

HSE National Cleaning Standards Manual: What Contract Cleaners Must Know

defines how healthcare facilities must be cleaned and must be cleaned. Risk zones, cleaning frequencies, colour-coded systems, terminal cleaning, and audit requirements explained for contract cleaning companies.

[Home](#) / [Guides](#) / [HSE Cleaning Standards](#)

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AT A GLANCE

HSE cleaning standards are the Irish healthcare environmental hygiene requirements set out in the HSE National Cleaning Standards Manual (V06) and its supporting Standards & Recommended Practices for Decontamination (SRSA) suite, issued by the HSE Quality & Patient Safety Directorate (QPSD) and aligned with the HIQA National Standards for the Prevention and Control of Healthcare-Associated Infections (HCAI) (2017).

They apply to every HSE-funded setting — acute hospitals, community hospitals, primary care centres, residential care, mental health units, disability services — and to contract cleaners working inside them. The framework covers four risk zones, a mandatory four-colour equipment system, terminal cleaning, PPE and hand-hygiene (the WHO 5 Moments for Hand Hygiene adopted by HSE), and a visual + ATP + microbiological audit regime. Compliance is audited by HSE facilities management, the Antimicrobial Resistance & Infection Control (AMRIC) programme at HPSC, and HIQA inspectors.

Reviewed by: Optus Glean Compliance Team · **Last updated:** 2026-04-18 · **Sources:** HSE V06 Manual, HPSC AMRIC IPC guides, HIQA 2017 National Standards, HSA contract-cleaning guidance.

Download the compliance summary

Printable 1-page HSE V06 + HIQA cross-reference, risk-zone matrix, colour-code chart, audit thresholds.

[Download PDF \(free\)](#)

What the HSE National Cleaning Standards Manual Covers

The **HSE National Cleaning Standards Manual** is the authoritative reference document for environmental cleaning in Irish healthcare facilities. Published by the Health Service Executive, it provides a standardised framework for cleaning practices across all HSE-funded healthcare environments, including acute hospitals, community hospitals, residential care facilities, primary care centres, mental health units, and disability services.

The manual was developed in consultation with infection prevention and control (IPC) teams, facilities management professionals, and cleaning service providers. It draws on international best practice, including guidance from the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC), and the UK NHS cleaning standards.

For contract cleaning companies working in or tendering for healthcare cleaning contracts, the manual is essential reading. It defines what “clean” means in a healthcare context, sets minimum frequencies, prescribes methodologies, and establishes the audit framework against which your performance will be measured.

The manual should be read alongside the HIQA National Standards for infection prevention and control, which provide the regulatory framework within which the cleaning standards operate.

The HSE IPC documentation stack (V06 and its companion documents)

The Manual does not sit alone. It is one document in an integrated HSE infection-prevention-and-control stack which contract cleaners need to recognise by name when reading specifications and audit reports:

HSE National Cleaning Standards Manual (V06) — the operational cleaning document. What, how often, with which colour, to which audit score.

HSE Standards & Recommended Practices for Decontamination (SRSA) — issued by the HSE Quality and Patient Safety Directorate (QPSD) on www2.healthservice.hse.ie. Covers medical device reprocessing, endoscope decontamination, and the Spaulding classification of equipment.

HPSC / AMRIC IPC guides — the Antimicrobial Resistance & Infection Control programme at the Health Protection Surveillance Centre (HPSC) publishes the IPC guidance contract cleaners apply in outbreak and alert-organism situations (MRSA, CRE, CPE, C. difficile, norovirus). CPE is a public-health priority in Ireland and drives much of the enhanced terminal-cleaning protocol below.

HIQA National Standards for the Prevention and Control of Healthcare-Associated Infections (2017) — the regulatory framework. Read the full text on hiqa.ie.

HSA contract-cleaning guidance — the Health and Safety Authority publishes Safety in Contract Cleaning, which sits alongside the HSE Manual and governs the chemical-safety and employee-safety side of the work.

Contract specifications will cite these documents by their exact names. When a tender says “compliance with V06 and SRSA,” it means both documents — missing either is a fatal scoring issue.

