

# Environmental cleaning assessment protocol

Version 2

November 2013

## **Environmental Assessment Cleaning Protocol**

Tasmanian Infection Prevention and Control Unit (TIPCU)

Department of Health and Human Services, Tasmania

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## Foreword

There is evidence to demonstrate that environment plays an important part in infection prevention and control. For this reason, we consider the evaluation of environmental cleanliness to be an integral part of any infection prevention and control program. Numerous studies in the literature discuss novel methodologies that assess both the extent of environmental contamination in the hospital environment and efficacy of cleaning (1-6). Methods of evaluating environmental cleanliness can be broken down into two types: process evaluation, such as visual inspection and fluorescent gel application; and outcome evaluation, in which cleanliness is measured using methods such as adenosine triphosphate (ATP) or microbial cultures (7). An important fact to remember, however, is that just because the environment may appear 'dirty', this does not necessarily mean it poses an increased risk of infection for patients. Conversely, an environment that appears 'clean' may harbour microorganisms that are potentially harmful.

The purpose of this protocol is to outline a program of environmental cleanliness evaluation that can be carried out in a standardised manner within Tasmanian healthcare facilities.

Brett Mitchell

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Dr Alistair McGregor

Handwritten signature of Dr Alistair McGregor in black ink.

## Background

The Tasmanian Infection Prevention and Control Unit (TIPCU) has undertaken a review of the literature and interviewed key stakeholders in Australia to establish and evaluate current methods to assess environmental cleanliness. This work has been published in a peer reviewed journal (7). The findings were presented to infection control professionals and environmental services managers from across Tasmania at a 2012 forum convened by the TIPCU. At this forum, there was consensus to develop a standardised method evaluating environmental cleanliness in Tasmanian healthcare facilities. The methods chosen to evaluate environmental cleanliness were visual inspection and the use of fluorescent light, using a framework similar to the assessment processes described in the national hand hygiene initiative. To that end, the TIPCU were to develop a protocol to enable implementation of a standardised method for evaluating environmental cleanliness in Tasmanian hospitals. This protocol is the result of this work.

## Overview

Evaluating environmental cleanliness will involve two elements, which are described in detail in this protocol:

1. The use of an ultraviolet (UV) solution and fluorescent light assessment conducted quarterly in rooms that have undergone a discharge clean.
2. A visual assessment conducted at least quarterly.

This protocol does not address the following issues:

- The product(s) used to clean and the circumstances of when certain products should be used
- How to clean or types of cleaning methods
- Frequency of cleaning
- Models of cleaning, including staffing
- Actions required to be taken as a result of the assessment

## Value of a standardised approach

A standardised approach to evaluating environmental cleanliness has a number of advantages, including:

- Demonstrating a collaborative commitment to tackle the issue of healthcare associated infections.
- Providing local feedback to staff to help identify and improve practices
- Evaluating the impact of changes to cleaning models and processes
- Identifying areas of high compliance to explore and share contributory processes and models.
- Benchmarking
- Assisting in meeting national accreditation standards, more specifically Standard 3 of the National Safety and Quality Health Service (8)

## Principles of participation

Participation in the Tasmanian environmental cleanliness of healthcare program is voluntary. To participate in this program you need to:

### **DHHS acute care hospitals:**

- Contact TIPCU via telephone or email to notify them of your organisations desire to participate in the program
- Complete form in Appendix A and ensure sign off by THO CEO/Executive Sponsor
- When you choose to participate TIPCU will provide your organisation with access to all TIPCU developed on-line tools.
- For DHHS acute care facilities, namely Royal Hobart Hospital, Launceston General Hospital, Mersey Community Hospital and North West Regional Hospital, TIPCU will provide the site with enough UV fluorescent gel markers and UV lights for the number of sites consistent with the protocol for one year from the date they agree to participate as long as the agreement is signed prior to December 31<sup>st</sup> 2013.

### **Other DHHS and non-DHHS healthcare facilities:**

- Contact TIPCU via telephone or email to notify them of your organisations desire to participate in the program
- Complete form in Appendix B and ensure sign off by THO CEO/Executive Sponsor
- When you choose to participate TIPCU will provide your organisation with access to all TIPCU developed on-line tools.

## Definitions

For the purposes of this protocol, we have defined a number of terms.

