Regional Infection Prevention Support (RIPS) Team
Infection Control Assessment and Response (ICAR) Tool

Please use this survey to record the results of your ICAR site visits. Some of these questions may not be applicable for all facility types, so please mark N/A for any questions that do not apply to the facility that you are evaluating.

Overview

1. Facility Demographics	
RIPS Region	
Assessment completed by:	
Assessment date	
Reason for assessment	❑ Routine IP visit ❑ Outbreak ❑ Identified IP breach ❑ Request from LHD, DHSR, or other partner ❑ Other (please specify): _____
Please record any other relevant information about visit here (optional).	
Facility name	
Facility county	
Facility zip code	
Facility type	❑ Adult care home/assisted living facility ❑ Nursing home/skilled nursing facility ❑ Family care home ❑ Mental or behavioral health facility ❑ Other (please specify): _____
Facility Contact	Name: Title: Phone number: Email address:
Number of licensed beds	
Facility certified by CMS? ***Note: CMS certified facilities have a <u>CMS Certification number</u> (CCN) which is always six digits, the first two will be 34 (indicates NC facility).***	❑ Yes *CCN is* _____ ❑ No

Facility licensed by state. ***Note: State license number(s) starts with the facility designation:*** ***HAL= Adult Care Homes*** ***FCL = Family Care Homes*** ***MHL=Mental Health Facilities, including ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities)*** ***NH=Nursing Homes***	❑ Yes *(Please record state license numbers for all facilities being assessed using this ICAR tool, if applicable.)* ❑ No
Facility affiliated with hospital. ***Note: Affiliated means <u>closely associated</u> with a hospital, either attached or free-standing (DOES NOT mean referral of residents to or from a hospital in the community).***	❑ Yes (please specify): _____ ❑ No
Total number of <u>infection preventionist (IP)</u> hours per week dedicated to IP. ***Note: The IP is the person(s) designated to have oversight of the infection prevention program.***	❑ 0-9 ❑ 10-19 ❑ 20-29 ❑ 30-39 ❑ 40+

2. Infection Control Program and Infrastructure		
Element to be Assessed	*Assessment*	*Notes*
The facility has specified a person (e.g., staff, consultant—*must be on-site*) who is responsible for coordinating the IP program.	❑ Yes ❑ No ❑ N/A	
The person responsible for coordinating the IP program has received *specialized* training in IP. ***Examples of training may include: CIC certification, participation in IP courses organized/authorized by the state (e.g., NC SPICE), recognized professional societies (e.g., APIC, SHEA), or federal agencies (e.g., CDC, CMS).***	❑ Yes ❑ No ❑ N/A	

The facility has a process for reviewing infection surveillance data and infection prevention activities (e.g., presentation at QA committee). ***Note: Ask to see infection prevention risk assessment, summary of data, graphs, infection logs, etc.***	❑ Yes ❑ No ❑ N/A	
Written IP policies and procedures are available and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations (e.g., CMS 483.80), or standards. ***Note: Policies and procedures should be tailored to the facility (i.e., not just copied and pasted corporate policies) and extend beyond required OSHA bloodborne pathogens and COVID-19 trainings or the CMS State Operations Manual.***	❑ Yes ❑ No ❑ N/A	
Written IP policies and procedures are reviewed *(and updated if needed)* at least annually, *when new evidence-based guidelines are published or the scope of care/services change,* and according to state and federal requirements. ***Note: Look for policy effective dates, review dates, revised dates, and approval person/committee signature.***	❑ Yes ❑ No ❑ N/A	
The facility has provided appropriate infection prevention education to all staff based on their job duties and potential for exposure to communicable diseases at time of hire, at least annually thereafter, ***and if job duties change (e.g., dietary worker trains to be CNA).***	❑ Yes ❑ No ❑ N/A	
The facility has a written plan for emergency preparedness (e.g., increased COVID-19 transmission, increase in cases or outbreak of other communicable disease *such as flu or norovirus,* or natural disaster).	❑ Yes ❑ No ❑ N/A	

