

**Invasive GAS in LTCF 2015  
Employee Survey**

Date Completed: \_\_\_/\_\_\_/\_\_\_

Check box if documented case

<b>A. Employee Background</b>		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>B. Job Description</b>		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				

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<b>C. Work Practice</b>	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																																																																						
<p>15. Please answer the following questions      <i>(circle answer)</i>      Never      Always</p> <table border="0"> <tr> <td>a. Do you wash your hands BEFORE physical contact with patients?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>b. Do you wash your hands AFTER physical contact with patients?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>c. Do you wash your hands BETWEEN contact with patients?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>d. Do you use the sink in the patient's bathroom?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>e. Do you use the sink at the nurse's station?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>f. Do you use gloves when changing bandages/dressing wounds?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>    If yes, do you change gloves between patients/patient rooms?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>g. Do you use gloves when cleaning soiled patients or linens?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>    If yes, do you change gloves between patients/patient rooms?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> <tr> <td>h. Do you use gloves when bathing patients?</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>N/A</td> </tr> </table>		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
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<b>D. Your Health</b>	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	<p>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></p> <p>b. When? _____ / _____ / _____</p> <p>c. Were you diagnosed with strep throat?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>d. Did you miss work for this illness?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      How many days did you miss? _____</p> <p>e. How many days were you ill? _____</p> <p>f. Did you receive antibiotics for this condition?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      If yes, antibiotic name _____</p>																																																																						
19	<p>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></p> <p>b. When? _____ / _____ / _____</p> <p>c. Did you miss work for this illness?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      How many days did you miss? _____</p> <p>d. How many days were you ill? _____</p> <p>e. Did you receive antibiotics for this condition?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      If yes, antibiotic name _____</p> <p>f. What was your diagnosis? _____</p>																																																																						
20	<p>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></p> <p>b. When? _____ / _____ / _____</p> <p>c. Did you miss work for this illness?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      How many days did you miss? _____</p> <p>d. How many days were you ill? _____</p> <p>e. Did you receive antibiotics for this condition?      <input type="checkbox"/> Yes      <input type="checkbox"/> No      If yes, antibiotic name _____</p> <p>f. What was your diagnosis? _____</p>																																																																						

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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!**