

DAILY CLEANING INSPECTION FORM

Place a "Y" for all areas that meet the inspection standard.
 Comment on areas that do not meet the standard.

Date Completed _____
 Completed by _____

PATIENT ROOM # _____	If Yes = Y If No = N and comment	COMMENT
Hand wash sink clean		
Soap, alcohol rinse dispensers are clean/stocked/not expired		
Ceiling tiles, air vents, sprinklers clean		
Sharps container checked, garbage cans emptied		
Equipment- i.e., IV and/or tube feeding pole and base, clean		
Computer keyboard and mouse		
Cabinet handles and surfaces clean and free of tape and hand prints		
TV, front and back wiped clean		
Bedside table surface and pulls clean		
Ceiling lift is clean and dust free		
Over bed table surface clean, track for slider clean, base clean		
Floors clean, not sticky, free of dust		
Telephone, hand set clean		
Remote control clean		
Room fan on countertop dust-free		
Sleeper couch/chair- clean		
Room chair arm rests, back, side, head rest, and seat clean		
Windows are clean on inside and ledges are dust free		
Countertops, desk area, and chair are clean		
Closet looks and smells clean		
BED		
All side rails are free of tape, and clean, including both sides of rails, crevices around controls, bottoms of rails		
Frame is dust free		
Controls at foot of bed are clean and dust free if applicable		
Call light and cord are clean		
BATHROOM		
Sink and counters free of water spots and clean		
Soap dispensers are clean and stocked		
Lights are dust free, mirror clean, light switches clean		
Toilet is clean, floor around and behind toilet is clean		
Pipes around toilet are free of water build up and clean		
Pull cords are clean and hang free of railings		
Bathroom smells clean, no odors noted		
Bathroom door is clean and free of handprints, handles are clean		
TOTAL ITEMS MET PER ROOM	/32	