Term	Definition
Cleaning	A process that removes dirt and debris from an object or a surface.
Discharge clean	A clean that is undertaken in a patient's bed area after transfer to another ward or unit or after discharge.
Fluorescent light	Source of ultraviolet (UV) light.
Fluorescent gel marker	A clear, non-toxic gel, designed for assessing environmental cleanliness, that fluoresces under ultraviolet (UV) light. For the purposes of this protocol, it refers to a product called Dazo®.
Patient care area	This refers to the space temporarily dedicated to an individual patient for that patient's stay. These include, but are not limited to, inpatient bed areas (including isolation rooms, patient bays, paediatric cots and neonatal incubators and/or cots), emergency department (where assessment or treatment is undertaken), theatre and outpatient clinics.
High risk areas	Patient care areas containing patients who are at a higher risk of developing a healthcare associated infection. These areas include adult and neonatal intensive care units, high dependency units and oncology/haematology wards both inpatient and outpatient.
UV gel sites	Specific sites on items within the patient care area that have been chosen to have fluorescent gel applied to them for the purposes of assessing cleaning using an ultraviolet (UV) light source. These sites are: patient call bell/button, patient tray table, bed rails, bedside locker/patient storage unit, patient chair, toilet/bathroom door handle, tap handle, door handle (inside patient room)
General ward areas	This refers to areas that adjoin patient care areas. These are areas where assessment and/or treatment of patients are not directly occurring. These include, but are not limited to, ward corridors, nurses' station, sterile stock rooms, equipment rooms and toilets/showers/bathrooms that are located off a ward corridor.

# Fluorescent gel and light assessment

## Overview

This method uses fluorescent gel applied to surfaces in patient care areas. The solution dries on surfaces and resists dry abrasion but is easily removed with light abrasion after wetting. The gel is visible only under UV light. Therefore, once the gel has been applied and after a room has been cleaned, the thoroughness of cleaning can be determined by using a fluorescent light to determine if gel remains. There are numerous studies demonstrating the usefulness of this methods (9-13).

## Principles

This protocol aims to be applicable to all Tasmanian hospitals that want to participate in the program (for example, acute public hospitals, rural hospitals, and private hospitals), so it is not possible to explicitly document all possible variations of how to undertake this evaluation. In order to provide consistency, there are some broad principles that should be followed, and these are:

- Only rooms/patient care areas that are undergoing a discharge clean should be assessed. The rationale for this is two-fold. First, evidence suggests that persons who inhabit a room following an occupant who had an infectious agent are then more likely to acquire that infectious agent themselves (14-16). Second, the assessment is easier to implement in rooms where the patient is no longer present.
- Only persons who are familiar with this protocol and who have received training on how to use the fluorescent gel and light should perform the assessment. A training package is available from the TIPCU.
- The UV gel sites assessed as part of this process are only those stipulated in this protocol (see “Selection of UV gel sites” for more detail).
- If a room/patient care area does not contain at least half of the required UV gel sites, do not perform the UV gel audit in this room/patient care area.
- The assessment should not be intentionally undertaken in a covert manner.
- For acute public hospitals, a minimum of 25% of patient care areas assessed should be from any ‘high risk’ areas (more detail provided under ‘Frequency and number of assessments’ section).
- Only UV gel sites deemed as ‘Not Clean’ should be re cleaned prior to a new patient being admitted to that patient care area. The entire room/patient care area does not require re-cleaning.
- The location of gel application does not indicate that only part of an object that should be cleaned.

## Selection of UV gel sites

The objects in a patient care area to which the gel can be applied vary; however, there is some consistency in the literature regarding the objects chosen. The purpose of stipulating the location of gel application is to aid the assessment of whether an object has been cleaned. For the purposes of this protocol, the fluorescent gel and light should be used **once** on each of the following objects, if they are present. Additional details on where to apply the UV gel are also provided in Appendix C – Example of where to apply the gel.

### 1. Patient call bell/button

- Apply to the call bell itself, not to any attachment, e.g. cord
- If there is more than one call bell in use, apply to the one closest to the patient bed area

### 2. Patient tray table

- Apply gel to the top of the table/tray or one of its sides.

### 3. Bed rails

- Apply to a bed rail on the sides of patient's bed or cot or to the access hatch on a neonatal incubator.

### 4. Bedside locker/patient storage unit

- Apply gel to the flat top of the locker or the top half of the sides or front.

### 5. Patient chair

- Apply gel to one of the arm rests or seat.

### 6. Toilet/bathroom door handle

- This refers to a door handle in an en-suite or where the toilet/bathroom is shared by patients in the same area. This does not apply to toilets or bathrooms that are outside the patient area, for example, in a corridor.
- Apply gel to any part of the door handle.