Cleaning Frequency by Risk Zone

The HSE manual classifies all areas within a healthcare facility into four risk zones. Each zone has different cleaning requirements based on the level of infection risk:

Very High Risk

Areas: operating theatres, intensive care units (ICU), high-dependency units (HDU), isolation rooms, sterile supply departments, neonatal units, bone marrow transplant units, burns units.

Task	Frequency	Method
Floors	Minimum twice daily + after each procedure	Damp mop with approved detergent/disinfectant
High-touch surfaces	Minimum twice daily + after each patient contact	Detergent wipe followed by disinfectant wipe

Equipment surfaces	After each use	Detergent clean then disinfection per manufacturer guidance
Terminal clean	After every procedure / patient discharge	Full terminal cleaning protocol (see below)
Walls and ceilings	Weekly + when visibly soiled	Detergent wipe; disinfection if contaminated

Minimum audit score: 85%

High Risk

Areas: inpatient wards, accident and emergency departments, treatment rooms, endoscopy units, dialysis units, day surgery units, maternity wards, laboratory areas.

Task	Frequency	Method
Floors	Minimum daily	Damp mop with approved detergent
High-touch surfaces	Minimum twice daily	Detergent wipe; disinfectant for clinical areas
Bathrooms/toilets	Minimum twice daily	Detergent and disinfectant (red colour-code)
Terminal clean	On patient discharge/transfer	Full terminal cleaning protocol
Bed frames and lockers	Daily + on discharge	Detergent wipe; disinfection on discharge

Minimum audit score: 80%

Significant Risk

Areas: outpatient departments, physiotherapy and rehabilitation areas, radiology, pharmacy, offices within clinical buildings, staff changing areas, public corridors within clinical zones.

Task	Frequency	Method
Floors	Daily	Damp mop or vacuum with approved detergent
High-touch surfaces	Daily	Detergent wipe
Bathrooms/toilets	Daily minimum; twice daily if high-traffic	Detergent and disinfectant
Desks and work surfaces	Daily	Detergent wipe

Minimum audit score: 75%

Low Risk

Areas: administrative offices (non-clinical), meeting rooms, non-clinical corridors, storage areas, non-public stairwells.

Task	Frequency	Method
Floors	3 times per week minimum	Vacuum or damp mop
Surfaces	3 times per week minimum	Detergent wipe
Bathrooms/toilets	Daily if in use	Detergent and disinfectant
Bins	When full or at least 3 times per week	Empty, reline, clean if soiled

Minimum audit score: 70%

Colour-Coded Cleaning System

The HSE mandates a colour-coded system for all cleaning equipment to prevent cross-contamination between areas. This is one of the most important infection prevention and control measures in

healthcare cleaning. For a full guide, see our colour-coded cleaning systems guide.

Colour	Area	Equipment
Red	Bathrooms, toilets, washroom floors, sanitary areas	Mops, buckets, cloths, gloves
Blue	General ward areas, offices, low-risk surfaces, corridors	Mops, buckets, cloths, gloves
Green	Kitchens, catering areas, food preparation, pantries	Mops, buckets, cloths, gloves
Yellow	Isolation rooms, clinical areas requiring specialist cleaning	Mops, buckets, cloths, gloves

The rules are absolute: a red mop never enters a kitchen. A blue cloth never cleans a toilet. Yellow equipment is dedicated to isolation rooms and must not be used elsewhere. Non-compliance with the colour-coded system is a serious audit failure and a direct infection control risk.

Contract cleaning companies must ensure all staff are trained on the colour-coded system during induction and that compliance is monitored through supervision and audit.

Standard Precautions, Transmission-Based Precautions and the 5 Moments for Hand Hygiene

Cleaning in an HSE setting is performed under the IPC concept of **standard precautions** — the baseline infection-control measures applied to every patient, every contact, every time, regardless of known diagnosis. For certain organisms, standard precautions are layered with **transmission-based precautions**:

Contact precautions — MRSA, CPE, CRE, C. difficile, norovirus. Single room or cohort, dedicated equipment, enhanced cleaning and terminal clean with 10,000 ppm chlorine or hydrogen peroxide vapour.

