SNF Symposium:
Unpacking ICAR Presentation

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Disclosures

There is no commercial support for today's presentation.

Neither the speakers nor planners for today's presentation have disclosed any financial interests related to the content of the presentation

This presentation is meant for healthcare facilities and is off the record.

Objectives

- Understand the purpose and scope of Infection Control Assessment and Response (ICAR)
- How to use ICAR findings and results to create actionable improvement within SNF
- Apply ICAR-related knowledge to real world scenarios

I. Brief Introduction + Review of ICAR

What is an ICAR?

- Infection Control Assessment and Response
- On-site assessment tool used to evaluate Infection Prevention and Control (IPC) practices within your facility
- Goal: to identify strengths and opportunities for improvement in your IPC Program
- Collaborative, not punitive
- Quality improvement and patient safety are key focuses

What is an ICAR?

- We want to identify your facility's capacity to detect and address HAIs and outbreaks
- We want to measure the differences between what is happening with IPC in our facilities and what are the best practices/regulations/requirements
- Identify and bridge the gaps
- At the end of the day this is a gap analysis

What does an ICAR cover?

- IPC Program structure: policies, protocols, risk assessments
- Hand Hygiene: observation of practices, product availability
- Personal Protective Equipment (PPE): Correct use, availability, donning/doffing
- Resident Care: Isolation protocols, device care
- Environmental Cleaning and Disinfection: products, processes, frequency
- High risk procedures: management of wounds, injection safety
- Dietary: food safety and prevention of foodborne illness
- + MORE!

What might an ICAR look like?

- Self Q &A + Staff Q & A
- Direct observations
- Chart/data review
- Feedback from staff

Q & A

Module 8: Respiratory Hygiene, Cough Etiquette and Source Control

The facility requires all personnel who are not immunized against influenza to wear a face mask while on duty during upper respiratory infection season.

- ○ Yes
- ○ No

reset

The facility implements source control in the following situations:

- ☐ Respiratory infection outbreak in the facility
- ☐ Increased respiratory infection activity in the community
- ☐ As ordered by Public Health

Select all that apply

The facility frequently reminds family and visitors that visits should be delayed if they are experiencing symptoms of a respiratory infection (coughing, shortness of breath, fever, sore throat, congestion).

- ○ Yes
- ○ No
- ○ Unknown or unsure

reset

Direct Observations: Adherence Monitoring

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Healthcare-Associated Infections Program Adherence Monitoring
Environmental Cleaning and Disinfection

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least two (2) different environmental services (EVS) staff members. Observe each practice and check a box if adherent ("Yes") or not adherent ("No"). In the right column, record the total number of "Yes" responses for adherent practices observed and the total number of observations ("Yes" + "No"). Calculate adherence percentage in the last row.

	Environmental Cleaning Practices
ES1.	Detergent/disinfectant solution is mixed and stored according to manufacturer's instructions.
ES2.	Solution remains in wet contact with surfaces according to manufacturer's instructions.
ES3.	Cleaning process avoids contamination of solutions and cleaning tools; a clean cloth is used in each patient area, and the cloth is changed when visibly soiled.
ES4.	Standard cleaning protocol is followed to avoid cross-contamination *(e.g. from top to bottom, patient room to bathroom, and clean to dirty)*
ES5.	Environmental Services staff use appropriate personal protective equipment *(e.g. Gowns and gloves are used for patients/residents on contact precautions upon entry to the Contact precautions room.)*
ES6.	Hand hygiene is performed throughout the cleaning process as needed, including before and after glove use.
ES7.	High-touch surfaces* are thoroughly cleaned and disinfected after each patient. *Mark "Yes" if Fluorescent Marker Assessment Tool result is 100%; mark "No" if <100%.*
ES8.	There are no visible tears or damage on environmental surfaces or equipment.
ES9.	The room is clean, dust free, and uncluttered.

***Examples of high touch surfaces:**

Bed rail	Chair	Room light switch	TV remote
Tray table	In-room medical cart	IV pole ("grab area")	Room inner door kno
Side table	Room sink	Call button	In-room cabinet
Side table handle	Room sink faucet	PPE container	In-room computer/k

# of Correct Practice Observed ("# Yes"): _____

Total # Environmental Services Observatic (Up to 27 Total)
If practice could not be observed (i.e. cell is bla

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Healthcare-Associated Infections Program Adherence Monitoring
Hand Hygiene

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can improve hand hygiene adherence. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least 10 hand hygiene (HH) opportunities per unit. Observe a staff member and record his/her discipline. Check the type of hand hygiene opportunity you are observing. Indicate if HH was performed. Record the total number of successful HH opportunities and calculate adherence.

