

# **AHRQ Safety Program for Long-Term Care: HAIs/CAUTI Facility Demographics**

Before beginning the questionnaire, please take a moment to read the following clarifications.

1. This questionnaire covers topics that pertain to both clinical knowledge and infection control. Therefore, it is best to have a staff member with knowledge of both areas on hand to complete this questionnaire.
2. Shared data WILL NOT include identifiers. All facility and individual data are confidential
3. This is not the Nursing Home Survey on Patient Safety (NHSOPS)

## **Demographics**

### **Your Information**

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Credentials:** \_\_\_\_\_

### **Facility information**

**1. State:** \_\_\_\_\_

**2. Facility/CLC name:** \_\_\_\_\_

**3. Select your lead organization:**

- Alabama Quality Assurance Foundation
- Arizona Health and Hospital Association
- Foundation for Healthy Communities (NH)
- Genesis Healthcare
- Grace Living Centers (OK)
- Healthcare Association of New York State
- Healthcentric Advisors (RI)
- HealthInsight (NV, NM, UT)
- Information & Quality Healthcare (MS)
- Massachusetts Senior Care Association
- Missouri Hospital Association
- Oregon Patient Safety Commission
- Pennsylvania Patient Safety Authority

- Presbyterian Manors of Mid-America (KS & MO)
  - Professional Nursing Solutions, LLC (AR)
  - Qualidigm (CT)
  - Quality Health Associates of North Dakota
  - South Carolina Hospital Association
  - South Dakota Association of Healthcare Organizations
  - South Florida Hospital & Healthcare Association
  - Spectrum Health (MI)
  - Telligen (IL and IA)
  - Tennessee Healthcare Association
  - Veteran's Health Administration
  - Other (Please Specify)
- \_\_\_\_\_

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**4. Please select your primary role in the facility/CLC (select only one):**

- |  |   |
|--|---|
| <p><input type="radio"/> Facility administrator</p> <p><input type="radio"/> Assistant Director of Nursing (ADON)</p> <p><input type="radio"/> Director of Nursing (DON)</p> <p><input type="radio"/> Staff development/education</p> <p><input type="radio"/> Infection prevention/control program coordinator (non-VHA only)</p> | <p><input type="radio"/> Infection prevention/control program managed by a dedicated CLC coordinator (VHA only)</p> <p><input type="radio"/> Infection prevention/control program managed as part of/within the Acute Care infection control program (VHA only)</p> <p><input type="radio"/> Quality manager</p> <p><input type="radio"/> Other (Please specify)</p> <p>_____</p> |
|--|---|

**5. It is important to have a back-up team lead to ensure success of this program. Please select primary role of the program team lead back-up in the facility/CLC (select only one):**

- |   |  |
|---|--|
| <p><input type="radio"/> Facility administrator</p> <p><input type="radio"/> Assistant Director of Nursing (ADON)</p> <p><input type="radio"/> Director of Nursing (DON)</p> <p><input type="radio"/> Staff development/education</p> <p><input type="radio"/> Infection prevention/control program coordinator (non-VHA only)</p> <p><input type="radio"/> Infection prevention/control program managed by a</p> | <p>dedicated CLC coordinator (VHA only)</p> <p><input type="radio"/> Infection prevention/control program managed as part of/within the Acute Care infection control program (VHA only)</p> <p><input type="radio"/> Quality manager</p> <p><input type="radio"/> No back-up identified</p> <p><input type="radio"/> Other (Please specify)</p> <p>_____</p> |
|---|--|

**6. Facility Ownership (Select all that apply)**

- Government – Department of Veterans Affairs - VHA
- Government - non - VA
- For profit
- Non profit
- Other (Specify) \_\_\_\_\_

**7. Basic facility/CLC information:**

Number of units: \_\_\_\_\_ (count of skilled nursing units in the facility/CLC)

Number of sub-acute beds: \_\_\_\_\_ (count of short-term beds)

Current number of residents: \_\_\_\_\_

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**8. Indicate the current number of staff (ie. FTEs) in your facility/CLC:**

