

# Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

## Section 1: Facility Demographics and Infection Prevention and Control (IPC) Infrastructure Long-Term Care

### General Facility Demographics and IPC Infrastructure

Date of Assessment: \_\_\_\_\_

Facility Name: \_\_\_\_\_

State/Territory: \_\_\_\_\_ County: \_\_\_\_\_

Zip Code: \_\_\_\_\_ State/Territory-assigned Unique ID (if applicable): \_\_\_\_\_

Facility type (Complete the demographic form that corresponds to the type of facility):

Acute Care Hospital / Critical Access Hospital

Long-term Care

● Outpatient/Ambulatory Care

Other (specify): \_\_\_\_\_

NHSN Facility Organization ID (if applicable): \_\_\_\_\_

CMS Facility ID (if applicable): \_\_\_\_\_

Facility Respondent Name(s) and Job Title(s):

Rationale for assessment:

Requested by facility

Requested by accrediting agency/ licensing organization

Requested by state or local health department

HAI prevention focused:

CAUTI

CLABSI

SSI

CDI

Other (specify): \_\_\_\_\_

Prevention collaborative (specify partners): \_\_\_\_\_

Outbreak (specify): \_\_\_\_\_

Other (specify): \_\_\_\_\_

**Obtain a list of products used for cleaning and disinfection of environmental surfaces and non-critical patient/resident care equipment in the facility**

EPA registration number(s) for products used in patient/resident rooms:

\_\_\_\_\_

EPA registration number(s) for products used in common areas:

\_\_\_\_\_

EPA registration number(s) for products used on non-critical patient/resident care equipment (e.g., blood glucose meters):

\_\_\_\_\_



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Health and Human Services**  
Centers for Disease  
Control and Prevention

1. Does the facility have access to **onsite** IPC expertise?

- Yes
- No
- Unknown
- Not Assessed

**If YES, specify:**

Healthcare epidemiologist (number of full-time equivalents **dedicated** to IPC activities):

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Infection preventionist (number of full-time equivalents **dedicated** to IPC activities):

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Other (specify, including number of full-time equivalents **dedicated** to IPC activities):

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**Note:** This is intended to identify individuals who work onsite at the facility or provide IP oversight at satellite locations (e.g., hospital IP provides IP oversight to affiliated outpatient clinics) and what proportion of their time is dedicated to IPC activities. Example: The facility has two IPs. IP #1 spends 25% of their time on IPC activities and the rest of their time on direct patient care and IP #2 spends 75% of their time on IPC activities and the rest of the time on direct patient care. This would be recorded as IP: 1 FTE dedicated to IPC activities. This breakdown could be further described in the notes.

2. Does the facility have access to **offsite** IPC expertise?

- Yes
- No
- Unknown
- Not Assessed

**If YES, specify:**

Healthcare epidemiologist (number of full-time equivalents dedicated to IPC activities **at the facility**):

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Infection preventionist (number of full-time equivalents dedicated to IPC activities **at the facility**):

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Other (specify, including number of full-time equivalents dedicated to IPC activities **at the facility**):

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**Note:** This is intended to identify individuals who do not work primarily onsite at the facility but might provide IPC support on a contractual or part-time basis. If a full-time equivalent cannot be determined, the level of support should be described in the notes.

3. Does the person(s) charged with directing the IPC program at the facility hold a nationally recognized credential in infection control (e.g., a-IPC, CIC, LTC-CIP, BCIDP)?

- Yes
- No
- Unknown
- Not Assessed

Lack of certification does not mean that an individual is not qualified to direct the IPC program. **Describe their qualification(s) (e.g., other certifications, specialized training):**

4. What additional duties are performed by personnel within the IPC program? *(select all that apply)*

- Occupational Health
- Education of personnel
- Safety officer
- Administrative (e.g., Director of Nursing)
- None
- Not assessed
- Other *(specify)*: \_\_\_\_\_

5. What does the director of the IPC program believe are the current strengths and weaknesses in the IPC program?

6. Does the IPC program have access to electronic medical records of patients/residents?

- Yes
- No
- Unknown
- Not Assessed

7. Does the IPC program utilize data mining/reporting software?

- Yes
- No
- Unknown
- Not Assessed

8. Does the IPC program perform an annual facility infection risk assessment that evaluates and prioritizes potential risks for infections, contamination, and exposures and the program's preparedness to eliminate or mitigate such risks?

- Yes
- No
- Unknown
- Not Assessed

9. Are written infection control policies and procedures available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards?

- Yes
- No
- Unknown
- Not Assessed

9a. How frequently are policies and procedures reviewed and updated? *(select all that apply)*

- Annually
- Every three years
- As needed when new guidelines or evidence is published (e.g., via subscription with a publisher)
- Unknown
- Not assessed
- Other *(specify)*: \_\_\_\_\_

**Note:** Facilities should have a schedule to regularly review policies and procedures to ensure they are current. At a minimum, updates should be made when new evidence-based guidance is published and if the scope of care delivered changes (e.g., new equipment is introduced or new procedures are performed).