3. Healthcare Personnel and Resident Safety		
Element to be Assessed	*Assessment*	*Notes*
Healthcare Personnel		
The facility has work-exclusion policies concerning avoiding contact with residents	❑ Yes ❑ No	

when personnel have potentially transmissible conditions that do not penalize sick employees with loss of wages, benefits, or job status. ***Note: Look for policies explaining when staff should not report to work (e.g., instructing staff with fever and sore throat not to report to work).***	❑ N/A	
The facility educates personnel on prompt reporting of signs/symptoms of a potentially transmissible illness to a supervisor.	❑ Yes ❑ No ❑ N/A	
The facility conducts baseline TB screening for all new personnel *at time of hire.* ***Note: NC TB rule states: All staff of NHs and ACHs shall have a <u>2-step TST or single IGRA</u> at time of hire. If the staff have ever had a documented negative 2-step or had a documented negative single TST in the past 12 months a <u>single</u> TST or IGRA is recommended.***	❑ Yes ❑ No ❑ N/A	
The facility has a policy to assess healthcare personnel risk for TB (based on regional and community data) and requires periodic (at least annual) TB screening if indicated. ***Note: Annual screening can be done through verbal elicitation of symptoms and documentation. Annual TSTs are not required.***	❑ Yes ❑ No ❑ N/A	
The facility offers ***(provides at no charge)*** Hepatitis B vaccination to all personnel who may have anticipated exposure to blood or body fluids as part of their job duties. ***Note: HBV should be offered after the staff have received bloodborne pathogen training and within 10 working days of initial job assignment. If staff refuse, they must sign a declination form.***	❑ Yes ❑ No ❑ N/A	
The facility offers all personnel influenza vaccination annually.	❑ Yes ❑ No ❑ N/A	
The facility maintains written records of personnel influenza vaccination from the most recent influenza season.	❑ Yes ❑ No ❑ N/A	
The facility offers all personnel COVID-19 vaccination.	❑ Yes ❑ No	

	❑ N/A	
The facility maintains written records of personnel COVID-19 vaccination.	❑ Yes ❑ No ❑ N/A	
The facility has ***a bloodborne pathogen*** exposure control plan which addresses potential hazards posed by specific services provided by the facility. ***Note: A model template, which includes a guide for creating an exposure control plan that meets the requirements of the OSHA Bloodborne Pathogens Standard is available here.***	❑ Yes ❑ No ❑ N/A	
All personnel ***with anticipated exposure to blood, body fluid, and/or other potentially infectious material*** *receive education/training and competency validation on* ***OSHA's*** *bloodborne pathogen standard at time of employment* ***and at least annually.*** ***Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an individual's duties.***	❑ Yes ❑ No ❑ N/A	
Resident Safety		
The facility currently has a written infection control risk assessment to assess risk of communicable diseases, such as TB and COVID-19, based on regional and local transmission.	❑ Yes ❑ No ❑ N/A	
The facility screens all new resident admissions for TB. ***Note: NC TB rule states: All new admissions to NHs and ACHs shall have a 2-step TST or single IGRA at time of admission.*** ***If the resident has had a documented negative 2-step and is admitted directly from a hospital or other long-term care setting, no additional TST is needed at time of admission.*** ***If the resident has ever had a documented negative 2-step or has had a documented negative single TST in the past 12 months, a single TST or IGRA is necessary.***	❑ Yes ❑ No ❑ N/A	

The facility documents resident immunization status for pneumococcal vaccine at time of admission **and offers pneumococcal vaccine as appropriate to residents.**	❑ Yes ❑ No ❑ N/A	
The facility documents resident immunization status for COVID-19 vaccination at time of admission and offers COVID-19 vaccine as appropriate to residents.	❑ Yes ❑ No ❑ N/A	
The facility maintains written records of resident COVID-19 vaccination status.	❑ Yes ❑ No ❑ N/A	
The facility offers annual influenza vaccination to residents.	❑ Yes ❑ No ❑ N/A	

4. Surveillance and Disease Reporting		
Elements to be Assessed	*Assessment*	*Notes*
Surveillance		
The facility has procedures to identify potentially infectious persons at time of admission. **Examples: Documenting COVID-19 exposure, recent antibiotic use, and history of infections or colonization with *C. difficile* or antibiotic-resistant organisms.**	❑ Yes ❑ No ❑ N/A	
The facility has a system for notifying the Infection Preventionist when antibiotic-resistant organisms or *C. difficile* are reported by clinical laboratory.	❑ Yes ❑ No ❑ N/A	
The facility has a process in place for outlining activities monitoring/tracking infections (i.e., communicable diseases, infections acquired while in the facility) occurring in residents of the facility. ***Note: Process should include items listed below based on type of facility, for example:*** ***Nursing Homes: What surveillance definitions are going to be used; how infection rates are calculated.*** ***Other settings: Surveillance should include communicable disease reporting, process (how***	❑ Yes ❑ No ❑ N/A	