HH Opportunity	Discipline	What type of HH opportunity was observed? (select/ ☑ 1 per line)	Was HH performed for opportunity observed? ✔ or Ø
Example	N	☐ before care/entering room* ☐ before task ☐ after body fluids ☐ after care* ☑ upon leaving room *Remember: Hand hygiene should be performed before and after glove use	✔
HH1.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH2.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH3.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH4.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH5.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH6.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH7.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH8.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH9.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH10.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	

Disciplines:
CNA = Nurse Assistant
D = Dietary
N = Nurse
P = Physician
RT = Respiratory Therapist
S = Student
VIS = Visitor
VOL = Volunteer
W = Social Worker
OTH = Other, Specify
U = Unknown

Opportunities:
✔ = Opportunity Successful
Ø = Opportunity Missed

For HH1-HH10:

Total # HH Successful ("# ✔"): _____ | Total # HH Opportunities Observed: _____ | Adherence: _____% (Total # HH Successful ÷ Total HH Opportunities Observed x 100)

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Facility-wide ICAR

- Comprehensive snapshot of your facility's general IPC practices
- Unknown reasons for below standard IPC practices
- Unknown state of IPC practices, not measured or tracked
- Outbreak or increased transmission seen throughout the facility

Focused or Targeted ICAR

- Deeper dive into specific unit, department, or IPC Practices
- Known reasons for below standard IPC practices
- Previous interventions did not yield improvement
- Outbreak or increased transmission seen in specific areas within the facility

When to perform an ICAR?

- On a set schedule, annually
- If HAIs increase
- New staff, or new IP
- Preparation for a regulatory survey

- ICARs can be facility-wide OR you can focus on certain areas of your facility, depending on the need

Who is involved in the ICAR?

- If you are conducting internal ICAR, typically the Infection Preventionist is the lead
- If facility-wide you can recruit other key leadership members or department heads
- If targeted, you can focus on specific leaders for the department or unit you are assessing

- If external, IP Consult, or LAC DPH (we do ICARs too!)

II. ICAR Results/Findings + What to do with them?

What do we do after an ICAR is finished?

- Review and analyze findings
- Prioritize areas for improvement
- Disseminate information, sharing results with staff
- Celebrate Successes
- Take Action! Implement action plans, interventions

Is there a theme that emerges?

- New staff/staff turnover
- Lack of training in a certain role type or overall
- Obstacles in the way of good IPC Practices
- No theme? Needs more information, observation? Nothings presented itself that happens too

- Where is your facility performing well?
- Can those behaviors be bundled or applied?

Theme continued

- Is there a theme?
  - New staff? → is new hire orientation up to par? Are staff's competencies to IPC practices assessed?
  - Lack of training? → how frequently are staff trained? (asked in the ICAR)
  - Obstacles in the way of good IPC practices? → can PPE or ABHR dispensers be placed in a better location?
  - No theme?
- Which areas is your facility performing well in? → e.g., dietary passes with flying colors
  - Why is this? Ask the staff and leadership; perhaps we can learn something from them

