Falling Standards, Rising Risks:

Issues in hospital cleanliness with contracting out

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Prior to publication copies of this report, along with requests for a response, were sent to the following: Ida Goodreau, President and CEO of Vancouver Coastal Health (VCH); Carl Roy, President and CEO of Providence Health Care; John Blatherwick, Chief Medical Health Officer for VCH; Perry Kendall, Provincial Health Officer; and Doug Cochrane, Chair of the Provincial Task Force on Patient Safety. Their responses are included in an addendum to this report on page 59.

Executive Summary

PURPOSE AND SCOPE OF THE PROJECT

This report is an examination of cleaning services and monitoring mechanisms at St. Paul's Hospital in Vancouver, British Columbia. It was prompted by concerns that the safety of Greater Vancouver hospitals and long-term care facilities has been compromised since the privatization of housekeeping services in 2003.

Nurses and other care providers in the Vancouver Coastal Health region are alarmed by deteriorating standards in cleanliness and by communication difficulties with cleaning contractors. In particular, hospital staff are deeply worried that infection control practices are slipping. They are concerned that the Vancouver Coastal Health Authority does not have a monitoring system that can accurately gauge the cleanliness of facilities, the soundness of infection control practices, and the capacity of vendors to deliver knowledgeable, responsive, and stable cleaning services. They are troubled that nurses must spend an inordinate amount of time making service requests, which means less time for direct patient care. They are concerned that cleaning problems are contributing to back-ups in the Emergency Department and hence to slower responses to the public. Risks to patients, the community, workers, and the health care system itself appear to be on the rise.

…hospital staff are deeply worried that infection control practices are slipping.

The project is a collaboration of the B.C. Nurses' Union and the Hospital Employees' Union in consultation with the Health Sciences Association. Our members wanted a systematic and credible means of assessing the state of cleaning and infection control practices since privatization. To this end, we conducted an environmental scan of one facility – St. Paul's Hospital, with a particular emphasis on the Emergency Department – and gathered data from the hospital's health care team. We also examined scientific literature regarding relationships between hospital cleanliness, hospital-acquired infections, and privatized housekeeping services; reviewed documents from the health authority; and interviewed experts. The project does not claim to be a full research study but rather a preliminary data collection and analysis that identifies key problems and future avenues for study and action.

RECOMMENDATION

This report outlines problems and risks that have emerged in the Vancouver Coastal Health region since housekeeping services were contracted out. We believe a more thorough study of the situation is urgently needed.

We recommend that the Vancouver Coastal Health Authority commission a comprehensive, independent audit of the region's housekeeping services, especially in the realm of infection control and other patient safety issues. In light of the problems described in this report, the audit should appraise issues relating to:

- communication and coordination between the contractor/cleaners and the hospital (RNs, Unit Coordinators, and Bed Booking staff; the infection control team; health and safety committee; and other relevant relationships);
- the VCHA's quality assurance structure and mechanisms, with particular attention to issues of sensitivity and thoroughness, feedback and enforcement mechanisms, and transparency and accountability features;
- hidden costs and savings, and hidden inefficiencies and efficiencies due to contracting out;
- cleaning staff retention and job satisfaction;
- contractors' compliance with Workers' Compensation Board requirements and with established occupational health and safety practices;
- skill development, training, and support of cleaners; and
- skills and support of cleaning supervisors.

We suggest that the B.C. Auditor General or another recognized professional auditor be charged with this research. The audit should be wide-ranging, descriptive, and analytic. We recommend that survey and qualitative data be collected from personnel at all levels of the system and in all relevant job categories, public and private employees alike. The views of patients and family members should also be solicited.

The results of the audit should be made public and any recommendations arising from the audit should be referred to a multi-stakeholder group for implementation.

BACKGROUND TO THE ISSUES

Privatization of support services

The Vancouver Coastal Health Authority began to contract out support services in 2003. Provincial legislation (Bill 29) had paved the way by eliminating job security and 'no contracting-out' clauses from the Hospital Employees' Union (HEU) collective agreement. Housekeepers, food service workers, security personnel, and laundry workers covered by the HEU were laid off en masse beginning in the fall of 2003.

The VCHA entered into an agreement with Aramark Canada Ltd. to deliver housekeeping services at all acute care hospitals and several long-term care facilities across the region. Aramark, a multinational corporation, entered into a partnership agreement with the Industrial Wood and Allied Workers (IWA) to represent the new housekeepers. Under the old HEU contract, the health region's former housekeepers received approximately $18 an hour, a range of benefits, seniority rights, and job security. Aramark cleaners receive from $9.50 to $11 an hour and minimal statutory benefits. Their remuneration is significantly lower than market rates for the health care and hospitality sectors everywhere in Canada, and extremely low given the high cost of living in Vancouver.

Hospital-acquired infection: The extent and sources of the problem

Most Canadians are familiar with the story of how severe acute respiratory syndrome (SARS) caused havoc in Toronto in the spring of 2003. Many will have heard of the "superbugs:" the antibiotic-resistant organisms such as MRSA (methicillin resistant *Staphylococcus aureus)*, Clostridium difficile (*C. difficile),* and VRE (vancomycin resistant *enterococcus)*. The Norwalk virus and similar viruses have surfaced in nursing homes with alarming frequency in recent years.

Yet most Canadians are unaware of the enormous toll these infections have taken on individuals, families, and the health care system itself. The human cost is estimated at 8,000 deaths a year.[1] According to Zoutman et al., hospital-acquired infections in U.S. acute care facilities are calculated to cost $4 billion (US) annually; in Great Britain, the figure is £900 million.[2] There are no published Canadian data on financial costs but they are understood to be comparable.

The human cost is estimated at 8,000 deaths a year.

Several factors account for the growing concerns about hospital-acquired infection: new strains of micro organisms; new diseases such as SARS; the aging and expanding population;

[1] Zoutman, Dick E., et al. "The state of infection surveillance and control in Canadian acute care hospitals." *AJIC* 31:5 (August 2003), p. 271.
[2] Ibid. p. 271

increased international travel; and rising numbers of Canadians living longer with chronic diseases and compromised immune systems. Conditions within the health care system can also heighten the risks.

Rapid turnover, lack of isolation, overcrowding: Imbalances and shortages throughout the system lead to rapid turnover of patients. This quick in-and-out translates into both intensified exposure and diminished opportunities to detect infection in patients who are sent home early and later return with full-blown disease.

Facilities are also less able to isolate infected and vulnerable patients due to a shortage of single-occupancy rooms. As a result, a person with a compromised immune system or a surgical patient with an open wound is often forced to share a room with an MRSA-infected individual.

Overcrowding is a known ingredient in the spread of MRSA. Studies show that a desirable bed occupancy rate is around 85%. Occupancy rates at St. Paul's Hospital and other Greater Vancouver facilities are running "over census" – at between 95% and 105%. Improving bed management and isolation facilities is one of seven action areas adopted by Britain's National Health Service to prevent and control hospital-acquired infections.[3]

The role of housekeeping in infection control

Infection control professionals think in terms of a web of causes that demands a web of responses. Conservative use of antibiotics, more isolation rooms, less pressure on beds, careful monitoring of patients and staff, regular hand washing, and high standards of environmental hygiene – these are some measures proven to be effective parts of a coordinated strategy. Fundamental to this picture are clean rooms with clean furnishings and clean equipment. Poor hospital sanitation is not just an enemy of good healing; it can be a leading cause of disease and death. Microbiologist S.J. Dancer notes that hospital cleaning "is, in fact, likely to be a critical factor in infection control and the continuing fight against hospital-acquired infections."[4]

The literature points to links between appropriate housekeeping practices and lower infection rates. Significantly, the campaign in the United Kingdom against nosocomial (hospital-acquired) infections deals with the role of housekeeping on a systems level.[5] The aim is to bring cleaners into close orbit with infection control personnel and the health care team in general.

[3] "Improving patient care by reducing the risk of hospital-acquired infection: A progress report." Report by the Comptroller and Auditor General, National Audit Office (United Kingdom), HC 876 Session 2003-2004: 14 July 2004.
[4] Dancer, S.J. "Mopping up hospital infection." *Journal of Hospital Infection* (October 1999) 43:85–100. p. 85.
[5] "Improving patient care by reducing the risk of hospital-acquired infection." p. 7.

The connection between contracting out and infection control: Employees of a private contractor are no longer integrated into a facility's infection control system and are no longer identified with the health care team itself. Responsibility for orienting and training cleaners is no longer under the hospital's control, which opens up questions about skill development and training standards. Contracting out adds layers of administration that make service flexibility more elusive and less likely. Evidence also points to the fact that privatizing hospital cleaning contributes to falling standards of cleanliness.[6]

The employment conditions of contracted workers are another factor. Privatized support services jobs are characterized by low wages, insecure hours of work, and few benefits. These working conditions are known to produce low morale and high turnover,[7] neither of which are conducive to a knowledgeable and self-assured approach to infection control.

The biggest hazard, however, is that the public loses control of the management of hospital cleaning when services are privatized. Both the health authority and the individual facility forfeit responsibility for managing the operation of support services. The vendor is contractually obliged to deliver services of a prescribed quality but has a free hand in determining how to do so. Factors relating to staffing, training, supervision, job design, hours of work, wages, and benefits are the vendor's business. The health authority now stands in an indirect relationship to the people who clean its facilities. Issues of public accountability and transparency are muddied by this indirectness, and the public's right to know suffers.

METHODS AND SOURCES

This project was a preliminary data collection that identified key problems and future avenues for action. We conducted an environmental scan of one facility, St. Paul's Hospital, in particular the Emergency Department (ER). Methods included a survey of 41 hospital employees in the ER; a walk-about audit of bedside and common areas in the ER over two 24-hour periods in May and June, 2004; and a survey of Unit Coordinators and Clinical Nurse Leaders in St. Paul's medical and surgical units. Other sources included interviews with former housekeeping supervisors and cleaners at St. Paul's, and Registered Nurses (RNs) and infection control personnel at St. Paul's. Documents, memoranda, and website pages from the Vancouver Coastal Health Authority, ValueIN, and Providence Health Care were reviewed, as was the "Aramark VCHA Cleaning Services Agreement Execution Copy July 28, 2003." We also examined scientific literature regarding relationships between hospital cleanliness, hospital-acquired infections, and contracting out of housekeeping services.

[6] Dancer. p. 86.
[7] Auditor General of Scotland. "A clean bill of health? A review of domestic services in Scottish hospitals." Audit Scotland. April 2000. www.audit-scotland.gov.uk

KEY FINDINGS

In our data collection, problems were evident in two service and performance areas:

1) Standards of cleanliness and
2) Response and flexibility.

Standards of cleanliness

At St. Paul's Hospital, 86% of respondents to the Emergency Department (ER) survey believed the overall cleanliness of the department had declined since housekeeping services were privatized. Another majority – 64% – observed housekeeping practices that did not meet commonly accepted infection control requirements. These findings were echoed throughout the data collection. Housekeeping tasks appeared to be either overlooked, unscheduled, or done so inadequately as to seem forgotten. For example, staff observed:

- "No cleaning of monitor cables; no cleaning of IV poles; no cleaning of stretchers; no cleaning of window sills or above curtain rods (acute beds); no cleaning of stairwells."
- "Leukemia patient's rooms not mopped, bathrooms not done, garbages not emptied."
- "Body fluids of all description on walls, on stretcher railings, on curtains. These include dried blood and sputum."
- "Old feces on curtains for several days. Bedsides and bedside tables sticky with juice, again for days."

"Body fluids of all description on walls, on stretcher railings, on curtains."

Staff also reported concerns that Aramark cleaners may not have been properly trained in the use of hospital cleansers and sanitation methods. In the survey, 54% of respondents said that Aramark staff seemed to lack training in general infection control standards; 61% said they seemed to lack training in isolation cleaning.

Response and flexibility

Privatization complicates service requests in several ways. The most obvious is that requests no longer involve two parties with a common employer and comparable employment conditions. Another complication is that requests no longer go through hospital channels but are routed through Aramark's Call Centre, a single number that services the company's Greater Vancouver facilities. This disconnection between hospital staff and cleaners, and these indirect lines of communication, may account for the slow and unsatisfactory responses to routine service requests reported in our data collection. For example, 54% of ER respondents said it took longer

for a stretcher to be prepared compared with pre-contracting out. These delays contribute to back-ups in the Emergency Department.

But response times are only part of the problem. Unexpected incidents are common with sick and elderly people, and staff at St. Paul's are concerned that Aramark's housekeeping system seems to have little flexibility to respond to non-routine requests and offers its cleaners little opportunity to exercise personal discretion. "There's more focus on the faraway central office. No 'hands-on' approach," said one ER staffer. Similarly, staff were frustrated by the relationship with Aramark supervisors, who often seemed overworked and under-supported themselves.

Communication between St. Paul's staff and Aramark staff is indirect at best, nonexistent at worst. Officially, nurses and other St. Paul's employees are not permitted to give direction to housekeepers, either to advise about a method of working or to redirect tasks. Hospital staff are struggling to understand what they are able to ask of Aramark cleaners (if anything) and feel hobbled by restrictions on the relationship. Contracting out has created barriers where barriers did not exist.

Contracting out has created barriers where barriers did not exist.

Finally, RNs are concerned that their workload has increased with the complications and delays in cleaning services. They spend an unacceptable amount of time on the phone to the Aramark Call Centre, making and repeating requests or registering complaints. Time on the phone is time away from patients and a costly and inefficient use of nurses' professional expertise. Anything that diverts an RN from the bedside and other nursing duties is contributing to slower services for patients and the public.

THE SOURCE OF THE PROBLEMS

In examining the source of these problems, two closely related themes emerged: 1) communication and coordination, and 2) training and skill development. A third issue also drew our attention: 3) the health authority's ability to monitor and enforce quality assurance in privatized housekeeping services.

Although participants in the project were not asked to speculate about why difficulties arose, they often referred to what was missing: the exchanges, actions, and attitudes that changed or ceased when housekeeping services were contracted out. What emerged was a picture of hospital-based housekeeping, pre-contracting out, that had many layers of quality control. These were the properties of the work environment that, in general, fostered personal responsibility, teamwork, continuous and reinforced learning, continuity, and role clarity. At St. Paul's and

other facilities, such practices were not necessarily stamped with an official 'quality assurance' label, yet they played a crucial role in producing a good-quality housekeeping service. Nor did they take the form of measurable outcomes such as a dust-free floor or a fast bed cleaning. Rather, they were organizational features that made such outcomes possible.

Communication and coordination

Disconnection between infection control team and housekeeping: Prior to privatization, the infection control (IC) team at St. Paul's Hospital had a close relationship with the housekeeping department (HK). IC nurses would have frequent, face-to-face meetings with HK supervisors to convey news about protocol changes for infectious conditions, give direct training (i.e., use of special gloves, masks, gowns, new germicides, etc.), or discuss a current outbreak. They would also provide written updates for the HK manual. The HK supervisors would then pass on this information or technique to their cleaners. On less frequent occasions, IC nurses would give in-services directly to cleaners on infection control methods for MRSA, TB, and SARS (for example). The hospital's joint health and safety team also worked closely with housekeepers on these issues.

These associations no longer exist. The IC team at St. Paul's has no formal link with Aramark supervisors and cleaners. They do not act as an ongoing resource for supervisors in personal meetings nor do they provide in-services to Aramark cleaners. New cleaners do not receive the basic orientation to infection control principles from St. Paul's IC team as they did in the past.

Isolated supervisors, broken links: Prior to contracting out, housekeeping supervisors at St. Paul's had regular morning meetings to share current information, receive in-services from infection control or other personnel, and generally orchestrate housekeeping activities. HK supervisors were the link between the hospital and its individual cleaners; they participated in the hospital's health and safety (H & S) committee and acted as problem solvers, schedulers, and quality inspection monitors.

Today the scope of the Aramark supervisors' responsibilities is not altogether clear. What is clear is their disconnection from hospital staff. Their relationship to their own cleaners is also indirect (via the Call Centre). They no longer have any representation on the hospital's H & S committee, nor does any Aramark worker. The role of supervisor as communicator of the hospital's ever- changing housekeeping needs is over, and there is no visible substitute for this important function.

Stifled initiative: In the past, hospital housekeepers with a regular unit assignment would learn to anticipate cleaning needs. They saw how their work affected care providers and patients. The tie between housekeeper and hospital is now broken, and one of the casualties is initiative. Aramark cleaners must observe strict adherence to Call Centre directives, and they often have irregular work assignments that do not foster taking initiative.

Cut off from the team: Teamwork is essential in a high-stress, life-and-death workplace like a hospital. Teamwork is also an essential ingredient in quality assurance. Support, interdependency, fairness, and accountability: these aspects of teamwork encourage high standards and pride in one's work. For housekeepers at St. Paul's, the team feeling is largely a thing of the past. The atmosphere of camaraderie has been replaced by troubled feelings: distrust and impatience towards cleaners among some hospital staff; compassion and worry among others. Many St. Paul's staffers see Aramark housekeepers as isolated and outside the team. The erosion of trust and teamwork is hard on everyone and does little to advance the cause of cleanliness.

High turnover, loss of continuity: Instability is another enemy of coordination and communication. Cleaners seem to be constantly changing at St. Paul's. An Aramark cleaning job does not have attractive terms: pay and status are low, benefits are few, job security is fragile, and hours of work may be unpredictable. High turnover has many negative consequences: a stream of inexperienced workers; little familiarity with job routines or special circumstances; no growth of the confidence and expertise that leads to problem-solving and taking initiative; and no chance to establish relationships and build trust. The continuity of St. Paul's housekeeping service has deteriorated, and the result can be found in unsatisfactory service and tense relationships.