Physicians: \_\_\_\_\_

Registered Nurses (RNs): \_\_\_\_\_

Licensed Practical Nurses (LPNs): \_\_\_\_\_

Certified Nursing Assistants (CNAs): \_\_\_\_\_

**9. Which of the following resident services are currently being delivered in your facility/CLC? (Check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> 24-hour a day on-site supervision by an RN               | <input type="checkbox"/> X-ray services only available on weekdays                        |
| <input type="checkbox"/> Access to laboratory services only available on weekdays | <input type="checkbox"/> Access to laboratory services available on weekdays and weekends |
| <input type="checkbox"/> Blood draws only available on weekdays                   | <input type="checkbox"/> Blood draws available on weekdays and weekends                   |
| <input type="checkbox"/> Central-line insertions                                  | <input type="checkbox"/> Care for residents with dementia in specialized unit             |
| <input type="checkbox"/> IV infusions using central or peripheral lines           | <input type="checkbox"/> Glucose monitoring   |
| <input type="checkbox"/> Management of residents on a ventilator                  | <input type="checkbox"/> Long-term custodial care   |
| <input type="checkbox"/> Management of residents with a tracheostomy              | <input type="checkbox"/> Management of residents with a Foley catheter                    |
| <input type="checkbox"/> Skilled nursing/short-term(sub-acute) rehabilitation     | <input type="checkbox"/> Respiratory therapy  |
| <input type="checkbox"/> Wound care   | <input type="checkbox"/> Whirlpool or therapeutic bathing                                 |
|   | <input type="checkbox"/> X-ray services available on weekdays and weekends                |

### **Infection Prevention**

**10. How many full-time employees (FTEs) are currently dedicated to your facility/CLC's infection control program?**

\_\_\_\_\_ FTEs

**11. In your facility/CLC, what level of professional training does the main point of contact for infection prevention related issues have?**

- |  |  |
|--|--|
| <input type="radio"/> Physician (MD)                 | <input type="radio"/> Other (Please specify) |
| <input type="radio"/> Licensed Practical Nurse (LPN) | _____  |
| <input type="radio"/> Registered Nurse (RN)          |  |

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**12. How many years of experience does the main point of contact for infection prevention-related issues have?**

Number of years in that position in this facility/CLC:

- |  |  |
|--|--|
| <input type="radio"/> Less than 1 year | <input type="radio"/> 5-10 years         |
| <input type="radio"/> 1-3 years        | <input type="radio"/> More than 10 years |
| <input type="radio"/> 3-5 years        |  |

Number of years with infection prevention experience:

- |  |  |
|--|--|
| <input type="radio"/> Less than 1 year | <input type="radio"/> 5-10 years         |
| <input type="radio"/> 1-3 years        | <input type="radio"/> More than 10 years |
| <input type="radio"/> 3-5 years        |  |

**13. Has the main point of contact for infection prevention-related issues received any specific infection prevention training? (Select all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Certified in Infection Control (CIC)   | <input type="checkbox"/> State or local training course |
| <input type="checkbox"/> APIC EPI 101 or 201                    | <input type="checkbox"/> Other (Please specify)         |
| <input type="checkbox"/> No specific infection control training |   |
- \_\_\_\_\_

**14. Are any of the activities listed below also performed by main point of contact for infection prevention-related issues? (Select all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Facility administration           | <input type="checkbox"/> Director of Nursing (DON)             |
| <input type="checkbox"/> Direct resident care              | <input type="checkbox"/> Resident assessment coordinator (RAC) |
| <input type="checkbox"/> Wound/treatment nurse             | <input type="checkbox"/> N/A                                   |
| <input type="checkbox"/> Staff education/staff development | <input type="checkbox"/> Other (Please specify)                |
| <input type="checkbox"/> Quality manager                   |  |
| <input type="checkbox"/> Employee health                   |  |
| <input type="checkbox"/> Resident services and training    |  |
- \_\_\_\_\_

**15. On average, during a normal (40 hour) work week, how many hours per week are spent performing all infection prevention-related activities?**

\_\_\_\_\_ hours

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**16. Who provides infection prevention-related training to the rest of the staff at your facility/CLC? (Check one answer)**

- |   |   |
|---|---|
| <input type="radio"/> The main point of contact for infection prevention-related activities<br><input type="radio"/> Medical Director<br><input type="radio"/> Director of Nursing (DON)<br><input type="radio"/> Education Coordinator | <input type="radio"/> External consultants<br><input type="radio"/> There is no designated person to provide infection prevention-related trainings<br><input type="radio"/> Other (Please specify)<br><hr style="width: 100%;"/> |
|---|---|