### 7. Tap handle

- This refers to a sink in the patient room, patient area or en-suite that is for patient or clinical use. It does not apply to sinks that are outside the patient area, for example, in a corridor, walkway, treatment rooms, etc.
- Apply gel to one of the tap handles.

### 8. Door handle (inside patient room)

- This applies only to single rooms. It refers to the inside door handle of a door that is in the patient area.
- Apply gel to the inside door handle

## Frequency and number of assessments

The assessment should be completed quarterly. Any data collected during the quarter will be saved and analysed. For the purposes of providing data to the TIPCU, the year is broken into the following quarters:

Quarter	Any data collection during these dates
1	1 <sup>st</sup> January – 31 <sup>st</sup> March
2	1 <sup>st</sup> April – 30 <sup>th</sup> June
3	1 <sup>st</sup> July – 30 <sup>th</sup> September
4	1 <sup>st</sup> October – 31 <sup>st</sup> December

In each quarter, the following minimum number of rooms should be assessed. For acute public hospitals, a minimum number of rooms is recommended to be assessed from any 'high risk' areas, as indicated in the table below. This number equate to approximately 25% of assessed rooms.

Hospital size	Minimum number of rooms to be assessed each quarter*	Minimum number of rooms assessed from a high risk area
<15 beds	2	0
15-50 beds	3	0
50-100 beds	8	2
100-150 beds	10	3
150-250 beds	15	4
250-400 beds	25	7
400-500 beds	40	8

\*The calculation of this equates to approximately 10% of hospital beds

## The procedure

Ideally, the cleaner who is cleaning the patient care area should not be aware that the assessment is being undertaken; however, this not mandatory. The procedure is:

1. Identify the patient care area that requires a discharge clean.
2. Apply the fluorescent gel once to each of 8 specified UV gel sites. If all 8 areas are not available or relevant, apply to as many as possible. The 8 sites are:
  - i. Patient call bell/button
  - ii. Patient tray table
  - iii. Bed rails
  - iv. Bedside locker/patient storage unit
  - v. Patient chair
  - vi. Toilet/bathroom door handle
  - vii. Tap handle
  - viii. Door handle (inside patient room)
3. Make a note as to which areas have had the fluorescent gel applied.
4. Allow time for the gel to dry (approximately three minutes)
5. Return to the patient care area after cleaning has taken place (same day) and use the light to determine whether an area has been cleaned.
  - a. If no fluorescence is present, then consider that object to have been cleaned. This should be marked as “Clean” on the assessment tool.
  - b. If **any** level of fluorescence is present, then consider that object not to have been cleaned. This should be marked as a “Not Clean” on the assessment tool.
  - c. If you have forgotten the location of the fluorescence gel, then leave the response blank on the assessment.
6. Complete the results of the assessment using the Online assessment tool.
7. Results should be fed back to the supervisor and/or cleaner as determined locally.

# Visual assessment

## Overview

The primary method for assessing the cleanliness of healthcare environments is visual inspection (17, 18). Commonly, environmental cleanliness assessments are undertaken by environmental cleaning staff, and the effectiveness of these is intermittently assessed by healthcare professionals such as infection control staff or trained monitoring consultants (19, 20). While visual assessment of the cleanliness of a hospital ward, surface or item may satisfy aesthetic obligations, it cannot reliably assess the infection risk posed to patients (17). It is for this reason that visual assessment in isolation is not necessarily a reliable indicator for standards of healthcare cleanliness. Visual assessments are, however, common practice in Tasmania, Australia and internationally.

## Principles

As this protocol aims to be applicable to all Tasmanian hospitals that want to participate in the program (for example acute public hospitals, rural hospitals, and private hospitals), it is not possible to explicitly document all possible variations of how to undertake this assessment. In order to provide consistency, only persons who are familiar with this protocol and who have received training on this assessment should undertake it.

## Tasmanian visual assessment

Visual assessments are used to look at cleanliness in all areas of the hospital. For the purposes of the Tasmanian assessment, two different visual assessment tools have been developed, to allow flexibility and additional clarity for specific items. The two visual areas are defined by the location in which the assessment is being undertaken, namely:

### I. Patient care areas.

- a. This refers to the space temporarily dedicated to an individual patient for that patient's stay.
- b. This refers to the space temporarily dedicated to an individual patient for that patient's stay. These include, but are not limited to, inpatient bed areas including isolation rooms, patient bays, paediatric cots and neonatal incubators and/or cots, emergency department (where assessment or treatment is undertaken), theatre and outpatient clinics.
- c. The surroundings to be included in a patient area are:
  - i. For single/isolation rooms, the entire room and any en-suite from which access can be gained from the room.
  - ii. For shared patient areas, the entire room in which all patients are physically located and also any shared toilet/bath/shower room that can be accessed directly from this area.
- b. Assessments should be undertaken after a routine clean or a discharge clean.