High turnover has many negative consequences…

Training and skill development of cleaners and supervisors

In the past, the hospital controlled whom it hired and set minimum educational or experience levels for each position. All new hires would be given a general orientation to the hospital; cleaners would then get introduced to the housekeeping department's routines and protocols, and be given health and safety and infection control information. Thereafter, housekeeping staff would receive updated information and in-services from supervisors, product salespeople, H & S representatives, IC nurses, and others as needed.

With privatization, the contractor assumed responsibility for hiring, orienting, and training. Aramark is not obliged to hire persons with any specific qualifications nor are they obliged to provide ongoing training or skill development. During this project, reports of

substandard cleaning were often accompanied by critical comments about cleaners' skills, confidence, and know-how. We can only speculate about the quality of the company's training and about any prior experience Aramark cleaners bring to the job. We know that Aramark supervisors and workers have no representation on the hospital's H & S committee. We also know that, as non-employees of the hospital, Aramark personnel are out of St. Paul's information and skills development loop.

Monitoring system and mechanisms

Given the numerous problems identified in our data collection, it became important to examine how the VCHA monitors service providers at St. Paul's Hospital and other facilities.

In 2002, the health authority created the Value Improvement Network (ValueIN) to manage contracts with vendors, establish performance standards and benchmarks, and monitor service outcomes. ValueIN monitors cleaning services according to five criteria: 1) quality audit scores (based on random spot inspections); 2) response times for service requests; 3) issues logging and resolution; 4) customer satisfaction surveys; and 5) infection control standards. Their Contract Management Team includes a Quality and Customer Service team (QCS), whose representatives deal with non-routine complaints and conduct the spot inspections, among other duties.

Tracking and resolving problems: ValueIN was unable to provide the B.C. Nurses' Union with data about day-by-day complaints when requested – Aramark is not required to report them. In effect, ValueIN cannot track the nature and frequency of these complaints, solutions (if any), and trends.

Bed-cleaning response times: ValueIN does track bed-cleaning response times, and Aramark's performance at various Greater Vancouver sites has been acceptable (published audit results do not include St. Paul's Hospital). However, response times can be misleading. A quick but inadequate bed cleaning is obviously not desirable. Similarly, eliminating one responsibility to deal with a more visible one is unacceptable. In short, a bed-cleaning response track record that comes at the expense of general quality, comprehensiveness, and safety is not in patients' interests, nor is it what ValueIN intends.

… response times can be misleading.

VCHA Quality Assurance Audit: ValueIN does random spot inspections of hospital rooms and areas to determine the quality audit scores. There are numerous built-in flaws in the audit itself and in the follow-up.

• **Unweighted:** The 31 items in the audit carry equal weight: the cleanliness of a bed is as significant as the cleanliness of a desk even though the infection risk of a soiled bed is much higher. A patient's room could have an unsatisfactory bed, toilet, IV pole, and monitor, and still earn the 85% approval rating if all other items were satisfactory.

• **Incomplete coverage:** Prior to contracting out, housekeeping supervisors at St. Paul's produced a monthly quality report based on inspections of every room in their unit(s). In contrast, ValueIN's system examines a fraction of rooms every month. This random and selective approach may mean that critical areas of the hospital do not receive the attention they deserve, such as surgical, dialysis, HIV/AIDS, and burn units.

• **Follow-up: Effective? Sustained?** ValueIN reports unsatisfactory ratings to the Aramark supervisor (and sometimes manager) and returns a week later to re-inspect the room. If problems still exist, they again notify the Aramark supervisor and manager, and again re-check the room. Hospital staff have repeatedly noticed that, although problems get fixed in the short-term (i.e., after audits or complaints), the changes are not sustained.

It is important to note that ValueIN's spot inspections are designed to monitor outcomes only, not the factors that produce outcomes such as cleaning frequency, techniques, materials, skills, or working conditions. In the absence of direct daily scrutiny and control of housekeeping operations, we believe it is essential that the health authority's outcome audits be regular, frequent, comprehensive, and critical.

Losing sight of the system

The flaws in ValueIN's spot audits are not the most serious problem. Even more disturbing is the inability of ValueIN to assess *why* problems exist or persist. A room inspection can turn up deficiencies, and statistics can show bed-cleaning response rates, but nothing in ValueIN's toolkit can examine or influence the system of control that creates defects in the first place.

Contemporary approaches to quality assurance auditing put great emphasis on checking the system, not merely the result or outcome. This emphasis reflects the public's crisis of confidence in institutions and a corresponding desire to probe to some structural depth, not just settle for superficial tallies. Auditing and governance are now inextricably linked.

They cannot make the distinction between performance problems and system problems.

ValueIN's Quality Assurance Audit and other measurement tools are not audits at all. They cannot provide insight into whether Aramark's *system* is working well. They cannot tell if deficiencies found during site inspections are performance

problems or system problems. They cannot make the distinction between a bad week and a defective operation.

ValueIN does inspections, not audits. These inspections are in a surveillance vein: the goal is to measure compliance and non-compliance, and to urge better results. They are not designed to evaluate what works and what needs fixing, nor can they appraise whether training, communication, and coordination are effective. These narrow parameters suggest that the health authority is counting on Aramark and other contractors to do genuine audits and genuine analysis and follow up, where needed. Given the many problems with cleaning services and the isolation of cleaning staff, we are concerned that the health authority has dropped its responsibilities in this vital area.

Not only is the public authority unable to inspect and influence the manner in which hospital cleaning services are delivered, the community too is affected. What the health authority cannot know, the public cannot know. This lack of transparency about a component of the health care system – one with direct bearing on the community's health and safety – is unacceptable.

Reciprocal audits: Is this the best approach?

ValueIN's Quality Assurance Team had suggested that the health authority consider an annual independent audit of contracted services in the region. The health authority opted for reciprocal audits with two other health regions: the Fraser Health Authority and the Calgary Health Authority. Both regions, like Vancouver Coastal, are heavily involved with privatized support services. Consequently, these reciprocal audits will not allow a comparison between privatized and public services.

The VCHA contracted out its support services with the aim of saving money and achieving efficiencies while maintaining (and improving) service and quality standards. An audit should examine whether these goals have been met and can only do so by comparing "the old" with "the new." Such a comparison is not possible with the current partners. In fact, all three authorities share an interest in the success of their contracting-out efforts.

The Northern and Interior Health Authorities in British Columbia have not contracted out their support services, and either would have been a more suitable choice for a reciprocal audit. However, we believe an audit by an independent team of professionals would best serve the need for a truly disinterested and arm's length evaluation.

1. Introduction

1.1 PURPOSE AND SCOPE OF THE PROJECT

This project examines the condition of cleaning services and monitoring mechanisms at St. Paul's Hospital in Vancouver, British Columbia. It was prompted by concerns that the safety of Greater Vancouver hospitals and long-term care facilities has been compromised since the privatization of housekeeping services. Although the project focuses on St. Paul's and the contractor, Aramark Canada Ltd., anecdotal information from other facilities leads us to believe that sanitation problems are widespread in the Vancouver Coastal Health (VCH) region. We believe these are structural and systemic issues that go beyond any one facility or group of workers.

1.1.1 Who did this project?

This project is a joint effort of the B.C. Nurses' Union, the Hospital Employees' Union, and the Health Sciences Association. The decision to collaborate reflects the fact that nurses and other health care professionals are directly affected by the quality of housekeeping and other support services. A nurse's ability to care for a patient is dependent on an infrastructure of services – food, laundry, and cleaning – that must comply with commonly accepted standards of quality. Deficiencies and gaps in support services are not just inconvenient, they pose a threat to patients and staff alike. As frontline care providers, nurses are acutely aware of the danger of hospital-acquired infection and the preventive role of housekeepers. Finally, all three unions share a common interest in preserving and strengthening Canada's public health care system and in promoting accountability and transparency throughout the system.

1.1.2 Methods and sources

Staff in hospitals and LTC facilities wanted a systematic and credible means of assessing cleaning and infection control issues since privatization. To this end, we conducted an environmental scan of one facility – St. Paul's Hospital, with a particular emphasis on the Emergency Department – by gathering data from many members of that hospital's health care team. We also wanted to present a broad view of the issues and thus consulted the scientific literature regarding associations between infection control, hospital cleaning, and contracting out. We examined documents from the health authority and interviewed various experts. This project does not claim to be a full research study but rather a preliminary data collection and analysis that identifies key problems and future avenues for study and action.

Our findings are based on the following methods and sources:
1. A survey of 41 hospital employees in St. Paul's Emergency Department. The survey included Registered Nurses (RNs), Unit Coordinators, Ward Aides, Licensed Practical Nurses, a physician, social worker, Clinical Nurse Leader, and X-ray technician. (See Appendix 1, Impact of Contracting Out Survey.)

2. A walk-about audit of bedside and common areas in St. Paul's Emergency Department. The cleanliness of these areas was rated by two RNs at St. Paul's over two 24-hour periods in May and June, 2004. Altogether, 21 inspections of bedside areas were conducted.

3. A survey of 12 Unit Coordinators (over 20 shifts) and 7 Clinical Nurse Leaders in St. Paul's medical and surgical units. (See Appendix 2, Hospital Housekeeping Response Time Survey.)

4. Interviews with former housekeeping supervisors and cleaners, infection control personnel, and RNs at St. Paul's Hospital.

5. Document review of various memoranda from the Vancouver Coastal Health Authority and its ValueIN division, including board presentations, inspection and auditing forms, and website; the VCHA and Providence Health Care "RFP #2002–SS–004 Cleaning Services"; and the "Aramark VCHA Cleaning Services Agreement Execution Copy July 28, 2003."

6. Examination of scientific literature regarding relationships between hospital cleanliness, hospital-acquired infections, and contracting out of housekeeping services.

1.2 Background to the Issues

Concerns about hospital cleanliness must be assessed against a backdrop of three issues: 1) the privatization of cleaning services in the Vancouver Coastal Health region; 2) the growing worldwide incidence of hospital-acquired infection; and 3) the role that environmental sanitation plays in the prevention and control of these infections.

1.2.1 Privatization of support services

The Vancouver Coastal Health Authority began to contract out support services in 2003. Their decision to terminate existing support staff was budgetary. Faced with a $40 million deficit, the

health authority determined that their operating costs for support services – primarily wage rates – were significantly higher than market rates and thus justified contracting out.[8] Provincial legislation (Bill 29) had paved the way by eliminating job security and 'no contracting-out' clauses from the Hospital Employees' Union (HEU) collective agreement. Housekeepers, food service workers, security personnel, and laundry workers represented by the HEU could now be laid off, and were laid off en masse beginning in the fall of 2003.

The VCHA entered into an agreement with Aramark Canada Ltd. to deliver housekeeping services at all acute care hospitals and several long-term care facilities across the region. The authority expects the five-year, $100 million contract to reduce the region's housekeeping costs by $13 million annually. Aramark, a multinational corporation, struck a partnership agreement with the Industrial Wood and Allied Workers (IWA) to represent the new housekeepers, prior to any hires. This unusual arrangement between employer and union has since been successfully challenged before the B.C. Labour Relations Board.

Under the old HEU contract, the health region's former housekeepers received approximately $18 an hour, a range of benefits, seniority rights, and job security. They had regular in-services and the other supports that flow from being team members in a public health care facility. The HEU cleaners were a stable and mature group; on average, HEU members have 11.6 years on the job and are 45 years old.[9]

Today, Aramark cleaners earn from $9.50 to $11 an hour with minimal statutory benefits. Unlike employees of the health authority, Aramark workers have no coverage for pension, long-term disability, dental, and maternity benefits. Aramark wage levels are the lowest in the country: approximately 26% below the national average for housekeepers working in the health sector. Even relatively low-wage provinces like Newfoundland, P.E.I., and New Brunswick pay their housekeepers more.[10] Aramark workers are even harder hit by the fact that the cost of living in Vancouver, particularly for housing, is the highest in Canada.[11]

Aramark wage levels are the lowest in the country…

1.2.2 Hospital-acquired infection: The extent and sources of the problem

People enter hospitals to get care and treatment. Regrettably, some patients are also afflicted by a hospital-acquired infection during their stay. Most Canadians are familiar with the story of how severe acute respiratory syndrome (SARS) caused grief and havoc in Toronto in the spring of

[8] From VCHA's ValueIN website (undated) www.vch.ca/vi/faq.htm
[9] "HEU Member Profile Survey" March 2002.
[10] Cohen, Marjorie Griffin and Marcy Cohen, "A return to wage discrimination: Pay equity losses through the privatization of health care." Vancouver: Canadian Centre for Policy Alternatives, April 2004. p. 13.
[11] Ibid., p. 15.

2003. Many will have heard of the "superbugs," the antibiotic-resistant organisms such as MRSA (methicillin resistant *Staphylococcus aureus)*, Clostridium difficile (*C. difficile),* and VRE (vancomycin resistant *enterococcus)*. The Norwalk virus and similar viruses have surfaced in nursing homes with alarming frequency in recent years. Public awareness was sharpened by outbreaks of *c. difficile* in Montreal and Calgary hospitals in 2003-04, which resulted in upwards of 80 deaths. In British Columbia, an MRSA outbreak forced infection control officials to restrict access to part of Nanaimo Regional General Hospital in April 2004.

Yet most Canadians are unaware of the enormous toll these infections take on individuals, families, and the health care system itself. The human cost is estimated at 8,000 deaths a year.[12] According to Zoutman et al., hospital-acquired infections in U.S. acute care facilities are calculated to cost $4 billion (US) annually; in Great Britain, the figure is £900 million.[13] There are no published Canadian data on financial costs but they are understood to be comparable.

Preventing and restraining the spread of infection is a major preoccupation of individual care providers, infection control teams within facilities, and health planners and policymakers. In the United Kingdom, avoiding hospital-acquired infection has been a priority of the National Health Service since 2000.[14] In this country, the Canadian Patient Safety Institute was recently created to promote best practices and coordinate effective strategies across a broad range of patient safety issues, including nosocomial (hospital-acquired) infections. In British Columbia, the Ministry of Health Services appointed a Patient Safety Task Force in May 2004 to scrutinize nosocomial infections (among other hazards) with the aim of improving provincial standards. Specifically, the task force will focus on developing "cultural changes in practices [to create] . . . open communications and systems" to better understand and prevent errors.[15]

Preventing and restraining the spread of infection is a major preoccupation of…health planners and policymakers.

These and other system-wide measures are evidence of the problem's magnitude. Aside from the obvious need to prevent human suffering and exhaustion of resources, at least part of the impetus for action may be the threat of legal action and financial repercussions. Early in 2004 a class action suit was filed in an Ontario court on behalf of SARS patients infected during Toronto's second outbreak in 2003. The claim alleges that "public health officials failed to

[12] Zoutman, Dick E., et al. "The state of infection surveillance and control in Canadian acute care hospitals." *AJIC* 31:5 (August 2003), p. 271.
[13] Ibid. p. 271
[14] The NHS's plan "was based on extensive consultation with the public, which found that patients believed standards of cleanliness had dropped in recent years. Many blamed this on the introduction of Compulsory Competitive Tendering (CCT) . . . . CCT has now been discontinued." From the Department of Health (UK) report, "National standards of cleanliness for the NHS." April 2001. (executive summary, np)
[15] "Provincial Task Force to Improve Patient Safety." News Release, B.C. Ministry of Health Services, May 7, 2004.

maintain sufficiently rigorous infection control precautions."[16] In September 2004 a group of Quebec patients and family members formed an organization to lobby for financial compensation from the provincial government for hardships caused by the c. *difficile* outbreak and other nosocomial infections.[17] Ontario patients who were exposed to infection from other alleged hospital oversights – such as improperly sterilized endoscopic and biopsy instruments – have launched or threatened to launch malpractice suits. A Scottish woman is currently suing a National Health Service board in Glasgow after contracting a severe MRSA infection while recuperating from heart surgery in a hospital that she alleges had substandard hygiene.[18]

A growing problem: Several factors account for increased concerns about hospital-acquired infection: new strains of microorganisms; new diseases such as SARS; the aging and expanding population; increased international travel; and rising numbers of Canadians living longer with chronic diseases and compromised immune systems. But conditions and pressures within the health care system can also heighten the risks.

Rapid turnover, lack of isolation: Imbalances and shortages throughout the system lead to rapid turnover of patients – maximum bed utilization, in the parlance of hospitals. This quick in-and-out translates into both intensified exposure (more people, more exposure to infection) and diminished opportunities to detect infection in patients who are sent home early and later return with full-blown disease.

Facilities are also less able to isolate infected and vulnerable patients due to a shortage of single-occupancy rooms. As a result, a person with a compromised immune system or a surgical patient with an open wound may end up sharing a room with an MRSA-infected individual.