**17. Is there a committee in your facility/CLC that reviews Healthcare Acquired Infections (HAIs) including CAUTI (e.g. reports, policies and procedures, etc.)?**

- Yes
  No

**17.1. If Yes, indicate the members represented in the committee: (Select all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Environmental services<br><input type="checkbox"/> Medical director<br><input type="checkbox"/> Nursing staff<br><input type="checkbox"/> Physician staff<br><input type="checkbox"/> Unit managers or supervisors<br><input type="checkbox"/> Resident/Family Council member | <input type="checkbox"/> Facility board members<br><input type="checkbox"/> Nursing administrators<br><input type="checkbox"/> Quality department<br><input type="checkbox"/> Pharmacy department<br><input type="checkbox"/> Other (Please specify)<br><hr style="width: 100%;"/> |
|--|--|

**18. For each statement below, please select “YES” or “NO”: “Our facility/CLC provides ...”**

	Yes	No	Don't Know
a. Education to staff on the Science of Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Assessment of teamwork and safety culture (e.g. Safety Attitude Questionnaire, Nursing Home Survey on Patient Safety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Readily available supplies necessary for aseptic urinary catheter insertion (i.e. supplies are available on your unit/floor in an unlocked location)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Patient education material in a language other than English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Catheter Management**

**19. Who inserts indwelling urinary catheters in your facility/CLC? (Select all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Physicians (MD)                | <input type="checkbox"/> Registered Nurse (RN)             |
| <input type="checkbox"/> Licensed Practical Nurse (LPN) | <input type="checkbox"/> Certified Nursing Assistant (CNA) |
| <input type="checkbox"/> Other (Please specify)         |  |

**20. For each item below, please check the answer that best applies on a scale from “Never” to “Always”**

	Never	Rarely	Sometimes	Often	Always
a. Urinary catheters used for management of incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Urinary catheters removed within 24-48 hours of admission unless there are appropriate indications (e.g. HICPAC) for continued use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Alternatives to indwelling catheters (e.g. urinals, bedpans, bedside commodes, intermittent catheters, condom catheters) used when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Urinary catheters inserted using aseptic technique and sterile equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Portable bladder (scanner) ultrasound used to assess urine volume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Use of urinary drainage systems with pre-connected, sealed catheter-tubing junctions used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Catheters changed at routine, fixed intervals (e.g. every 30 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Systemic anti-microbial prophylaxis for urinary catheters used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Urinary drainage bags kept below level of bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Urinary catheters disconnected from collecting systems (e.g. irrigations, leg bag attachment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Screening for asymptomatic bacteriuria (ASB) performed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Measuring adherence to proper aseptic insertion of urinary catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Measuring adherence to documentation of catheter insertion and removal dates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Measuring adherence to documentation of indication for urinary catheter placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Measuring adherence to hand hygiene policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## Surveillance

**21. Is surveillance for CAUTI performed at your facility/CLC?**

- Yes  No

**21.1. If yes, where is surveillance data entered: (Select all that apply)**

- MDS  
 NHSN  
 Other (Please specify) \_\_\_\_\_

**22. Do you know your facility/CLC's catheter-associated urinary tract infection rate?**

- Yes  No

**23. For each statement below, please select YES or NO: "Our facility/CLC ..."**

	Yes	No	Don't Know	N/A
a. Collects CAUTI data using an Electronic Health Records (HER) or Electronic Medical Records (EMR) system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Keeps records of residents with healthcare-associated CAUTI in an electronic spreadsheet, database, logbook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Uses standard definitions to determine if a resident has CAUTI (McGeer criteria or CDC NHSN definitions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Uses new antibiotic prescriptions to determine if a resident has CAUTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reviews provider notes to determine if a resident has CAUTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Tracks rates of CAUTI over time to identify trends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Creates summary reports of healthcare associated CAUTIs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Shares CAUTI surveillance data with facility board members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Shares CAUTI surveillance data with facility leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Shares CAUTI surveillance data with facility managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shares CAUTI surveillance data with all facility nursing staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Shares CAUTI surveillance data with residents and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### CAUTI Prevention

**24. Are any quality improvement (QI) programs for CAUTI prevention in place?  
(Select all that apply)**

- Electronic alerts or reminders for removing unnecessary catheters
- Multidisciplinary urinary catheter “rounds”
- Stop orders for urinary catheters
- Nurse initiated discontinuance of urinary indwelling catheter
- Other (Please specify)\_\_\_\_\_
- None

