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## Room Turnover Times: 'Trash-and-Dash' Approach Jeopardizes Patient Outcomes

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Environmental hygiene, at its best, follows a prescribed set of steps in an evidence-based protocol, and guided by best-practice recommendations. Deviate from this protocol, or worse yet, cut corners, and patient outcomes can be jeopardized. As hospitals respond to the call to do more with less, the expediency with which patient rooms are turned over is increasing, leading some experts to sound the alarm about compromising patient safety.

"More hospitals are coming to the realization that they cannot rush the processing of a patient room," says John Scherberger, CHESP, REH, founder and president of Healthcare Risk Mitigation and incoming president of the Healthcare Laundry Accreditation Council (HLAC). "When I talk about processing, this includes cleaning and disinfection practices, because healthcare environmental services (EVS) is process-driven, just as surgery and nursing is process-driven. EVS is finally standing up and saying, 'We are process-driven and we cannot cut out parts of our process and expect to get proper results. We must follow our processes, and we require sufficient time to perform the job properly, and if we don't, we risk poor patient outcomes.

Scherberger continues, "Hospitals are realizing there has to be communication, cooperation and collaboration between all of the disciplines, and too often, EVS is being given orders and they haven't been involved in the communication or collaboration components -- they have only been told, 'Get this room done in 10 minutes.' But if you were to tell a surgeon to remove a gall bladder in 10 minutes, he or she would revolt because they can't do it properly. If we tell a nurse to insert a central line in 5 minutes, the nurse would say 'I have standards, I cannot do that.' EVS is finding its voice and saying enough is enough, we have to stand up for our patients."

Other industries are facing similar time pressures. "I have a colleague in hospitality and she told me that it takes housekeepers 30 to 35 minutes to clean a 300-square-

foot hotel room in a three- to four-star hotel," Scherberger says. Her boss is now saying cleaning needs to be done in 20 minutes, and she is saying that it can't be done. Too many people are looking at the time as an expenditure of funds as opposed to an investment of funds. I have always believed that EVS should be viewed by the C suite as an investment and not an expense."

Scherberger continues, "There is a plethora of studies in the literature that address the role of the environment in infection transmission. For example, Stephanie Dancer showed us that the more time and attention we spend on cleaning, the better the outcomes we can achieve. Other studies by experts such as John Boyce and Philip Carling acknowledge that proper cleaning and monitoring of that cleaning requires adequate time. There are many studies that show the environment has to be tended to properly and in the proper amount of time. We all want the best results for our patients, and people need to see environmental services as an investment in these patient and quality outcomes. They also need to support and invest in the education and training of EVS professionals, getting down to the level of why we are doing this a certain way, or why we are using this specific broad-spectrum disinfectant as opposed to a mere detergent. We must educate people about why it's being done, not just that it has to be done, and that performing proper cleaning takes time -- because it's an integral part of infection prevention."

Daniyal Zuberi, associate professor of social policy and the RBC Chair in Applied Social Work Research Factor-Inwentash Faculty of Social Work and School of Public Policy and Governance University of Toronto, is the author of the book *Cleaning Up*, which looks at the perils of cutting corners, slashing EVS budgets and/or outsourcing environmental services work. In "Cleaning Up," Zuberi notes, "Clean hospital environments are critical for reducing hospital-acquired infections. Yet hospitals in many parts of the world continue to slash the resources dedicated to support services ... Unfortunately, hospitals are increasingly unwilling to spend the money to support the workers on the front lines of the fight against germs. As recently reported in the *Canadian Medical Association Journal*, 'budget cuts and outsourcing have seen the proportion of hospital budgets devoted to support staff drop from 26 percent in 1976 to 16 percent in 2002. These cuts mirror disinvestment

in support services by U.S. hospitals, which are estimated to have reduced cleaning staff by at least 25 percent since 1995."

Zuberi describes one housekeeper's viewpoint in *Cleaning Up* that they are the first line of defense against infections but that they rarely have enough time to fully complete their line of defense: "It is too much because when there are too many patients the only thing you can do is pick up the garbage, do a little wiping and dusting here and there, and that is it -- just the essentials, not like working thoroughly from top to bottom and side to side. You don't have that much time." In his research for the book, Zuberi says he "found that cleaners were being pressured to work quickly and as a result cutting corners." He continues, "Part of the challenge is that pathogens are not visible to the naked eye, and the causes of contamination and outbreaks are often multi-causal and complex. Issues around sanitation often emerge in a crisis, such as a major outbreak, but then concerns diminish when things return to status quo, even if that status quo includes preventable hospital-acquired infections. Cleaning is devalued feminized work and it is all too easy for administrators and other members of the healthcare team to diminish its fundamental importance, especially when it has been easy to turn to antibiotics as a crutch to treat infections and the market-driven focus on the bottom line. Personally I have been somewhat surprised by the lack of attention to cleanliness and hospital sanitization by infection control experts, especially compared to important, and highly visible campaigns around hand cleaning by healthcare workers and improving antibiotic stewardship."