HH is performed) and outcome (infections) measures.		
The facility has a system to follow up on clinical information (e.g., laboratory, procedure results, and diagnoses) when residents are transferred to acute care hospitals for management of suspected infections, including sepsis. ***Note: Determine if the facility uses a standardized referral form when resident is transferred to or received from another care setting (hospital or other long-term care setting).*** *Receiving discharge records at the time of readmission is NOT sufficient to answer "yes."* InterfacilityTransferInstructionsandForm.pdf (ncdhhs.gov)	❑ Yes ❑ No ❑ N/A	
Disease Reporting		
The facility has a written plan for outbreak response which includes a definition, procedures for surveillance and containment, and a list of syndromes or pathogens for which surveillance is performed and how they are monitored.	❑ Yes ❑ No ❑ N/A	
The facility has a current list of diseases reportable to public health authorities.	❑ Yes ❑ No ❑ N/A	
The facility can provide points of contact at the local or state health department for assistance with outbreak response ***(e.g., communicable disease nurse).***	❑ Yes ❑ No ❑ N/A	

5. Hand Hygiene		
Elements to be Assessed	*Assessment*	*Notes*
Hand hygiene (HH) policies promote preferential use of alcohol-based hand rub (ABHR) over soap and water in most clinical situations. ***Note: Soap and water should be used when hands are visibly soiled (e.g., blood, body fluids), and is also <u>preferred</u> after caring for a patient with known or suspected C. difficile or norovirus during an outbreak or if rates of C.***	❑ Yes ❑ No ❑ N/A	

difficile infection in the facility are persistently high.		
Sinks are used only for hand washing (i.e., not used for disposal of body fluids, cleaning equipment, or rinsing linen).	❑ Yes ❑ No ❑ N/A	
All personnel receive training and competency validation on HH at the time of employment. ***Notes: Competency validation can be done via staff completing a return demonstration of the activity or verbally describing all the steps in the process correctly.***	❑ Yes ❑ No ❑ N/A	
All personnel received training and competency validation on HH within the past 12 months. ***Note: Review training records and monitoring results to determine compliance.***	❑ Yes ❑ No ❑ N/A	
The facility routinely audits (monitors and documents) adherence to HH. ***Note: If yes, the facility should describe auditing process and provide documentation of audits.***	❑ Yes ❑ No ❑ N/A	
The facility provides feedback to personnel regarding their HH performance. ***Note: If yes, facility should describe feedback process and provide documentation of feedback reports.***	❑ Yes ❑ No ❑ N/A	
Supplies necessary for adherence to HH (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible in resident care areas (e.g., nursing units, resident rooms, therapy rooms).	❑ Yes ❑ No ❑ N/A	
Hand lotion supplied by facility is approved for use in healthcare setting. ***Note: Staff should avoid bringing hand lotions in from home due to potential contamination of lotion. Some lotions may be incompatible with facility ABHR or other antiseptics used by the facility.***	❑ Yes ❑ No ❑ N/A	
Facility hand hygiene policy addresses fingernail issues such as nail length and use of artificial nails.	❑ Yes ❑ No ❑ N/A	

Note: Artificial nails and long natural nails may interfere with PPE use (gloves) and may prevent adequate disinfection with hand hygiene.		