Droplet precautions — influenza, pertussis, meningococcal disease. Surgical mask within 1–2 metres, routine environmental cleaning plus disinfection of high-touch surfaces.

Airborne precautions — pulmonary tuberculosis, measles, varicella. Negative-pressure isolation where available, FFP2/FFP3 respirator, terminal clean after air clearance.

The WHO 5 Moments for Hand Hygiene (adopted by HSE)

Every HSE-trained cleaner must know and demonstrate the WHO 5 Moments, which are enforced during audit observations:

1. Before touching a patient
2. Before a clean or aseptic procedure
3. After body-fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

For cleaning operatives, Moments 2 and 5 are the most frequently observed — before entering a clean isolation room with fresh equipment, and after leaving any patient zone. HSE alcohol-hand-rub dispensers (see the HSE patient-facing guide on hand hygiene) must be accessible at the point of care.

PPE: donning and doffing sequence

PPE for healthcare cleaning is task-specific and risk-assessed. The correct sequence is load-bearing — most contamination events happen during doffing, not cleaning:

Donning order: hand hygiene → apron or gown → mask (surgical or FFP2/FFP3 per precaution) → eye protection

→ gloves.

Doffing order: gloves → hand hygiene → gown/apron → eye protection → mask → hand hygiene.

Doff inside the patient zone, bin into clinical waste, perform hand hygiene before leaving the isolation room.

PPE selection is also governed by the **Safety, Health and Welfare at Work (Biological Agents) Regulations 2013 (S.I. No. 572 of 2013)**, which classify biological agents into four groups and set employer duties on exposure control.

Terminal Cleaning Procedures

Terminal cleaning is the most critical cleaning activity in a healthcare setting. It is a thorough, systematic clean and disinfection of a patient area after the patient has been discharged, transferred, or has died, or after an isolation period for a patient with an infectious condition.

When Terminal Cleaning Is Required

Patient discharge or transfer from any inpatient bed

After an infectious patient has been de-isolated

After a patient death

After a procedure in an operating theatre, endoscopy suite, or treatment room

When directed by the IPC team due to an outbreak or alert organism

Terminal Cleaning Protocol

- 1. Preparation:** remove all patient belongings. Strip bed linen and place in appropriate laundry bags (alginate bags for infected linen). Remove waste. Open curtains/blinds.
- 2. Detergent clean:** clean all surfaces with neutral detergent and warm water, working from high to low and from clean to dirty. This removes organic matter that would inactivate disinfectant.
- 3. Rinse and dry:** remove detergent residue. Allow surfaces to dry before applying disinfectant.
- 4. Disinfection:** apply approved disinfectant to all surfaces. For standard terminal cleans, use 1,000 ppm available chlorine solution (or approved alternative). For high-risk organisms (*C. difficile*, norovirus, CPE), use 10,000 ppm chlorine or hydrogen peroxide vapour (HPV) as directed by the IPC team.
- 5. Contact time:** allow the disinfectant to remain on surfaces for the manufacturer's recommended contact time (typically 5–10 minutes for chlorine-based products).
- 6. Final wipe:** wipe down all surfaces to remove disinfectant residue.
- 7. Equipment:** clean and disinfect all reusable equipment in the area (IV poles, monitors, commodes, bed frames).
- 8. Curtains:** replace privacy curtains with freshly laundered ones.
- 9. Verification:** complete the terminal cleaning checklist, sign, date, and time it.
- 10. Notification:** inform the ward/department that the area is clean and ready for the next patient.

Terminal cleaning is time-sensitive. Delays in terminal cleaning directly delay patient admissions, increasing emergency department crowding and affecting hospital flow. Contract cleaning companies are typically expected to complete a standard terminal clean within 45–60 minutes of notification.

Environmental Cleaning vs Disinfection

The HSE manual draws a clear distinction between environmental cleaning and disinfection. Understanding when each is appropriate is fundamental to safe healthcare cleaning.

