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

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 _____

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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!*