Zuberi adds, "Pathogens in the hospital are invisible, but deadly. It is easy to ignore problems until an outbreak. Yet hospital-acquired infections are a leading cause of morbidity and mortality. The insights of Florence Nightingale are becoming ever more important again as antibiotic resistance emerges as a frightening challenge. Hospital cleaning and environmental sanitation is a core function of the hospital as it is a critically important part for improving patient safety and providing high quality of care. The empirical literature suggests that high quality cleaning requires skills. Sanitizing the hospital environment to eliminate different pathogens requires different approaches, and increasingly we are learning that specialized equipment

and techniques can help in some cases. On the other hand, failure to follow best practice can result in outbreaks. Inadequate staffing levels and poorly trained cleaners who cut corners can themselves literally become super-spreaders, contaminating hospitals and infecting patients."

Mounting time pressures and the resulting wide variations in cleaning practices and durations led the Association for the Healthcare Environment Services (AHE) in 2009 to reaffirm previously published practice guidance for the minimal time for proper cleaning and surface disinfection of patient rooms. In terms of cleaning an occupied patient room, the AHE notes, "To ensure consistent quality of cleaning and adequate staffing resources for infection prevention, a total facility cleaning standard should be agreed upon in advance by environmental services, infection control and operations or administrative management. By following all of the recommended practice steps, an occupied patient room clean will take approximately 25-30 minutes per room. Time is determined by the number of tasks and the time to perform each task in an efficacious manner." And for the terminal cleaning of the patient room upon discharges or transfer, the AHE advises, "To ensure consistent quality of terminal cleaning and adequate staffing resources for infection prevention, a total facility cleaning standard should be agreed upon in advance by environmental services, infection control and operations or administrative management. By following all of the recommended practice steps, a terminal clean will take approximately 40-45 minutes per terminal clean. Time is determined by the number of tasks and the time to perform each task in an efficacious manner."

The AHE emphasizes that "Time adjustments may be needed due to factors such as the size of the room, number of high touch surfaces and the amount of furniture in the patient room. If times require an adjustment, a detailed time and task study should be employed to ensure all areas receive proper cleaning and disinfection. The infection control committee should approve any deviations from recommended cleaning times based on the AHE Practice Guidance."

Pam Toppel, CHESP, director of Environmental Service – Eastern Region at OSF Saint James - John W. Albrecht Medical Center, says that the AHE-suggested room

turnover times still represent an appropriate benchmark, however, she adds, "We need to approach this as a guideline or tool. The actual times for any facility will vary depending on many factors; some examples are size of the room, room type, number of items/equipment in the room, type of isolation, and length of stay. In order to get an appropriate turnover time for a specific facility, each environmental service leader or team would need to complete an inventory of such. There are a few ways this can be accomplished, one could perform a time study, multiply a documented average time per number of rooms, frequency of cleaning, etc. We also have industry partners that consult in this area as well."

As Toppel acknowledges, a number of factors can impact cleaning times, and a timetable can go out the window in a unique situation, such as an outbreak. "In an outbreak scenario," she adds, "more than likely the unit or section would be shut down until terminal cleaning was completed in the entire unit, including hallways and such."

In recent years the emergence of new microorganisms and the process for removing them from surfaces has required more time and attention, particularly to high-touch surfaces.

"Back in 2009 when the AHE said the standard processing of an occupied patient room should take 25 to 30 minutes, and a terminal processing should take 40 to 45 minutes, that was before we had the influx of *C. difficile*, *Acinetobacter baumannii*, and all of these pathogens we weren't dealing with before. Now that they are coming into hospitals, and it's no longer a 'trash-and-dash' process -- we can no longer go in and take out the trash and leave. I have been saying for years that it is easier to keep a hospital clean than it is to clean a hospital. If you think about it, it's easier to do a little bit at a time and do the right thing every time. Unfortunately people are finance-driven and we have so many contractors coming in and when they say 'We can do a room in 12 or 14 minutes,' that's unrealistic. Hospitals should say, 'You might be able to do it but we want it done properly and we know it's going to take 25 to 30 minutes, minimum.'"