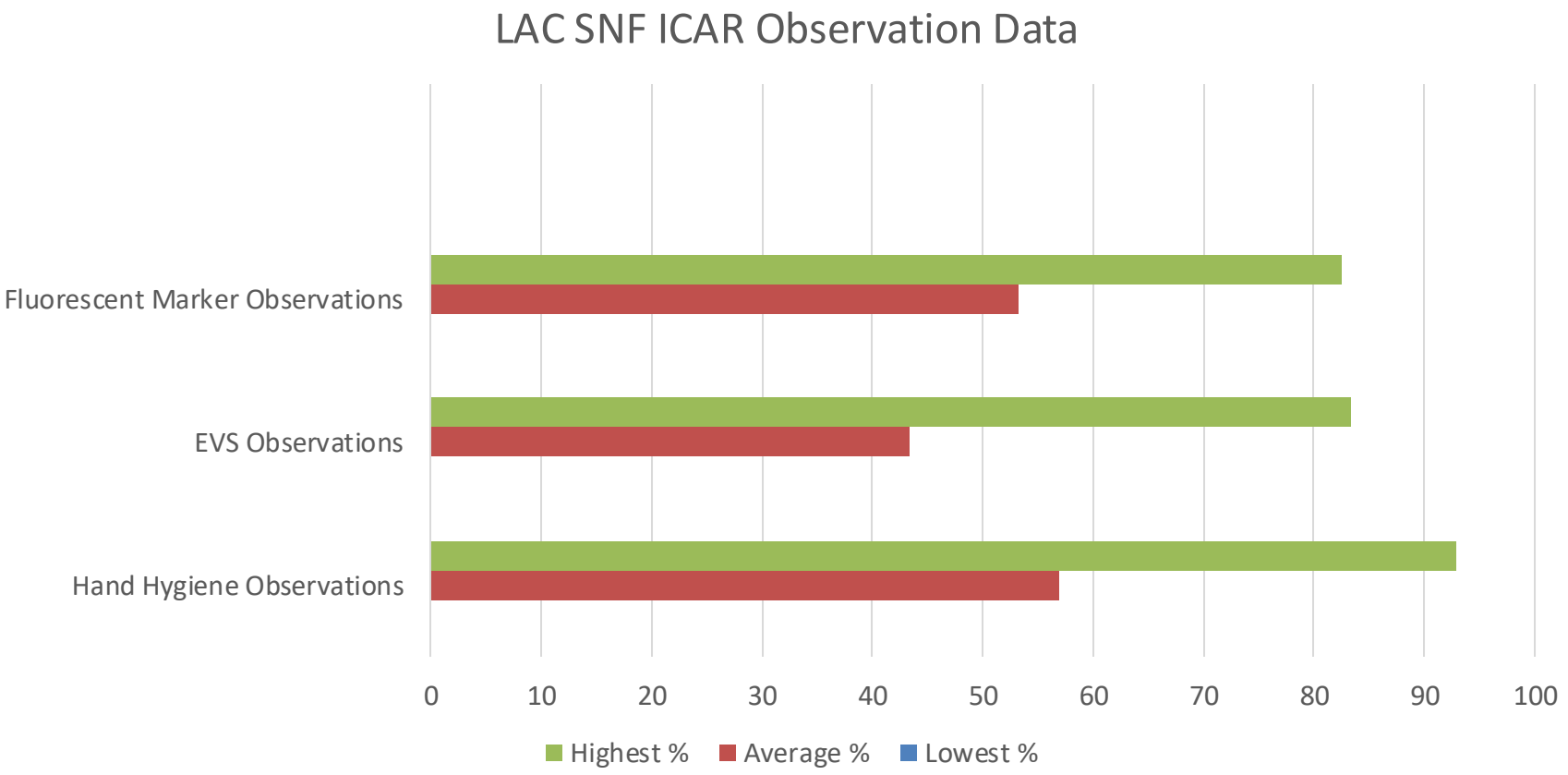
Summarize ICAR results

Example				
Training, Auditing Feedback	Laundry Services	Occupational Health	Hand Hygiene	Standard and Transmission-based precautions
• Environmental Services staff do not receive infection prevention training after onboarding	• One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	• Master list of staff who are required to receive annual fit testing is outdated	• The majority of missed opportunities are: after contact with the patient environment • 3 ABHR dispensers were found to be defective	• Multiple rooms with residents on TBP did not have the isolation signage posted at room entry • Several isolation carts were found without the appropriate disinfectant product

Summarize ICAR results

Example							
Training, Auditing Feedback	Laundry Services	Occupational Health	Hand Hygiene	Standard and Transmission-based precautions	Wound Care	Antimicrobial Stewardship	Environmental Services
• Environmental Services staff do not receive infection prevention training after onboarding	• One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	• Master list of staff who are required to receive annual fit testing is outdated	• The majority of missed opportunities are: after contact with the patient environment • 3 ABHR dispensers were found to be defective	• Multiple rooms with residents on TBP did not have the isolation signage posted at room entry • Several isolation carts were found without the appropriate disinfectant product	• Few CHG wipes are available to the wound care team	• The committee is set to meet quarterly, but was not able to meet in Q3	• Staff did not know when to change mop water • Microfiber towels are overused, torn, and discolored • 2 staff were found using detergent-based products for disinfecting surfaces

Review Findings: LA County SNF ICAR Data (n=11)



Prioritize

- Breakdown results by module/domain
- What are the major fallouts?
- What is a critical area for improvement, or might need immediate action?