6. Personal Protective Equipment (PPE)		
Elements to be Assessed	*Assessment*	*Notes*
The facility has a policy on Standard Precautions which includes selection and use of PPE (e.g., indications, donning/doffing procedures).	❑ Yes ❑ No ❑ N/A	
The facility has a policy on transmission-based precautions that includes the clinical conditions for which specific precautions should be used ***(e.g., MDROs- contact, Influenza-droplet, COVID-19-Special droplet plus contact).***	❑ Yes ❑ No ❑ N/A	
Facility has appropriate signage available with transmission-based precautions (TBP) instructions.	❑ Yes ❑ No ❑ N/A	
Personnel receive job-specific training and competency validation on proper use of PPE at the time of employment.	❑ Yes ❑ No ❑ N/A	
Personnel received job-specific training and competency validation on proper use of PPE within the last 12 months.	❑ Yes ❑ No ❑ N/A	
Staff who may need to use N-95 respirators have been fit-tested and trained on proper use.	❑ Yes ❑ No ❑ N/A	
The facility has a written respiratory protection program. ***Note: Program should include fit testing, medical evaluation, staff training, etc.***	❑ Yes ❑ No ❑ N/A	
The facility routinely audits (monitors and documents) adherence to PPE use (e.g., adherence when indicated, donning/doffing). ***Note: If yes, facility should describe auditing process and provide documentation of audits.***	❑ Yes ❑ No ❑ N/A	
The facility provides feedback to personnel regarding their PPE use. ***Note: If yes, facility should describe feedback process and provide documentation of feedback reports.***	❑ Yes ❑ No ❑ N/A	

Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., **outside the room of residents on precautions,** nursing units, therapy rooms).	❑ Yes ❑ No ❑ N/A	

7. Respiratory Hygiene and Cough Etiquette		
Elements to be Assessed	*Assessment*	*Notes*
The facility provides resources for **complying with respiratory hygiene/cough etiquette at facility entrance(s) and in common area (e.g., waiting areas).** ***Note: Facility should have signage with instructions, ABHR, tissues, no touch waste receptable, and masks available at entry to facility and in common areas where visitors may be encountered.***	❑ Yes ❑ No ❑ N/A	
The facility has signs posted at the entrances instructing visitors with symptoms of a respiratory infection that they may not enter the facility until their symptoms have resolved.	❑ Yes ❑ No ❑ N/A	
All personnel receive education on the importance of IP measures to contain respiratory secretions to prevent the spread of respiratory pathogens. ***Note: This can be achieved through the educational sessions on standard precautions that are conducted at time of hire and annually thereafter, if those sessions include information about respiratory hygiene and cough etiquette.***	❑ Yes ❑ No ❑ N/A	

8. Injection Safety and Point of Care Testing		
Elements to Assess	*Assessment*	*Notes*
The facility has a policy that all injections are prepared using aseptic technique in a clean area that is not adjacent to potential sources of contamination.	❑ Yes ❑ No ❑ N/A	

Note: Should be at least 3 feet from sinks or other water sources (or splash guard in place at sink) and no items that could have come in contact with blood or body fluids are present (e.g., fingerstick devices, phlebotomy equipment).		
The facility has a policy that ALL needles and syringes are used for only one resident one time and then discarded.	❑ Yes ❑ No ❑ N/A	
The facility has a policy that SINGLE dose medication vials are used for one resident, one time only and remaining contents are discarded.	❑ Yes ❑ No ❑ N/A	
The facility has a policy that all multi-dose vials are dated when opened and discarded within 28 days.	❑ Yes ❑ No ❑ N/A	
The facility has a policy on injection safety which includes protocols for performing finger sticks and point of care testing using injectable devices, such as assisted blood glucose monitoring (ABGM).	❑ Yes ❑ No ❑ N/A	
Personnel who perform point of care testing (e.g., ABGM) receive training and competency validation on injection safety procedures at time of employment. ***Note: If point of care tests are performed by contract personnel, facility should verify that training is provided by contracting company.***	❑ Yes ❑ No ❑ N/A	
Personnel who perform point of care testing (e.g., ABGM) received training and competency validation on injection safety procedures within the last 12 months. ***Note: If point of care tests are performed by contract personnel, facility should verify that training is provided by contract company.***	❑ Yes ❑ No ❑ N/A	
The facility routinely audits (monitors and documents) adherence to injection safety procedures during point of care testing (e.g., ABGM). ***Note: If yes, facility should describe auditing process and provide documentation of audits.***	❑ Yes ❑ No ❑ N/A	
The facility provides feedback to personnel regarding their adherence to injection safety	❑ Yes ❑ No ❑ N/A	

