ASIA PACIFIC SOCIETY OF INFECTION CONTROL

# APSIC
# Environment Hygiene Self-Assessment Form

schülke

# A. Hospital cleanliness

**IMPORTANT: Items highlighted in blue are mandatory.**

**Q1.** A detailed environmental hygiene plan is developed in consultation with relevant stakeholders, including infection prevention and control (IPC) personnel, and reviewed annually.

- Annual plan developed and implemented
- Ad-hoc plans developed and implemented
- No documented plan

**Q2.** Financial and manpower resources are allocated to organise and execute the environmental hygiene plan.

- FTE assigned to implement plan
- FTE assigned ad-hoc basis
- No FTE assigned

**Q3.** Policies are in place to provide standard by which environmental services staff perform to meet best practices.

- Policies in place and complied by ES staff
- Policies exist but not full implementation by ES staff
- Inadequate policies guiding ES staff

**Q4.** Cleaning schedules are developed with frequency of cleaning; using risk assessment based on whether surfaces are high-touch or low-touch; vulnerability of patients in area and probability of contamination.

- Clear schedule developed and complied with for all areas in facility
- Schedule exists only for high risk areas
- Cleaning scheduled left to cleaning staff to determine as per contract

**Q5.** Cleaning products are approved by IPC and environmental services and used according to the manufacturers' recommendations such as recommended use-dilution, material compatibility, storage, shelf-life, and safe use and disposal.

- IPC involved in review and approval for all cleaning products used in facility
- IPC involved in review and approval only for selected products
- IPC not involved in review and approval

**Q6.** 'No-touch' technologies such as hydrogen peroxide vapor systems, ultraviolet-C light devices, electrostatic spraying may be considered for terminal room decontamination after discharge of patients on contact precautions, especially if the patient had a high consequence pathogen (e.g., Ebola, *C. auris*).

- UV-C or HPV treatment used in enhanced terminal room decontamination for identified scenarios agreed with IPC team
- UV-C used in enhanced terminal room decontamination only during pandemic or emerging infectious disease scenarios
- No-touch technologies not available

**Q7.** Basic education on cleaning and IPC is provided to all staff e.g. cleaning staff on use of personal protective equipment, cleaning agents and their preparation and cleaning of infected and noninfected areas.

- All staff involved in cleaning are trained in cleaning and IPC
- Only environmental cleaning staff are trained in cleaning and IPC
- No training plan on IPC for staff involved in cleaning

**Q8.** There should be a process in place to measure the quality of cleaning in the healthcare setting. Methods of monitoring cleanliness should include at least the conventional visual assessment and/or fluorescent marking.

- Visual and fluorescent marking used in audit
- Visual and fluorescent marking used in audit of selected areas only
- Visual assessment used only in audit

**Q9.** Results of cleaning audits should be collated and analysed with immediate feedback to staff, and an action plan developed to identify and correct deficiencies.

- Done facility wide
- Done only for high-risk areas
- No feedback given to staff

**Q10.** Non-critical medical equipment requires cleaning and disinfection after each use.

- Active plan for this facility wide
- Disinfection done only for selected equipment
- Only cleaning is done i.e. no disinfection

## Hospital cleanliness

### Mandatory score

### Total score

# B. Indoor air quality

**IMPORTANT: Items highlighted in blue are mandatory.**

**Q1.** The healthcare facility is designed and built according to at least national specifications.

- Clear specifications facility wide
- Specifications exist only for high-risk areas
- No specifications applied

**Q2.** The IPC team should be in close collaboration with the architects, engineers and project teams in designing of new facilities or renovation of existing healthcare facilities.

- Active participation of IPC team
- IPC team only involved in selected projects
- IPC team not involved

**Q3.** Healthcare facilities should have a plan to assess risks for HAIs for renovation and construction activities.

- ICRA tool used in assessing risks for HAIs in renovation and construction activities facility-wide
- ICRA tool used assessing risks for HAIs only in renovation and construction activities in high-risk areas
- ICRA tool not in use

**Q4.** Risks for fungal and *Legionella* infections are assessed especially in areas housing immunocompromised hosts.

- Done facility wide
- Only in areas housing immunocompromised hosts
- Not done

**Q5.** Plans for mould control plan are in place esp. for patients in high-risk areas.

- All patient care areas
- Only for high-risk areas
- No plans in place

**Q6.** Critical ventilation systems should be inspected at least 6 monthly and certified at least once every two years or as required by national requirement.