Environmental Cleaning

Environmental cleaning is the physical removal of dirt, dust, and organic matter from surfaces using **detergent and water**. It is the foundation of all healthcare cleaning. A surface that is visibly dirty cannot be effectively disinfected because organic matter (blood, body fluids, skin cells) shields microorganisms from the action of disinfectants.

Environmental cleaning is appropriate for:

- Routine daily cleaning in all risk zones
- Non-clinical areas (offices, corridors, meeting rooms)
- General surfaces that are not in direct contact with patients
- The first step of any two-step clean-then-disinfect process

Disinfection

Disinfection is the application of a chemical agent to kill or inactivate microorganisms on a surface that has already been cleaned. Disinfection without prior cleaning is ineffective and is a violation of HSE cleaning standards.

Disinfection is required for:

- High-touch surfaces in Very High Risk and High Risk areas
- Terminal cleaning after patient discharge
- Following known or suspected contamination with blood or body fluids
- Isolation rooms (during and after isolation period)
- Outbreak situations as directed by the IPC team
- Equipment shared between patients

Approved Disinfectants

Product Type	Concentration	Use Case
Sodium hypochlorite (chlorine-based)	1,000 ppm	Standard disinfection of surfaces
Sodium hypochlorite (chlorine-based)	10,000 ppm	C. difficile, norovirus, CPE, blood spills
Hydrogen peroxide wipes	As per manufacturer	Equipment, electronic surfaces
Hydrogen peroxide vapour (HPV)	N/A — automated system	Terminal disinfection for high-risk organisms, whole-room decontamination
70% isopropyl alcohol	70%	Small equipment surfaces, injection ports

Never mix disinfectants. Never use disinfectant on a surface that has not been cleaned with detergent first. Never use a chlorine-based disinfectant on metal surfaces as it causes corrosion. Always follow manufacturer instructions for dilution and contact time.

The Spaulding classification of items and surfaces

Where environmental cleaning governs the building fabric, the **Spaulding classification** governs the equipment used on or near the patient. It is referenced in the SRSA suite and determines what level

of reprocessing each item requires:

Category	Definition	Examples	Reprocessing
Critical	Contact with sterile tissue or bloodstream	Surgical instruments, implants, biopsy forceps	Sterilisation (steam / low-temp)
Semi-critical	Contact with mucous membranes or non-intact skin	Flexible endoscopes, laryngoscope blades, respiratory therapy equipment	High-level disinfection (or sterilisation)
Non-critical	Contact with intact skin only	BP cuffs, bed rails, commodes, mattresses, floors	Cleaning + low/intermediate-level disinfection — the cleaning operative's remit

Contract cleaners are primarily responsible for non-critical items. Semi-critical and critical reprocessing is handled by Sterile Services / HSSD or clinical teams under the SRSA protocols — but cleaners must not attempt to clean or disinfect these items unless explicitly trained and authorised. Product efficacy claims in this space are governed by **EN 14885**, which references the European test standards (EN 1276, EN 13727, EN 14476, EN 13697, EN 16615) that an HSE-approved disinfectant must satisfy.

COSHH, CLP and Safety Data Sheets — the chemical-safety layer

Every chemical used in an HSE cleaning programme sits inside a three-layer chemical-safety framework that HIQA and HSA inspectors audit in parallel with the IPC audit:

COSHH (Control of Substances Hazardous to Health) — a written risk assessment per substance per task, listing the hazard, exposure route, controls, PPE, first aid, and spill procedure. See our COSHH cleaning guide for templates.

CLP Regulation (EC) No 1272/2008 — governs Classification, Labelling and Packaging of hazardous chemicals. Every bottle, decant container, and dilution station must carry the correct CLP pictogram, signal word, hazard and precautionary statements. Unlabelled decants are a straight audit failure.

Safety Data Sheets (SDS) — the 16-section technical document supplied by the chemical manufacturer. Current SDS must be on site, accessible to every cleaner, and version-controlled. Full HSA guidance is available at hsa.ie.