procedures during point of care testing (e.g., ABGM). ***Note: If yes, facility should describe feedback process and provide documentation of feedback reports.***		
Supplies necessary for adherence to safe injection practices (e.g., single-use, auto-disabling lancets, sharps containers) are readily accessible in resident care areas (e.g., nursing units).	❑ Yes ❑ No ❑ N/A	
The facility has policies and procedures for cleaning, disinfection, and storage of blood glucose meters. ***Note: Blood glucose meters dedicated to a single resident should be cleaned, disinfected when visibly soiled, and on a routine basis (e.g., daily). Ideally these meters should be stored in the resident's room and if this is not feasible, they should be disinfected after use and stored in a labeled container in a secure location (e.g., medication cart).*** ***Blood glucose meters that are shared between residents must be cleaned and disinfected after each use according to manufacturer's instructions and be stored in a manner that reduces the risk of inadvertent contamination. Meters that do not have manufacturer instructions for disinfection SHOULD NOT BE USED ON MORE THAN ONE RESIDENT.***	❑ Yes ❑ No ❑ N/A	
The facility has policies and procedures to track personnel access to controlled substances to prevent narcotics theft/drug diversion. ***Note: Have facility describe the process and how they would respond to unusual access patterns.***	❑ Yes ❑ No ❑ N/A	

9. Environmental Cleaning		
Elements to be Assessed	*Assessment*	*Notes*
The facility has written cleaning/disinfection policies which include routine and terminal cleaning and disinfection of resident rooms.	❑ Yes ❑ No ❑ N/A	

The facility has written cleaning/disinfection policies which include routine and terminal cleaning and disinfection of rooms of residents on contact precautions (e.g., *C. difficile*).	❑ Yes ❑ No ❑ N/A	
The facility has written cleaning/disinfection policies which include cleaning and disinfection of high-touch surfaces in common areas.	❑ Yes ❑ No ❑ N/A	
The facility has cleaning/disinfection policies which include handling of equipment shared among residents (e.g., blood pressure cuffs, rehab therapy equipment) **per manufacturer's instructions for use.** ***Note: Facilities should have protocols outlining what service cleans specific equipment (i.e., what is clinical staff responsible for cleaning and what is EVS responsible for cleaning). Disinfectant name, usage frequency, and contact time should be included.***	❑ Yes ❑ No ❑ N/A	
The facility has policies and procedures to ensure that reusable medical devices (e.g., blood glucose meters, wound care equipment, podiatry equipment, and dental equipment) are cleaned and reprocessed appropriately prior to use on another patient. ***Note: If external consultants (e.g., wound care nurses, dentists, or podiatrists) provide services in the facility, the facility must verify these providers have adequate supplies and space to follow appropriate transport, cleaning, and disinfection (reprocessing) procedures to prevent transmission of infectious agents.*** ***Note: Select "N/A" for the following:*** ***1. All medical devices are single use only or dedicated to individual residents*** ***2. No procedures involving medical devices are performed in the facility by staff or external consultants*** ***3. External consultants providing services which involve medical devices have adequate***	❑ Yes ❑ No ❑ N/A	

supplies that no devices are shared on-site and all reprocessing is performed off-site.		
Personnel receive job-specific training and competency validation on cleaning and disinfection procedures at time of employment. ***Note: If environmental services are performed by contract staff, facility should verify that training is provided by contracting company.***	❑ Yes ❑ No ❑ N/A	
Personnel received job-specific training and competency validation on cleaning and disinfection procedures within the past 12 months. ***Note: If environmental services are performed by contract personnel, facility should verify that training is provided by contracting company.***	❑ Yes ❑ No ❑ N/A	
The facility routinely audits (monitors and documents) quality of cleaning and disinfection procedures. ***Note: If yes, facility should describe auditing process and provide documentation of audits.***	❑ Yes ❑ No ❑ N/A	
The facility providers feedback to personnel regarding the quality of cleaning and disinfection procedures. ***Note: If yes, facility should describe feedback process and provide documentation of feedback reports.***	❑ Yes ❑ No ❑ N/A	
Supplies necessary for cleaning and disinfection procedures **are EPA-registered.** EPA-registered products labeled as effective against *C. difficile*, COVID-19, and norovirus are **also** available. ***Note: If environmental services are performed by contract personnel, facility should verify that appropriate EPA-registered products are provided by contracting company and all staff are aware of contact time and Instructions for Use (IFUs).***	❑ Yes ❑ No ❑ N/A	

