**Infection Prevention and Control Assessment Tool (ACPHD Revised-ICAR)**

The Infection Prevention and Control Assessment tool (ICAR) should be used to help Long Term Care Facilities (LTCF) prepare for COVID-19 and can be used to identify gaps in LTCF response to an active COVID-19 outbreak.

Areas assessed include:

* Visitor restriction
* Education, monitoring, and screening of healthcare personnel (HCP)
* Education, monitoring, and screening of residents
* Ensuring availability of PPE and other supplies
* Ensuring adherence to recommended infection prevention and control (IPC) practices
* Communicating with the Public Health Department and other healthcare facilities

Additional Information:

* The assessment includes a combination of staff interviews and direct observation of practices in the facility and can be conducted in-person or remotely (e.g., Tele-ICAR via phone or video conferencing). It may be helpful to provide a copy of the tool to the facility in advance of completing the Tele-ICAR and encourage them to take their own notes as you conduct the assessment.
* Assessments can be conducted by state or local health department (HD) staff or a designee even if they do not have an extensive IPC background.
* The goal is to convey key messages to LTCF and identify COVID-19 specific control and preparedness needs. IPC questions and concerns can be noted and addressed after the ICAR is completed.
* Assessment activities provide an opportunity for dialogue and information sharing
	+ **Discuss the purpose of the assessment and emphasize that it is not a regulatory inspection and is designed to ensure the facility is prepared to quickly identify and prevent spread of COVID-19**
	+ Promote discussion by asking additional questions to prompt or probe. Use this opportunity to address concerns and offer available resources
* Be aware of applicable CMS rules, Health Officer orders, as well as CDC, CDPH, and ACPHD guidance and recommendations that may impact implementation of recommended practices
* Provide feedback or a high-level written summary answers to the facility’s questions and recommended next steps directly to the facility within 2-3 days.
* If possible, schedule a follow-up call with the facility (e.g., within the next week after the assessment findings are shared).

|  |  |
| --- | --- |
| Facility Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Facility City & Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Facility POC Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Title/Position: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| POC Phone:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| POC E-mail Address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* Number of beds in the facility: \_\_\_\_\_\_\_\_
* Total number of residents in the facility: \_\_\_\_\_\_\_\_\_\_\_
* Total number of units: \_\_\_\_\_\_\_\_\_\_
	+ Specialty Units (check all that apply): ☐ Vent/trach ☐Dialysis ☐Dementia/Memory ☐Skilled or Subacute Rehab

☐Behavioral Health/Psychiatric *These units have residents at higher risk for poor outcomes. Vent/trach units provide respiratory support and dementia/memory units are often secured, and limit resident movement to other locations.*

**Which of the following situations apply to the facility? (Select all that apply)**

□ No cases of COVID-19 currently reported in their community

□ Cases reported in their community

□ Sustained transmission reported in their community

□ Cases identified in their facility (either among HCP or residents)

|  |  |  |
| --- | --- | --- |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Facility restricts all visitation except for certain compassionate care situations, such as end of life situations.
 |  |  |
| * Decisions about visitation are made on a case-by-case basis.
 |  |
| * Do you use a visitor screening form to ensure consistency?
 |  | If N, offer Screening Tool |
| * Where are visitors screened?
 |  |  |
| * Are visitors provided procedure masks?
 |  |  |
| * Do you have hand sanitizer available for visitor use?
 |  |  |
| * Facility has sent a [communication](https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf) to families advising them that no visitors will be allowed in the facility and that alternative methods for visitation will be facilitated by the facility.
 |  |  |
| * Facility has provided alternative methods for visitation.
 |  |  |
| * Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.
 |  |  |
| * Non-essential personnel including volunteers and non-medical service providers (e.g., salon, barbers) are restricted from entering the building.
 |  |  |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Changes to usual policies/procedures in response to PPE or staffing shortages
 |  |  |
| * COVID-19 (e.g., symptoms, transmission)
 |  |  |
| * + Hand hygiene
 |  |  |
| * + Selection and use of PPE; don/doff
 |  |
| * Cleaning and disinfecting environmental surfaces and resident care equipment
 |  |
| * Sick leave policies and adhering to exclusion protocol
 |  |  |
| * All HCP are reminded to practice social distancing when in common areas and to keep mask on at all times.
 |  |  |
| * Does the Facility screen staff at the beginning of their shift for fever and symptoms of COVID-19
 |  |  |
| * How are results documented? Is there a screening form?
 |  | If N, offer Employee Screening Form |
| * If symptoms are present, they are instructed to put on a facemask and return home.
 |  |  |
| * Are presence of symptoms reported to all locations of employment?
 |  |  |
| * Facility keeps a list of symptomatic HCP.
 |  |  |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Facility has provided education to **residents** about:
 |  |  |
| * COVID-19 (e.g., symptoms, how it is transmitted)
 |  |
| * Immediately informing HCP if they feel feverish or ill
 |  |
| * Infection control practices: hand hygiene, covering their cough, maintaining social distancing
 |  |
| * Actions the facility is taking to keep them safe.
 |  |
| * Residents with COVID symptoms are immediately placed in appropriate Transmission-Based Precautions.
 |  |  |
| * Facility assesses residents for fever and symptoms of COVID-19 upon admission and at least q4 hours.