## 2. General ward areas.

- a. This refers to areas that adjoin patient care areas. These are areas where assessment or treatment of patients does not directly occur. These include, but are not limited to, ward corridors, nurses' station, sterile stock rooms, equipment rooms and toilets/showers/bathrooms that are located off a ward corridor.
- b. Assessments should be undertaken after a routine clean.

## Areas to be assessed and determination of cleanliness

The areas to be assessed for both the Patient Care Area Assessment and the General Ward Area Assessment are detailed in the following table. The areas were chosen to ensure consistency with approaches taken in NSW (21), Victoria (22) and existing practices in Tasmania. Additionally, some sites are more specific so as to allow comparisons between the visual assessment and fluorescent gel for those sites.

An assessed area will be deemed "Clean" or "Not clean", based on the descriptor provided in the table below. If an area is not assessed, "Not applicable" may be selected on the assessment tool.

## Areas to be assessed and determination of cleanliness

Patient care areas	General ward areas	Descriptor
-	External features, fire exits and stairwells	Includes landings, ramps, fire exits, porches, patios, balconies, eaves and external light fittings. These items must be free from dust, grit, dirt, leaves, cobwebs, cigarette butts and bird excreta.
Walls, skirting, ceilings	Walls, skirting, ceilings	Free from dust, grit, lint, soil, film and cobwebs. Free from marks caused by furniture or equipment. Light switches free from fingerprints, scuffs and marks.
Windows	Windows	Free from streaks, spots and marks, including fingerprints and smudges.
Doors & door frames to include handle inside patient room; toilet/bathroom door handle; all other	Doors & door frames	Free from dust, grit, marks and spots.
Floors - hard	Floors - hard	Free from dust, grit, litter, marks and spots, traffic lanes and scratches. Polished/buffed floors appear uniform.
Floors - carpeted	Floors - carpeted	Free from dust, grit, litter, marks and spots, water or other liquids and traffic lanes.
Ducts, grills and vents	Ducts, grills and vents	Kept unblocked and free from dust, grit, soil, film, cobwebs, scuffs and other marks.
-	Electrical fixtures and appliances	Free from grease, dirt, dust, encrustations, marks, stains and cobwebs.
Furnishings and fixtures - to include patient tray table; bedside table/locker; patient chair; bed rail; patient call bell/button; tap handle/s; patient bed curtains; blinds and drapes; all other	Furnishings and fixtures	Free from spots, soil, film, dust, fingerprints, spillages, dust and bodily fluids. Curtains/blinds/eaves are free from dust, stains, lint and cobwebs. 'All other' includes beds and other patient furniture not listed.
-	Pantry fixtures and appliances	Free from spots, soil, film, dust, fingerprints, spillages, dust and bodily fluids. Fridges/freezers are clean and free from ice build-up.
Toilet and bathroom fixtures, broken into toilet, sink/s, shower, bath	Toilet and bathroom fixtures - Toilet	Free from smudges, smears, body fats and bodily fluids, soap build-up, mineral deposits and mould. Sanitary disposal units are clean and operational.
Patient equipment	Patient equipment	Free from soil, smudges, dust, fingerprints, grease and spillages, bodily fluids and tissue.
-	Cleaning equipment	Free from smudges, smears, body fats and bodily fluids, soap build-up, mineral deposits and mould.
General tidiness	General tidiness	Appears tidy and uncluttered. Floor space is clear.
-	Odour	Odour free

## Frequency and number of assessments – patient care areas

For ease of implementation and consistency with the fluorescent gel assessment, the **patient care assessments** should be completed at least quarterly. Any data collected during the quarter will be kept and analysed. For the purposes of providing data to the TIPCU, the year is broken into the following quarters:

Quarter	Any data collection during these dates
1	1 <sup>st</sup> January – 31 <sup>st</sup> March
2	1 <sup>st</sup> April – 30 <sup>th</sup> June
3	1 <sup>st</sup> July – 30 <sup>th</sup> September
4	1 <sup>st</sup> October – 31 <sup>st</sup> December

In each quarter, the following minimum number of rooms should be assessed. For acute public hospitals, a minimum number of rooms are recommended to be assessed from any 'high risk' areas, as indicated in the table below. This number equate to approximately 25% of assessed rooms.