Prioritize

ICAR Module	Fallout	Priority Level
Training, Auditing Feedback	Environmental Services staff do not receive infection prevention training after onboarding	Low
Laundry Services	One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	Moderate
Occupational Health	Master list of staff who are required to receive annual fit testing is outdated	Low
Hand Hygiene	The majority of missed opportunities are: after contact with the patient environment	High
Hand Hygiene	3 ABHR dispensers were found to be defective	High
Standard and Transmission-based precautions	Multiple rooms with residents on TBP did not have the isolation signage posted at room entry	High
Standard and Transmission-based precautions	Several isolation carts were found without the appropriate disinfectant product	High
Wound Care	Few CHG wipes are available to the wound care team	High
Antimicrobial Stewardship	The committee is set to meet quarterly, but was not able to meet in Q3	Low
Environmental Services	Staff did not know when to change mop water	Moderate

Disseminate

- What happens after you review findings and prioritize?
- Bring forth this information to leadership and/or staff
  - Structured meeting
  - Daily Huddles
  - QAPI/IPC Committee meetings
  - Summarize findings
  - Ensure that staff/leadership understand information shared with them, including next steps

Disseminate Findings + Recommendations

ICAR Module	Fallout	Priority Level	Recommendation	Reference
Training, Auditing Feedback	Environmental Services staff do not receive infection prevention training after onboarding	Low	EVS to implement regular IP training annually; IP to assist in creating the education	• Facility policy • External regulation • Best practice or guidance

Example: EVS Common Fallouts

- Environmental Cleaning and Disinfection
  - Cross contamination when cleaning
  - PPE related challenges while cleaning
  - Inadequate supplies
  - Need for additional staff training
  - Flow of room cleaning
  - Disorganized EVS Carts
  - Preparation for cleaning a room
  - No cleaning schedule
  - Lack of follow through with high touch surfaces

Examples: Recommendations

- Cleaning from top to bottom
- Educating staff on flow of room cleaning
- Clean to dirty
- Just in time training
- Inventory checks
- Visual step by step cleaning procedures
- Pre-cleaning checklist
- List of high touch surfaces
- Fluorescent marker exercises for learning

Example: HH Fallouts

- Hand Hygiene
  - Missing opportunities for hand hygiene
  - Inadequate supplies for HH
  - Hand hygiene during donning and doffing process
  - Hand hygiene prior to aseptic technique

HH Recommendations

- Direct observation audits
- Real time feedback
- Adequate supply of ABHR
- Daily stock checks
- Hands on training
- Visual reminder for point of care
- Signage in relevant language

Example: Visitor Education

- Visitor Education
  - Visitors who refuse to don PPE
  - Visitors who are unaware of TBP
  - Visitors who do not perform HH
  - Visitors who adjust medical equipment

Visitor Education Recommendations

- Clear signage in relevant languages
- Just in time training
- Education on TBP
- Pre-visit education or educational material sent to visitors
- Staff encouragement or hands on training about donning and doffing PPE

Celebrate Successes

- Acknowledge staff successes not just the pitfalls
- Embrace the patterns and behaviors that are working in certain areas and apply them to others

Take Action!

- QAPI Framework
- Performance Improvement Project
- Adherence Monitoring
- Staff and Visitor Education
- Resource Check

Next Steps: Get into the QAPI Mindset

- ICAR identifies risks, QAPI Framework serves as the vehicle to address these risks
- We don’t want to just “band-aid” the solution, we want something sustainable

Performance Improvement Project (PIP)

- Root Cause Analysis (RCA)
- 5 Whys?
- Create SMART Goals

- Example: ICAR Finding: Hand Hygiene is at 50% compliance on Main Unit
  - SMART Goal: increase hand hygiene compliance among nursing staff on the main unit from 50% to 90% within 60 days

Adherence Monitoring: The Key to Sustainability

- Ongoing process, not a one time thing
- Routine Audits
- Data as a tool
- Make it sustainable

Staff and Visitor Education

- Targeted Education
- Hands-on training
- 1:1
- Teach-back
- Keep clear and simple

The Resource Check: Equipping for Success

- Are we equipped?
- Availability
- Access
- Accountability

Another ICAR?

- Time has passed, start the process again, back to the drawing board, sometimes interventions or follow up doesn't stick or maybe was not the best solution, so we try another solutions.
- Something more sustainable.

Scenarios / Interactive

Hand Hygiene Scenario

- During a targeted ICAR focusing on Hand Hygiene:
- 50 hand hygiene opportunities were recorded.
- Staff performed hand hygiene correctly for only 25 of those opportunities (50% compliance).
- Most missed opportunities (20 out of 25) happened when staff exited resident rooms.
- Alcohol-based hand rub and sinks were available, and supplies were fully stocked

Possible Follow Up: Hand Hygiene

- Reinforce that **hand hygiene is required when exiting every resident room**.
- Place **visual reminders** at room exits.
- Conduct **real-time observations with on-the-spot feedback**.
- Track monthly through QAPI until compliance reaches 90% or above.