**Note:** Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, or diarrhea, chills, new loss of taste or smell. |  |  |
| * Facility has stopped group activities inside the facility and field trips outside of the facility.
 |  |  |
| * Facility has stopped communal dining.
 |  |  |
| **Additional actions when COVID-19 is identified in the facility:** |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Residents are restricted (to the extent possible) to their rooms except for medically necessary purposes.
 |  |  |
| * If residents leave their room, they wear a facemask, perform hand hygiene, limit movement in the facility and practice social distancing.
 |  |  |
| * How often are masks being replaced?

|  |  |
| --- | --- |
| > Once per day | □ |
| Once a day | □ |
| Once a week | □ |
| More than once a week | □ |
| Only when soiled | □ |
| Not replacing | □ |

 |
| * Facility clusters resident care and treatment activities to minimize entries into resident room (e.g. clinical staff disinfect high-touch surfaces while in the room)
 |  |  |
| * How is the facility isolating symptomatic PUI from the other residents?
 |  |  |
| * How is the facility isolating COVID-19 (+) from the other residents?
 |  |  |
| * If there are no COVID-19 (+) residents, do they have a plan to isolate/cohort residents if an outbreak occurs?
 |  |  |
| * DEVELOP A PLAN for cohorting ill residents and COVID-19 (+) residents with dedicated HCP.
 |  |  |
| * The facility monitors ill residents at least q4h including symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and quickly manage serious infection.
 |  |  |
| **Availability of PPE and Other Supplies** |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues).
 |  |  |
| **Which of the following PPE and other supplies do you need?**

|  |  |  |  |
| --- | --- | --- | --- |
| Item | Have | Need | Current # days supply |
| Facemasks | □ | □ |  |
| N-95 or higher-level respirators | □ | □ |  |
| Isolation gowns | □ | □ |  |
| Goggles/eye protection | □ | □ |  |
| Face shields | □ | □ |  |
| Gloves | □ | □ |  |
| Shoe covers | □ | □ |  |
| ABHS | □ | □ |  |
| Disinfectant wipes and/or spray | □ | □ |  |
| Thermometers | □ | □ |  |

 |  |  |
| * Facility has implemented measures to optimize PPE supply
 |  |  |
| * If PPE shortages are identified or anticipated, facility knows how to make a **Resource Request with MHOAC**
 |  |  |
| **\*\*\*\*Review resource request process and provide list of vendors\*\*\*\*** |
| * PPE is readily available in resident care areas (e.g., outside resident rooms). PPE includes: gloves, gowns, facemasks, N-95 or higher-level respirators (if HCP are fit-tested) and eye protection
 |  |  |
| * Do you have onsite laundry service?
 |  |  |
| * Are you using cloth gowns?