Cleaner-facing breaches (unlabelled bottles, incorrect dilution, no SDS accessible, no COSHH for in-use chemical) are the single most common finding in HSA contract-cleaning inspections. Employment conditions for the cleaners themselves — pay, working hours, rest breaks — are enforced by the Workplace Relations Commission (workplacerelations.ie) under the Contract Cleaning Joint Labour Committee ERO.

Audit and Inspection Framework

The HSE cleaning audit framework is a structured system for assessing and monitoring cleaning performance. It is used by HSE facilities management, infection prevention and control teams, and HIQA inspectors.

Audit Types

Visual audits: the most common audit type. A trained auditor walks through the area, assessing each element (floors, surfaces, fixtures, equipment) against a standardised scoring system. Scores are expressed as a percentage.

ATP bioluminescence testing: a rapid microbiological assessment that measures organic residue on surfaces using an ATP (adenosine triphosphate) meter. Results are in Relative Light Units (RLUs). High RLU readings indicate inadequate cleaning.

Microbiological sampling: surface swabs sent to the laboratory for culture. Used in outbreak investigations or to verify cleaning effectiveness in high-risk areas.

Fluorescent marker audits: UV-fluorescent markers are applied to surfaces before cleaning. After cleaning, the area is inspected under UV light to see which surfaces were actually cleaned. This objectively measures whether all surfaces are being reached.

Minimum Acceptable Audit Scores

Risk Zone	Minimum Score	Target Score
Very High Risk	85%	90%+
High Risk	80%	85%+
Significant Risk	75%	80%+
Low Risk	70%	75%+

Contract cleaning companies working in healthcare are audited regularly — typically monthly for high-risk areas and quarterly for lower-risk areas. Persistent failure to meet minimum scores will trigger corrective action requirements, escalation meetings, and ultimately could lead to contract termination.

For a full cross-reference of HSE V06 audit thresholds against HIQA National Standard 4 (safe and clean environment) and the HPSC AMRIC IPC audit tool, see our **HSE/HIQA Compliance Audit Tool** — a free downloadable checklist that mirrors the audit categories actually used on-site. Request a copy below.

Documentation Requirements

Healthcare cleaning requires comprehensive documentation. This is not bureaucracy for its own sake — it is a critical part of the audit trail for infection prevention and control, and it is examined by HIQA inspectors during unannounced inspections.

Required documentation includes:

Daily cleaning records: signed and timed records showing which areas were cleaned, by whom, and when. These must be completed in real-time, not retrospectively.

Terminal cleaning checklists: completed for every terminal clean, listing every element cleaned and disinfected, signed by the cleaning operative and verified by the supervisor.

Equipment maintenance logs: records of cleaning equipment servicing, PAT testing, and replacement schedules.

Chemical inventory and COSHH assessments: current Safety Data Sheets (SDS) for all chemicals, risk assessments, and COSHH compliance records. See our COSHH guide.

Staff training records: induction training, competency assessments, refresher training, and specialist training (e.g., HPV operation, isolation cleaning protocol).

Audit reports: all visual and microbiological audit results, trend analysis, corrective action plans, and evidence of implementation.

Incident reports: records of any cleaning-related incidents, near-misses, complaints, or contamination events.

Quality meeting minutes: records of regular quality review meetings between the cleaning company and the healthcare facility.

Biological-agent exposure records: where work creates a reasonably foreseeable exposure to Group 2+ biological agents under the Safety, Health and Welfare at Work (Biological Agents) Regulations 2013, an exposure register must be maintained and retained for the periods set by the Regulations (up to 40 years for Group 3/4 agents).

Records must be retained for a minimum of **7 years** and be available for inspection at any time. Many healthcare facilities now require electronic record-keeping for audit trail integrity.

How HSE Standards Relate to HIQA

The **Health Information and Quality Authority (HIQA)** is the independent authority responsible for monitoring the quality and safety of healthcare services in Ireland. HIQA inspectors conduct unannounced inspections of healthcare facilities and assess compliance with the National Standards for infection prevention and control in community services.

