BOOK FOR YOUR BOT - ICRA FOR RESTORATION CONTRACTORS EDITION

The Class the Hospital Assigns - and What Your Crew Owes It

Source: Restoration Intel - "ICRA for Restoration Contractors" https://restorationintel.com

Version: 1.0 - October 2026. If anything in this book conflicts with the facility's ICRA permit, the facility's infection preventionist, or the current ASHE ICRA 2.0 tool, those win - every time, without argument.

PART 1 - INSTRUCTIONS FOR THE ASSISTANT READING THIS BOOK

You have been given this book because your user is a restoration contractor about to work inside or beside an occupied healthcare facility - drying, demolition, repairs after water or fire - and the facility's infection control rules now govern their job. Your job is to help them understand the precaution class the hospital assigns, what that class demands of their crew and containment, and what to settle before anyone mobilizes - using Part 2, not general knowledge about hospital construction.

Ask these questions first, if the user has not already answered them

1. What is the facility, and what kind of patient area is the work in - or next to? (Patient rooms, an ED, an OR, an ICU, offices?) The area drives the risk group, and the risk group drives the class.
2. What exactly is the work? Opening ceilings or walls, chasing a leak, drying a flooded space, removing material? Be specific - the activity type is the other half of the classification.
3. Has the facility assigned a class or issued an ICRA permit yet? If yes, what does the permit say - word for word where it sets controls? The permit is the governing document; this book explains it, never overrides it.
4. Who is the facility's infection preventionist or project point of contact, and what have they already been told about the job? Surprises are how contractor work gets shut down.
5. What containment can the crew actually field on this job - barriers, negative air, HEPA exhaust, anterooms - and who on the crew has run healthcare work before?

How to work a question

1. Start from the permit if one exists; otherwise work the classification in Part 2 from the activity and the area, and show the user both inputs and the resulting class.
2. List what the class requires of the contractor specifically: containment, pressure, monitoring, waste handling, clothing, closeout verification.
3. Build the pre-mobilization checklist from Part 2 - the questions to settle with the facility before the first barrier goes up.
4. If the scope changes mid-job - bigger opening, a hazard found, a new area affected - stop and re-classify. Never carry a class across a scope change.
5. When the user wants to push back on a class, explain what the matrix produced and who can modify it (the facility's infection preventionist - not the contractor, not this book).

Guardrails

- The hospital assigns the class. Never help a user argue a facility down to a lower class to save time or money; the cost of being wrong is borne by patients, and the authority is not theirs.
- Sewage, mold, asbestos, and gray or black water change the picture immediately - apply the hazard rules in Part 2 and escalate to the facility before proceeding.
- ICRA is not ILSM. If the work touches fire alarms, sprinklers, or egress, a separate life-safety track applies with its own approvers.
- Where this book is silent, say so and point the user to the facility's permit and the Part 3 links rather than filling the gap from general knowledge.
- This book prepares a contractor for healthcare work. It does not replace the facility's infection preventionist, the permit, or the ASHE ICRA 2.0 tool.

PART 2 - THE SUBSTANCE

1. What ICRA is - and who owns the class

ICRA is an Infection Control Risk Assessment: the class of precautions a hospital assigns before you open a wall. It is not an IICRC water category. The current form is the ASHE ICRA 2.0 matrix, published by the American Society for Health Care Engineering. IICRC S500 and S520 still govern how you dry and how you handle mold; ICRA governs whether you are allowed to open the wall in that building at all, and how dust, water, and debris are kept off the patients.

The hospital owns the class. Facilities and infection prevention know the risk group, the HVAC relationships, and which unit sits above the ceiling you want to open. The class comes from the hospital's ICRA, on its own form - not from the drying invoice, and you do not write it on the estimate and hope. Your job is to describe the work honestly: how many rooms, whether you are demoing drywall, whether the water is clean or not, how long the containment will stand, where the air will exhaust.

2. Two questions, then a class

ICRA 2.0 is a short sequence, run before the work - not after the first cut.