If so describe how: |  |  |
| * EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available and accessible for **all** staff.
 |  |  |
| * Housekeeping staff understand and observes the correct **contact time** for their supply of disinfectant
 |  |  |
| * Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
 |  |  |
| **Infection Prevention and Control Practices** |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * HCP perform hand hygiene in the following situations:
 |  |  |
| * Before resident contact, even if PPE is worn
 |  |
| * After contact with the resident
 |  |  |
| * After contact with blood, body fluids or contaminated surfaces or equipment
 |  |
| * Before performing an aseptic task
 |  |  |
| * After removing PPE
 |  |
| HCP wear the following PPE when caring for residents with suspect/confirmed COVID:

|  |  |
| --- | --- |
| Gloves | □ |
| Isolation gown | □ |
| Facemask (procedure) | □ |
| N95 respirator | □ |
| Eye protection (goggles or face shield) | □ |
| Not replacing | □ |

 |  |  |
| * How often is PPE being changed when interacting with a COVID-19 + resident?
 |  |  |
| * How often is PPE being changed when interacting with a COVID-19 (-) resident?
 |  |  |
| * Are staff trained on proper donning and doffing of PPE?
 |  |  |
| * Are PPE removed in a manner to prevent self-contamination, hand hygiene performed, and new PPE put on for each resident.
* **[Except** in the case of limited supply – if HCP is working with a cohorted group (all +COVID) and PPE is unsoiled]
 |  |  |
| * What education has been provided on reusing or extending PPE?
 |  |  |
| * How are staff managing their uniforms to prevent bringing contaminants into their homes?
 |  |  |
| * Hand hygiene supplies are available in all resident care areas.
 |  |  |
| * Alcohol-based hand sanitizer with 60-95% alcohol in every resident room and other resident care and common areas.
 |  |  |
| * Sinks are stocked with soap and paper towels.
 |  |  |
| * Hand hygiene and PPE compliance are audited by DON/DSD
 |  |  |
| * EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim\* against SARS-CoV-2 are readily available
 |  |  |
| * High-touch surfaces and shared resident care equipment frequently disinfected.
 |  |  |
| * Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.
 |  |  |
| * EPA-registered disinfectants are prepared and used in accordance with label instructions.
* All staff are aware of instructions for product use.
 |  |  |
| * Name of EPA-registered disinfectant used in facility:
 |  |
| * Contact time for EPA-registered disinfectant:
 |  |
| * All HCP are reminded to wear masks and practice social distancing when in break rooms or common areas.
 |  |  |
| **When COVID-19 is identified in the facility*** Recommendation: HCP wear all recommended PPE (gown, gloves, eye protection, N95 or facemask) with all residents r/t statistics of asymptomatic but +COVID cases
 |  |  |
| **Communication** |
| **Elements to be Assessed** | **Assessment(Y/N)** | **Notes/Areas for Improvement** |
| * Facility notifies the health department about any of the following:
* COVID-19 is confirmed in a resident or HCP
* A cluster of new-onset respiratory symptoms among residents or HCP (≥2 cases over 72 hours)
 |  | ACPHD at (510) 267-3250, M-F 8:30 am to 5 pm. After hours and on weekends, Alameda County Fire Dispatch at (925) 422- 7595 and ask to speak to the Public Health Duty Officer on call. |
| * Facility completes ACPHD’s line list of COVID-19 (+) and symptomatic residents.
 |  |  |
| * Line list is completed correctly
 |
| * Line list is sent to ACPHD daily
 |  |  |
| * Facility has process to notify residents, families and staff members about COVID-19 cases occurring in the facility.
 |  |  |
| * Facility communicates to transport personnel and receiving facility before transfer (e.g. dialysis and acute care facilities) using ACPHD Infection Control Transfer Form
 |  | Use the ACDPH Infection Control Transfer Form. |
| * Information about known or suspected COVID-19 residents
 |  |  |
| * Reporting that there is COVID-19 in the facility
 |  |  |

|  |
| --- |
| **Additional Assessment Team Notes** |
| **Immediate Needs or Concerns: (advise Med/Health Branch and Public Health)** |
| **Director of Nursing or Management Rep advised of immediate needs or concerns**

|  |  |  |
| --- | --- | --- |
| Yes □ | No □ | N/A no immediate concerns □ |

 |

|  |  |
| --- | --- |
| **Team Member #1:** | **Agency:** |
| **Team Member #2:** | **Agency:** |