Many cleaning companies rely on the cleaning times established by the International Sanitary Supply Association (ISSA), which are based on square footage-driven estimates. "I have always had a problem basing things on square footage," says Scherberger. "I could put one staff person on an empty football field of artificial turf and say, 'I want you to vacuum this field in an hour.' That's probably doable. But if I add 100 beds and 100 nightstands and 200 trash cans, and everything has to be tended to properly -- how long will it take them to do that? Certainly not the allotted hour."

Scherberger says that the kind of standardization that square-footage calculations rely on is problematic and even potentially dangerous. He uses the differences between level one and level three trauma centers, for example. "We can look at a level one trauma center that takes care of everything and then we could look at a level three trauma center that can't take care of everything. The level one will have a lot more traffic, they are going to have many more exposures to biologicals, and many more things that can cause infections, as opposed to a level three trauma center, and so the need for the level of processing is going to be different. However, if you say you want everything done the same, it's not going to work properly. I tell people, yes, you should benchmark, but forget about the square footage because your hospital is different from any other hospital in terms of patient demographics and clinical acuities, and many other factors. People should conduct their own time study so they can confidently state they can process a room properly in 'X' amount of time."

Scherberger advocates for the use of protocols and tools such as checklists. "A big problem is that hospitals still refuse to have the checklists that they need. They say 'clean this room,' but how exactly is a person supposed to do that if they don't have a checklist? In surgery we have checklists because the OR team wants to go step by step in the process so they get the proper outcome. With EVS, unless they use a checklist that has been defined for their facility and their unique circumstances, they are not going to know what to do. And EVS managers need to say, 'I will not have my staff process in 10 minutes what should take 40 minutes, according to the checklist. A lot of hospitals say they want a disinfectant that has a dwell time of 3 minutes

because they want to decrease the amount of time that staff has to be in the room. They also have also not given EVS staff the proper training on the importance of keeping a surface wet in order to achieve the disinfectant's dwell time. If I am processing a room and do everything the right way, it's going to take more than a few minutes."

Toppel says not every hospital administrator has a "need for speed," adding that, "We all must strive for efficiency without putting anyone at risk, which requires knowledge and the willingness to educate. Any time we push quantity over quality, then we introduce many risks for all involved. Environmental services leadership has that responsibility to help our administrative team understand exactly how we play a vital role and impact patient care, HAIs, readmission rates, improved outcomes, patient satisfaction, as well as reimbursement. As an environmental services leader it is imperative that we look for, understand, know, and implement guidelines, recommendations and best practice."

Toppel emphasizes the importance of the data calling for proper and rigorous cleaning and disinfection. "Following those recommendations and guidelines we can absolutely impact infection transmission. How can these studies be used to make a case for adequate time to clean? As I mentioned previously, it is our responsibility as environmental services leaders to educate all on what vital team members we are in healthcare. Not only is it a must to be in front of our Administrative Teams, but we also must educate the Environmental Service Technicians. This month, AHE will launch the first AHE CHEST (Certified Healthcare Environmental Services Technicians) train-the-trainer workshop. The CHEST certification is critically important to our profession, to show that our front line staff are professionals who are well trained, competent in infection prevention and have the expertise to care for our environments."

Humanizing the healthcare experience is something Scherberger recommends for all healthcare workers, especially EVS personnel. "We must always do the right moral and ethical thing for our patients, taking responsibility for outcomes," he says. "We don't want patients to be discharged with something that they shouldn't have, just because we were cutting corners. I tell people that when we process a room, they

must treat it as if their mother or father or other loved one was going into that room, not some stranger."

Scherberger tells the true story of an EVS supervisor who asked an EVS tech, 'Did you know your mother's being admitted here? I'm going to put her in the room that you just cleaned.' The EVS tech said, 'Well I need to go back and do a better job in that room, as it's not good enough for my mother.' That's a true story from a hospital visit I conducted in Atlanta. It all goes back to the ethics of 'mother care' -- we must treat every room as if our mother was in there. We must remember that the patient is our reason for being there. I understand in an emergency where you have to get the patient through quickly, but when it comes to the processing of a room -- if we are charging \$1,500 a day for that room, that's the patient's home and they deserve a clean environment. People need to understand that environmental services is a clinical department and it is an aesthetic department -- clinically they remove bacteria from the environment, and aesthetically, they provide a place for the patient to recover in an atmosphere that is going to be clean, safe and pleasant."

#### References:

Association for the Healthcare Environment Services. Minimal Time Guidelines for Patient Room Occupied and Terminal (Discharge or Transfer) Cleaning and Disinfecting. 2009. AHE press release.

Zuberi D. Cleaning Up. Cornell University Press. 2013.

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