Overcrowding: Overcrowding is a known ingredient in the spread of MRSA. Studies show that a desirable bed occupancy rate is around 85%. We were unable to obtain statistics regarding the rates at St. Paul's Hospital and other Greater Vancouver facilities, but it is understood that hospitals are running "over census" – at between 95% and 105%.[19] The National Audit Office in the United Kingdom, where a serious MRSA incidence sparked the national campaign to systematically curb the problem, reported in 2004 that

> The increased throughput of patients . . . has resulted in considerable pressure towards higher bed occupancy, which is not always consistent with good infection control and bed

[16] Ries, Nola M. and Timothy Caulfield. "Accountability in Health Care and Legal Approaches." Health Care Accountability Papers No. 3; CPRN/RCRPP. Health Network, May 2004. p. 17.
[17] CBC-Montreal online news. "Victims' group fights hospital infections." September 23, 2004. http://montreal.cbc.ca/newsmtl
[18] "MRSA test case heads to the court." <http://news.scotsman.com/health.cfm?id=1034082004> September 3, 2004.
[19] The bed census is the occupancy rate based on number of funded beds. We were unable to get confirmation of the bed censuses because VCH officials would not supply the information. This lack of transparency is unacceptable and underscores the problems with assessing patient and public safety.

management practices. . . . The lack of suitable isolation facilities also remains a concern . . . as does the increase in frequency of moving patients and a lack of sufficient beds to separate elective and trauma patients.[20]

Improving bed management and isolation facilities is one of seven action areas adopted by the UK's National Health Service to prevent and control hospital-acquired infections. Adopting high standards of hygiene is another.[21]

1.2.3 Infection control: What is the role of housekeeping?

Infection control is a complex matter. Microorganisms can proliferate and travel by a variety of routes, under a variety of conditions. For this reason, infection control professionals think in terms of a web of causes that demands a web of responses. Conservative use of antibiotics, more isolation rooms, less pressure on beds, careful monitoring of patients and staff, regular hand washing, and high standards of environmental hygiene – these are some measures proven to be effective parts of a coordinated strategy.

Microorganisms can proliferate and travel by a variety of routes…

Fundamental to this picture is something obvious: clean rooms with clean furnishings and clean equipment. Microbiologist S. J. Dancer has noted that hospital cleaning "is, in fact, likely to be a critical factor in infection control and the continuing fight against hospital-acquired infections."[22] Florence Nightingale's 150-year-old insight has lost none of its urgency: Poor hospital sanitation is not just an enemy of good healing, it can be a leading cause of disease and death. Hospitals need to be cleaned in accordance with industry standards precisely because they are not, by their nature, infection free. Hand washing is strongly emphasized precisely because hands come in contact with many people and many surfaces – walls, tables, shelves, counter tops, basins, and poles – that may harbour infectious agents. Yet hand washing, an individual tactic to avoid spreading infection, only makes sense within a comprehensive strategy that includes sanitary practices and environments, and well-orchestrated responses to outbreaks.

Integrated, not separated: Infection control is an evolving arena with ongoing research into best practices, products, and protocols. The literature points to links between appropriate housekeeping practices and lower infection rates. Significantly, the campaign in the UK against

[20] "Improving patient care by reducing the risk of hospital-acquired infection: A progress report." Report by the Comptroller and Auditor General, National Audit Office, HC 876 Session 2003-2004: 14 July 2004. p.3.
[21] Ibid. p. 5.
[22] Dancer, S.J. "Mopping up hospital infection." *Journal of Hospital Infection* (October 1999) 43:85–100. p. 85.

nosocomial infections deals with the role of housekeeping on a *systems* level. The National Audit Office's 2004 report recommends that "all staff receive [orientation] and update training" regarding infection control guidelines, roles and responsibilities, and that staff training and education be monitored by the National Health Service's electronic staff records system to ensure no worker slips between the cracks.[23] The report describes the move to create a Modern Matron position in some hospital units (to coordinate a multidisciplinary team response to infection control) and a Ward Housekeeper position (to act as coordinator and liaison between the ward's head nurse and cleaning staff, as well as to perform supervisory duties).[24] The aim of these measures is to bring housekeeping into close orbit with infection control personnel, in particular, and with the hospital health care team, in general.

1.2.4 Contracting out and infection control: Is there a connection?

Unintended yet predictable disruptions to infection control may arise when hospital housekeeping is contracted out. In the United Kingdom, "contracting out hospital cleaning services has . . . contributed toward falling standards [of hospital cleanliness]."[25] Barriers between personnel is one such disruption. Privatization is about separation. The employees of a private contractor are no longer integrated into a facility's infection control system and are no longer identified with the health care team itself. Under contracting out, cleaners do not and cannot take direction or advice from a facility's RNs nor do they receive in-services from a facility's infection control team – all connections that existed in the past. Innovations and research into infection control practices that involve housekeepers become complicated by the fact that cleaners are no longer hospital employees. Responsibility for orienting and training cleaners is no longer in the hands of the hospital, which opens up questions about skill development and training standards. In the UK, the National Health Service's audit of hospital cleaning services determined that "where services are contracted out they are more likely to have failed."[26]

Privatization is about separation.

[23] "Improving patient care." p. 7.
[24] Ibid. The Ward Housekeeper also helps to relieve nurses of housekeeping work, regarding which the report says: "Introducing [Ward Housekeepers] has not always required additional resources. There is growing evidence that nursing staff spend up to 30 percent of their time on non-nursing activities . . .' p. 18.
[25] Dancer, p. 86. Citing Hempshall, P. and M. Thomson. "Grime watch." *Nursing Times* 94 (1998): 66-69; Rennie, M. "Germ warfare." Editorial. *British Journal of Intensive Care* 8 (1998): 77.
[26] The United Kingdom Parliament. *Supplementary memorandum by UNISON (PS 33A).* www.parliament.the-stationery-office.co.uk/pa.cm200101/cmselect.cmhealth/308. p. 1. Qtd. in Murphy, Janet. "Literature review on relationship between cleaning and hospital acquired infections." Vancouver: HEU, 2002. p. 6.

The employment conditions of contracted workers are another worrisome factor. Privatized support service jobs are characterized by low wages, insecure hours of work, and few benefits. These working conditions are known to produce low morale and high turnover,[27] neither of which are conducive to a knowledgeable and self-assured approach to infection control.

In an era of rising infection rates, new antibiotic-resistant strains, high bed occupancy, and rapid turnover, the need for a well-trained, adaptable, and stable cleaning service would seem of paramount importance. British infection control physicians Barrett et al have noted that cleaning quality worsens "where control has . . . been lost to outside organizations."[28] The literature demonstrates that contracting out has negative effects on staff morale, which translate into lower productivity, higher turnover, and declining standards.

[27] Auditor General of Scotland. "A clean bill of health? A review of domestic services in Scottish hospitals." Audit Scotland. April 2000. www.audit-scotland.gov.uk. Qtd. in Murphy, p. 7.
[28] Barrett, S.P. et al. "Trying to control MRSA causes more problems than it solves." *Journal of Hospital Infection*. 39 (1998):85-93. p. 90. Qtd. in Murphy, p. 6.

2. Observations and experiences: What are the problems with cleaning?

This project was undertaken because staff at St. Paul's Hospital were concerned about the quality and standards of cleanliness since the hospital contracted out its housekeeping services. Day to day, they were often dissatisfied about how well, how frequently, how expeditiously, and how appropriately their unit or department was cleaned. They were also frequently frustrated about communicating, or trying to communicate, with contracted supervisors, managers, and cleaners. These communication problems included access to supervisors, follow-up on complaints, and ability to give direction to workers. Finally, staff raised questions about the quality assurance mechanisms that monitor the contractor's performance.

These issues – service standards, communication, and quality assurance – are clearly related. If nursing or other staff are unhappy about a support service, they must be able to communicate well with the responsible parties. They must also be able to trust that monitoring will actually detect problems and lead to timely and sustained solutions.

It is important to note that the staff who participated in the data collection expressed no doubt that housekeepers were working hard and often at top speed. Indeed, the cleaners' volume and pace of work was another concern for St. Paul's staff, who worried about their well-being and safety. The problems identified in this project are structural rather than individual. Based on what staff reported, two key service and performance areas emerged (chart 1).

Chart 1

Key Service and Performance Issues St. Paul's Hospital ER	
Standards of cleanliness • Comprehensiveness • Appropriateness • Effectiveness • Frequency	**Response and flexibility** • Response times • Efficiency • Adaptability • Satisfaction

2.1 STANDARDS OF CLEANLINESS

This section examines the question of whether St. Paul's Hospital looks clean and is cleaned in accordance with commonly recognized hospital standards. Beds, stretchers, floors, toilets, walls, IV poles, suction equipment, commodes, cabinets, railings, sinks, table tops, desks, even the garbage can itself: all such surfaces and items must not only appear to be clean, but in fact *be* cleaned in an appropriate, regular, and effective manner.

Housekeeping in a hospital setting is a complex matter. Prior to contracting out, hospitals in the VCHA usually hired cleaners who had completed Building Service Worker college certificate courses or an equivalent program. Among other things, this hiring practice recognized that the diverse needs of patients call for specialized cleaning techniques and products, and that the physical environment of a hospital varies from unit to unit, department to department. It is beyond the scope of this project to discuss the complexities of health care sanitation. Suffice to say that experienced staff at St. Paul's recall the standards of cleanliness delivered by the hospital's former housekeeping department and understand the essential role that cleaners play in infection control. This project takes as a given that the level of cleanliness since contracting out should be at least as high as the level prior to contracting out, an expectation reflected in the VCHA's agreements with its vendors.[29]

2.1.1 Key findings from surveys and audits

The survey of Emergency Department (ER) staff at St. Paul's shows that 86% of respondents believe the overall cleanliness of the department has declined since housekeeping services were privatized (Table 1). Another strong majority – 64% – observed housekeeping practices that did not meet commonly accepted infection control requirements (Table 4).

Table 1

Overall Cleanliness* St. Paul's Hospital ER			
Perception of overall cleanliness	86% worse	12% no change	2% better

* Housekeeping Survey, May 2004 (n .41 respondents)

[29] The health authority actually expects improvements from privatized service providers; ValueIN's goals include "ensuring that support services are able to improve on standards of efficiency, effectiveness and quality." Source: ValueIN website FAQs (undated) www.vch.ca/vi/faq.htm

These findings were echoed in interviews and in the walk-about audit of the Emergency Department (Table 2).

Table 2

Walk-About Audit of Cleanliness* St. Paul's Hospital ER				
In bedside area	**Cleanliness – Good**	**Cleanliness – Deficient**	**n/a**	**No response**
Stretcher	33 %	57 %		10 %
Floor	24 %	76 %		
Curtains**	90 %	5 %	5 %	
Monitor leads	19 %	71 %	10 %	
IV poles	10 %	33 %	43 %	5 %
Bedside table	29 %	57 %	14 %	
Counter	14 %	57 %	24 %	5 %
Window sill	5 %	62 %	33 %	

* May 3, April 6, 7, 8, 2004 (n .21 bedside areas) , ** 14 curtains were new

2.1.2 Comprehensiveness: What is being cleaned and re-supplied?

Our project reveals a litany of concerns about housekeeping tasks that appear to be either overlooked, unscheduled, or done so inadequately as to seem forgotten. In the Emergency Department, staff observed:

- "No cleaning of monitor cables; no cleaning of IV poles; no cleaning of stretchers; no cleaning of window sills or above curtain rods (acute beds); no cleaning of stairwells."
- "They never clean the floor in patient care areas (bays, exam rooms, eye room, cast room, ENT room)."
- "Bedside rails are not wiped down."
- "Cleaners do not move any equipment or furniture to clean. The floors are dirty. Counter tops are not wiped down, and the waste basket is always full."
- "Bedside tables, laundry carts, cylinder containers, and trauma carts are never moved to dust the floor."

Elsewhere in the hospital, staff observed:

- "Leukemia patient's rooms not mopped, bathrooms not done, garbages not emptied."
- "Dirty Utility rooms are filthy; dirty items are left for days (IV poles, etc.); things pile up impeding access to clean items. It's disgusting. It's sometimes a mess. It's very disorganized. I hope they clean the floors in there, but I'm not sure that they do."
- "The staff washrooms are disgusting . . . I've worked in this hospital for 14 years and it's the worst I've ever seen."
- "They do the floors, but they don't go around the PCs or in nooks and crannies."
- "Garbages not emptied, floors not cleaned sometimes, inadequate equipment cleaning [and] sterile technique."
- "Chronically not cleaning private rooms; had to call [Aramark] Call Centre already today; they said they'd see what they can do."

Cleanliness is not the only issue. The cleaning service is supposed to replace bedside aids (e.g., "blue ware" such as bedpans and basins) and replenish supplies for staff, patients, and visitors (e.g., paper towels, toilet paper, hand soaps). Oversights in these areas are not just inconvenient, they relate directly to the ability of people to wash and dry their hands properly. According to the walk-about audit of the ER, it seemed almost normal for hand-washing stations and patient bathrooms to lack soap and paper towels and for the garbage to be overflowing: "Often no soap for patients or hand-washing soap for staff. Often all paper towel dispensers are empty." Complaints were common in other parts of the hospital, too:

"Often no soap for patients or hand-washing soap for staff."

- "A lot of the times we have run out of soap and paper towels in the dispensers."
- "Bedside blue ware is not being placed in side tables. Often old personal care items are still in drawers."
- "[Less] blue ware, decreased attention to cleaning outside tables, cupboards."
- "Bed cleaning is adequate, however majority of times the basin, bedpan, or urinal is not replaced in bedside stand."

2.1.3 Effectiveness: How well is the cleaning done?

Perhaps even more alarming than cleaning that does not get done is cleaning that is done poorly. Staff often saw the results of housekeeping services that were deficient, rushed, or haphazard. In the Emergency Department, staff observed:

- "Body fluids of all description, on walls, on stretcher railings, on curtains. These include dried blood and sputum."
- "Old feces on curtains for several days."
- "Public men's washroom on main floor [had] blood squirts; not cleaned [for] 2 months."
- "Bathrooms smell badly of urine. Bedside curtains are stained. Bedside tables are seldom wiped, often have litter left behind or food stains."
- "Patient noted how dirty the hospital has become."
- "Visitors and patients are always complaining about the washrooms being disgusting."
- "Blood splashes remained on wall in trauma unit [for] 3 weeks."
- "Common areas seem 'junky looking,' i.e., untidy and cluttered."
- "The floors are filthy, scuff marks, stains, no shine, dull dusty finish."

These observations were supported by the walk-about audit of the ER, especially in bedside areas (Table 2). The audit also showed that common areas such as hallways, waiting rooms, entrances, and staff lounges were frequently littered, dusty, and generally unclean.

Elsewhere in the hospital, staff observed:

- "This is a hospital. It's filthy. Our floors on the unit are disgusting."
- "The place is filthy . . ."
- "Bed cleaning not so bad; larger problem is general cleanliness of ward, floors, sinks, walls, etc."
- "Floors are still dirty. Bedside tables have crumbs left on them. They still have previous person's stuff left behind."

2.1.4 Appropriateness: Are proper methods and materials used?

Hospital cleaning involves the use of specialized products and careful techniques. It also involves common sense: replace dirty water; don't use the same cloth to wipe both a toilet and a sink, etc. Based on what they've seen, staff at St. Paul's have many concerns about whether Aramark cleaners have been properly trained to use products and methods (Table 3). Staff are also concerned that workload and time pressures may be clouding the individual worker's common sense. (Infection control is the focus of an upcoming section.)

Table 3

Workers' Training & Knowledge* St. Paul's Hospital ER			
Situations in which Aramark cleaners appeared to lack training or understanding	**Observed**	**Not observed**	**Don't know**
General infection control standards	54%	12%	34%
Isolation cleaning standards	61%	17%	22%
Use of appropriate cleaning solutions	29%	15%	56%
Safety prevention practices	39%	32%	29%

* Housekeeping Survey, May 2004 (n .41)

In the Emergency Department, staff observed:

- "[The cleaners] wash beds with gloves, then use potentially contaminated gloves on clean linens."
- "They are wearing the same gloves from task to task, such as using the telephone."
- "Housekeepers do not seem to change cloths. One cloth is used for everything. I do not see greater effort being taken when there is an MRSA/TB risk."
- "Improper disinfection of equipment, etc. Improper [or] no hand washing between jobs; not changing gloves; not changing garbage bags."
- "Not emptying sharps buckets until close to filling, which poses a great BBF [blood and body fluids] risk."
- "The water in the mop bucket is black and doesn't look like it has ever been changed."

2.1.5 Frequency: Is cleaning as often as it should be?

Regular and frequent cleaning is also important. Prior to contracting out, most surfaces, fixtures, and equipment in a St. Paul's unit were cleaned daily and as needed (either washed, wiped, mopped, or dusted). This daily cleaning included patient bathrooms, bedsides, furnishings, equipment in rooms, window sills, common areas, staff lounge and staff bathrooms, the Clean Utility Room, and the Dirty Utility Room (where soiled basins, IV poles, bedpans, and urinals are placed). Hand washing stations were cleaned twice daily, and curtains were cleaned monthly or as needed.

Since contracting out, staff have noticed not only gaps in the daily routine but failure to act on the important "as needed" value. As a former cleaner said, "If the housekeeper noticed dirt

or a spill, they would clean again. Same thing with the garbage – Housekeeping would notice if it needed to be emptied again."

The VCHA/Providence Health Care "RFP #2002–SS–004 Cleaning Services" document states that the contractor "is required to provide cleaning services at whatever frequencies are deemed necessary in order to meet the required Infection Control Standards of Cleanliness." The document then gives detailed specifications about required cleaning frequencies.[30] The Emergency Department is rated "A" in overall priority, which signifies "constant, cleaning critical" within a time frame for rectifying problems of "immediate, 5–30 minutes" (see Appendix 3). This standard is not reflected in our surveys. In the Emergency Department, staff observed:

- "Emergency X-ray room is not cleaned on a regular basis. Garbage (blood-stained gauze and Band-Aids, Kleenex, etc.) is left on the floor all day. Main department radiology is also not cleaned on a consistent basis."
- "Recently I had a family member . . . complain how dirty Emergency was. She noted that the floor by the patient's bedside was not cleaned for almost 6 hours."
- "Staff lounge garbage accumulates and is not emptied regularly. Staff bathroom not cleaned regularly."
- "During some shifts I've noticed washrooms and wait rooms stay dirty all night and not cleaned unless requested. I've noticed supplies not replenished."
- "Dirty Utility Rooms very messy. Garbage often overflowing containers. Very reluctant to enter isolation rooms or locked psychiatric unit too; these areas are really dirty."
- "In general, the department is disgusting."

