



Abstract

In April 2022, the American Society of Healthcare Engineering (ASHE) released an updated version of the Infection Control Risk Assessment (ICRA) for construction, known as ICRA 2.0¹. Notable changes include a total of 5 containment classifications within the matrix, a “highest” risk area category and a more comprehensive list of risk areas. Applying this at our organization, a tertiary cancer center, all oncology areas are defined as highest risk per ASHE ICRA 2.0. As a result, all future ICRA’s are deemed higher in containment classification than feasible. Using the new guidance, and looking at risk within our population, the Infection Prevention (IP) team have tailored ICRA 2.0 to meet the needs of the institution.

Objectives

Upon completion, participant will be able to:

- Determine if ICRA 2.0 guidelines may be amended for their institution
- Perform a risk assessment for their institution for construction
- Apply ICRA 2.0 that meet realistic needs of their organization

Methods

In order to determine a baseline, 25 completed ICRA’s following ICRA 1.0 guidelines between 2021-2022 were reviewed to determine if containment classifications would change due to the new guidelines. Additionally, IP reviewed all patient care and non-patient care areas across the enterprise and each area was reassigned a risk level ranging from: low, medium, high or highest risk. The reassignment of risk levels were based on acuity, epidemiological data, and area type. Next, each containment classification criterion in ASHE ICRA 2.0 was reviewed and amended based on the feasibility of the institution being able to meet the criteria listed without compromising patient safety. As a result, a tailored Cancer Center (CC) ICRA 2.0 was created. The same ICRA’s that were reviewed for baseline data were rereviewed to see if there was a shift in containment classification based on CC ICRA 2.0 guidelines.

Results

Applying ASHE ICRA 2.0 to 25 ICRA’s, which show the ICRA 1.0 containment classification designations in Table 1, guideline changes showed significant impact on 24 of the 25 ICRA’s and one showing no difference, as shown in Figure 1. Of the 24 significantly impacted, each ICRA went up one or more containment classification levels. After creating the CC ICRA 2.0 guidelines, the same 25 ICRA’s were rereviewed to determine the difference in containment classification levels between ASHE and CC ICRA 2.0. Figure 2 shows the difference in ICRA containment classification levels between ICRA 1.0; ASHE ICRA 2.0; and CC ICRA 2.0. Even though CC ICRA 2.0 guidelines still showed an increase between some classification levels; class IV → V; III → IV; III → V; II → III/IV, the changes were not as significant as ASHE ICRA 2.0. Additionally, 4 of the 25 ICRA’s remained the same as ICRA 1.0 guidelines.

Table 1.

Containment Class	Number of ICRA’s Assigned
I	1
II	4
III	15
IV	5
N = 25	

Figure 1.

