Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

HEALTHCARE ASSOCIATED INFECTIONS (HAI) PROJECT: FOLLOW-UP 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 40 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:)**			**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:)**			**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 been since your facility's last CA-BSI event: ___ # DAYS

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

	Annual (specify year: ____)			**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
a. Symptomatic urinary tract infections (SUTI)							

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):

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8. Surgical Site Infections (SSI)

PROCEDURES	**Annual (specify year: ____)**	
	Number SSIs	Rate: infection/1000 patient days
a. Total hip arthroplasty		
b. Total knee arthroplasty		
c.		
d.		

9. **We are interested in your additional comments regarding collection of information on HAIs. Does your facility collect global HAI information (i.e., estimating an overall rate from aggregated rate-specific information)? Do you believe the HAI rates that your facility collects are useful and actionable? Your opinion about successes achieved and barriers and challenges in infection prevention are welcome.**

Thank you very much for completing this assessment.

Please return this form to:

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