Hospital Score
					15	90.3%
Group A - Very High Risk / weighting 7					5	93.6%
Operating Theatres, ICU, Level 2&3 Nurseries, Protective Isolation Areas						
Group B - High & Moderate Risk / weighting 6					6	85.3%
CSSD, Sterile Supply Areas, Emergency Dept, Pharmacy Clean Area, Wards, Level 1 Nursery, Laboratories, Medical Imaging						
Group C - Low Risk / weighting 4					4	94.0%
Mortuary, Waiting Rooms, Administration Areas						
Group D - Minimal Risk / weighting 2					0	Nil
Non Sterile Supply, Record Archives, Engineering Workshops, Plant Rooms, Ext. Surrounds						
Functional Area	Cluster	Risk Group	Demerit Points	Area Weight	Score	Weight'd Score
00 ICU	Nurses Stn & Public Area	A	4	7	96	672
00 ICU	Patient Bay #1	A	0	7	100	700
00 ICU	Patient Bay #2	A	7	7	93	651
00 ICU	Utility Rm #1	A	7	7	93	651
00 ICU	Utility Rm #2	A	14	7	86	602
00 Ward 2 East	Bathrm #1	B	12	6	88	528
00 Ward 2 East	Bathrm #2	B	12	6	88	528
00 Ward 2 East	Nurses Stn & Public Area	B	22	6	78	468
00 Ward 2 East	Patients Rm #1	B	12	6	88	528
00 Ward 2 East	Patients Rm #2	B	6	6	94	564
00 Ward 2 East	Utility Rms & Pantry	B	24	6	76	456
00 Patient Services	Admissions Office	C	4	4	96	384
00 Patient Services	Patients Accounts	C	4	4	96	384
00 Patient Services	Reception & Waiting Area	C	4	4	96	384
00 Patient Services	Unisex Toilet	C	12	4	88	352
Totals			144	87	1356	7852

ANNEX D:
AUDIT SCORES CHART
(EXAMPLE)

Audit Scores Chart



ANNEX E:
HOSPITALS AUDITED

1 – Barwon South Western Region

- 11 Barwon Health – The Geelong Hospital
- 12 Colac Community Health Services
- 13 Hesse Rural Health Service
- 14 Portland & District Hospital
- 15 Southwest Healthcare
 - Warrnambool Campus
- 16 Terang & Mortlake Health Service
- 17 Western District Health Service

2 – Grampians Region

- 21 Ballarat Health Services
- 22 Beaufort & Skipton Health Services
- 23 Djerriwarrh Health Services
- 24 Hepburn Health Service
- 25 Stawell District Hospital
- 26 Wimmera Health Care Group - Horsham

3 – Loddon Mallee Region

- 31 Bendigo Health Care Group
- 32 Echuca Regional Health
- 33 Kyabram & District Memorial Community Hospital
- 34 Maryborough District Health Service
- 35 Mildura Base Hospital
- 36 Rochester & Elmore District Health Service
- 37 Swan Hill District Hospital

4 – Hume Region

- 41 Benalla & District Memorial Hospital
- 42 Goulburn Valley Health
- 43 Seymour District Memorial Hospital
- 44 Tallangatta Health Service
- 45 Wangaratta District Base Hospital
- 46 Wodonga Regional Health Service

5 – Gippsland Region

- 51 Bairnsdale Regional Health Service
- 52 Central Gippsland Health Service
 - Sale Campus
- 53 Gippsland Southern Health Service
 - Leongatha

- 54 LaTrobe Regional Hospital - Traralgon
- 55 West Gippsland Healthcare Group - Warragul
- 56 Wonthaggi & District Hospital

6 - Western Region

- 61 Royal Children's Hospital
- 62 Royal Women's Hospital
- 63 Royal Melbourne Hospital
- 64 Northern Hospital
- 65 Sunshine Hospital
- 66 Western Hospital
- 67 Williamstown Hospital
- 68 Mercy Public Hospital, Werribee Campus

7 - Northern Region

- 71 Austin & Repatriation Medical Centre
- 72 Mercy Public Hospital
 - East Melbourne Campus

8 - Eastern Region

- 81 The Alfred
- 82 Sandringham & District Memorial Hospital
- 83 The Angliss Health Services
- 84 Box Hill Hospital
- 85 Maroondah Hospital
- 86 Yarra Ranges Health Service
- 87 The Royal Victorian Eye & Ear Hospital
- 88 Peter MacCallum Cancer Institute
- 89 St Vincent's Hospital

9 – Southern Region

- 91 Dandenong Hospital
- 92 Monash Medical Centre
- 93 Frankston Hospital
- 94 Rosebud Hospital
- 95 Kooweerup Regional Health Service