10. Does the IPC program provide infection prevention education to patients, family members, and other caregivers?

- Yes
- No
- Unknown
- Not Assessed

**If YES:**

10a. What topics are covered? *(specify)*

10b. How is this education provided (e.g., information included in the admission or discharge packet, videos, signage, in-person training)? *(specify)*

11. Does the facility have an interdisciplinary infection control committee to address issues identified by the IPC program?

- Yes
- No
- Unknown
- Not Assessed

**Note:** Issues identified by the IPC program often impact multiple areas of the facility. An interdisciplinary committee, including facility leadership (e.g., ownership, chief medical officer, director of nursing), is needed to allocate resources and successfully implement long-term solutions.

**If YES, specify:**

11a. Who is part of the infection control committee? *(select all that apply)*

- Chief Medical Officer
- Director of Nursing
- Environmental Services
- Unknown
- Not Assessed
- Other *(specify)*: \_\_\_\_\_

11b. How often does the infection control committee meet?

- Monthly
- Quarterly
- Unknown
- Not Assessed
- Other *(specify)*: \_\_\_\_\_

**Notes**

## Facility Demographics: Long-Term Care

1. Facility type (*select all that apply*):

Nursing home  
Intermediate care facility  
Assisted living facility  
Inpatient Rehabilitation Facility

Other (*specify*): \_\_\_\_\_

2. Certification:

Dual Medicare/Medicaid  
Medicare only  
Medicaid only  
State only

3. Ownership:

For profit  
Not for profit, including church  
Government (not VA)  
Veterans Affairs

4. Affiliation:

Independent, free-standing  
Independent, continuing care retirement community  
Multi-facility organization (chain)  
Hospital system, attached  
Hospital system, free-standing

5. Floor Plan/Layout:      Number of Floors: \_\_\_\_\_      Number of Units or Wings: \_\_\_\_\_

6. Total Number of Licensed Beds: \_\_\_\_\_      Number of Pediatric Beds (age <21): \_\_\_\_\_

7. Current Census: \_\_\_\_\_

Unit Type	Number of Rooms	Current Census	Number of single/private rooms	Number of doubles/semi-privates	Number of triples	Number of quads
Subacute/Skilled						
Long-term general nursing						
Memory Care						
Other ( <i>specify</i> ):						
1.						
2.						
3.						

8. Does the facility have communal bathing areas?

Residents have dedicated, private bathing areas  
Communal areas are used for showering

9. Does the facility provide onsite hemodialysis for residents?

Yes  
No

9a. If yes, where is hemodialysis performed?

Resident's room  
Shared location in the facility (e.g., den)  
Other (*specify*): \_\_\_\_\_

**10. What laboratory support is available? (select all that apply)**

- Onsite  
 Affiliated medical center, within same health system  
 Medical center, contracted locally  
 Commercial referral laboratory  
 Other (specify): \_\_\_\_\_

11. Which services are provided by contracted vendors? *(select all that apply)*

- |   |                  |
|---|------------------|
| No services are contracted                              | Wound Care       |
| Environmental Services/Housekeeping supervisors         | Podiatry         |
| Environmental services/Housekeeping frontline personnel | Dental           |
| Linen/Laundry   | Other (specify): |

## Ventilator Unit

**12. Does the facility have ventilator-dependent residents or residents with tracheostomies NOT on a ventilator?**

(If no, skip remainder of this section)

- Yes  
No

**12a. Current census of residents with tracheostomies NOT on ventilators:** \_\_\_\_\_

**12b.** Current census of ventilator-dependent residents: \_\_\_\_\_

**12c.** Do ventilator-dependent residents or those with tracheostomies participate in communal services/group activities with residents who are not ventilator-dependent and do not have tracheostomies?

- Yes  
No

**Note:** Such mixing is residents is permissible; however, the facility will need to ensure they have policies and procedures (e.g., how and where to safely perform suctioning, if indicated) and readily accessible supplies (e.g., hand hygiene and environmental cleaning supplies) to minimize transmission risks.

**12d. Is there a dedicated ventilator unit?**

- Yes  
No

***If NO:***

**12e.** On which units are ventilator-dependent residents roomed? (*specify units*): \_\_\_\_\_

**If *YES*:**

**12f.** Are residents not on ventilators (e.g., patients with a trach or other device) ever roomed on the vent unit?

- Yes  
No

**12g. Specify the types of rooms in the vent unit:**

Room type	Number per unit
Single rooms	
Double rooms	
Triple rooms	
Quad rooms	

## Notes

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