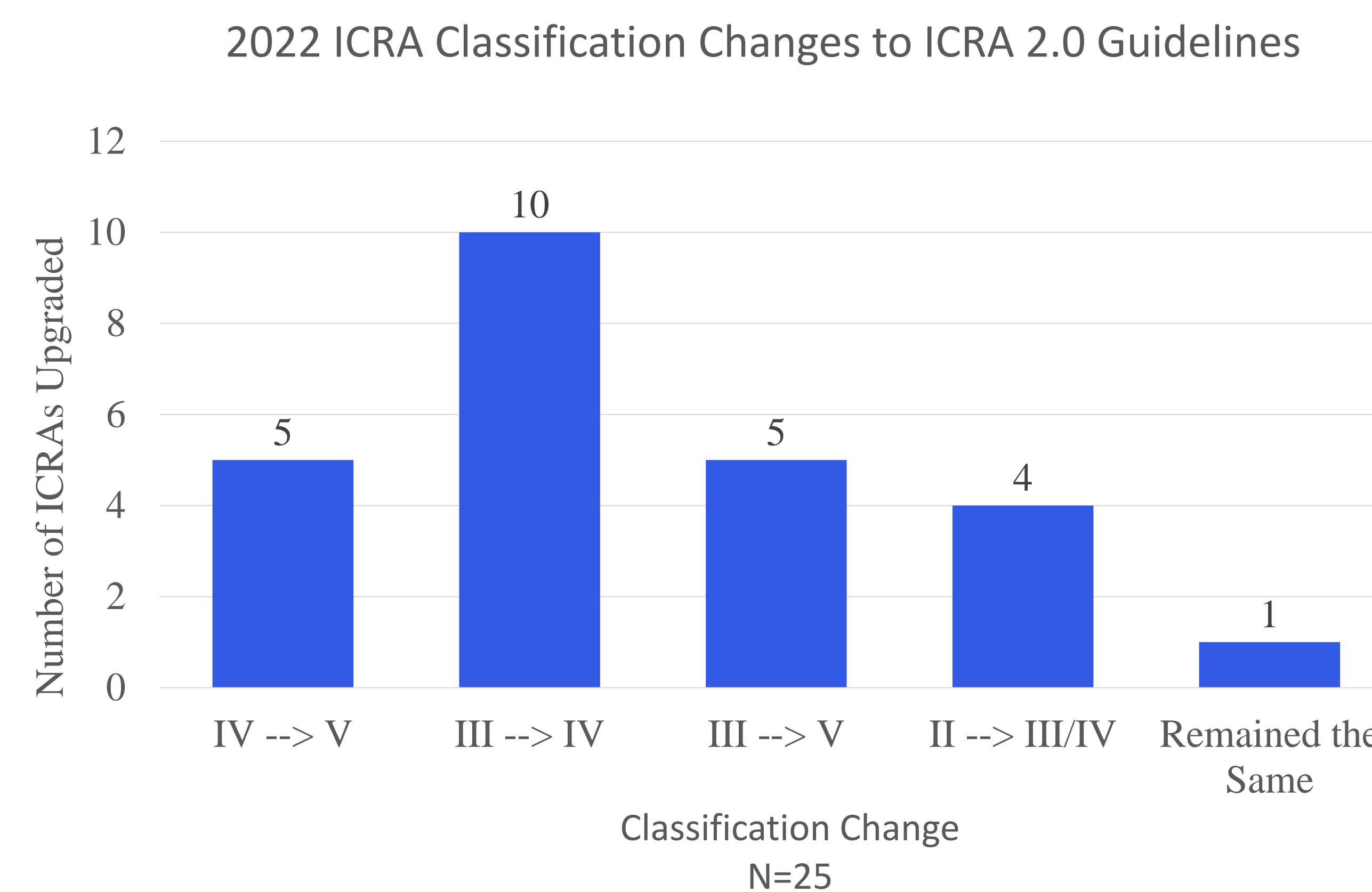
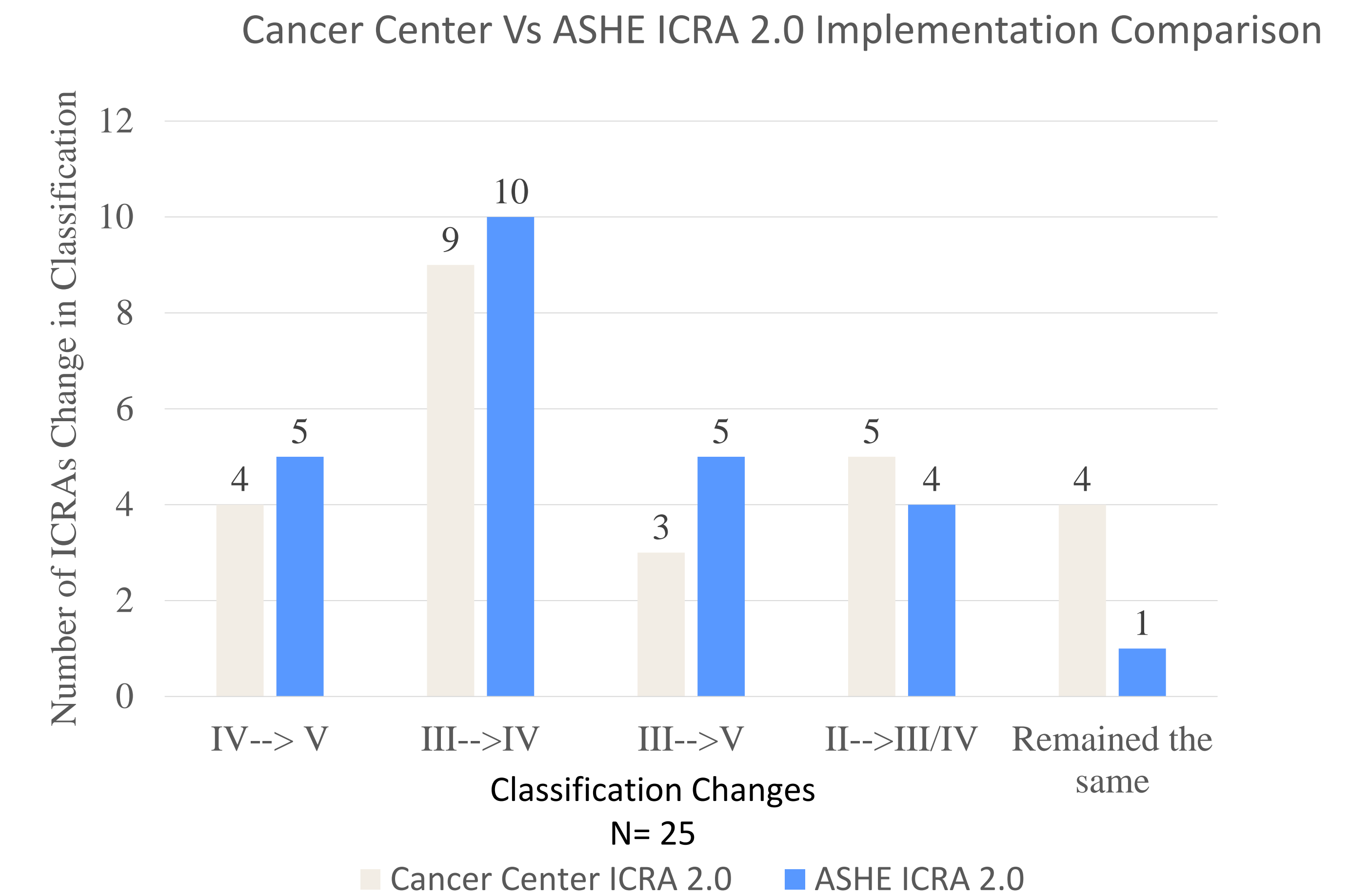


Figure 2.



Conclusions

Although ASHE ICRA 2.0 provides defined guidance for construction, it does not take into consideration specialty facilities such as cancer centers which would lead to significant impact in deploying ICRA containment classifications when not warranted. Therefore, it is important that specialty hospitals review their areas and define their own risk level based on baseline data.

References

1. American Society of Healthcare Engineering, ICRA 2.0, 2024. <https://www.ashe.org/icra2>

Disclosures

Nothing to disclose.

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