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A Handbook on Housekeeping and Disinfection Practices for Healthcare Facilities



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CHAPTER 2

Staffing

INTRODUCTION

Adequately skilled manpower is the main ingredient to the success of any service especially the housekeeping department. One of the critical factors that determine the level of sanitation and hygiene is manpower. Hence, staffing levels must be in consonance to the needs of the healthcare organization. Similar to the need of flexibility of expansion while planning a healthcare organization, the same flexibility needs to be maintained while staffing a housekeeping department. Cleaning standards for Victorian health facilities as drafted by the Department of Health State Government of Victoria recommend that staffing levels need to be calculated on the basis of the average time taken by any worker to complete a given task. It is the sum of all the time required by the worker to complete all individual tasks assigned to them. It further states that the average cleaning time is the normal time required for a qualified worker, working at a comfortable pace, to complete an operation when following a prescribed method.[1,2]

Experience, skill, training, and education play an important role in determining the average cleaning time. An inexperienced worker will work at a slower momentum as compared to a experienced worker. Standardization of practices is crucial in determining the efficiency and quality of cleaning, it also helps in timely and efficient cleaning as it ensures that no steps are missed during the cleaning process. Organizations and the top management should conduct time motion studies in their individual organizations prior to deciding upon the appropriate staffing numbers both supervisory and cleaning. These numbers should clearly be indicated in the tender document being prepared in event if the organization decides to outsource its services. In addition to the time motion studies, as recommended by the Ministry of Health and Family Welfare, Government of India in their guidelines "*Kaya Kalp*", other factors which should be taken into consideration are:[3-5]

- *Building factors:*[5]
  - Age of the facility—older buildings are harder to clean
  - Design of the facility—e.g., amount of walking required to complete a task
  - Size of the facility
  - Climate

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  - Season
  - Exposure of facility to outside dust and soil, e.g., construction site
  - Type of floors and walls
- *Occupancy factors:*[5]
  - Occupancy rate and volume of cases
  - Patient mix and type of care in the area (e.g., acute care, long-term care, administrative area, etc.)
  - Frequency of cleaning required in an area (e.g., once daily vs. after each case)
  - Square meters to be cleaned in patient care areas
  - Square meters to be cleaned in nonpatient care areas
  - Admissions/discharges/transfers from a department/unit/area—more rapid turnover entails a shorter turnaround time and more frequent discharge/transfer cleaning
- Equipment factors
- Training factors
- Infection control factors
- Presence of outbreaks

The Ministry of Health and Family Welfare, Government of India, in their guidelines "*Kaya Kalp*", has further proposed the following rule of thumb for calculating the human resource required for sanitation services for a hospital, district level, and above:[3,5]

- One Sanitary Attendant for every two hospital beds (it takes into account the total manpower requirement for all three shifts including manpower required for reliever duty and leave reserve)
- One Sanitary Supervisor for 12–15 Sanitary Attendants
- One Sanitary Inspector for 5–7 Sanitary Supervisors
- One Sanitary Officer for 5–7 Sanitary Inspectors
- One Senior Sanitation Officer and Officer In-charge for a healthcare organization
- One plumber should be physically available at all times depending upon the size of the healthcare organization.

On the basis of the type of patient care area, manpower can be calculated using the following norms. For the purpose of manpower planning, wards have been categorized into two groups—wards having >30 beds and wards having <30 beds. Likewise, ICU/HDU also have been categorized into two groups—ICU having >20 beds and ICU having <20 beds (**Tables 2.1** and **2.2**).

TABLE 2.1 **Calculation of the number of hospital attendants required based on the patient care area.**

	Wards (>30 beds)	Wards (<30 beds)	ICU (>20 beds)	ICU (<20 beds)	Operation theater
Morning shift	3	2	5	3	2
Evening shift	2	2	3	2	1
Night shift	2	1	3	2	1

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TABLE 2.2 **Calculation of the number of sanitation attendant required based on the patient care area.**

	Wards (>30 beds)	Wards (<30 beds)	ICU (>20 beds)	ICU (<20 beds)	Operation theater
Morning shift	4	3	8	4	2
Evening shift	3	2	5	3	1
Night shift	3	2	5	2	1

Emergency and OPD: One dedicated sanitary attendant should be posted for each public toilet considering the number of footfalls and for other areas, separate allocation should be made.[5]

Administrative and office areas: One dedicated sanitary attendant should be posted on each floor depending upon the space.[5]

A dedicated cleaning gang of sanitation attendants comprising of 4 to 8 sanitation attendants needs to be made which shall be involved in deep/intensive cleaning of patient care areas on a weekly basis. Female sanitation attendants should be posted wherever two attendants are posted.

CONCLUSION

Availability of optimum resources and their maximum utilization should be a priority for all healthcare providers. However, time as a resource should also be given adequately to all sanitation staff, sanitation managers, and supervisors[4] to perform their duties. Resource planning should take account of what is realistically achievable. It should be clearly recognized that exigencies may alter the requirement of the housekeeping department for a short duration of time. These exigencies cannot be predicted with accuracy, but the same should be considered while preparing the budgetary estimate in each financial period.

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