- Done facility wide
- Only in high-risk areas
- Not done

**Q7.** $CO_2$ monitoring is used as a proxy to assess ventilation adequacy ($CO_2$ < 800 ppm).

- Done facility wide
- Only in high-risk areas
- Not done

**Q8.** There is adequate ventilation in patient care areas:

**Ventilation rate**

- minimum 60 L/sec/person or 6ACH for general wards and outpatients
- minimum 160L/sec/person or 12 ACH where AGPs are performed
- minimum 2.5 L/sec/m3 for corridors and other transient spaces without fixed patient numbers
- Airflow direction from clean to less clean zones

- All clinical areas
- Only in high-risk areas
- No reviews done

**Q9.** Immunocompromised patients e.g. bone marrow cell transplant, neutropenic patients, etc are housed in appropriate rooms with HEPA filtered units and positive pressured rooms.

- Adequate PE rooms exist in haematology wards
- At least 2 PE rooms in haematology ward
- No PE rooms

**Q10.** IPC works in collaboration with Facilities department on prevention of acquisition of pathogens via airborne transmission.

- All areas
- Only for high-risk areas
- No collaborative work

## Indoor air quality

### Mandatory score

### Total score

# C. Water management

**IMPORTANT: Items highlighted in blue are mandatory.**

**Q1.** There is a healthcare water management program to identify risk points and corrective actions planned to minimise the growth and spread of waterborne pathogens.

- Program exists with clear plans and review processes
- Program exists only for high-risk areas
- No program

**Q2.** A multidisciplinary water management committee is appointed to design, implement and review the water management plans for the facility.

- Committee appointed to report to IPC Committee
- Committee appointed but reporting structure not defined
- No committee

**Q3.** Potential hazards and risks in water system are identified and plans developed for targeted monitoring, risk mitigation and strategies for control.

- Identified and strategic plans developed for mitigation
- Identified but unclear or no plans developed
- Not in existence

**Q4.** Surveillance for Legionella or other Gram-negative bacilli is conducted at cooling towers, and other risk points e.g. shower heads to monitor for biofilms that may pose risks for HAIs

- Clear surveillance plan and monitoring system for Legionella and other Gram-negative bacilli
- Clear surveillance plan and monitoring system for Legionella only
- Not in existence

**Q5.** Policies are in place to guide response actions as and when there is a case of healthcare onset Legionellosis.

- Policies in place and complied with
- Policies in place but not fully complied with
- Not in existence

**Q6.** Water management construction (WMC) ICRA is conducted prior to construction and renovation where building water distribution system construction activities and scope of work and risk of patients in area are assessed before appropriate infection prevention and control precautions are taken for respective class of risks described.

- Done for all renovation and construction projects
- Done only for major projects involving areas housing immunocompromised hosts
- Not in existence

**Q7.** There is adequate total residual chlorine level ≥ 0.3mg/L in water system.

- Yes, facility-wide
- Only for high risk areas
- Not measured / unknown

**Q8.** Hot water systems are maintained at >60°C.

- All the time facility wide
- Only for high-risk areas
- Not in existence / unknown

**Q9.** Where water is sampled for Legionella surveillance, it is well controlled when routine sampled yield <1 cfu/ml *Legionella sp.*

- All the time facility wide
- Only for high-risk areas
- Not in existence / unknown

**Q10.** Prior to occupancy of new buildings, verification of safe water system is done viz. targeted microbiological testing (including *Legionella sp.*), residual chlorine level; and results are reviewed by Water Management Committee.

- Done for all projects facility wide
- Processes carried out but not reviewed by Water Management Committee
- Not in existence

## Water management

### Mandatory score

### Total score

| | MANDATORY | TOTAL |
|---|---|---|
| A. Hospital cleanliness | | |
| B. Indoor air quality | | |
| C. Water management | | |
| TOTAL | | |