Elsewhere in the hospital, staff observed:

- "Called Call Centre and Aramark supervisor about the TB rooms. They do not get cleaned daily and they must be! Chronic oversight."
- "I've had to call for the cleaners to restock the room a lot."
- "In our office, the garbage doesn't get collected enough – maybe once a week – and they rarely dust our desks and workspace."
- "A friend of mine was a patient here and she said that her floor wasn't cleaned for one week."

[30] We refer to this document because we were unable to review Schedule 4 of the "Aramark VCHA Cleaning Services Agreement," which outlines service levels and quality outcomes. The schedule was excluded in our initial FOI request (another request is pending), a situation that underscores the lack of transparency and accountabiltiy in the contracting-out environment.

2.1.6 Infection control: Are cleaners supported in their role?

In a health care facility, infection control requires a system-wide commitment that deploys good practices, quick responses, appropriate resources, and solid surveillance and data – all within a context of clear roles and responsibilities. The role and responsibility of the cleaning contractor should be obvious: after all, they are not only charged with keeping the hospital clean and tidy, they must also avoid having their workers become conduits for infection as they move from room to room. In the age of MRSA, SARS, *c. difficile,* and Norwalk-like viruses, one would expect the cleaning contractor to be especially vigilant and fully prepared to fulfill their role in preventing the spread of hospital-acquired infections.

Table 4

Cleanliness & Infection Control*
St. Paul's Hospital ER

	Yes	No	Don't know
Observed Aramark cleaning practices that did not meet infection control requirements	64%	12%	24%

* Housekeeping Survey May 2004 (n .41)

In the surveys and interviews, staff at St. Paul's Hospital often expressed the opposite view of Aramark's knowledge and capabilities. We received many reports about cleaners who seemed generally unaware of commonly accepted infection control practices (Tables 3 and 4) and particularly unaware of cleaning after the discharge of an MRSA patient. Hospital staff were concerned for the safety of the cleaners themselves, whose lack of knowledge seemed to put them at risk.

In the Emergency Department, staff observed:

• "Not doing floors in patient care area is surely an invitation to air-borne bacterial infections."

• "Areas are only being cleaned when asked. [In] areas that need a total clean, say for MRSA/VRE/TB precautions, Housekeeping has to be asked to clean monitoring equipment."

• "I do not feel confident that appropriate disinfection procedures are followed, for stretchers and floors generally."

• "Bedside tables missed. Stretchers removed from area and put somewhere else without cleaning."

• "Never clean the utensils for possible infections. Never use gloves."

Elsewhere in the hospital, staff observed:

- "MRSA rooms seem to be cleaned as normal rooms, which shouldn't be."
- "Lack of knowledge re: MRSA and precautions."
- "An MRSA patient was discharged . . . . Housekeeping came to clean, but left the room as it was before. . . . It seemed, being an MRSA+ room, that the cleaning only took 10 minutes. This was very disappointing."
- "We wanted to transfer an MRSA patient from a four-bed to a private room, so we asked the housekeeper to clean the bathroom and wash the floor in the room. She came back within three minutes and said she had finished. Give me a break! There's no way she cleaned it that quickly, at least not properly."

2.2 RESPONSE AND FLEXIBILITY

This section looks at how well Aramark responds to the needs of staff and patients at St. Paul's. Some of these needs pertain to speed (how quickly housekeeping performs a task); others pertain to communication and problem solving (how easily housekeeping can be reached, and how readily concerns and complaints are addressed); and others to flexibility (how smoothly housekeeping adapts to emerging or unforeseen situations).

An upcoming section, "Monitoring Systems and Mechanisms," looks specifically at the issue of bed-cleaning response times.

2.2.1 Response times: How long between request and service?

On a day-to-day basis, hospital staff are to phone the vendor's Call Centre with service requests and for routine operational matters. Aramark has a single number for its Greater Vancouver facilities.[31] The surveys and interviews show problems with service response times. In the survey of Emergency Department staff, 54% of respondents said it took longer for a stretcher to be prepared compared with pre-contracting out, and 49% said it took longer for unexpected hazards to be cleaned (see Table 5).

[31] This off-site, centralized telecommunication system is vulnerable to systems failure. In August 2004, the Aramark Call Centre went down due to technical difficulties, leaving numerous facilities without access to housekeeping supervisors.

Table 5

Response Times* St. Paul's Hospital ER				
Length of response time, compared with pre-contracting out service	**Longer**	**Shorter**	**Same**	**Don't know**
Preparing stretcher	54%	24%	12%	10%
Cleaning unexpected hazards	49%	27%	17%	7%

*Housekeeping Survey, May 2004 (n .41)

In the Emergency Department, staff observed:

• "The housekeepers are so overworked, understaffed – takes them longer to respond to pages."

• "Up to 1-hour wait for stretcher cleaning. Periods of up to 45 minutes without coverage."

• "Takes too long to get ER stretchers cleaned."

• "Long periods unable to find housekeeping staff."

• "3.5 hours' wait one Saturday for housekeeping to clean stretcher in FT [fast track]."

• "Body fluids spills aren't being cleaned as fast [as before]."

• "Have to wait so long to get a housekeeper, [it's] easier to wipe stretchers by myself and clean overhead rather than wait."

• "I tend to not ask housekeeping to do things because they can't keep up. No longer part of the team. Nursing is now doing housekeeping tasks."

2.2.2 Efficiency: How often are service requests repeated?

Service requests are routine transactions in a hospital such as St. Paul's, and privatization complicates these transactions. The most obvious change is that requests no longer involve two parties with a common employer and comparable employment rights and responsibilities. Another complication is that requests no longer go through hospital channels but are routed through the company's Call Centre, whose personnel relay a request (by phone or pager) to the appropriate individual. This fundamental disconnection between hospital staff and contract workers, and these indirect lines of communication, may account for the slow and

There are hidden costs when response times are slow.

unsatisfactory responses to routine service requests reported in the surveys and interviews.

There are hidden costs when response times are sluggish. Nurses at St. Paul's were concerned about how much time they were forced to spend initiating and then repeating service requests. For an RN, time on the phone to the Aramark Call Centre is time away from direct patient care. It also represents an increase in their workload, a costly and inefficient use of their professional expertise, and a delay of service to patients. When an ER nurse is phoning and waiting for a bedside area or stretcher to be cleaned, a would-be patient is waiting too.

In the Emergency Department, staff observed:

- "Cleaners are called 3–6 times over the PA system to clean a stretcher."
- "Almost always have to call them for everything like washing a stretcher."
- "Less response, have to call the Call Centre more often. [Cleaners] don't seem to know what to do."
- "Multiple phone calls to bed cleaning."

Elsewhere in the hospital, staff observed:

- "Calls are repeatedly made to complete the jobs."
- "[Supervisors] often don't call back until 3–4 calls have been made or don't call at all."
- "Very difficult. Supervisor notified by Call Centre twice yesterday with no response. Supervisor notified at 0800, 1000, 1300, and 1600 today. Call returned at 1600."
- "Housekeeping generally needs to be called a few times every shift whether it's for bed cleaning, floors being cleaned, and especially having the garbages emptied."
- "Constantly being asked to call the main number for bathrooms to be cleaned, paper towel refilled."
- "Sometimes have to phone Call Centre 3 times and still wait 3 hours for somebody to show up."

2.2.3 Adaptability: Are cleaners able to respond to emerging needs?

Health care facilities are not assembly lines. Unexpected incidents and sudden changes are common with sick and elderly people, and housekeeping services must be nimble to accommodate unpredictable events. This flexibility derives from a combination of factors, such as having: 1) 'room to give' in the housekeeping schedule; 2) the discretion to react to emergent situations as part of the job design; and 3) the mindset to anticipate, recognize, and respond to new circumstances. As a former hospital employee said regarding his role as an ER cleaner, "When [the ER entrance] was dirty, I would go out and clean . . . . If a customer was sick out there, I

was called. When accidents would happen, we were called and we did them. There was no 'it's not my job' routine. We just did it."

The staff in the surveys and interviews often reported frustrations with Aramark's housekeeping system, which seems to have little or no flexibility to respond to non-routine requests (everything must go through the supervisor) and offers its cleaners little if any personal discretion in their job design.

In the Emergency Department, staff observed:

- "More focus on far away central office. Decreased verbal one-on-one relationship. Very different. No 'hands-on' approach."
- "They are not members of the team . . . Difficult to ask to perform tasks. They are not easy to find. There is often a language barrier."

Elsewhere in the hospital, a Unit Coordinator reported an experience echoed by other unit staff:

- "[We] aren't allowed to ask cleaning staff to do any duties at all. Even if there is an accidental spill, staff have to phone the Call Centre to report it and have somebody come to clean it."

2.2.4 Satisfaction: Are supervisors able to respond quickly and well?

As mentioned above, the lack of direct access to Aramark supervisors and managers is problematic for both hospital staff and cleaners themselves. Prior to contracting out, both groups had ready access to housekeeping supervisors. "The supervisor was there," said a former ER housekeeper. "If I needed an answer or had a problem with nurses, the supervisor was there." Now, staff are obliged to phone the Call Centre; they do not know the supervisor's pager or phone number. Staff often wait for responses to their messages and are not always satisfied that the problem is addressed. Aramark supervisors are sometimes not easily identifiable, wearing neither a uniform nor a visible ID badge.

Throughout the hospital, staff reported:

- "I've complained and complained to the Aramark supervisors and manager, but it seems to fall on deaf ears. It's very frustrating."
- "From my experience, talking to a supervisor doesn't resolve any of the housekeeping issues."
- "Constant issues with bedside curtains being hung wrong [in the ER] . . . despite many complaints about this to housekeeping supervisors."

3. What is causing service and performance problems?

Surveys and interviews yielded ample evidence of obstacles and deficiencies in housekeeping services at St. Paul's. In this section we offer an analysis of what causes these problems.

Although participants in the project were not asked to speculate about why difficulties arose, they often referred to what was missing: the exchanges, actions, and attitudes that changed or ceased when housekeeping services were contracted out. What emerged was a picture of hospital-based housekeeping, pre-contracting out, that had many layers of quality control. These were the properties of the work environment that, in general, fostered personal responsibility, teamwork, continuous and reinforced learning, continuity, and role clarity. At St. Paul's and other facilities, such practices were not necessarily stamped with an official 'quality assurance' label, yet they played a crucial role in producing a reasonably high-quality housekeeping service. Nor did they take the form of measurable outcomes such as a dust-free floor or a fast terminal clean. Rather, they were organizational features that made such outcomes possible.

Two closely related themes emerged: 1) communication and coordination, and 2) training and skill development. Charts 2 and 3 show summaries of these themes.

3.1 COMMUNICATION AND COORDINATION

> "Whatever trust is, it is widely agreed that it is easier to destroy than to create, and 'climates of trust' are only noticed after their demise."[32]

By its very nature, contracting out is a process of disintegration. Workers, supervisors, and managers who formerly were employees of the hospital – integrated, part and parcel of the institution – no longer are. Their hiring, training, supervision, and terms of employment are now determined by a private company. Their organizational culture and work ethic reflect the company. Their co-workers and teammates are other privatized staff, not the RN who starts an IV drip, the Bed Booker who requests a terminal clean, or the infection control nurse who monitors a viral outbreak. At St. Paul's, cleaners work for Aramark Canada Facilities Services Ltd., not for the hospital or the health authority.

…contracting out is a process of disintegration.

The consequences of this disintegration are many. In this section, we examine the ruptures in communication and coordination at St. Paul's Hospital due to contracting out.

[32] Based on Baier, 1994, qtd in Michael Power, *The Audit Society: Rituals of Verification.* New York: OUP, 1997. p. 134.

3.1.1 Disconnection between infection control and housekeeping

Prior to privatization, the infection control (IC) team at St. Paul's Hospital had a close relationship with the housekeeping department (HK). IC nurses would have frequent, face-to-face meetings with HK supervisors to convey news about protocol changes for infectious conditions, give direct training (i.e., use of special gloves, masks, gowns, new germicides, etc.), or discuss a current outbreak of infection. They would also provide written updates for the HK manual. The HK supervisors would then pass on this information or technique to their cleaners. On less frequent occasions, IC nurses would give in-services directly to cleaners on infection control methods for MRSA, VRE, TB, and SARS (for example). The hospital's joint health and safety team also worked closely with housekeepers on these issues.

A former cleaner with the Emergency Department described the connections:

> Training was strictly with our supervisors, but when something [serious] came in, we had everybody there to help us, to train us – infection control, health and safety. It was extremely well done.

Another former cleaner talked about the resources for infection control as "memos, training for cleaning, the whole nine yards." Housekeepers also felt free to talk to unit nurses about cleaning isolation rooms and the appropriate use of protective clothing.

These close associations no longer exist, according to our discussions with infection control staff. The IC team at St. Paul's has no formal link with Aramark supervisors and cleaners. They do not act as an ongoing resource for supervisors in personal meetings nor do they provide in-services to Aramark cleaners. New cleaners do not receive the basic orientation to infection control principles from St. Paul's IC team as they did in the past. Upon privatization, the hospital provided Aramark management with its written infection control protocols for the company's internal use in training. Thereafter, communication with Aramark supervisors has been via email.

The IC team at St. Paul's has no formal link with Aramark supervisors and cleaners.

Supervisors are able to look up IC information on the hospital's internal website. As for the workers' personal access to information about IC practices, the IC manual is now computerized and essentially out of reach; as privatized workers, Aramark cleaners are not allowed to use the hospital's computers. And as employees of a private company, they are not supposed to ask for advice from the hospital's RNs.

The disconnection between housekeeping and infection control goes even deeper. There is no formal connection between the IC team and ValueIN's Quality and Customer Service Team, which monitors housekeeping performance.[33] In effect, although Aramark has the text of St. Paul's IC standards and is obliged to follow them, the hospital's own IC experts are no longer involved in monitoring, updating, assisting, problem solving, and training the people who clean the hospital.

3.1.2 Isolated supervisors, broken links

Prior to contracting out, housekeeping supervisors at St. Paul's had regular morning meetings to share current information, receive in-services from infection control or other personnel, and generally orchestrate housekeeping activities. HK supervisors were the link between the hospital and its individual cleaners, and they were directly available to their workers and other staff ("the supervisor was just a page away," said a former cleaner). They participated in the hospital's health and safety committee and were an important conduit of H & S information to frontline cleaners. They were also problem solvers, schedulers, and quality inspection monitors.

Today the scope of the Aramark supervisors' job is not altogether clear; what is clear, however, is their disconnection from hospital staff and possibly from one another. Their relationship to their own cleaners is indirect (via the Call Centre) and they no longer have any representation on the hospital's health and safety committee. The role of supervisor as communicator of the hospital's ever-changing housekeeping needs no longer exists, and there is no visible substitute for this important function.

3.1.3 Same space, different employers: Real barriers in real time

Prior to privatization, housekeepers were able to respond to unscheduled service requests from their co-workers (e.g., RNs, Unit Coordinators). A degree of give-and-take was the norm, especially when patient transfers or unexpected events arose. As a former cleaner at St. Paul's said:

> If you had an MRSA . . . it's a lot of work, but it got done. And just telling the nurse to hold off, give me 20 minutes to get there and I'll have it done for you, and they used to hold off. If you don't have that communication, how can you handle it?

[33] ValueIN and its Quality and Customer Service team are discussed in more detail in the Monitoring section.

Today, communication between St. Paul's staff and Aramark staff is indirect at best, nonexistent at worst. Hospital staff are struggling to understand what they are able to ask of Aramark cleaners (if anything) and feel hobbled by restrictions on the relationship. Officially, nurses and other St. Paul employees are not permitted to give direction to housekeepers, either to advise about a method of working or to redirect a task. All service requests must go through the Aramark Call Centre, even if a cleaner is already on the unit. As a staffer in Emergency said, "Some of the cleaners will take requests from us to have a bed cleaned, while others will tell us they need us to call the Call Centre." Another staffer said, "They only respond to pages or messages left at Call Centre."

All service requests must go through the Aramark Call Centre…

As mentioned earlier, making contact with an Aramark supervisor can also be frustrating; unit staff do not have the supervisor's pager or phone numbers. In the past, as a current ER worker said, "We didn't need to call a Call Centre to get things cleaned. Also we knew which housekeeper was on that day and who the supervisor was." The communication blocks take many forms. Many Unit Coordinators do not have a cleaning schedule – none is posted on the unit – and are thus unsure when to expect a cleaner or what their routine looks like. One ER staffer said, "I don't know the policy regarding expectations and /or job description [of the cleaners]."

Contracting out has created barriers where barriers did not exist. The difficulties with inflexibility and inaccessibility cited in "Response and Flexibility" show this is more than an administrative hassle. It is an impediment to meeting patients' needs and a drag on good working relations.

3.1.4 Stifling initiative and coordination

In the past, hospital housekeepers with a regular assignment and an established relationship with a unit would learn to anticipate cleaning needs. Sometimes they would step in and do something not on the schedule, a kind of informal coordinating of labour and task that did not appear on any work flow chart. As a former housekeeper said:

> You're communicating all along. I would know when the patient would be leaving, and they didn't have to [page] Housekeeping. I would just say, 'Give me the list, the numbers, where are they going, give me the time,' and they were done. It would take that stress off of the nurses and the Unit Coordinators because they didn't have to worry about paging me. Because it's a unit, and I don't like being called over that intercom. It sounded like you weren't doing your job.

