Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Invasive GAS in LTCF 2015
Employee Survey

Date Completed: ____/____/____ **□ Check box if documented case**

A. Employee Background

1. Study Number: ___ ___ ___

2. Age:

3. Sex: Male Female

4. City of Residence:

5. State of Residence:

6. List occupation: RN/LPN CNA PT/OT RNA Housekeeping Dietary Physician Pharmacist Other _____

B. Job Description

7. As part of your job, do you have physical contact with patients? Yes No

8. Areas usually worked: Patient rooms Nurses' station Cafeteria Other _____

9. Shifts usually worked: Day Evening Night Other_____

10. Patient units usually worked: 3W 2W 3E 2E Do not work in patient units All patient units

11. Which days do you usually work *(circle ALL that apply)*:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

12. What kind of patient contact do you have? *(check ALL that apply)*

 Give oral medications Feeding resident Respiratory therapy Tracheostomy care
 Change dressings/wound care Gastrostomy care Handle urinary catheter Bathe resident
 Assist with patient transfer Clean room Handle soiled linens/bedding Handle soiled diapers/bedpans
 Deliver meal trays Take vital signs

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Invasive GAS in LTCF 2015
Employee Survey

C. Work Practice

13. Do you use soap and water to clean your hands? ☐ Yes ☐ No
14. Do you use alcohol-based gel to clean your hands? ☐ Yes ☐ No

15. Please answer the following questions *(circle answer)*	Never				Always	
a. Do you wash your hands BEFORE physical contact with patients?	1	2	3	4	5	N/A
b. Do you wash your hands AFTER physical contact with patients?	1	2	3	4	5	N/A
c. Do you wash your hands BETWEEN contact with patients?	1	2	3	4	5	N/A
d. Do you use the sink in the patient's bathroom?	1	2	3	4	5	N/A
e. Do you use the sink at the nurse's station?	1	2	3	4	5	N/A
f. Do you use gloves when changing bandages/dressing wounds?	1	2	3	4	5	N/A
If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
g. Do you use gloves when cleaning soiled patients or linens?	1	2	3	4	5	N/A
If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
h. Do you use gloves when bathing patients?	1	2	3	4	5	N/A

D. Your Health

16. Do you have paid "Sick Leave"? ☐ Yes ☐ No
17. Did you receive prophylaxis for Group A Streptococcus infection? ☐ Yes ☐ No If yes, when? _____ / _____ / _____

18 a. Since May 2, 2015, did you have a sore throat? ☐ Yes ☐ No *(If no, skip to #19)*
b. When? _____ / _____ / _____
c. Were you diagnosed with strep throat? ☐ Yes ☐ No
d. Did you miss work for this illness? ☐ Yes ☐ No How many days did you miss? _____
e. How many days were you ill? _____
f. Did you receive antibiotics for this condition? ☐ Yes ☐ No If yes, antibiotic name _____

19 a. Since May 2, 2015, did you have a rash, open wound, or skin infection? ☐ Yes ☐ No *(If no, skip to #20)*
b. When? _____ / _____ / _____
c. Did you miss work for this illness? ☐ Yes ☐ No How many days did you miss? _____
d. How many days were you ill? _____
e. Did you receive antibiotics for this condition? ☐ Yes ☐ No If yes, antibiotic name _____
f. What was your diagnosis? _____

20 a. Since May 2, 2015, did you have fever, cough, and/or other respiratory infection? ☐ Yes ☐ No *(If no, skip to #21)*
b. When? _____ / _____ / _____
c. Did you miss work for this illness? ☐ Yes ☐ No How many days did you miss? _____
d. How many days were you ill? _____
e. Did you receive antibiotics for this condition? ☐ Yes ☐ No If yes, antibiotic name _____
f. What was your diagnosis? _____

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Invasive GAS in LTCF 2015
Employee Survey

21 a. How many people are in your household? _____ *(If none, END)*

b. How many children under 18 years of age are in your household? _____

c. During the past 3 months, did anyone in your household have a sore throat? ☐ Yes ☐ No

d. When? _____ / _____ / _____

e. Was he/she diagnosed with strep throat? ☐ Yes ☐ No

f. Who? _____ When? _____ / _____ / _____

g. Were they treated? ☐ Yes ☐ No If so, with what? _____

h. During the past 3 months, did anyone in your household have impetigo or cellulitis (skin infections)? ☐ Yes ☐ No

i. When? _____ / _____ / _____

22 a. Do you work in another patient-care facility? ☐ Yes ☐ No *(If no, skip to End)*

b. Name of facility: _____

c. Have you been in contact with a patient infected with group A Strep in that facility? ☐ Yes ☐ No *(If no, skip to End)*

d. When? _____ / _____ / _____

e. What was that patient's diagnosis?

☐ Strep throat ☐ Impetigo ☐ Cellulitis ☐ Bacteremia ☐ Other _____

END – *Thank you!*