# Infection Control Post Construction Checklist

| Project Type: ☐ Construction ☐ Renovation ☐ Maintenance |
| --- |
| Preventive Measures:    I ☐   II ☐   III ☐   IV ☐ |
| Project Name: |
| Project Location: |
| Regional IP&C Coordinator or Infection Control Practitioner: |
| Date: |

| Item/Action | All work is completed | | | Date of completion | Comments/Deficiencies |
| --- | --- | --- | --- | --- | --- |
| | Yes | No | Not Applicable | | |
| Area has been cleaned and is free of construction debris and equipment (prior to and again following hoarding removal). | | | | | |
| Contracted and/or in-housecleaning completed. | | | | | |
| Correct hand washing sinks and faucets present, properly located and functioning. | | | | | |
| Soap dispensers filled and functioning and properly located. | | | | | |
| Hand drying paper towels available and properly located. | | | | | |
| Alcohol based hand rub available (optional may be placed later). | | | | | |
| Area is dust free (all horizontal surfaces, headwalls, ledges, inside of cabinets, drawers, tops of clocks etc.). | | | | | |
| Surfaces in patient care/procedure/service areas are appropriate (i.e. smooth, nonporous, water resistant). | | | | | |
| Area is free of fissures or open joints and crevices that retain or permit dirt particles. | | | | | |
| If plumbing has been affected or shutdown, plumbing has been flushed. | | | | | Verified by: _____ (provide name and title) |
| If affected, plumbing has been checked for leaks. | | | | | Verified by: _____ (provide name and title) |

| Item/Action | All work is completed | | | Date of completion | Comments/Deficiencies |
|---|---|---|---|---|---|
| | Yes | No | Not Applicable | | |
| Aerators are not present in patient care areas. | | | | | |
| Integrity of walls is maintained (i.e. not stained or damaged). | | | | | |
| Ceiling tiles are in place, well approximated and not stained. | | | | | |
| HVAC systems are clean, function restored and verified. | | | | | Verified by: _____<br>(provide name and title) |
| Negative pressure rooms verified to be negative. | | | | | Verified by: _____<br>(provide name and title) |
| General Comments: | | | | | |
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**Work is complete and ready for turnover:** ☐ **Yes**     ☐**No**     **Date:** _____

**Regional IP&C Coordinator or ICP:** _____