

HEALTHCARE ASSOCIATED INFECTIONS (HAI) PROJECT: BASELINE INFECTION RATES SUMMARY

Thank you for agreeing to complete this summary on infection rates at your facility as part of a project to identify factors associated with the implementation of training that can assist facilities in successfully preventing infections associated with the process of care and sustaining these reductions. It will take approximately 30 minutes to complete this form. You may need to consult someone else for specific information you need. All the answers you give are CONFIDENTIAL. Individual responses will not be shared. We are requesting identification information for data-coding use only. Thank you very much for agreeing to participate in this project.

Today's date: | | | | / | | | | / | | | |
(month) (day) (year)

HAI Master Site Name: _____

Name and location of this site:
(ADD CODING FOR SUB-SITES HERE)

1. What is your present position (title) at this institution?

2. How long have you been in your present position? # | | | | YEARS AND/OR # | | | | MONTHS

3. How long have you been working at this institution? # | | | | YEARS AND/OR # | | | | MONTHS

4. How long have you worked in the healthcare field? # | | | | YEARS AND/OR # | | | | MONTHS

Public reporting burden for this collection of information is estimated to average 30 minutes per response, the estimated time required to complete the survey. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

Please provide information for the following rates, defining the period represented. Please report the rates using CDC's National Healthcare Safety Network (NHSN) definitions (http://www.cdc.gov/ncidod/dhqp/nhsn_members.html). If you have quarterly rate information, please provide that for the past year. If you don't already collect this information, you do not need to fill in all or parts of any of the sections for which you do not have information.

5. Ventilator Associated Pneumonia (VAP)

Ventilator Associated Pneumonia (VAP)	Annual (specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>)			If available, please give quarterly rates for 2007			
	Number VAP Infections	Number of ventilator days	Rate: VAP/1000 ventilator days	Quarter 1	Quarter 2	Quarter 3	Quarter 4

Please fill in whether these rates apply to the entire facility or to a specific set of units only (Please specify the units, if applicable): _____

If known, please provide us with the number of days it has been since your facility's last VAP event: # DAYS

6. Blood Stream Infections (BSI)

b. Catheter-associated Blood Stream Infections (CA-BSI)	Annual (specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>)			If available, please give quarterly rates for 2007			
	Number CA-BSIs	Number of CVC line days	Rates: CA-BSI/1000 CVC line days	Quarter 1	Quarter 2	Quarter 3	Quarter 4

Please fill in whether these rates apply to the entire facility or to a specific set of units only (Please specify the units, if applicable): _____

If known, please provide us with the number of days it has # DAYS

been since your facility's last CA-BSI event:

7. Catheter-Associated Urinary Tract Infection (CAUTI) Events

a. Symptomatic urinary tract infections (SUTI)	Annual (specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>)			If available, please give quarterly rates for 2007			
	Number CAUTIs	Number of catheter days	Rate: CAUTI/1000 urinary catheter days	Quarter 1	Quarter 2	Quarter 3	Quarter 4

Please fill in whether these rates apply to the entire facility or to a specific set of units only (Please specify the units, if applicable):

8. Surgical Site Infections (SSI)

PROCEDURES	Annual (specify year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>)	
	Number SSIs	Rate: infection/1000 patient days
a. Total hip arthroplasty		
b. Total knee arthroplasty		
c.		
d.		

We are interested in whether your facility collects information on numbers of central line insertions or chest tube insertions. Please fill in the following where you have information.

9. Central Line (CL) Insertions (CVC)

Central Line (CL) insertions (CVC)	Number CL insertions	Please specify period covered
<p><i>Note: In Jan. 08, NHSN included in its Manual a monitoring indicator for CL insertions (to measure adherence to recommended catheter insertion practices). The Central Line Insertion Practices Adherence Monitoring form can be used for every central line insertion that occurs during the month chosen for surveillance.</i> http://www.premierinc.com/quality-safety/tools-services/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafety_Protocol_CURRENT_b.pdf (page 13-14)</p> <p>Please check here if you have begun to use this monitoring form: <input type="checkbox"/></p>		

10. Chest Tube (CT) Insertions

Chest Tube (CT) insertions	Number CT insertions	Please specify period covered

Thank you very much for completing this assessment.

Please return this form to:

(NOTE: Leave blank for each individual facility to insert name.)