These cleaners had a sense of owning their jobs. They saw how their work affected other people on the unit and would try to follow more than the letter of the job. This is not to suggest that all cleaners in St. Paul's pre-privatized past were self-starters and paragons of team spirit. However, former cleaners *were* tied to the hospital as employees, usually with an assigned post, a steady work schedule, benefits, and other features that make a person feel as though they belong and are valued – and respond accordingly.

The tie between housekeeper and hospital is now broken…

The tie between housekeeper and hospital is now broken, and one of the casualties is initiative. That Aramark cleaners would be unlikely to exercise their discretion is not surprising, given their workload and strict adherence to Call Centre directives. But Aramark cleaners also do not appear to have the stable assignment that encourages initiative. "In the past the housekeepers were regulars (with the exception of relief), so you knew what to expect," said an ER staffer. "It must be quite uncomfortable for new staff coming to a new department so often; especially places like the ER that is so big, so many different types of patients and such large staff."

Even more is at play. "There is minimal rapport," said another ER staffer, "because housekeeping staff in large part do not seem to understand the broadness or importance of their job." Another staffer said, "The contracted-out staff [show] little or no initiative in their jobs. There is either a language barrier or the training they receive is totally inadequate. Most seem to require very specific direction. There is no teamwork as there was with the previous staff."

In other words, the lack of initiative is not simply a lack of personal freedom or time, though these are significant shortcomings in the Aramark job design. There is also a structural gulf that makes it difficult for cleaners to see where their work fits into the bigger picture of health care and where their responsibilities dovetail with the needs of patients and staff. What is missing is teamwork.

3.1.5 Cut off from the team . . .

Prior to contracting out, housekeepers had a strong sense of being members of St. Paul's health care team. "We were very much like a family. A team," said a former housekeeping supervisor, a 12-year veteran of the hospital. Another former cleaner described the connection with RNs, Ward Aides and Unit Coordinators as "very good. First-name basis. It wasn't, 'Hey you, Housekeeper.' They knew who I was. I felt like part of the team."

Teamwork is essential in a high-stress, life-and-death workplace like a hospital. When asked about the challenges of the job, a former cleaner in the ER said:

> The abuse that the drug-users gave the staff – I think that was the hardest. Saving people's lives and then being told to f-off and actually spitting at you and throwing shit at you and all this nonsense. That used to happen down there and probably still does. As a unit, we all came in together and helped – including security, the nurses, the Ward Aides and the housekeeper – everyone came in and we were a unit. If they don't have that there now, I would not feel safe working there . . . It's really scary to work there.

Teamwork is also an essential ingredient in quality assurance. Support, interdependency, fairness, and accountability: these aspects of teamwork encourage high standards and pride in one's work. For housekeepers at St. Paul's, the team feeling is largely a thing of the past. In many parts of the hospital, the atmosphere of camaraderie has been replaced by troubled feelings: distrust and impatience towards cleaners among some hospital staff; compassion and worry among others. (We cannot speak for the Aramark cleaners and supervisors, who were not part of this project.)

Of course, this is not a monolithic situation. In the surveys some respondents were satisfied with the housekeeping service and some had positive perceptions of the cleaners. One ER staffer said, "The cleaners are friendly and do try very hard to please. This is a difficult place to work, and it seems like they are given very little education about how an Emergency Department works." Another commented that "the housekeeping staff is very friendly." And another said, "Many of the cleaners are friendly and trying to do their jobs well."

Nevertheless, the majority of respondents saw Aramark housekeepers as isolated, sometimes fearful and demoralized, and outside the team. Cleaners were often described as silent and unapproachable. One RN said, "No, [they're] not at all part of the team. Most won't say boo to you." An office worker said, "They come in, do their job, but . . . they're not approachable. I think they're probably afraid." An ER staffer said, "I don't know their names. I don't know who to trust, whether they know what they are doing. They don't identify themselves to me."

A vicious circle is in evidence. When contracting out began, Aramark cleaners were perceived as outsiders and even usurpers of union jobs. Then the new cleaning service was found to be unsatisfactory, communication with the company was often difficult, and old relationships were missed. These experiences exacerbated the division. Some hospital staff are understandably alarmed by what they see as falling standards and infection risks, and they have little faith in Aramark. An ER staffer said, "There doesn't seem to be a sense of belonging or team family. [With] lack of cleanness, you get lack of trust [and] therefore a poor relationship." Another staffer put it simply: "I do not trust that the hospital is being properly cleaned."

Teamwork becomes virtually impossible in this climate. Not only is this an unfair set-up for the Aramark cleaners, but the erosion of trust and teamwork is hard on everyone and does little to advance the cause of cleanliness.

3.1.6 . . . And cut off from the patients

Although housekeeping is designated as a non-patient-care job, it is well understood in health care circles that cleaners often have important interactions with patients (even more so with residents in long-term care facilities). For one thing, they work near and around patients and will often be asked for something – a blanket, a cup – when no one else is close by. They notice if a patient has taken a turn for the worse or has a request, and notify nursing staff accordingly. They may merely exchange a few pleasantries with a lonely patient. A staffer at St. Paul's recalled the housekeeper's role: "Old housekeeping staff would always let nursing staff know of patient requests or if a patient didn't look right." Another staffer was more explicit: "Previous house-keeping staff talked to patients and the staff, and would partake in tasks if asked by RN (e.g., 'Please get bed 3 glass and juice,' etc)."

Aramark cleaners have been told by their employer not to talk to patients. This is clearly unfortunate for patients (loss of human contact and a helping hand) and it deprives nursing staff of that extra set of eyes (an additional layer of vigilance). But prohibiting any connection with patients also further cements the isolation of housekeepers, robs them of one of the job's humane features, and makes it less likely they will make a tangible connection between their tasks and their role: protecting the health and safety of patients through high quality cleaning services.

3.1.7 High turnover equals loss of continuity and reliability

Instability is another enemy of coordination and communication. "Before contracting out we had permanent cleaners," said an ER staffer at St. Paul's. "Now they constantly change." Unlike the former hospital job, the Aramark cleaning job does not offer attractive terms. The pay is low (almost half the pay for the same demanding work, if not more work), benefits are few, job security and status are low, and hours of work may be unpredictable. We heard reports that some Aramark cleaners are hired in a permanent capacity only to be later told they are casual. They enjoy few of the social and emotional advantages of being part of a team.

Reports of high turnover and little continuity among cleaners were common in this environmental scan. We also heard of cleaners who seemed frightened of their employer and/or overwhelmed by their working conditions. "There's

Reports of high turnover and little continuity among cleaners were common…

been a lot of turnover, so it's been really difficult," a unit RN said. "Some of the cleaners are really fun . . . and others look scared to death. They aren't afraid of us, they're afraid of their company. It's terrible." Another RN said:

> There is too much turnover to keep asking each new face for their name. I have to call them by 'housekeeping' only, which is not an ideal situation. I'd look at their name badge but they often don't wear one.

An ER staffer said, "We see that they are in work transitions and are poorly treated by their employer. They will not stay long in this job."

High turnover has many negative consequences: a stream of inexperienced workers; little familiarity with job routines or special circumstances; no growth of the confidence and expertise that leads to problem-solving and taking initiative; and no chance to establish relationships and build trust. The continuity of St. Paul's housekeeping service has deteriorated, and the result can be found in unsatisfactory service and tense relationships.

Chart 2

Quality Assurance via **Communication & Coordination** Formerly, housekeeping (HK) staff and supervisors were seen as and saw themselves as part of the health care team. They had frequent contact with the infection control team, anticipated cleaning needs, responded to staff requests, related to patients, and generally understood how the quality of their work affected patient care and hospital safety.	
****** THEN ****** **Before contracting out**	****** NOW ****** **With contracting out**
Regular, in-person connection between infection control and housekeeping supervisors and sometimes cleaners	No connection between infection control and housekeeping (except electronically)
Daily meeting of HK supervisors to receive and coordinate information	HK supervisors are isolated from each other and from hospital staff
Direct and easy access to HK supervisors (via pager)	Indirect and restricted access to HK supervisor (via regional Call Centre)
HK staff have open communication and a working relationship with unit/department staff, and will respond to staff requests	Lines of communication are broken; cleaners have little or no flexibility to respond to staff requests
HK staff took initiative, recognized cleaning needs (e.g., terminal cleans) and responded	Cleaners take little or no initiative (e.g., no anticipation of cleaning needs or hazards)
HK staff played a role in helping with and communicating patients requests	Cleaners not permitted to speak or otherwise relate to patients
Teamwork was acknowledged and valued, within a climate of trust	Cleaners no longer seen as team members; often seem isolated or demoralized; subjected to distrust
High staff retention, hence continuity and stability in HK positions	Considerable turnover among cleaners; loss of continuity and familiarity with job
Housekeeping schedule posted on unit	No posted cleaning schedule

3.2 TRAINING AND SKILL DEVELOPMENT OF CLEANERS

This section examines how contracting out has disrupted St. Paul's ability to provide quality assurance via skill development and training of cleaning staff. We are aware that it is somewhat artificial to make a distinction between "communication and coordination" and "training and skills." The two are usually linked; for example, the disconnection between Aramark housekeepers and St. Paul's infection control team creates a serious gap in information exchanges. We make the distinction here to focus on training and skill enhancement concerns.

In the past, the hospital controlled whom it hired and set minimum educational or experience levels for each position.[34] New hires would be given a general orientation to the hospital. Cleaners would then receive a specific orientation to the housekeeping department's routines and protocols, as well as health and safety (WHMIS, etc.) and infection control information. Thereafter, housekeeping staff would receive updated information and in-services from their supervisors, product salespeople, H & S representatives, IC nurses, and others as needed.

With privatization, the contractor assumed responsibility for hiring, orienting, and training. Aramark is not obliged to hire persons with any specific qualifications nor are they obliged to provide ongoing training or skill development. The housekeeping contract with Vancouver Coastal Health is very detailed about ends and very general about means.[35] Whether a cleaner at St. Paul's has the skills and knowledge framework to do the job properly is literally none of the hospital's business today.

In the data collection, reports of substandard cleaning were often accompanied by critical comments about cleaners' skills, confidence, and know-how. New Aramark hires are given a 2–3-day orientation and training session from Aramark personnel. We can only speculate about the quality of the company's training and about any prior experience Aramark cleaners bring to the job. We know that Aramark supervisors and workers have no representation on the hospital's health and safety committee. We also know that, as non-employees of the hospital, Aramark personnel are out of St. Paul's information and skills development loop.

3.2.1 How well trained are the cleaners?

Problems with cleanliness at St. Paul's seem at least partially attributable to workers who are unfamiliar with or unaware of how to do the job. Hospital staff in the Emergency Department offered many such comments. "The department is disgusting," said one ER staffer. "I feel the

[34] As mentioned earlier, hospitals prefer to hire cleaners who have completed a Building Service Worker program or equivalent college program.
[35] In the RFP for St. Paul's housekeeping contract, the "Standard of Work" clause reads: "The Contractor is expected to use quality materials and high standards of workmanship in accordance with Infection Control Standards, and to produce, in these designated areas, end results that will conform to high standards of cleanliness, appearance and sanitation." VCHA and Providence Health Care RFP #2002-SS-04 Cleaning Services, p.5.

workers did not receive proper orientation to the department, or training." Another staffer said, "I think cleaners have to be instructed to clean more thoroughly." Another noted that she was "constantly orientating the housekeepers as to how a stretcher is put into the trauma room (head first)." Observations were made about cleaners being uncertain of their duties and unclear about their job description. An ER staffer described inconsistency among individual housekeepers: "One says replacing blue laundry bins is not in the job description, yet another will replace without request."

Some cleaners do not seem to understand when they are interfering with nursing processes. A unit RN described how a housekeeper came into the nursing station to clean during report (when patients' cases are discussed), interrupting the meeting and raising confidentiality concerns. Another was frustrated when a cleaner was polishing the floor around her med cart during morning medication rounds. Prior to contracting out, cleaners would have known to avoid such disruptions.

There are questions, too, about how Aramark cleaners are trained to use new products and equipment. In the past, salespeople would give in-services to HK supervisors, who relayed the information to cleaners. Manufacturers would provide specifications and in-services about new chemical products, sometimes giving samples so that the staff could do test trials and give feedback to their supervisor. It is now unclear what system is used to orient Aramark cleaners to new products.

3.2.2 Awareness of isolation and infection control issues

Even more significant were the many comments about cleaners who misunderstood infection control practices. In the ER, a staffer said:

> I don't believe the cleaners are offered proper cleaning solutions or education around MRSA and the prevention of the spread of infection. They often don't understand what needs to be washed or changed with patients with MRSA or TB. Sometimes I don't think they know when they need to wear masks.

The most common observations were of cleaners who seemed unaware of isolation types and appropriate work methods and cleaning products. The risks are not only to patients and staff, but to the cleaners themselves. An ER staffer said, "[Cleaners are] not wearing proper masks when entering isolation rooms. They are not protecting themselves. Never have seen them wash their hands." A Unit Coordinator noted that cleaners had been wearing their isolation gowns back-wards – open at the front. A unit RN said the "new cleaners were all scared [of MRSA]. They

wouldn't even go into the rooms. They didn't have proper training, but they go in now." Another ER staffer acknowledged feeling sorry for the cleaners and worried on their behalf: "If I ask them to do things which involves TB or MRSA, I am concerned for their safety, that they don't know how to properly protect themselves."

As we saw from the numerous reports of improper cleaning in "Standards of cleanliness," many hospital staff are worried that infection controls are slipping. An ER worker said, "Once when I asked the housekeepers for refill of Microsan[36], she said they don't refill them. This particular employee is a regular staff member, so how educated are they? What do they use for cleaning stretchers?"

These concerns call into question the extent and quality of Aramark cleaners' training but also suggest deficiencies in their supervision. Nobody just 'gets' the requirements of a multi-tasked job in a complex institution like a hospital; a worker needs continuous reinforcement of practical details, concepts, and values. A cleaner at St. Paul's could not be expected to grasp infection control principles and methods without such reinforcement or mentoring. Yet in St. Paul's privatized service environment, the hospital is no longer responsible for ensuring the skill level of cleaners or even supervising their work.

Nobody just 'gets' the requirements of a multi-tasked job in a complex institution like a hospital…

3.2.3 Are Aramark supervisors able to support their cleaners?

As described earlier, St. Paul's housekeeping supervisors and managers were the frontline information source for cleaners prior to contracting out, along with the hospital's infection control and health and safety teams. With the severing of these connections, the burden of training and skill development falls to Aramark supervisors and managers. How well trained and well informed are these Aramark supervisors? How much room do they have in their schedules to give hands-on advice to their cleaners? How frequently do they meet with each other to discuss housekeeping or skill development issues? Are there enough supervisors to provide quality supervision?

Our environmental scan gave rise to these questions without being able to answer them directly. We do know that Aramark supervisors no longer meet with the IC team, nor do they attend the hospital's joint health and safety meetings. We were also told of concerns regarding some supervisors' own knowledge. A clerical staff person at St. Paul's described being asked by an Aramark supervisor if he could leave a fully made bed in the hall beside a stretcher – an

[36] Microsan is an antiseptic instant hand sanitizer in gel form.

obvious hallway obstruction should there be a Code Blue (an emergency code). "He said, 'This bed is okay here isn't it? It's not in the way.' I told him to check with the nurse on duty." An ER staffer said, "I feel the cleaners need direction, which they don't get from the supervision." Our sense is that, just as cleaners are cut off from the hospital's support and teamwork structures, so too are Aramark supervisors isolated.

We also detected problems with the entire supervisory structure. There were frequent reports of Aramark supervisors stepping in to do hands-on cleaning. Not only does this imply problems with staffing levels and/or with staff replacement practices, it may also help to explain why Aramark cleaners seem to lack support and why Aramark supervisors can be difficult to access. Some supervisors were clearly unhappy with their circumstances: frustrated by how much cleaning they did and by how it detracted from their ability to supervise. The job satisfaction, retention, and turnover of Aramark supervisors are additional concerns.

Chart 3

Quality Assurance via **Staff Training & Development** Formerly, HK staff supervisors were regularly trained about cleaning methods, infection control, and new product usage. Performance was monitored in a system that encouraged direct feedback and problem solving. Cleaners were integrated into the hospital's information and skills network, and had access to expert knowledge from health and safety, and infection control personnel, in meetings and written materials.	
****** THEN ****** **Before contracting out**	****** NOW ****** **With contracting out**
Staff hired on the basis of college certificate or equivalent experience	Questions about hiring criteria, and concern that unattractive employment terms may discourage skilled candidates
New HK hires were given initial orientation and departmental training by hospital staff	No orientation or training by hospital staff, but by contractor only
Staff received regular in-services from supervisors, and hands-on advice when needed	Unclear whether in-services are provided; little evidence of hands-on advice.
Supervisors received in-services from RNs and from sales people (re: new products)	Questions about the knowledge/skills base of supervisors and their ongoing development
As employees of facility, HK staff had full coverage and access to H&S information and training	Concern that cleaners are denied access to H&S standards and procedures; contractor is absent from H&S meetings

4. Monitoring System and Mechanisms

Given the numerous problems identified in the data collection, it became important to scrutinize how the Vancouver Coastal Health Authority monitors companies that provide support services to St. Paul's Hospital and other facilities. The following is not an exhaustive account of the health authority's methods but rather focuses on visible shortcomings in relation to privatized housekeeping.

In 2002, the health authority created the Value Improvement Network (ValueIN) to "identify opportunities to make better use of health resources"[37] – to manage the contracting out of support, clinical, and other services. ValueIN pinpoints the services to be privatized; negotiates and manages contract terms with vendors; establishes performance standards and benchmarks; and monitors service outcomes.

