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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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):

_____

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

_____

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

_____

> **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**):

_____

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

_____

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

_____

> **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):**

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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 (specify):						
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