The HSE National Cleaning Standards Manual is the operational standard. HIQA's National Standards are the regulatory framework. They work together:

HIQA says what must be achieved (safe, clean environment; effective IPC; evidence-based cleaning practices)

The HSE manual says how to achieve it (specific frequencies, products, methodologies, audit scores)

When HIQA inspectors visit a facility, they expect to see the HSE cleaning standards being implemented. They will check cleaning records, audit scores, staff training evidence, and the condition of the environment. A HIQA inspection finding of inadequate environmental cleaning is a serious compliance issue that requires an immediate corrective action plan.

For contract cleaning companies, understanding both HIQA and HSE standards is essential. You are not just cleaning — you are contributing to a regulatory compliance framework. For more detail, read our HIQA cleaning standards guide.

Implications for Contract Cleaning Companies

If you provide or are tendering for healthcare cleaning services in Ireland, the HSE National Cleaning Standards Manual defines your service specification. Here is what it means in practice:

Staff training: all cleaning operatives working in healthcare must be trained to the HSE standard. This includes induction training, competency assessments, and regular refresher training. Budget for approximately 40 hours of initial training per operative.

Supervision: healthcare cleaning requires a higher level of supervision than commercial cleaning. Expect to deploy dedicated supervisors on healthcare contracts, with supervisor-to-operative ratios of approximately 1:8–1:12.

Equipment: healthcare cleaning requires specific equipment: colour-coded mops and cloths, microfibre systems, hospital-grade vacuum cleaners with HEPA filters, dedicated cleaning trolleys, and PPE (gloves, aprons, eye protection for chemical handling).

Chemicals: you must use HSE-approved cleaning products. This typically means hospital-grade detergents, chlorine-based disinfectants, and hydrogen peroxide products. Consumer-grade cleaning products are not acceptable.

Documentation: the documentation burden is significantly higher than commercial cleaning. Factor documentation time into your staffing calculations — approximately 10–15% of productive cleaning hours.

Pricing: healthcare cleaning costs more than standard commercial cleaning due to higher training, supervision, documentation, and equipment requirements. Expect labour rates 15–25% above standard commercial rates. See our hospital cleaning cost guide for benchmarks.

IPC assurance evidence for tenders: HSE eTenders cleaning specifications now routinely ask for a method statement that explicitly names HSE V06, SRSA, HPSC AMRIC, the 5 Moments for Hand Hygiene, and the Biological Agents Regulations 2013. A tender response that refers only to "HSE standards" without naming these

documents will score poorly on quality.

Frequently Asked Questions

What is the HSE National Cleaning Standards Manual?

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What are the HSE cleaning risk zones?

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How often should healthcare areas be cleaned?

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What is the colour-coded cleaning system?

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What is terminal cleaning?

+

What is the difference between cleaning and disinfection?

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How does the HSE audit cleaning?

+

What documentation is required?

+

What is the difference between HSE cleaning standards and HIQA infection control standards?

+

What PPE and hand hygiene is required under HSE cleaning standards?

+

How is cleaning different for MRSA, CPE, C. difficile or norovirus?

+

Is there a free checklist for auditing an existing cleaning provider against HSE/HIQA?

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Download our HSE/HIQA Compliance Audit Tool

A free audit workbook that cross-references HSE V06, SRSA, HPSC AMRIC IPC guidance and HIQA National Standard 4 in one checklist. Used by facility managers to assess incumbent cleaners before retendering, and by IPC leads as an internal pre-inspection tool. One page per risk zone. PDF and editable formats.

Name
<input type="text"/>
Role
<input type="text" value="IPC Lead / FM / Procurement"/>
Work email
<input type="text"/>
Facility type
<input type="text" value="Acute hospital"/>
Send me the audit tool

WHERE THESE STANDARDS APPLY

Optus Glean delivers HSE-compliant cleaning into: HSE acute and community hospital contracts · HIQA-registered nursing homes under the Health Act 2007 · primary care centres · HSE disability services (Section 38 and Section 39) · approved mental-health centres under the Mental Health Commission · GP practices operating under HSE contracts. Every site is delivered to V06 + SRSA + HPSC AMRIC with full documentation retained for seven years.

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