It is important to note that, with privatization, both the health authority and the individual facility forfeit responsibility for managing the operation of support services. Providence Health Care (PHC), which administers St. Paul's Hospital, is explicit about this fact. In a memorandum regarding housekeeping, they state: "Performance management is the responsibility of Aramark, the employer. PHC will monitor standards and outcomes."[38] The vendor is contractually obliged to deliver services of a prescribed quality but has a free hand in determining how to do so. Factors relating to staffing, training, supervision, job design, hours of work, wages, and benefits are the vendor's business. Measuring the results – and the complaints – is the health authority's.

It also bears noting that Vancouver Coastal Health has not only shed its power to manage these support services, it has assumed the administrative costs of monitoring the quality of, and dealing with the consequences of the vendor's work.

ValueIN established a Contract Management Team to manage contract and quality assurance issues. They also created a Quality Assurance Team to act as an independent watchdog to ensure that quality standards are met.[39] The QAT's strategic goals include strengthening "the authority's capacity to monitor Vendor services by taking a systematic approach to the measurement of quality outcomes."[40] These quality outcomes were set within core values of service "quality, quantity, and timing"[41] (see Appendix 4).

[37] "ValueIN." VCH website, February 27, 2004.
[38] Providence Health Care, "Aramark Housekeeping Services – Frequently Asked Questions" (undated memorandum).
[39] ValueIN's website: www.vch.ca/vi/quality.htm
[40] "Quality Management in Support Services / Vancouver Coastal Health" presentation by ValueIn's Quality Assurance Team. Open Board Meeting, February 18, 2004. The co-leaders of QAT are Dr. John Blatherwick, the region's chief medical health officer, and Pat Semeniuk, VCH's acting chief nursing officer and executive lead for professional practice.
[41] Ibid.

Inspections and surveys are the primary tools in the health authority's quality assurance arsenal. The Contract Management Team includes a Quality and Customer Service team (QCS), whose representatives and managers wield the tools. Specifically, ValueIN monitors cleaning services according to five criteria:

1) quality audit scores (based on random spot inspections);
2) response times for service requests;
3) issues logging and resolution;
4) customer satisfaction surveys; and
5) infection control standards.

The QCS team is also responsible for specific services across several facilities, and they deal with issues and complaints that go beyond day-to-day operational matters. Importantly, the QCS team conducts and does follow-up on the spot inspections that are crucial to ValueIN's promise of quality assurance.[42]

4.1 TRACKING AND RESOLVING PROBLEMS: DOES IT HAPPEN? HOW CAN WE TELL?

As described in "Response and Flexibility," hospital staff phone the vendor's Call Centre with service requests and routine housekeeping issues, including routine complaints. ValueIN was unable to provide the B.C. Nurses' Union with data about these day-by-day complaints when requested – Aramark is not required to report them. Consequently, ValueIN cannot track the nature and frequency of these complaints, solutions (if any), and trends. But even if a tracking mechanism were in place, a true picture of 'customer satisfaction' might not emerge. At St. Paul's and other hospitals, nursing staff have expressed their reluctance to phone the vendor with complaints about housekeeping service. They don't want to get an individual cleaner in trouble, a cleaner whom they perceive to be working very hard with little security and low pay.

For persistent problems and dissatisfaction, hospital staff are supposed to contact ValueIN's Quality and Customer Service team. The QCS manager will raise the problem with the vendor and may sometimes follow up with the complainant. Hospital staff are concerned about this lack of transparency and inconsistent follow up.

[42] Information on ValueIN's quality assurance processes comes from ValueIN's website, memos issued to hospital staff, and from a June 24, 2004 meeting between ValueIN and BCNU representatives.

4.2 BED-CLEANING RESPONSE TIMES: A VALID PICTURE?

As one of its five criteria for housekeeping services, ValueIN does track bed-cleaning response times – the time it takes to do a "terminal clean" from request to result.[43] Aramark's performance at various Greater Vancouver sites has been acceptable. Unfortunately, published audit results do not include St. Paul's Hospital (similarly, St. Paul's was not included when performance benchmarks were set prior to contracting out).

But bed-cleaning response times, and response times in general, can be misleading. A quick but inadequate bed cleaning is obviously not desirable. Similarly, eliminating one responsibility to deal with a more visible one is unacceptable, just as compelling hospital cleaners to work at an unreasonable pace is an invitation to injury, illness, and job turnover. In short, a bed-cleaning response track record that comes at the expense of general quality, comprehensiveness, and safety is not in patients' interests, nor is it what ValueIN intends. Yet this may be the kind of response time Aramark is delivering at St. Paul's.

4.3 VCHA QUALITY ASSURANCE AUDIT

ValueIN's QCS team conducts checks of hospital rooms and areas – the VCHA Quality Assurance Audit—Cleaning Services – to determine the quality audit scores. These site inspections are theoretically random (no advance warning), frequent (for example, Vancouver General Hospital receives 40 spot audits per month), and consistent (all QCS team members received the same training).

The QCS team uses a one-page form to assess the cleanliness of a room (see Appendix 5). The form lists 31 items plus the cleaning standard for each item. For example, a bed must be "clean, free of dust, stains, soil, old tape, chrome finish is streak free, wheels, brakes are free of dirt and debris." Each item is inspected and then checked off: 'yes' or 'no' with respect to 'satisfactory.' Ratings are tallied for each room, and the percentage calculated. The monthly score for the facility is derived from the average of all audits done in the month. ValueIN set a score of 85% 'yes' to be a pass.

We have many concerns about this inspection process and its effectiveness in assessing cleanliness and correcting deficiencies. But first the good news. Our observations suggest that QCS inspectors are rigorous in their approach. Nurses who have attended an audit say that the inspectors are thorough, strict (any blood or stain on an item warrants an automatic 'no') and in synch with the RN's own assessment. There are, however, several built-in flaws in the audit itself and in the follow-up.

[43] "Quality Management in Support Services / Vancouver Coastal Health." Presentation at the Open Board Meeting, February 18, 2004. "Terminal clean" refers to cleaning after a patient leaves the bed, either as a discharge, transfer, or mortality.

Setting the standard: ValueIN set a baseline in October 2003 against which the performance of the contractors would be measured. This baseline was derived from inspections prior to contracting out; it is a statistical expression of hospital cleaners' performance for use in comparison with Aramark cleaners'. However, the inspections were conducted during the period that St. Paul's cleaners were given layoff notices; consequently the baseline scores represent a time of distress, upheaval, and, for many St. Paul's cleaners, betrayal. This was hardly a typical period and hardly a reliable indicator of St. Paul's old standards. We question the validity of this baseline.

Unweighted and insensitive: A critical problem is that the 31 items in the audit carry equal weight. The cleanliness of a bed is as significant as the cleanliness of a foot stool even though the infection risk of a soiled bed is much higher. A patient's room could have an unsatisfactory bed, toilet, IV pole, and monitor, and still earn the 85% approval rating if all other items were okay.

A critical problem is that the 31 items in the audit carry equal weight.

Not only do all items carry equal weight but the audit form cannot distinguish degrees of satisfactory and unsatisfactory, nor can it detect problematic trends. A window sill with a discarded coffee cup will receive the same rating as a window sill with grimy dust; yet the former is a short-term bother while the latter could be a sign of real trouble. Further, the audit form is unable to capture a pattern of grimy dust in several rooms, over several weeks.

The auditing process is also impervious to certain kinds of information. While doing the audits, the QCS representative may hear from unit staff about improper cleaning methods or frustrations with service, yet there is no place to record these observations. At the very least, staff comments could offer an explanation as to why a room is failing the audit or why other rooms are passing.

In short, the audit form and the scoring method are overly simple. As a result, deficiencies in housekeeping performance could go undetected and the cause of the problem go unnoticed.

Questionable selection, questionable coverage: On the surface, the random selection of rooms for spot audits appears to be a desirable feature of ValueIN's approach. However, we have several concerns relating to the thoroughness and fairness of this approach.

Prior to contracting out, housekeeping supervisors at St. Paul's Hospital produced a monthly quality service report for their manager. To do so, they would inspect 4 or 5 rooms a week per unit; by month's end, all rooms would be surveyed. This old quality assurance system scrutinized every room, every month. In contrast, ValueIN's system examines a fraction of

rooms every month. Presumably the QCS team will ensure coverage of all rooms during a reasonable time period, though we are unaware of such a safeguard.

We are also concerned that ValueIN's random and selective approach means that critical areas of the hospital are not receiving the attention they deserve. Operating rooms, surgical units, dialysis, HIV/AIDS, and burn units – these are examples of areas that require especially high standards of cleanliness and should be subject to regular and frequent monitoring. Again, ValueIN's current system does not guarantee this intensity of monitoring.

> …ValueIN's system examines a fraction of rooms every month.

It bears repeating that these ValueIN spot inspections are designed to monitor outcomes only, not the factors that produce outcomes such as cleaning frequency, techniques, materials, skills, or working conditions. In the absence of direct, daily scrutiny and control of housekeeping operations, we believe it is essential that the health authority's outcome audits be regular, frequent, comprehensive, and critical.

Follow-up: How effective? How sustained? It is also essential that the inspections lead to change when change is needed. Our understanding is that the QCS team reports unsatisfactory ratings to the relevant Aramark supervisor, with the expectation that the problems will be corrected. The QCS member returns a week later to re-inspect the room. If problems still exist, they again notify the Aramark supervisor, and again re-check the room. The QCS manager could also arrange a meeting with the Aramark manager and supervisor in the problem areas and go over the matter directly.

Staff at Greater Vancouver hospitals have expressed concerns to QCS managers that, although some problems get fixed in the short-term (i.e., after audits or complaints), the changes are not sustained. The findings in earlier sections of this report support this view. When 86% of survey respondents in the Emergency Department of St. Paul's believe their workplace is less clean now than before contracting out, the effectiveness of cleaning services *and* monitoring methods are called into question.

4.4 LOSING SIGHT OF THE SYSTEM

Flaws in ValueIN's spot audits and lack of complaint tracking are not, however, the most serious problems. Even more disturbing is the inability of ValueIN to assess *why* problems exist or persist. A room inspection can turn up deficiencies, and statistics can show bed-cleaning response rates, but nothing in ValueIN's toolkit can examine or influence the system of control that creates defects in the first place.

A hospital is known as a "sociotechnical system" by researchers who study risk manage-

ment and accident prevention. Sociotechnical systems are characterized by complex organizational relationships and decision-making paths; advanced and changing technologies; ongoing pressures from governments, the public, and/or the marketplace; and shifting demands on the workforce's skills and education. Managing risk in such a dynamic environment requires

> [the creation of] feedback paths . . . . If instructions from above are not formulated or carried out, or if information from below is not collected or conveyed, then the system can become unstable and start to lose control of the hazardous process . . .[44]

In this view, incompetence and mistakes by individuals are not the authentic problem, and so dealing with a problematic situation by simply enforcing "a culture of personal accountability and vigilance"[45] would be ineffective. Instead, ongoing problems should be viewed as a system design failure in which staff act incompetently or with complacency "not by choice, but because they are working within, and responding to, a system that was not designed to provide adequate feedback, resources, oversight, and competencies to safeguard public health."[46] Thus, the system itself must be checked and redesigned to ensure that safe practices can be acted on and monitored in both routine and unanticipated scenarios.

Contemporary approaches to quality assurance auditing also put great emphasis on checking the system, not merely the result or outcome. "The unit of regulatory attention is now the organization and its system of control rather than the individual," writes Michael Power in *The Audit Society*.[47] This emphasis reflects the public's crisis of confidence in institutions and a corresponding desire to probe to some structural depth, not just settle for superficial tallies. Auditing and governance are now inextricably linked, says Power, and "institutional changes . . . are being accomplished by relying on [audits]"[48]

Privatized support services are an example of institutional change, and so the question arises: How substantial are ValueIN's auditing methods? With regard to cleaning, ValueIN's Quality Assurance Audit and other measurement tools are not audits at all. They cannot provide insight into whether Aramark's *system* is working well. They cannot tell if deficiencies found during site inspections and data collections are performance problems or system problems – an important distinction because an audit "can provide assurance that the system works well even when substantive performance is poor."[49] In other words, a genuine audit can make the distinction between a bad week and a defective operation.

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[44] Woo, Dennis M. and Kim J. Vincente. "Sociotechnical system, risk management, and public health: comparing the North Battleford and Walkerton outbreaks." *Reliability Engineering and System Safety* 80 (2003) 253-269 (www.elsevier.com/locate/ress). p. 254.
[45] Ibid. p. 268
[46] Ibid. p. 268.
[47] *The Audit Society*. 67.
[48] Ibid. 67.
[49] Ibid. 6.

ValueIN does inspections, not audits. These inspections are in a surveillance vein: the goal is to measure compliance and noncompliance, and to urge better results. They are not designed to evaluate what works and what needs fixing, nor can they appraise whether training, communication, and coordination are effective. These narrow parameters suggest that the health authority is counting on Aramark and other contractors to do genuine audits and genuine analysis and follow up, where needed.

Given the many problems with cleaning services and the isolation of cleaning staff, we are concerned that the health authority has dropped its responsibilities in this vital area.
Not only is the public authority unable to inspect and influence the manner in which hospital cleaning services are delivered, the community too is affected. What the health authority cannot know, the public cannot know. This lack of transparency about a component of the health care system – one with direct bearing on the community's health and safety – is unacceptable.

4.5 RECIPROCAL AUDITS: IS THIS THE BEST COMPARISON?

ValueIN's Quality Assurance Team had suggested that the health authority consider an annual independent audit of contracted services in the region. The health authority took another route, ostensibly for budgetary reasons, and opted for reciprocal audits with two other health regions: the Fraser Health Authority and the Calgary Health Authority. The reciprocal audit with the Fraser region is scheduled for October 2004; the Calgary audit is in the planning stages.

Both regions, like Vancouver Coastal, are heavily involved with privatized support services. Consequently, these reciprocal audits will not allow a comparison between privatized and public services. The VCHA contracted out its support services with the aim of saving money and achieving efficiencies while maintaining (and improving) service and quality standards. An audit should examine whether these goals have been met and can only do so by comparing "the old" with "the new." Such a comparison is not possible with the current partners. In fact, all three authorities share an interest in the success of their contracting out efforts.

The Northern and Interior Health authorities in British Columbia have not contracted out their support services; either would have been a more suitable choice for a reciprocal audit. However, we believe an audit by an independent team of professionals would best serve the need for a truly disinterested and arm's length evaluation.

5. Conclusion

Nurses, health sciences professionals, and support staff in the VCH region are alarmed by deteriorating standards in cleanliness and by communication difficulties with cleaning contractors. In particular, staff are deeply worried that infection control practices are slipping. They are concerned that the health authority does not have a monitoring system that can accurately gauge the cleanliness of facilities, the soundness of infection control practices, and the capacity of vendors to deliver knowledgeable, responsive, and stable cleaning services. They are unhappy that nurses must spend an inordinate amount of time on the phone making service requests, which means less time for patients. They are alarmed that cleaning problems are contributing to back-ups in the Emergency Department and hence to slower responses to the public. Risks to patients, the community, workers, and the healthcare system itself appear to be on the rise.

> Crucial relationships in the health care team have been severed.

Privatization is a disruptive process. People lose their jobs, remaining staff lose their colleagues, lines of communication are altered, and new faces and new work routines appear. Yet the concerns raised in this report are not the by-product of a transition period. They are based on visible evidence and direct experiences that have been frequent and ongoing since contracting out in 2003. Staff are appalled by blood-stained curtains, dirty floors, uncollected garbage, empty soap dispensers, unmasked cleaners, inaccessible housekeeping supervisors, and similar shortcomings. Other concerns are less tangible but perhaps even more significant. Crucial relationships in the health care team have been severed. Layers of administration have been added, making service flexibility more elusive and less likely. Taken as a whole, these defects are a sign of structural problems.

Staff are apprehensive that deteriorating housekeeping services could be a blow to the health care system over the long term. Forcing nurses to spend time on non-nursing tasks is an expensive and inefficient use of their expertise. Increases in hospital-acquired infection will translate into longer hospital stays and longer waiting lists. Stressful and unsanitary working conditions can lead to increased staff sick time and turnover. Scarce resources could be diverted to deal with avoidable crises, and trust in the health care system would be further eroded. There is a real uneasiness that savings from the offloading of support services may be penny wise and pound foolish, with the community paying a steep price.

> …the public has lost control of how hospital cleaning is managed.

Today, the health authority stands in an indirect relationship to the people responsible for the cleanliness of its facilities. In effect, the public has lost control of how hospital cleaning is managed. Internal checks and balances, data about cleaning practices and staff development, integrated systems of quality assurance and feedback, team-based problem-solving: all these have become circuitous with the splitting off of support services. Issues of public accountability and transparency are muddied by this indirectness, and the public's right to know suffers.

6. Recommendation

This report is the result of a preliminary examination of problems and risks that have emerged in the Vancouver Coastal Health region since housekeeping services were contracted out in October 2003. We believe a more thorough study of the situation is urgently needed.

We recommend that the Vancouver Coastal Health Authority commission a comprehensive, independent audit of the region's housekeeping services, especially in the realm of infection control and other patient safety issues. We suggest that the B.C. Auditor General or another recognized professional auditor be charged with this task.

