Study ID #: _R☐☐☐

Appendix 1. Invasive GAS in Long Term Care Facility 2016

Employee Survey

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

Date Completed: ____/____/____

☐ **Check box if documented case**

A. Employee Background

1. Name: 2. Age:

3. Sex: ☐ Male ☐ Female

4. Employed at Facility since: ______/______/______

5. List occupation: ☐ Activity aid ☐ Administrative ☐ CNA ☐ Dietary ☐ Food service ☐ Housekeeping ☐ Laundry ☐ PT/OT ☐ Pharmacist ☐ Physician ☐ Maintenance ☐ RNA ☐ RN/LPN ☐ Social service ☐ Van driver ☐ Wound care team ☐ Other ___________________________

6. Since July 17, 2015 to present, have you worked in any other patient-care facility? ☐ Yes ☐ No *(If no, skip to Section B)*

Name & city of facility	Dates of employment	Have you been in contact with a patient infected with group A strep?	What was the patient's diagnosis?
	Start: ____ / _____ / _______ End: ____ / _____ / _______	☐ Yes ☐ No If yes, date of contact: ____ / _____ / _______	☐ Strep throat ☐ Impetigo ☐ Cellulitis ☐ Bacteremia/Sepsis ☐ Other, specify: _________________
	Start: ____ / _____ / _______ End: ____ / _____ / _______	☐ Yes ☐ No If yes, date of contact: ____ / _____ / _______	☐ Strep throat ☐ Impetigo ☐ Cellulitis ☐ Bacteremia/Sepsis ☐ Other, specify: _________________
	Start: ____ / _____ / _______ End: ____ / _____ / _______	☐ Yes ☐ No If yes, date of contact: ____ / _____ / _______	☐ Strep throat ☐ Impetigo ☐ Cellulitis ☐ Bacteremia/Sepsis ☐ Other, specify: _________________

7. a. Since the outbreak, have you had a screening culture for group A Streptococcus? ☐ Yes ☐ No *(If no, skip to # 8)*
   b. If yes, when? ______ / _______ / _______
   c. Where was the culture obtained from? ☐ Throat ☐ Rectal ☐ Vaginal ☐ Skin/wound ☐ Other
   d. What were the results? ☐ Positive ☐ Negative

B. Job Description at Warren Barr Gold Coast

8. As part of your job, do you have physical contact with patients? ☐ Yes ☐ No *(If no, skip to Section D)*

9. Areas usually worked: ☐ Patient rooms ☐ Nurses' station ☐ Cafeteria ☐ Rehab floor ☐ Other _____________________

10. Shifts usually worked: ☐ Day ☐ Evening ☐ Night ☐ Other________________________

11. Patient units usually worked: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ Do not work in patient units ☐ All patient units

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

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

13. 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
- ☐ Bedside incision and debridement aspiration/drainage
- ☐ Provide PT/OT
- ☐ Other beside surgical procedures

C. Work Practice

14. Do you use soap and water to clean your hands? ☐ Yes ☐ No

15. Do you use alcohol-based hand sanitizer to clean your hands? ☐ Yes ☐ No

16. Please answer the following questions *(circle answer)*

		Never				Always	
a.	Do you perform hand hygiene BEFORE physical contact with patients?	1	2	3	4	5	N/A
b.	Do you perform hand hygiene BEFORE physical contact with each patient's environment or belongings (e.g. bedside table, refrigerator, rolling walker, etc.)?	1	2	3	4	5	N/A
c.	Do you perform hand hygiene AFTER physical contact with patients?	1	2	3	4	5	N/A
d.	Do you perform hand hygiene AFTER physical contact with each patient's environment or belongings (e.g. bedside table, refrigerator, rolling walker, etc.)?	1	2	3	4	5	N/A
e.	Do you perform hand hygiene BETWEEN contact with patients?	1	2	3	4	5	N/A
f.	Do you use the sink or alcohol-based sanitizer in the patient's room or outside patient's room?	1	2	3	4	5	N/A
g.	Do you use the sink or alcohol-based sanitizer at the nurse's station?	1	2	3	4	5	N/A
h.	Do you use gloves when changing bandages/dressing wounds?	1	2	3	4	5	N/A
i.	If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
j.	If yes, do you perform hand hygiene before donning gloves?	1	2	3	4	5	N/A
k.	If yes, do you perform hand hygiene after removing gloves?	1	2	3	4	5	N/A
l.	Do you use gloves when cleaning soiled patients or linens?	1	2	3	4	5	N/A
m.	If yes, do you change gloves between patients/patient rooms?	1	2	3	4	5	N/A
n.	If yes, do you perform hand hygiene before donning gloves?	1	2	3	4	5	N/A
o.	If yes, do you perform hand hygiene after removing gloves?	1	2	3	4	5	N/A
p.	Do you use person protective equipment (PPE) when bathing patients?	1	2	3	4	5	N/A

q. If yes, please specify type of PPE: ____

D. Your Health

17. Do you have paid "Sick Leave"? ☐ Yes ☐ No

18. Did you receive prophylaxis for group A streptococcal infection? ☐ Yes ☐ No When? ___ / ___ / ___

19.
a. Since July 17, 2015, have you had a sore throat? ☐ Yes ☐ No *(If no, skip to #20)*
b. When? ______ / _______ / _______
c. Was a throat swab for testing collected from you? ☐ Yes ☐ No d. If yes, specify month: _________________
e. Was a rapid strep throat test done (you would have been given results immediately)?
f. If yes, specify month: _________________ g. If yes, was the result positive? ☐ Yes ☐ No
h. Were you diagnosed with strep throat? ☐ Yes ☐ No i. If yes, specify month: _________________
j. Did you miss work for this illness? ☐ Yes ☐ No k. How many days did you miss? ____________
l. How many days were you ill? _____________
m. Did you receive antibiotics for this condition? ☐ Yes ☐ No n. If yes, antibiotic name ___________________

20.
a. Since July 17, 2015, did you have a rash, open wound, or skin infection? ☐ Yes ☐ No *(If no, skip to #21)*
b. When? ______ / _______ / _______ c. What was your diagnosis? _____________________________
d. Did you miss work for this illness? ☐ Yes ☐ No How many days did you miss? ____________
f. How many days were you ill? _____________
g. Did you receive antibiotics for this condition? ☐ Yes ☐ No If yes, antibiotic name __________________

Study ID #: _R

Appendix 1. Invasive GAS in Long Term Care Facility 2016
<u>Employee Survey</u>

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

21. a. Since July 17, 2015, did you have fever, cough, and/or other respiratory infection? Yes No *(If no, skip to #22))*
    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? ____________________________

22. If you're feeling sick before a work shift, how do you notify Warren Barr Gold Coast?
____

23.. 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. Since July 17, 2015, did anyone in your household have a sore throat? Yes No
        d. When? ______ / _______ / _______ e. Who (relationship)? ______________________
        e. Was he/she diagnosed with strep throat? Yes No
        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? ______ / _______ / _______

END – *Thank you!*

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)