Hand Hygiene Scenario

- During a targeted ICAR focusing on Hand Hygiene:
- 50 hand hygiene opportunities were recorded.
- Staff performed hand hygiene correctly for only 25 of those opportunities (50% compliance).
- Most missed opportunities (20 out of 25) happened when staff exited resident rooms.
- Alcohol-based hand rub and sinks were available, and supplies were fully stocked

- After interventions were implemented, hand hygiene compliance initially improved for 2 months. However, compliance then dropped below the original baseline levels

Possible Follow Up: Hand Hygiene

- Emphasize that sustainability requires **ongoing monitoring**, not one-time fixes.
- Add hand hygiene as a **standing QAPI agenda item**.
- Use **leadership rounding and peer accountability** to reinforce.

EVS Scenario

- While conducting an environmental cleaning observation for your facility's ICAR, two high-touch surfaces in a common area were missed during daily cleaning.
- Cleaning products and checklists were available

Possible Follow Up: EVS

- Re-educate staff on the importance of **cleaning all high-touch surfaces**.
- Supervisors could **spot check daily** and give immediate coaching/teaching.

- QAPI performance improvement project with 2 weekly observations to confirm sustained improvement

EVS Scenario

- While conducting an environmental cleaning observation for your facility's ICAR, two high-touch surfaces in a common area were missed during daily cleaning.
- Cleaning products and checklists were available

- The facility introduced a cleaning checklist, and compliance improved for about 3 weeks. However, once staff stopped using the checklist, compliance levels dropped again.

Possible Follow Up: EVS

- Incorporate the checklist into **daily workflow** with **supervisor sign-off**.
- Conduct **random fluorescent marker testing** to verify surfaces are cleaned.
- Share audit results in **QAPI meetings** and recognize staff who improve.
- Explore workload or turnover issues as potential barriers.

Fluorescent Marker (High Touch Surface) Scenario

- Fluorescent marker testing showed that after routine cleaning, only 60% of marked high-touch surfaces had been properly cleaned and disinfected.
- The remaining 40% of surfaces still had visible fluorescent marker.

Possible Follow Up: Fluorescent Marker (High Touch Surface)

- Provide **immediate feedback** to EVS staff.
- Reinforce **cleaning technique and attention to all surfaces**.
- Track results through QAPI, with a goal of 90% or higher of cleaned surfaces.
- Share results visually with staff to encourage accountability.

Fluorescent Marker (High Touch Surface) Scenario

- Over a three-month period, fluorescent marker audits were conducted weekly.
- Initial results showed 85% of surfaces were being cleaned effectively.
- However, by the third month, compliance had dropped to 55%.
- When staff were asked, many said they thought audits were ‘temporary’ and had stopped prioritizing the process.

Possible Follow Up: Fluorescent Marker (High Touch Surface)

- Sustainability requires **ongoing and transparent feedback**-share results with staff regularly.
- Incorporate fluorescent marker audits as a **standing QAPI measure** (not a one-time project).
- Engage **EVS supervisors and leadership rounding** to reinforce importance.
- Recognize staff/units for strong compliance to motivate continued performance.

EBP/PPE Scenario

- During Enhanced Barrier Precautions (EBP) observation, staff were not consistently donning gowns and gloves upon entering resident rooms.
- PPE supplies were available at room entry, and signage posted.

Possible Follow Up: EBP/PPE

- Reinforce that **EBP requires gown and gloves for all high-contact resident care activities**.
- Ensure **clear signage** and supplies remain at entry points.
- Provide **just-in-time coaching** when staff are observed noncompliant.
- Monitor PPE adherence in QAPI and celebrate units with high compliance.

EBP/PPE Scenario

- During ICAR follow-up, staff compliance with Enhanced Barrier Precautions (EBP) was observed to be inconsistent.
- While most staff donned gowns/gloves for wound care, they did not consistently do so for high-contact activities such as assisting with bathing or transfers.
- Interviews revealed staff believed PPE was only required for ‘isolation cases’, not under EBP.

Possible Follow Up: EBP/PPE

- Provide **targeted education** clarifying that EBP applies to all residents with MDROs, not just those in isolation.
- Revise signage to highlight **specific high-contact activities** requiring PPE.
- Use **direct observation audits** with just-in-time feedback.
- Track compliance in QAPI: include both **education and monitoring** as action items.

Questions