10. Outbreak Management

If the facility is currently in outbreak status, please fill out this section of the ICAR tool. If the facility does not have an outbreak, you may skip to the next section.	
What is the outbreak disease?	❑ COVID-19 ❑ Influenza ❑ Norovirus ❑ *C. difficile* ❑ CRE or other MDRO ❑ Group A Strep ❑ Legionella ❑ Scabies ❑ Other (please specify): _____
Check off the control measures that the facility has implemented. ***Note: These control measures may not be required for every outbreak. Facilities should follow guidance from the LHD about what control measures are needed for their specific situation.***	❑ Screening for cases ❑ Implemented transmission-based precautions ❑ Halted admissions ❑ Halted group dining and communal activities ❑ Halted visitation ❑ Visitation occurring, but visitors are educated about the outbreak and instructed to adhere to transmission-based precautions ❑ Sick residents are housed together in a wing/area ❑ Staff are cohorted so certain staff exclusively care for patients with the outbreak disease ❑ Vaccine or post-exposure prophylaxis administered ❑ None of the above
Notes about outbreak and control measures (optional):	

Elements to be Assessed	*Assessment*	*Notes*
The facility has notified the LHD of the outbreak.	❑ Yes ❑ No ❑ N/A	
The facility is following all screening/testing recommendations from the LHD.	❑ Yes ❑ No ❑ N/A	
The facility is following all infection control recommendations from the LHD.	❑ Yes ❑ No ❑ N/A	
Cases are in private rooms or housed with other people with the same diagnosis.	❑ Yes ❑ No ❑ N/A	

Close contacts are being appropriately screened, quarantined, and/or monitored as recommended by the LHD.	❑ Yes ❑ No ❑ N/A	
Correct transmission-based precautions signs are posted on the patient's door for all cases.	❑ Yes ❑ No ❑ N/A	
All staff, including environmental services and non-clinical staff, are following appropriate transmission-based precautions when entering a case's room.	❑ Yes ❑ No ❑ N/A	
All staff, including contracted and non-clinical staff, are aware of the outbreak and have received education about what precautions they need to take.	❑ Yes ❑ No ❑ N/A	

11. Antibiotic Stewardship (Nursing Homes Only)		
If evaluating a nursing home, please fill out this section. For all non-nursing-home facilities, if the facility does have an antibiotic stewardship program, you may use this section to record information about it. Otherwise, skip to the next section.		
Elements to be Assessed	*Assessment*	*Notes*
The facility can demonstrate leadership support for efforts to improve antibiotic use (antibiotic stewardship). ***Note: Look for a written statement from leadership stating support of antibiotic stewardship (AS) that communicates expectations to staff.***	❑ Yes ❑ No ❑ N/A	
The facility has identified individuals accountable for leading antibiotic stewardship activities. ***Note: Determine who is accountable and if AS is included in their position description.***	❑ Yes ❑ No ❑ N/A	
The facility has access to individuals with antibiotic prescribing expertise (e.g., ID trained physician or pharmacist). ***Note: Ask if they have partnered with a consultant pharmacist, either through a local hospital network or the SPICE AS collaborative.*** https://spice.unc.edu/ncclasp/	❑ Yes ❑ No ❑ N/A	

The facility has written policies on antibiotic prescribing. ***Note: Policies should be consistent and apply during the care of any resident suspected of an infection or prescribed an antibiotic.***	❑ Yes ❑ No ❑ N/A	
The facility has implemented practices to improve antibiotic use. ***Note: Review processes in place to monitor and report antibiotic use and outcome.***	❑ Yes ❑ No ❑ N/A	
The facility has a report summarizing antibiotic use from pharmacy data created within the last 6 months. ***Note: Report could include number of new starts, types of drugs prescribed, number of days of antibiotic treatment. Report should be obtained from the pharmacy on a regular basis.***	❑ Yes ❑ No ❑ N/A	
The facility has a report summarizing antibiotic resistance (i.e., antibiogram) from the laboratory created within the last **12** months.	❑ Yes ❑ No ❑ N/A	
The facility provides clinical prescribers with feedback about their antibiotic prescribing practices. ***Note: If yes, facility should provide documentation of feedback reports.***	❑ Yes ❑ No ❑ N/A	
The facility has provided education on antibiotic use (stewardship) to all nursing staff within the last 12 months.	❑ Yes ❑ No ❑ N/A	
The facility has provided education on antibiotic use (stewardship) to all clinical providers with prescribing privileges within the last 12 months.	❑ Yes ❑ No ❑ N/A	