The audit should be wide-ranging, descriptive, and analytic. We recommend that survey and qualitative data be collected from personnel at all levels of the system and in all relevant job categories, public and private employees alike. The views of patients and family members should also be solicited. The Cleaning Services Agreement between the VCHA and Aramark Canada Ltd. allows the health authority and its agents considerable access to the contractor's operating records and quality control practices, as well as some influence over the training needs of cleaners.[50]

In light of the problems underlined in this report, the audit should examine and appraise issues relating to:

- communication and coordination between the contractor/cleaners and the hospital (RNs, Unit Coordinators, and Bed Booking staff; the infection control team; health and safety committee; and other relevant relationships);

- the VCHA's quality assurance structure and mechanisms, with particular attention to issues of sensitivity and thoroughness, feedback and enforcement mechanisms, and transparency and accountability features;

- hidden costs and savings, and hidden inefficiencies and efficiencies due to contracting out;

- cleaning staff retention and job satisfaction;

[50] For information about the health authority's ability to view Aramark records, refer to articles 7.1 (Reporting Requirements), 7.4 (Cleaning Committee), 9.4 (Access to Operating Documents) and Schedule 6 (Reporting Requirements) of the "Aramark VCHA Cleaning Services Agreement Execution Copy July 28, 2003". For example, Article 7.4 (e) calls for the joint cleaning committee to "ensure that standard administrative and training requirements of the Contractor and the Health Authority are identified and met." p. 16.

• contractors' compliance with Workers' Compensation Board requirements and with established occupational health and safety practices;

• skill development, training, and support of cleaners; and

• skills and support of cleaning supervisors.

The results of the audit should be made public and any recommendations arising from the audit should be referred to a multi-stakeholder group for implementation.[51]

[51] This group could include employers, unions, academics, and health care professionals (especially infection control experts).

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Addendum

Prior to publication, copies of this report were sent to the following: Ida Goodreau, President and CEO of Vancouver Coastal Health (VCH); Carl Roy, President and CEO of Providence Health Care; Perry Kendall, Provincial Health Officer; John Blatherwick, Chief Medical Health Officer for VCH; and Doug Cochrane, Chair of the Provincial Task Force on Patient Safety.

All were asked for a response to the report's central recommendation, which calls for an independent external audit. The scope and terms for the proposed audit are outlined on page two of the report.

In addition, the report's authors requested meetings with John Blatherwick and Doug Cochrane.

The following responses were received.

Name	Response
Ida Goodreau	No response
Carl Roy	Zulie Sachedina, VP of Human Resources, responded on behalf of Providence. The report's central recommendation was not addressed. The letter stated that improvements had been made in housekeeping since May/June 2004, that they were working in collaboration with VCH and that they would benefit from any "regional improvements."
Perry Kendall	Referred us to John Blatherwick
Doug Cochrane	Stated that he had nothing to contribute and therefore a meeting was not required.
John Blatherwick	Met with representatives from BCNU and HEU. Pointed out that Providence Health Care was not part of Valu-In. Said he was in agreement with the need for an independent audit, but did not commit to a timeline or to the scope and terms of reference recommended in this report.

Authors' Comment

On the relationship between Providence and Valu-In:

It is not clear what monitoring and enforcement mechanisms are in place at Providence and/or how they link with Valu-In. This lack of transparency presents problems for both staff and the public when it comes to reporting and correcting problems with quality.

On quality assurances:

Although Zulie Sachedina states that housekeeping improvements have taken place since the research project was undertaken in May/June 2004, our members continue to raise concerns about deteriorating conditions at St. Paul's hospital.

On the need for an independent audit:

John Blatherwick's general support for an independent audit is encouraging. However, we are concerned that if a crisis situation is to be avoided, the audit must include Providence Health Care, be timely and adhere to the scope and terms of reference outlined in this report's recommendation.

APPENDIX 1

Impact of Contracting-Out Housekeeping and Security Services

The BC Nurses' Union, Health Sciences Association and Hospital Employees Union is carrying out a research project to determine changes, if any, to the quality and efficacy of housekeeping and security since November, 2003 when these services were contracted out. Your assistance in this project is greatly appreciated. It is our intention to make the results available to the public but individual anonymity will be respected.

Job Title _____

Number of years worked in this department _____

Number of years worked in this hospital _____

Housekeeping

1. In terms of the overall cleanliness, do you think that in comparison to pre-contracting-out, the unit is now: (please tick)

   _____ cleaner
   _____ about the same
   _____ worse

   Please give concrete examples:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

2. Since contracting-out, have you observed any work practices and/or procedures that do not meet basic requirements for infection control? (please tick)

   Yes ____ No____ Don't Know_____

   Please Explain:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

3. Have you observed any situation where it is clear that the contracted-out workers lack the required training and understanding or knowledge of: (please tick)
   - General infection control cleaning standards. Yes ___ No ___Don't Know___
   - Isolation cleaning standards (i.e. TB, MRSA). Yes ___ No ___Don't Know___
   - Use of appropriate cleaning solutions. Yes ____ No ____Don't Know____
   - Application of safety prevention (e.g. wet floor warnings, securing electrical cords, etc.) Yes ____ No ____Don't Know____

4. In your experience since contracting out has the response time for cleaning up unexpected spills/hazards: (please tick)

   ____ increased
   ____ decreased
   ____ remained the same
   ____ don't know

5. In your experience since contracting out has the response time for getting a stretcher ready: (please tick)

   ____ increased
   ____ decreased
   ____ remained the same
   ____ don't know

6. How has contracting-out affected your relationship to housekeeping staff?

Security

7. Since contracting out, have you been directly involved in any incidents involving security? Yes___ No____
   Please explain:

   Was the incident(s) reported to the OH&S Committee? Yes___ No_____

8. In your experience since contracting out have the response times by security:
   ____ increased
   ____ decreased
   ____ remained the same
   ____ don't know

9. In your experience do the new security personnel have the required training to respond to security needs in a medical setting? Yes ___ No ___Don't Know___

   Please explain:

10. Has the shift to contracting-out affected your relationship to security staff?

Thank you for taking the time to complete this questionnaire.

APPENDIX 2

The Walk-About: Audit of Cleanliness

Patient Bathrooms (twice per shift)

Date: _____ **Shift:** _____ **Time:** _____

a) Visible fresh staining: yes ___no ___ If yes, with what?

_____

_____

b) Odour: yes___ no __ If yes, of what?

_____

c) Garbage overflowing: yes____ no ____

d) Paper towels stocked: yes ____ no ____

e) Soap stocked: yes ____ no ____

Comments: _____

_____

_____

_____

Patient Bathrooms

Date: _____ **Shift:** _____ **Time:** _____

a) Visible fresh staining: yes ___no ___ If yes, with what?

b) Odour: yes___ no __ If yes, of what?

_____

c) Garbage overflowing: yes____ no ____

d) Paper towels stocked: yes ____ no ____

e) Soap stocked: yes ____ no ____

Comments: _____

_____

_____

_____

Bedside Area – to be checked after discharge clean

Date and Time _____

Stretcher # _____	**General cleanliness**	**Visible fresh staining on rails** Yes ____ No ____	**Stained with what**	**Base, under side, wheels Soiled** Yes _____ No _____	**Soiled with what**
Floors		**Visible fresh staining** Yes ____ No _____	**Stained with what**	**Equipment or items left behind** Yes ____ No _____	**What left**
Curtains		**Visible fresh staining** Yes ____ No ____	**Stained with what**		
Monitor leads		**Visible fresh staining** Yes ____ No _____	**Stained with what**		
IV Poles		**Visible fresh staining** Yes ___ No ____	**Stained with what**		
Other equipment		**Visible fresh staining** Yes ____ No ____	**Stained with what**		
Counter		**Visible fresh staining** Yes ____ No ____	**Stained with what**	**Left items** Yes ____ No _____	**Dust** Yes ____ No ____
Window Sill		**Visible fresh staining** Yes ____ No ____	**Stained with what**	**Left items** Yes ____ No _____	**Dust** Yes ____ No _____
Sharps Container		**Full or over-Flowing** Yes ____ No _____			

Common Areas (twice per shift)

a) Hand Washing Stations:

Visible fresh staining: yes ____ no ____ If yes, with what?

_____

Paper towels stocked: yes ____ no ____

Soap stocked: yes ____ no ____

b) Common Hallway and Waiting Area:

Dust: yes ____ no ____

Litter: yes ____ no ____ If yes, with what?

_____

_____

Visible staining: yes ____ no ____ If yes, with what?

_____

_____

c) Entrance:

Litter: yes ____ no ____ If yes, with what?

_____

_____

Other Comments on Common Areas:

_____

_____

_____

_____

_____

_____

Utility Rooms

a) Clean Utility Room

Comment on the overall cleanliness of the floors in the clean utility room:

Garbage full or overflowing: yes ___ no ____

b) Dirty Utility Room

Comment on the overall cleanliness of the floors in the dirty utility room:

Garbage full or overflowing: yes ____ no _____

5. Staff Lounges

Comment on the overall cleanliness of the staff lounge:

Please return completed forms to:
Patricia Wejr
BC Nurses' Union
4060 Regent Street
Burnaby, BC V5C 3P5
pwejr@bcnu.org
fax 604 433 7945

APPENDIX 3

SPH HOUSEKEEPING RESPONSE TIME SURVEY

Purpose: *monitoring project by BCNU, HSA and HEU to determine the quality and efficacy of Housekeeping since contracting-out in November 2003.*

Date: _____ **Shift:** _____ (Day/Evening/Night)

Name of Unit: _____ **Your Job Title:** _____

1. How many "terminal cleans" were done during your shift today? _____

2. After entering a discharge/transfer in ADT during your shift, how many times did you have to make a *follow-up* phone call to the Aramark Call Centre? _____

   Is this documented? ____ (Yes/No). If so, how/where?

   _____

3. On average, how long did the "terminal cleans" take during your shift from the time you made the entry in ADT to the bed being ready for a new admission? *(Please check one)*

less than one hour _____ ***1-2 hours*** _____ ***greater than two hours*** _____

If there was a delay (i.e. more than one hour), please elaborate:

_____

4. In your opinion, is this ***longer than*** ____, ***shorter than*** ____ or ***about the same*** ____ as it was prior to contracting-out? *(Please check one)*

5. Could you comment on the quality of the "bed cleaning" (be as specific as possible)?

_____

_____

6. How difficult is it to reach an Aramark Housekeeping **supervisor**? What is the result (i.e. response time, actual clean)?

_____

7. Are you able to isolate immune-compromised patients from MRSA patients:

   always ___, ***most of the time*** ___, ***sometimes*** ___, ***infrequently*** ___, ***never*** ___ ?
   (Please check one)

8. Thinking about the past three years, has your ability to isolate immune-compromised patients from MRSA patients ***become worse*** ____, ***improved*** ____, ***stayed about the same*** ___, ***don't know/not applicable*** ____? *(Please check one)*

   Any comments on this?

_____

Thank you for taking the time to fill-out this survey.

APPENDIX 4: SPECIFICATIONS FOR CLEANING SERVICES

1.0 Scope

This specification is for the cleaning services (which includes, but is not limited to, waste management, cleaning of floors, washrooms, furniture, fixtures, and surfaces based on established frequencies and standards per the Infection Control Guidelines to achieve and maintain a consistent acceptable working environment) of the requested facilities.

Please see **Appendix 2** for complete list of facilities and buildings.

Health Care Group Area Definitions

Health Care Area Group	Definition
Group 1	Office Areas, Includes Administrative, Admitting, & Common Non Patient Areas, Inventory Control, Employee Health Centre, Housekeeping.
Group 2	All Outpatient Care Units (Excluding Bone Marrow And Transplant Clinics); Diagnostics, Cafeteria, Cardiac Ultrasound, Central Laboratories, Physiotherapy, Respiratory Services Division (Excluding Pulmonary Function Laboratory), Tissue Bank & Cell Culture Laboratories & Microbiology, Pharmacy & Outpatient Blood Collection Area, Endoscopy Suites, Radiology / MRI Unit.
Group 3	All Patient Wards
Group 4	Burn Unit, Bone Marrow Transplantation & its Clinics (CP-E6 (VGH)), Solid Organ Transplantation & its Clinics (CP-E10 (VGH)), Intensive Care Units (ICUs), Cardiac Care Units (CCUs), Operating Rooms (ORs), Post-Anaesthetic Care Unit, Sterile Supply Division (SSD), Cardiac Catheterization, Angiography Suite & Pharmacy Admixture Rooms, Dialysis & Emergency.

VCHA Area Square Footage Summary (by Site)

Facility	Group 1 Sq Ft	Group 2 Sq Ft	Group 3 Sq Ft	Group 4 SqFt	Total Sq Footage
UBC	285,050	138,707	215,966	36,434	676,157
GFS	127,135	16,450	61,590	-	205,175
GPC	79,700	26,000	46,200	-	151,900
Lions Gate	279,776	9,900	311,975	41,550	643,201
Richmond	162,600	65,100	208,300	39,500	475,500
VGH	930,507	313,641	331,464	134,876	1,710,488
NSCG	190,167	39,544	438,165	18,874	686,750
PHC	591,553	198,326	326,039	51,234	1,167,152
Totals	2,646,488	807,668	1,939,699	322,468	5,716,323

2.0 General Duties & Obligations

Contract Performance

a) All cleaning operations are to be conducted in a manner that facilitates minimal inconvenience to staff, patients, and the general public.

b) Cleaning services vary by site, which may also include, from time to time, specialized services from the Contract provider. Such services will not be pre-planned or pre-scheduled and thus should be considered short notice requests for service. Please see Appendix 13 for a breakdown of services.

c) All employees of the Vendor should be bonded or bondable.

Uniforms

a) It is a requirement of VCHA, for the purpose of identification and safety that the Vendor's staff be suitably uniformed at all times. The uniforms shall be dissimilar to VCHA uniforms and shall be suitable for the work carried out under this Agreement.

b) It will be the responsibility of the Vendor to provide individual custodial I.D. cards to their staff and ensure they are worn at all times.

Service Requirements

a) Conduct of the Vendor's staff shall be above reproach at all times.

b) The Vendor's cleaning staff are not to interfere with building or occupant's property.

c) Lights are not to be left on unnecessarily.

d) Building occupant's desk drawers or storage cabinets are not to be opened.

e) The Vendor's cleaning staff are not to disturb books, papers, etc. located on desks, counter tops, displays, etc.

f) The Vendor's staff are not to use telephones (except in an emergency), office equipment (e.g.) computers, photocopiers, calculators, radios, T.V. sets or any other equipment belonging to VCHA or building occupant.

g) Only employees of the Vendor shall be allowed access to the building.

Security

a) VCHA has serious concerns pertaining to the security of staff, patients, the general public and property at the building locations. The Vendor shall not allow entry into any building or room but instead will direct individuals seeking access to contact Security. Every room shall be left secured by the Vendor's staff when unoccupied.

Supervision

a) The Contractor shall have Contract Manager located on-site who will be responsible for the work to be carried out and for directing and managing the contractor's employees engaged to carry out work.

b) The Contractor's Manager will be accessible to VCHA Representative so that any special requests for service and/or complaints may be addressed and met with the appropriate action.

c) The Contractor shall be responsible for his employee's personal belongings while they are on VCHA's premises.

3.0 Equipment and Supplies

Supplies

a) All materials and cleaning supplies used in the cleaning operation shall be provided by the Contractor including ALL washroom supplies, such as, but not limited to, toilet paper, hand soap for existing dispensers, sanitary napkins/tampons, paper towels as required, deodorizing products etc., plastic garbage bags for general garbage disposal and plastic liner bags for individual waste bins. **The Contractor shall provide a listing of supplies used in the cleaning operation and associated pricing as an appendix to their submission.** All material and cleaning supplies must thoroughly clean the facilities and must not be detrimental to the life of systems and building components (e.g. floors, walls, carpet, etc), and meet VCHA Infection Control Standards. Also, all consumable supplies must be compatible with existing dispensing systems within buildings / locations.

b) All materials and cleaning supplies shall be stored in lockable, clearly defined Building Service Rooms designated and made available to the Contractor by VCHA.

c) A complete set of Material Safety Data Sheets (MSDS) of supplies used must be kept on-site.

d) All cleaners, strippers, floor finishes and waxes, and any other materials, cleaning methods, machines or equipment used by the Contractor, are to be approved by VCHA Representative or appointee before use. Approval of materials does not relieve the Contractor of general responsibility under this RFP.

Equipment

a) All equipment used in the cleaning operation shall be provided by the Contractor.

b) Equipment used in the cleaning operation shall be in excellent working condition throughout the term of the Agreement.

c) The Contractor's equipment shall not damage or cause unnecessary wear to building surfaces, furnishings and other equipment belonging to VCHA.

d) All equipment used on a daily basis shall remain on the premises, stored in the designated Building Services Room(s).

e) Unless otherwise approved by VCHA, other powered or specialized equipment used periodically by the Vendor shall not be kept on the premises. The Vendor shall not use VCHA's facilities for storage of materials or equipment used elsewhere, nor shall other operations of the Vendor be directed from VCHA's premises.

f) All equipment is to be kept clean, appropriately maintained, and neatly stored in designated Building Services Rooms.

g) Propane power equipment may NOT be used.

Dispensers

a) All paper towel dispensers, sanitary napkin disposal units, sanitary napkin dispensers, toilet paper dispensers, and hand lotion soap dispensers shall be supplied by VCHA.

b) All supplies used in the dispensers must be provided by the Vendor.

VCHA reserves the right to examine the Contractor's supplies and equipment from time to time to ensure that the supplies and equipment are suitable for the performance of the work.

Where materials, methods or equipment not approved by VCHA Representative are used, the Contractor will be required to re-execute work, remove equipment or alter methods to the satisfaction of, and without additional expense to, VCHA.