**25. Please indicate if and when training is offered for the following topics. These trainings may be provided by facility/CLC staff members or external organizations.**

	Not offered	Offered to new staff	Offered annually	Offered as needed
a. Appropriate antibiotic use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hand hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Catheter insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Catheter maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reporting requirements to the health department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**26. For each statement below, please select YES or NO: “Our facility/CLC has a policy on...”**

	Yes	No	Don't Know
a. Appropriate indications for catheter use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Urinary catheter insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Urinary catheter maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Prevention of CAUTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Perineal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Fluid monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Assessment, observation and documentation of residents on urinary catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Require a Physician order for the placement of a Foley catheter with documentation of reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Appropriate antibiotic use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Education regarding infection risk-reduction behavior for vendors or contractual staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Education regarding infection risk-reduction behavior for visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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**27. Which aspects of infection prevention are the top challenges for your facility/CLC at this time? (Select all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Blood borne pathogen exposure control compliance<br><input type="checkbox"/> Employee hand hygiene compliance<br><input type="checkbox"/> Handling linens, equipment and medical waste<br><input type="checkbox"/> Influenza vaccine to staff<br><input type="checkbox"/> Preventing spread of MRSA<br><input type="checkbox"/> Preventing spread of VRE<br><input type="checkbox"/> Staff turnover<br><input type="checkbox"/> Tracking infections<br><input type="checkbox"/> Resident and family engagement<br><input type="checkbox"/> Other (Please specify) _____<br><br> | <input type="checkbox"/> Communication between facilities<br><input type="checkbox"/> Environmental cleaning compliance<br><input type="checkbox"/> Identifying or managing outbreaks/clusters<br><input type="checkbox"/> Preventing spread of <i>C. difficile</i><br><input type="checkbox"/> Preventing spread of Resistant gram-negative organisms (e.g. ESBLs)<br><input type="checkbox"/> Providing sufficient education and training<br><input type="checkbox"/> Standard precautions compliance<br><input type="checkbox"/> Transmission-based precautions compliance<br><input type="checkbox"/> There are no infection prevention challenges |
|--|--|

**28. Indicate how well you think important changes in infection prevention-related definitions, policies procedures or regulations are communicated to your facility/CLC from the following agencies**

	No communication	Poorly	Neither poorly nor well	Well
a. Centers for Disease Control and Prevention (CDC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Centers for Medicare and Medicaid Services (CMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. State office of Licensure and Certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. State or local health department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**29. Indicate how your facility/CLC currently maintains infection prevention-related activities during times of staff turnover or when personnel resources are limited: (Select all that apply)**

- Cross-train staff members about infection prevention-related issues
- Designate a chain of command so that it is clear who will oversee infection
- Include an infection prevention-related component in the orientation of new employees
- Make infection prevention-related trainings and resources accessible as needed
- Make written and updated policies and procedures easily available
  
- Other (Please specify) \_\_\_\_\_
- No specific policy

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**30. How are CAUTIs communicated when transferring residents in and out of your facility/CLC? (Select all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Discharge orders              | <input type="checkbox"/> E-mail                 |
| <input type="checkbox"/> Phone call                    | <input type="checkbox"/> Transfer sheet         |
| <input type="checkbox"/> Uniform Assessment Instrument | <input type="checkbox"/> Other (Please specify) |
| <input type="checkbox"/> No communication              |   |
- 

**Comments on resident transfer process including barriers:**

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**31. What type of infection prevention related information would be useful for you? (Select all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Antibiotic duration                           | <input type="checkbox"/> Antibiotic indication                  |
| <input type="checkbox"/> Antibiotic type                               | <input type="checkbox"/> Colonization with <i>C. diff</i>       |
| <input type="checkbox"/> Colonization with MDROs                       | <input type="checkbox"/> Need for barrier precautions           |
| <input type="checkbox"/> Presence and indication for feeding tubes     | <input type="checkbox"/> Presence and indication for PICC lines |
| <input type="checkbox"/> Presence and indication of a urinary catheter | <input type="checkbox"/> Other (Please specify)                 |
- 

**Additional Comments:**

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**Thank you for your time in completing this questionnaire.  
Results of this questionnaire will be sent to your organizational leads**