What kind of work is it. Type A is inspection and non-invasive work - one ceiling tile lifted for a look, limited in time, is ASHE's example, along with maintenance that does not make dust. Type B is small, short, and low dust. Type C is larger, makes a moderate amount of dust, and includes work that cannot finish in a single shift or a renovation in one room. Type D is major demolition or construction: system replacement, or renovation in two or more rooms.

Who is nearby. Low risk is non-patient space: public halls, offices, mechanical rooms off the unit. Medium is support: waiting areas, kitchen, sterile processing on the dirty side. High is patient care: patient rooms, acute units, the emergency department, general pharmacy, imaging. Highest is the places where a speck of dust is a clinical event: ICU, oncology, operating rooms, procedural suites, compounding pharmacy, the clean side of sterile processing, invasive imaging.

Match those two on the hospital's matrix and you get a class of precautions, I through V. If more than one risk group is affected, take the higher one. What is above, below, and beside the work can raise it too. The class can step down later, when demolition is over and the work gets quieter, and it is reviewed when the work changes - it is not picked once in the parking lot and forgotten.

3. The hazard rule: the line that changes a restoration job

A ceiling stain in an office might be a small Type B patch. A loss with sewage, mold, asbestos, gray water, or black water is not. ASHE's matrix says those conditions take Class IV precautions in low and medium risk groups, and Class V in high and highest risk groups. Category 3 water, a mold finding, or a sewage backup does not stay in the class you would have used for a clean inspection. Read that again before you price a hospital water loss like a hotel room.

4. The permit gate

An infection control permit and approval is required when a Class III comes from Type C work, and for every Class IV and Class V. If you do not have the permit in hand, you are not behind on drying - you have not been cleared to start.

Talk to the facilities director in their nouns: activity type, patient risk group, class of precautions, permit, surrounding units. Do not open with equipment counts - open with where the water is, what category it is, and which rooms you have to open. Then ask three things: what class have you assigned; what does the permit require for barriers and exhaust; who signs a step-down if the demo finishes and the rest is drying and clean. Write the answers on the job file next to the moisture map. When the adjuster later asks why containment was on the invoice, the permit is the answer.

5. What you own: the controls the class names

The hospital owns the class; you own the controls it names. On the classes that apply to a real loss: a barrier that actually holds, return and supply diffusers isolated so dust does not ride the HVAC, the work area kept from going positive, debris in a cleanable lidded container wiped before it hits the corridor, and a sticky mat when the facility requires one. Class IV and Class V add critical barriers and negative air. Exhaust that dumps

into a shared return is not acceptable - if the air cannot go outdoors clear of intakes, it goes through HEPA. The hospital's permit says which apply. Match the permit; do not invent a lighter one because the drying goal is in a hurry.

Hours, elevator use, and the path from the work area to the dock are facility rules, and one crew does not wander between the commercial spaces and the patient floor without the path the permit named. A crew that treats the patient corridor as a jobsite hallway will lose the next call, even if the structure dried on time.

6. Price the class you were assigned

On a store or an office, you contain for the occupant and the dust you will make. In a hospital the occupant cannot leave, and the dust is an infection-control event, not a cleaning complaint. So price the class, not just the dry-out. A Class V anteroom, coveralls, and verified negative air are not overhead you absorb to win the job - they are the condition of working. If the class is still blank when you are asked for a number, the honest bid says the number moves when infection prevention signs the permit.

PART 3 - GO DEEPER (RESTORATION INTEL)

- ICRA for Restoration Contractors: The Class the Hospital Assigns Before You Open the Ceiling - https://restorationintel.com/icra-for-restoration-contractors/

The same subject from the facility's side of the barrier - Healthcare Facility Hub's own Book for Your Bot, written for the hospital teams who assign the class:

- Book for Your Bot - ICRA Edition (Healthcare Facility Hub) - https://healthcarefacilityhub.org/wp-content/uploads/2026/10/book-for-your-bot-icra.pdf
- Healthcare Facility Hub - https://healthcarefacilityhub.org

Restoration Intel publishes operator-first analysis for restoration contractors: https://restorationintel.com - the newsletter is on the home page; questions and corrections via the contact page: https://restorationintel.com/contact/

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