4.0 Building Keys and Card Access Systems

a) The Contractor shall be issued keys and/or access cards by VCHA for the performance of the work.

b) The Contractor shall be held responsible for any loss of security due to the misuse or loss of keys and/or access cards. All losses must be reported immediately to VCHA Representative and, on the decision of VCHA, the cost of rekeying an area or the building shall be charged to the Contractor.

c) VCHA reserves the right to inspect the Key Inventory and/or access cards issued at any time.

d) The Contractor is responsible for issuing keys and/or access cards to his staff and maintaining proper documentation at all times.

e) The Contractor shall not duplicate any of VCHA's keys.

5.0 Cleaning Standards and Inspections

The Contractor shall perform all the work as required.

A monthly Quality Assurance inspection is to be carried out by a senior member of the Contractor's firm and VCHA's representative. Prior to each monthly inspection, arrangements shall be made with VCHA's representative for the inspection tour.

Standard of Work

The Contractor is expected to use quality materials and high standards of workmanship in accordance with Infection Control Standards, and to produce, in these designated areas, end results that will conform to high standards of cleanliness, appearance and sanitation. Should it be necessary in the opinion of VCHA Representative or his/her appointee, to increase the frequency of the service to meet the required standards, the Contractor shall do this without additional expense to VCHA.

Frequency of Service

The service provider is required to provide the cleaning service at whatever frequencies are deemed necessary in order to meet the required Infection Control Standards of Cleanliness.

Table 1 below sets out the current cleaning frequencies to apply to each element within a functional area. A cross-reference matrix is included. (see Table 2).

Table 1: Current Cleaning Frequencies

	Priority	Time frame for rectifying problems
A+	Constant, cleaning critical	Immediate
A	Constant, cleaning critical	Immediate 5 – 30 minutes
B	Frequent, cleaning important and requires maintaining	0 – 48 hours
C	Regular, on a less frequent scheduled basis and as required in between	2 – 7 days
D	Infrequent, on a scheduled or project basis	1 – 4 weeks

The priorities A+, A, B, C or D are intended to reflect the importance of cleaning each element in the particular functional area. For example, a toilet in the Operating Theatre and a toilet in a waiting room should be equally clean, while the floors of a plant room require less attention than the floors in an ICU.

Table 2: Group 1 Current Cleaning Frequency

	Group 1																																		
Scope of Work	Offices	Medical Records	Finance	Payroll	Benefits	Corp Admin	Medical Admin	Nursing Admin	Foundation	Human Resources	Communications	Locker rooms	Lobbies	Cafeteria	Kitchens	Laundry	Library	Maintenance	Power Plant	Compactor room	Computer room	Chapel	Transport	Receiving	Stores	Switchboard	Ladies Auxiliary	Conference room	Central Processing Dept	Coffee Shop	Biomedical Engineering	Housekeeping Areas	Printing Services	Archives	Storage area
Building																																			
Entrance & Stairwells											C											C						C							
Walls & Ceilings	C	C	C	C	C	C	C	C	C	C	C	B	B	B	B	C	D	D	D	D	D	D	D	D	D	D	D	D	C	C	D	D	D	D	D
Windows & Glass																																			
Doors	C	C	C	C	C	C	C	C	C	C	C	C	B	C	C	C	C	D	D	D	D	D	D	D	D	D	D	D	C	C	D	D	D	D	D
Hard Floors																																			
Soft Floors	C	C	C	C	C	C	C	C	C	C	C	B	B	B	B	B	C	D	D	D	D	D	D	D	D	D	D	D	B	B	D	D	D	D	D
Vents																																			
Fixtures																																			
Electrical Fixtures																																			
Appliances	C	C	C	C	C	C	C	C	C	C	C	C	B	B	B	B	C	D	D	D	D	D	D	D	D	D	D	D	B	B	C	C	D	D	D
Furnishings																																			
Bathroom Fixtures	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	D	D	D	D	C	B	B	B	B	B	B	B	B	B	B	D	D	
Patient Equipment																																			
Commodes																																			
Wheelchairs	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	
IV Poles																																			
Walkers	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/		
Environment																																			
Odour Control	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	
General Tidiness																																			
Overall Priority																																			

Group 2, 3, 4 Current Cleaning Frequencies

	Group																	Group		Group								
Scope of Work	Ambulatory Care	Psyh Day Care	Clinics	Respiratory	Physio Therapy	Cardio	Nuclear Med	Occupational Therapy	Enterostomal Therapy	Laboratories	Imaging	Pharmacies	Histology	Cytogenetics	Morgue	Special Procedures	Patient Units	Resident/Long Term Care Units	★Emergency	★Operating rooms	Intensive Care Unit	★Renal Unit	Critical Care Unit	Cardiac Surgical Intensive Care	Post Anaesthetic Care Unit	★Special Care Nursery	Surgical Day Care
Buildin																												
Entrance & Stairwells	C	C	C	C	C	C	C	C	C	B	B	B	A	A	C	B	C	C	B	B	B	B	B	B	B	B	B	B
Walls & Ceilings	B	B	B	B	B	B	B	B	B	C	C	C	C	C	D	B	B	B	A	A	A	B	A	A	A	A	A	A
Windows & Glass	B	B	B	B	B	B	B	B	B	C	C	C	C	C	D	B	B	B	A	A	A	B	A	A	A	A	A	A
Doors	B	B	B	B	B	B	B	B	B	C	C	C	C	C	D	C	B	B	B	B	B	B	B	B	B	B	B	B
Hard Floors	B	B	B	B	B	B	B	B	B	B	B	B	B	B	D	B	B	B	A	A	A	A	A	A	A	A	A	A
Soft Floors	B	B	B	B	B	B	B	B	B	B	B	B	B	B	D	B	B	B	A	A	A	A	A	A	A	A	A	A
Vents	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	C	C	C	C	C	C	C	C	C	C	C	C
Fixture																												
Electrical Fixtures	C	C	C	C	C	C	C	C	C	B	B	B	B	B		B	B	B	B	B	B	B	B	B	B	B	B	B
Appliances	C	C	C	C	C	C	C	C	C	B	B	B	B	B		B	B	B	B	B	B	B	B	B	B	B	B	B
Furnishings	B	B	B	B	B	B	B	B	B	B	B	B	B	B		B	B	B	A	A	A	B	A	A	A	A	A	A
Bathroom Fixtures	B	B	B	B	B	B	B	B	B	B	B	B	B	B		B	B	B	A	A	A	B	A	A	A	A	A	A
Patient Equipmen																												
Commodes	B	B	B	B	B	B	B	B	B							B	B	B	A		A	B	A	A	A			
Wheelchairs	B	B	B	B	B	B	B	B	B							B	B	B	A	A	A	A	A	A	A	A	A	A
IV Poles	C	C	C	C	C	C	C	C	C							B	B	B	B	B	B	B	B	B	B	B	B	B
Walkers	C	C	C	C	C	C	C	C	C							B	B	B	B	B	B	B	B	B	B	B	B	B
Environmen																												
Odour Control	B	B	B	B	B	B	B	B	B	C	C	C	C	C	C	B	A	A	A	A	A	A	A	A	A	A	A	A
General Tidiness	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	A	A	A	A	A	A	A	A	A	A
Overall Priorit	B	B	B	B	B	B	B	B	B	B	B	B	B	B	D	B	B	B	A	A	A	A	A	A	A	A	A	A

6.0 Cleaning Quality Standards**

Cleaning and regular maintenance prevent the buildup of soil, dust or other foreign material that can harbour pathogens and support their growth. The aim of cleaning is to achieve a clean environment with regular and conscientious general housekeeping. Visible dust and dirt should be removed routinely with water and detergent and / or vacuuming. Cleaning schedules and methods vary according to the area of the hospital, type of surface to be cleaned, and the amount and type of soil present. Horizontal surfaces (for example, bedside tables and hard-surfaced flooring) in patient care areas are usually cleaned on a regular basis, where soiling or spills occur, and when a patient is discharged.

Definitions:

- *Standard:* an established level of achievement
- *Clean:* if no visible soil apparent, even on close inspection.
- *Visible soil:* not readily apparent but visible on close inspection
- *Sanitize:* to reduce bacteria present to a safe level according to Public Health Standards
- *Disinfect:* to free from pathogenic organisms or render them inert
- *Sterilize:* to render sterile, aseptic, free from living organisms

Note – in areas where the standard indicates a situation that is not within the scope of the contract (i.e. ceilings not intact, loose or missing tiles) it is to be brought to the attention of VCHA representative who will in turn direct the situation to the appropriate department.

**References: Health Canada *Infection Control Guidelines*; U.S. Department of Health and Human Services Centres for Disease Control (CDC) *Guideline for Hand Washing and Hospital Environment Control*; Joint American Health Care Organization Standards (JAHCO) & Department of Human Services & Infection Control (Australia).

1. Building	
a. Walls, Ceilings & Skirtings / Baseboards	• Free of dust, grit, lint, soil, film & cobwebs • Walls & ceilings free of marks caused by furniture, equipment, staff or patients • Light switches are free of fingerprints, scuffs & any other marks • Light covers and diffusers are free of dust, grit, lint & cobwebs • Polished surfaces are of uniform luster
b. Baseboards	• Free of dust, debris, soiling including wax and fluid build up • Corners & top of baseboards are free of dust, lint & soil
c. Ceilings	• Good overall appearance • Ceiling intact, no loose or missing tiles (if present) • Free of dust, cobwebs and soil film • Molding (if present) is free of dust and lint deposits • No cracks or holes which could produce a safety hazard
d. Windows:	• Internal and external surfaces of glass are clear of all streaks, spots & marks, including fingerprints and smudges • Window frames, tracks, ledges are clear and free of dust, grit, marks and spots • No soil film accumulation on inside of glass

APPENDIX 5

Performance Criteria

Laundry Services

- 98% LINEN QUOTA FILL RATE
- 3RD PARTY LAB TESTING CRITERIA
- DELIVERIES WITHIN +/- 1 HOUR OF SCHEDULE
- LINEN REPLACEMENT
- 85% QUALITY AUDIT SCORE

Security Services

- 99% SHIFT FILL RATE
- RESPONSE TIMES FOR CODE ALERTS
- MANAGEMENT OF AGGRESSIVE BEHAVIOUR
- BREACH INVESTIGATIONS & RESOLUTION
- RESPONSE FOR ADDITIONAL SERVICE

Housekeeping Services

- 85% QUALITY AUDIT SCORE
- RESPONSE TIMES FOR SERVICE REQUESTS
- ISSUES LOGGING AND RESOLUTION
- CUSTOMER SATISFACTION SURVEYS
- INFECTION CONTROL STANDARDS

Performance criteria based on:

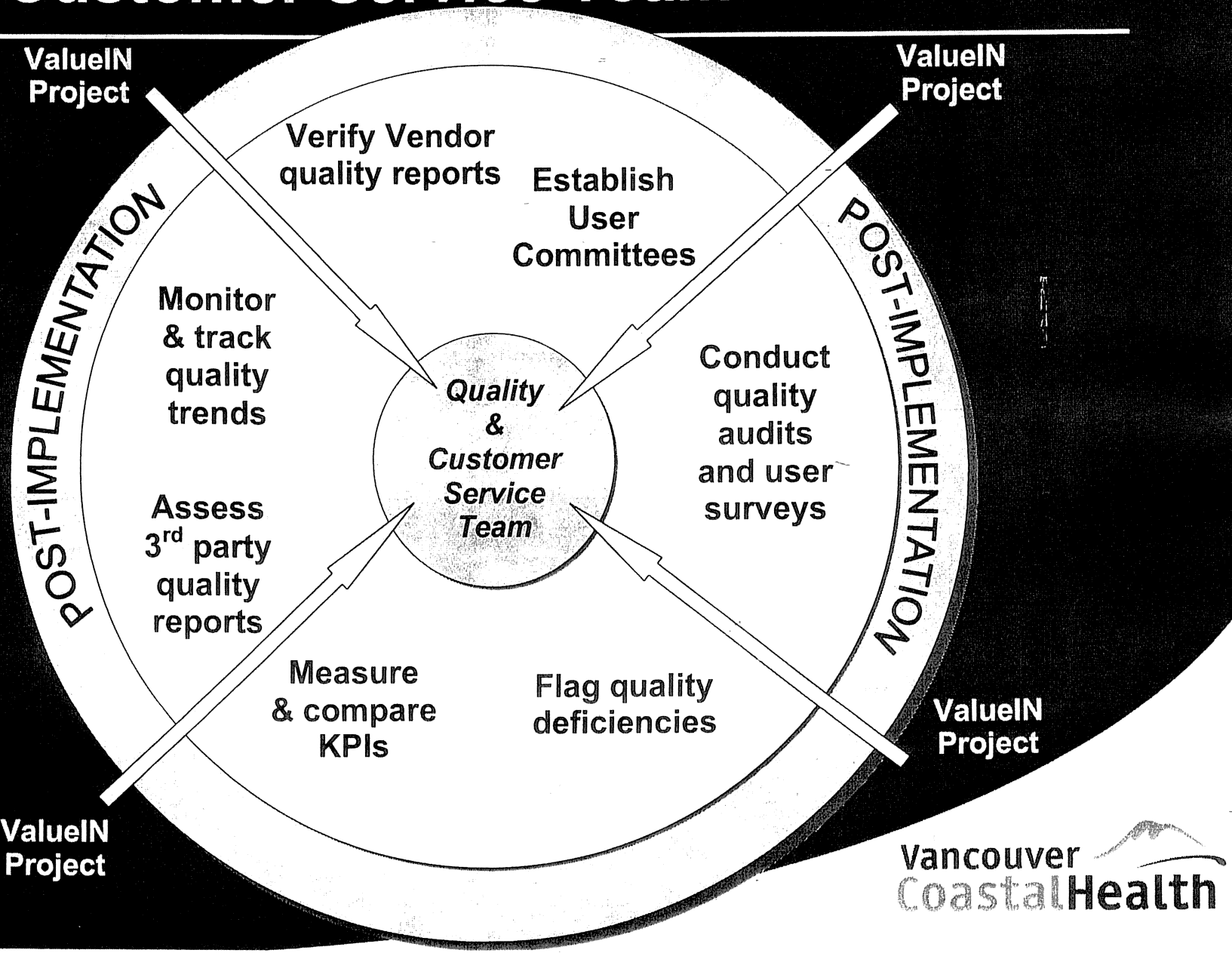
Quality

Quantity

Timing

Vancouver CoastalHealth

Role of Quality & Customer Service Team



Vancouver CoastalHealth

Vancouver Coastal Health Authority
North Shore/Coast Garibaldi, Vancouver & Richmo.

VCHA QUALITY ASSURANCE AUDIT- Cleaning Services

APPENDIX 6

SITE _____ BUILDING _____

EA/UNIT _____ ROOM NUMBER _____

GROUP: 1 2 3 4

ROOM TYPE: Patient Washroom Office Treatment Waiting

Conference Nutrition Operating ICU LTC Other

Standard	Item		Only Audit Applicable Items Satisfactory YES	NO
free of litter, dust, stains and liquids, appropriate gloss; is it clean under the shine, Corners/Edges/Baseboards are free of dust and build up from floors finish	Hard Floors	1		
Appears clean, vacuumed; stain and chewing gum free, free of dust build up around edges	Carpeted Floors	2		
doors frames, hinges, push and kick plates are dust and stain free, glass is clean and free of marks	Door	3		
the walls are free of dust and marks	Walls	4		
the low level interior glass are clear of streaks, spots and marks including prints and smudges	Windows/Glass	5		
the drapes properly hung, free of stains and dust	Window coverings	6		
ledges, picture frames, curtain rods are free of dust	High Dusting	7		
the exterior is free of dust and lint build-up, the surface area around the vent free of dust	Vents/Grills	8		
chair and table bases, baseboard ledges are free of dust and stains	Low Dusting	9		
clean, free of stains, soil and dust	Telephone	10		
clean, free of stains, soil and dust	Lights Fixtures/Lamps	11		
clean, free of stains, soil and dust, properly relined with clean plastic liner as appropriate	Waste Container	12		
[illegible]n, free of stains, soil and dust	Television/Computer	13		
[illegible]ean, free of stains, soil and dust	Desks	14		
clean, free of stains, soil and dust	Cabinets/lockers	15		
clean, free of stains, soil and dust	Chairs	16		
clean, free of dust, stains, soil, old tape, the chrome finish is streak free, wheels, brakes are free of dirt and debris	Tables/Overbed tables	17		
Surfaces are clean, free of stains, soil and dust	Monitors	18		
clean, free of dust, stains, soil, old tape, chrome finish is streak free, wheels, brakes are free of dirt and debris	Bed	19		
clean, free of stains, soil and dust	Foot Stool	20		
clean, free of dust, stains, soil, old tape, chrome finish is streak free, wheels, brakes are free of dirt and debris	Commodes	21		
clean, free of dust, stains, soil, old tape, chrome finish is streak free, wheels, brakes are free of dirt and debris	IV Poles	22		
the curtains properly hung, free of visible soil and dust	Cubicle Curtains	23		
the fixtures clean and stain free, there is no build up under and around ledges and rims, drain is free of debris, mirrors, tiles and surfaces are clean and streak free	Sink	24		
the fixtures clean and stain free, there is no build up under and around ledges and rims, drain is free of debris, walls, tiles and surfaces are clean and streak free.	Shower/Tub	25		
surfaces are clean and streak free. Dispensers are fully stocked and in good working order	Dispensers	26		
the fixtures clean, soil and stain free, there is no build up under and around ledges and rims, wall and floor around the toilet is clean and stain free.	Toilet	27		
clean, free of stains, soil and dust	Toilet Partitions	28		
clean, free of stains, soil and dust	Sharps Container + Wall	29		
	Other 1:_____	30		
	Other 2:_____	31		
[illegible]tal Satisfactory				
Total Items Checked				
Quality Percentage				

EVALUATOR _____ DATE _____ SIGNATURE _____