

ATTACHMENT E:

FACILITY INFORMATION FORM

ADMINISTRATOR INTERVIEW



Collaborative Studies of Long-Term Care

Antibiotic Use In Long-Term Care Settings

Facility Information Form (FAC)

1.06.2010

Facility ID:

Master Facility ID:

Interviewer

Developed / adapted for the Collaborative Studies of
Long-Term Care
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University of North Carolina at Chapel Hill
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I. Facility

1. Is your

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W W D D Y Y

2a. Is your facility owned or operated in association with a (or another):

No **Yes**

1. continuing care retirement community (CCRC)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1
2. hospital?.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1
3. nursing home?.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1
4. residential care facility?.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1

b. Is it affiliated with a religious organization?

0 1

c. Does the owner of your facility own other facilities?	<input type="checkbox"/> 0	<input type="checkbox"/> 1
3. How many years has this facility been in operation? <i>[Round to nearest whole number. If < one year, record number of months.]</i>	____ Years or ____ Months	
	(1) Total	(2) Occupied
4a. How many beds does this facility have overall, and how many are occupied today? _____	_____	
b. How many licensed residential care beds does this facility have, and how many are occupied today? _____	_____	
c. How many licensed nursing home beds does this facility have, and how many are occupied today? _____	_____	

II. Facility Staff

The next questions are about the number of paid employees you have on staff. Please be thinking of the **primary position of your staff; even if a paid staff member fulfills more than one role, assign him or her to a single primary classification.** [If 4a ≠ 4b on page 2, say]: Since this is a multi-level facility, only include persons who spend at least one-half of their work time in the _____ [NH] portion of the facility.

PRESENT TIME

1. How many (1) FULL and (2) PART TIME paid staff are there in each of these positions at THE PRESENT TIME, not including contract workers and other persons not paid by the facility?

[Ask full and part time for each row before moving onto the next row.]

Staff Classification	Total Number Paid Staff Now	
	1. Full Time	2. Part Time
a. Administrative Director or Assistant Director		
b. Registered Nurses		
c. Licensed Practical Nurses or Licensed Vocational Nurses		
d. Certified Nursing Assistants or Personal Care Providers		

LAST 6 MONTHS

2. How many (1) FULL and (2) PART TIME paid staff persons left this position in the LAST SIX MONTHS, not including contract workers and other persons not paid by the facility?

[Ask full and part time for each row before moving onto the next row.]

Staff Classification	Total Number Paid Staff Last 6 months	
	3. Full Time	4. Part Time
a. Administrative Director/Assistant Director		
b. Registered Nurses		
c. Licensed Practical Nurses or Licensed Vocational Nurses		
d. Certified Nursing Assistants or Personal Care Providers		

III. Resident Characteristics

For the rest of this interview, when I use the word “facility”, I mean only the nursing home portion of your facility that is participating in this project. [In most cases, it will be the entire facility.] The next few questions ask for numbers of residents within certain categories. Please provide your best estimate of these numbers. It is not necessary for you to review records for this information.

5. How many of all of your current residents are....		Number
a. Resident Age Distribution <i>[Items 1-6 should sum to the total number of residents in the participating portion of the facility]</i>	1. 0 -18 years old	_____
	2. 19-64 years old	_____
	3. 65-74 years old	_____
	4. 75-84 years old	_____
	5. 85 - 94 years old	_____
	6. 95 years old and over	_____
b. Resident Gender	Male	_____
c. Resident Racial Background <i>[Items 1-5 should sum to the total number of residents in the participating portion of the facility]</i>	1. American Indian or Alaskan Native	_____
	2. Asian or Pacific Islander	_____
	3. Black	_____
	4. White	_____
	5. Other	_____
d. Resident Ethnicity	of Hispanic Origin	_____
e. Acute care/rehab		_____
f. Have a diagnosis of dementia? Diagnoses include: Alzheimer’s Disease (AD); Senile Dementia; Senile Dementia of the Alzheimer’s Type (SDAT); Organic Brain Syndrome (OBS); Cerebral Arteriosclerosis; Multi-Infarct Dementia (MID); Subcortical Dementia; Binswanger’s Disease; Pick’s Disease; Creutzfeldt-Jakob Disease; Lewy Body Disease; Any other diagnosis that includes dementia, such as “Alcoholic Dementia” or “Parkinson’s Disease with Dementia”; and Dementia not otherwise specified.		_____
g. Are currently receiving state financial assistance or Medicaid?		_____