12. Hand Hygiene and Transmission-Based Precautions Observation			
Observation 1			
Staff type	❑ Nurse ❑ Nurse practitioner ❑ Nursing assistant ❑ Physician	❑ Physician's assistant ❑ Rehab staff ❑ Dietary staff ❑ Environmental services	❑ Social worker ❑ Unknown ❑ Other: _____
Type of opportunity	❑ Room entry ❑ Room exit ❑ Before resident contact ❑ After resident contact	❑ Before glove ❑ After glove ❑ Other: _____	
HH performed?	❑ Yes, alcohol-based hand rub	❑ Yes, washed hands	❑ No
HH performed correctly?[1]	❑ Yes ❑ No		
PPE indicated (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used correctly?[2]	❑ Yes ❑ No		

Observation 2			
Staff type	❑ Nurse ❑ Nurse practitioner ❑ Nursing assistant ❑ Physician	❑ Physician's assistant ❑ Rehab staff ❑ Dietary staff ❑ Environmental services	❑ Social worker ❑ Unknown ❑ Other: _____
Type of opportunity	❑ Room entry ❑ Room exit ❑ Before resident contact ❑ After resident contact	❑ Before glove ❑ After glove ❑ Other: _____	
HH performed?	❑ Yes, alcohol-based hand rub	❑ Yes, washed hands	❑ No
HH performed correctly?[1]	❑ Yes ❑ No		
PPE indicated (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used correctly?[2]	❑ Yes		

	❑ No		
Observation 3			
Staff type	❑ Nurse ❑ Nurse practitioner ❑ Nursing assistant ❑ Physician	❑ Physician's assistant ❑ Rehab staff ❑ Dietary staff ❑ Environmental services	❑ Social worker ❑ Unknown ❑ Other: _____
Type of opportunity	❑ Room entry ❑ Room exit ❑ Before resident contact ❑ After resident contact	❑ Before glove ❑ After glove ❑ Other: _____	
HH performed?	❑ Yes, alcohol-based hand rub	❑ Yes, washed hands	❑ No
HH performed correctly?[1]	❑ Yes ❑ No		
PPE indicated (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used correctly?[2]	❑ Yes ❑ No		

Observation 4			
Staff type	❑ Nurse ❑ Nurse practitioner ❑ Nursing assistant ❑ Physician	❑ Physician's assistant ❑ Rehab staff ❑ Dietary staff ❑ Environmental services	❑ Social worker ❑ Unknown ❑ Other: _____
Type of opportunity	❑ Room entry ❑ Room exit ❑ Before resident contact ❑ After resident contact	❑ Before glove ❑ After glove ❑ Other: _____	
HH performed?	❑ Yes, alcohol-based hand rub	❑ Yes, washed hands	❑ No
HH performed correctly?[1]	❑ Yes ❑ No		
PPE indicated (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used correctly?[2]	❑ Yes ❑ No		

Observation 5			
Staff type	❑ Nurse ❑ Nurse practitioner ❑ Nursing assistant ❑ Physician	❑ Physician's assistant ❑ Rehab staff ❑ Dietary staff ❑ Environmental services	❑ Social worker ❑ Unknown ❑ Other: _____
Type of opportunity	❑ Room entry ❑ Room exit ❑ Before resident contact ❑ After resident contact	❑ Before glove ❑ After glove ❑ Other: _____	
HH performed?	❑ Yes, alcohol-based hand rub	❑ Yes, washed hands	❑ No
HH performed correctly?[1]	❑ Yes ❑ No		
PPE indicated (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used (check all that apply)	❑ Gown ❑ Glove ❑ Surgical mask	❑ N-95 respirator ❑ Eye protection ❑ None	
PPE used correctly?[2]	❑ Yes ❑ No		

1. Correct hand hygiene procedure includes assuring contact with all hand surfaces and occurring for at least 20 seconds.
2. Correct PPE use includes using the correct technique to don/doff PPE and donning/doffing PPE in the correct sequence.

Notes:

13. Assisted Blood Glucose Monitoring Observation						
Please complete as many observations as is appropriate for the situation at the facility; you do not need to complete every observation. Skip this section if the facility does not have any patients that require ABGM.						
Observation	HH performed	Clean gloves worn	Single-use lancet used	Testing meter cleaned and disinfected	Gloves removed	Hand hygiene performed
1	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
5	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Lancet holder devices (e.g., lancet penlets) are not appropriate for multi-patient use.