Hospital size	Minimum number of rooms to be assessed each quarter*	Minimum number of rooms assessed from a high risk area
<15 beds	2	0
15-50 beds	3	0
50-100 beds	8	2
100-150 beds	10	3
150-250 beds	15	4
250-400 beds	25	7
400-500 beds	40	8

\*The calculation of this equates to approximately 10% of hospital beds

## Frequency and number of assessments –general ward areas

The **general ward assessments** can be undertaken at a frequency determined locally.

### The procedure

The procedure is set out below:

1. Identify a room to be assessed. This should be after the room has been cleaned, either a routine or discharge clean.
2. Complete the assessment (patient care area and/ or general ward area) using the online assessment tool.
  - a. For each item in the assessment tool, mark “Clean” or “Not Clean”.
  - b. If an item is not present or cannot be assessed, mark “Not applicable”.
3. Results should be fed back to the supervisor and/or cleaner as determined locally.

## Online assessment tool

Use the online assessment tool developed by the TIPCU for completion of both the fluorescent gel assessment and visual assessment. Participating hospitals will be given their own unique web address that links directly to the tool. Information regarding access to data/reports is provided in the next section.

The TIPCU will manage the online assessment tool to ensure consistency across the State. Examples of the online assessment tool are provided in Appendix B, but are subject to change.

## Assessors

Only persons who have undergone training and successfully undertaken an exam may undertake the assessments contained in this protocol. This is to ensure a high level of inter-rater reliability given the relatively subjective nature of these assessments and to have a mechanism for communicating changes and updates to the assessors. To support this process, the TIPCU have developed a PowerPoint presentation explaining this protocol and the assessment process. The TIPCU will provide initial training on the assessment tool to a limited number of hospital hotel services manager/s or supervisors and infection control staff.

The following process should occur for anyone who wants to or is required to undertake assessing:

1. Hospitals should identify individuals who will undertake this assessment.
2. Potential assessor should review the PowerPoint presentation provided by the TIPCU. If they have any questions, they should seek advice from their infection control unit and/or relevant hotel services manager/s or supervisors.
3. Once ready to undertake an exam, the infection control unit and/or hotel services manager/s or supervisor/s will provide the potential assessor with a link to an online multiple choice questionnaire exam. This exam is written in a manner that is easily understood.
4. Once the exam is completed, the TIPCU will be notified of the result.
  - For persons who obtained an 80% or above result:
    - TIPCU will notify the assessor and supervisor<sup>1</sup> of the result.
    - Their name will be added to list of assessors on the online assessment tool.
  - For persons did not obtain an 80% or above result:
    - The TIPCU will contact their supervisor<sup>1</sup>.

<sup>1</sup> Supervisor details will be collected as a mandatory part of the exam process

## Reporting

Reports regarding both the fluorescent gel and visual a can be run locally by nominated persons in the participating hospital. For each participating hospital, the TIPCU will provide a unique password protected web link from which reports can be run. The report data can be downloaded into an Excel document for further manipulation as needed.

The Tasmanian healthcare associated advisory committee (or equivalent) will review data at a State level to examine any trends.

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## Appendix A – Agreement to Participate – DHHS acute care facility

**Date:**

**Name of facility/hospital participating:**

We, the undersigned, agree to participate in the Tasmanian Environmental Assessment Program that has been designed by the Tasmanian Infection Prevention and Control Unit (TIPCU) for use in healthcare facilities.

**By signing this agreement we agree to:**

- Perform the environmental assessments as outlined in the TIPCU Environmental Assessment Program Protocol.
- Submit collected data via the on-line data collection tool

**We acknowledge that:**

- TIPCU will provide Access to the password protected on-line data collection and reporting tool
- TIPCU will supply, for the Royal Hobart Hospital, Launceston General Hospital, NW Regional Hospital and Mersey Hospital, enough UV fluorescent gel markers and UV lights for the number of sites consistent with the protocol for one year from the date on this agreement, so long as the agreement is signed prior to December 31<sup>st</sup> 2013. After this time, the supply of such equipment is discretionary.
- TIPCU may use data submitted by your hospital for the purposes of aggregating Tasmanian level data i.e. state level – not hospital level data. These state level data may be published.

