

**Invasive GAS in LTCF 2015
Employee Survey**

Date Completed: ___/___/___

Check box if documented case

A. Employee Background		1. Study Number: ___ ___ ___				
2. Age:		3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
4. City of Residence:		6. List occupation: <input type="checkbox"/> RN/LPN <input type="checkbox"/> CNA <input type="checkbox"/> PT/OT <input type="checkbox"/> RNA				
5. State of Residence:		<input type="checkbox"/> Housekeeping <input type="checkbox"/> Dietary <input type="checkbox"/> Physician				
		<input type="checkbox"/> Pharmacist <input type="checkbox"/> Other _____				
B. Job Description		7. As part of your job, do you have physical contact with patients? <input type="checkbox"/> Yes <input type="checkbox"/> No				
8. Areas usually worked: <input type="checkbox"/> Patient rooms <input type="checkbox"/> Nurses' station <input type="checkbox"/> Cafeteria <input type="checkbox"/> Other _____						
9. Shifts usually worked: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Other _____						
10. Patient units usually worked: <input type="checkbox"/> 3W <input type="checkbox"/> 2W <input type="checkbox"/> 3E <input type="checkbox"/> 2E <input type="checkbox"/> Do not work in patient units <input type="checkbox"/> All patient units						
11. Which days do you usually work (<i>circle ALL that apply</i>):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12. What kind of patient contact do you have? (<i>check ALL that apply</i>)						
<input type="checkbox"/> Give oral medications		<input type="checkbox"/> Feeding resident		<input type="checkbox"/> Respiratory therapy		<input type="checkbox"/> Tracheostomy care
<input type="checkbox"/> Change dressings/wound care		<input type="checkbox"/> Gastrostomy care		<input type="checkbox"/> Handle urinary catheter		<input type="checkbox"/> Bathe resident
<input type="checkbox"/> Assist with patient transfer		<input type="checkbox"/> Clean room		<input type="checkbox"/> Handle soiled linens/bedding		<input type="checkbox"/> Handle soiled diapers/bedpans
<input type="checkbox"/> Deliver meal trays		<input type="checkbox"/> Take vital signs				

**Invasive GAS in LTCF 2015
 Employee Survey**

C. Work Practice	13. Do you use soap and water to clean your hands? <input type="checkbox"/> Yes <input type="checkbox"/> No
	14. Do you use alcohol-based gel to clean your hands? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Please answer the following questions <i>(circle answer)</i> 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"? <input type="checkbox"/> Yes <input type="checkbox"/> No
	17. Did you receive prophylaxis for Group A Streptococcus infection? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ / _____ / _____
18	a. Since May 2, 2015, did you have a sore throat? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to #19)</i> b. When? _____ / _____ / _____ c. Were you diagnosed with strep throat? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Did you miss work for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days did you miss? _____ e. How many days were you ill? _____ f. Did you receive antibiotics for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, antibiotic name _____
19	a. Since May 2, 2015, did you have a rash, open wound, or skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to #20)</i> b. When? _____ / _____ / _____ c. Did you miss work for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days did you miss? _____ d. How many days were you ill? _____ e. Did you receive antibiotics for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, skip to #21)</i> b. When? _____ / _____ / _____ c. Did you miss work for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days did you miss? _____ d. How many days were you ill? _____ e. Did you receive antibiotics for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, antibiotic name _____ f. What was your diagnosis? _____

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. When? _____ / _____ / _____	
	e. Was he/she diagnosed with strep throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Who? _____ When? _____ / _____ / _____	
	g. Were they treated? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, with what? _____	
	h. During the past 3 months, did anyone in your household have impetigo or cellulitis (skin infections)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i. When? _____ / _____ / _____	
22	a. Do you work in another patient-care facility?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to End)
	d. When? _____ / _____ / _____	
	e. What was that patient's diagnosis?	
	<input type="checkbox"/> Strep throat <input type="checkbox"/> Impetigo <input type="checkbox"/> Cellulitis <input type="checkbox"/> Bacteremia <input type="checkbox"/> Other _____	

END – Thank you!