If manufacturer does not provide instructions for cleaning and disinfection, the testing meter should not be used for more than one patient.

Testing meters that are dedicated to an individual resident should still be cleaned and disinfected when visibly soiled and after each use, if not stored in the resident's room.

Gloves should be changed and hand hygiene should be performed before moving on to the next resident.

Notes:

14. Indwelling Urinary Catheter (IUC) Observation									
Please complete as many observations as is appropriate for the situation at the facility; you do not need to complete every observation. Skip this section if the facility does not have any patients with IUCs.									
Observation	Need for IUC assessed regularly	HH before & after handling IUC	Clean gloves donned before & doffed after handling IUC	Bag < 2/3 full	Bag below bladder	Flow not blocked	Device secured properly	Bag emptied properly	Specimen collected properly
1	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
5	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Ongoing need for IUC should be regularly assessed for appropriateness, and indication is documented in medical records.

Proper bag emptying procedure: Clean container is used to catch urine and spigot does not come into contact with container; additional PPE (e.g., face shield, gown) should be worn per facility policy to prevent body fluid exposure.

Proper specimen collection procedure: HH performed and clean gloves worn to manipulate IUC sample collection port; port is cleaned with alcohol prior to access; specimen is collected using blunt syringe, leur lock syringe, or 10 cc syringe; specimen not obtained from collection bag.

Notes:

15. Central Venous Catheter (CVC) Observation									
Please complete as many observations as is appropriate for the situation at the facility; you do not need to complete every observation. Skip this section if the facility does not have any patients with CVCs.									
Observation	Need for CVC assessed regularly	Maintained regularly	Dressing clean, intact, dry, and dated	HH before & after handling CVC	Clean gloves donned before & doffed after handling CVC	Aseptic technique used	CVC hub scrubbed and let dry	Unused ports are capped	Accessed with sterile devices only
1	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
5	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Appropriate maintenance should include documentation of the following in the medical record: date and site of insertion, assessment of ongoing need for CVC, and frequency of dressing changes and replacement of system components (e.g., catheter tubing, connectors) per facility policy.

Dressing should be labeled with date changed and should be within timeframe for routine dressing changes specified by facility.

Procedure for “Scrub the Hub”: Hub is handled aseptically (i.e., ensuring hub does not touch anything non-sterile) while port cap is removed and discarded; Appropriate antiseptic pad is used to scrub end and sides (threads) of hub, thoroughly applying friction for 10-15 seconds; Catheter line is disinfected several centimeters toward resident’s body using same antiseptic pad to apply friction; Hub is left uncapped for the shortest time possible.

Notes:

16. Wound Dressing Change Observation									
Please complete as many observations as is appropriate for the situation at the facility; you do not need to complete every observation. Skip this section if the facility does not have any patients that require wound care.									
Observation	Supplies gathered before starting[1]	HH before & after dressing change	Clean gloves donned before & doffed after dressing change	Multi-dose meds used correctly[2]	Cross-contamination prevented[3]	Reusable equipment cleaned & disinfected correctly[4]	Clean, unused supplies discarded or dedicated to resident	Wound assessed regularly[5]	Supply cart is clean[6]
1	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
2	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
3	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
5	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

1. Dedicated wound dressing change supplies and equipment should be gathered and accessible on a clean surface at resident's bedside before starting procedure.
2. Multi-dose wound care medications (e.g., ointments, creams) should be dedicated to a single resident whenever possible or a small amount of medication should be aliquoted into clean container for single-resident use. Meds should be stored in centralized location and never enter a resident treatment area.
3. To prevent cross-contamination: Gloves should be changed and HH performed when moving from dirty to clean activities (e.g., after removal of soiled dressings, before handling clean supplies); Debridement or irrigation should be performed in a way to minimize cross-contamination of surrounding surfaces from aerosolized irrigation solution; All soiled dressings should be discarded immediately.
4. In addition to reusable medical equipment, any surface in the resident's immediate area contaminated during a dressing change should be cleaned and disinfected.
5. Wound care should be documented in medical record and documentation should include wound characteristics (e.g., size, stage), dressing assessment (e.g., clean, dry), and date and frequency of dressing changes.
6. Wound care supply cart should never enter the resident's immediate care area nor be accessed while wearing gloves or without performing HH first.