**Executive Sponsor**

**Infection Control Manager/Unit**

**Environmental Services Manager**

Name

Name

Name

Signature

Signature

Signature

Date

Date

Date

## Appendix B – Agreement to Participate – non DHHS facility

**Date:**

**Name of facility/hospital participating:**

We, the undersigned, agree to participate in the Tasmanian Environmental Assessment Program that has been designed by the Tasmanian Infection Prevention and Control Unit (TIPCU) for use in healthcare facilities.

**By signing this agreement we agree to:**

- Perform the environmental assessments as outlined in the TIPCU Environmental Assessment Program Protocol.
- Submit collected data via the on-line data collection tool

**We acknowledge that:**

- TIPCU will provide access to the password protected on-line data collection and reporting tool
- TIPCU may use data submitted by your hospital for the purposes of aggregating Tasmanian level data i.e. state level – not hospital level data. These state level data may be published.

**Executive Sponsor**

**Infection Control Manager/Unit**

**Environmental Services Manager**

Name

Name

Name

Signature

Signature

Signature

Date

Date

Date

## Appendix C – Agreement to Participate – DHHS Non - acute care facility

**Date:**

**Name of facility/hospital participating:**

We, the undersigned, agree to participate in the Tasmanian Environmental Assessment Program that has been designed by the Tasmanian Infection Prevention and Control Unit (TIPCU) for use in healthcare facilities.

**By signing this agreement we agree to:**

- Perform the environmental assessments as outlined in the TIPCU Environmental Assessment Program Protocol.
- Submit collected data via the on-line data collection tool

**We acknowledge that:**

- TIPCU will provide access to the password protected on-line data collection and reporting tool
- TIPCU will supply data collection tools, UV fluorescent gel markers and UV lights for the number of sites consistent with the protocol for one year from the date on this agreement.
- TIPCU will evaluate the Tasmanian Environmental Assessment Program in non-acute DHHS sites after six months.
- TIPCU may use data submitted by your hospital for the purposes of aggregating Tasmanian level data i.e. state level – not hospital level data. These state level data may be published.

<b>Executive Sponsor</b>	<b>Infection Control Manager/Unit</b>	<b>Environmental Services Manager</b>
Name	Name	Name
Signature	Signature	Signature
Date	Date	Date

## Appendix D – Example of where to apply the gel

### Patient call bell / button



### Bed rail



### Bed side – neonatal cot



**Access hatch – neonatal incubator**



**Bedside locker / patient storage unit**



**Patient tray table**



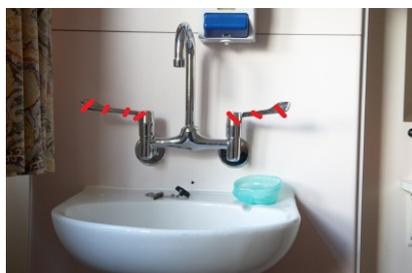
**Patient chair**



**Toilet / bathroom door handle**



**Tap handle**



**Door handle (inside patient room)**



## Appendix E – Examples of the online assessment tool

(Note that these are provided as examples and are subject to change)



Tasmanian Infection Prevention and Control Unit

Environmental Assessment

THO - South

**Assessment period and location**

**\*1. Assessment period**

**\*2. Hospital**

**\*3. Auditor**

**\*4. Date of audit**  
 Date DD / MM / YYYY  
 /  /

**\*5. Ward / location**  
  
 Other or comment (please specify)

**\*6. Bed number or patient area**

**\*7. What assessment are you undertaking?**  
 Fluorescent gel  
 Visual inspection

### 2. Fluorescent gel marker assessment

+ Add Question ▼

Q8 Edit Question ▼ Move Copy Delete

#### 8. Document the outcome from the assessment (leave blank if object not audited)

	Clean	Not clean
Patient call bell / button	<input type="radio"/>	<input type="radio"/>
Patient bedside table or tray	<input type="radio"/>	<input type="radio"/>
Bed rail	<input type="radio"/>	<input type="radio"/>
Bedside table / locker	<input type="radio"/>	<input type="radio"/>
Patient chair	<input type="radio"/>	<input type="radio"/>
Toilet / bathroom door handle	<input type="radio"/>	<input type="radio"/>
Tap handle	<input type="radio"/>	<input type="radio"/>
Door handle (handle inside patient room).	<input type="radio"/>	<input type="radio"/>



Tasmania  
Explore the possibilities

**TASMANIAN INFECTION  
PREVENTION AND CONTROL  
UNIT**

Population Health

Department of Health and  
Human Services

GPO Box 125, Hobart 7001