**Nursing Home Prevalence Survey: Resident Infection From**

Survey Date: //Date Form Completed: //Data Collected by: \_\_\_\_\_ (initials)

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| **For local use only, will not be Transmitted to CDC**  Resident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| This form is being completed because the resident (check one): | was receiving  systemic antimicrobials | had condition that may  indicate infection |
| The date of interest is: | Antimicrobial start date:  / / | Prevalence survey date:  / / |
| The time period of interest for chart review begins: | 7 days before the antimicrobial start date, beginning on  / / | 7 days before the survey date,  beginning on  / / |
| Date of first sign or symptom onset:  / /  First sign or symptom onset occurred while resident was in:  This facility  Prior to admission | | |

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| **Section A: Constitutional signs and symptoms: CHECK ALL THAT APPLY** | |
| Check hereif after your review **NO** constitutional signs or symptoms are documented | |
| Acute change in mental status from baseline  WERE ANY OF THE FOLLOWING DOCUMENTED:  Fluctuating: Behavior fluctuating (e.g., coming and  Going, or change in severity during assessment)  Inattention: Difficulty focusing attention ( e.g., unable to keep  track of discussion or easily distracted)  Disorganized thinking: Thinking is incoherent (e.g., rambling  conversation, unclear flow of ideas, unpredictable switched  in subject)  Altered consciousness: Level described as different from  baseline (Hyperalert, sleepy, drowsy, difficult to arouse,  nonresponsive)  Confusion  Other , please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Acute functional decline: increase in assistance with activities of  daily living (ADL) from baseline  WAS AN INCREASES IN LEVEL OF ASSISTANCE REQUIRED FOR ANY OF THE FOLLOWING DOCUMENTED:  Bed mobility  Transfer  Locomotion within the facility  Dressing  Toilet use  Personal hygiene  Eating |
| Rigors or chills  Myalgias or body aches    Malaise  Loss of appetite or decreased oral intake  New-onset hypotension  Respiratory rate >=25 breaths per minute  Decreased oxygenation  Select which of the following were documented:  Pulse oximetry with single O2 saturation reading of <94%  Pulse oximetry with single O2 saturation reading showing  reduction of 3% from baseline  Resident newly placed on oxygen  Leukocytosis  Select which of the following were documented:  Neutrophilia (>14,000 leukocytes/mm3)  Left shift (6% bands or ≥1,500 bands/mm3) | Fever  SELECT WHICH OF THE FOLLOWING WERE DOCUMENTED:  Single temperature >37.8oC (>100oF)  Repeated temperatures >37.2oC (99oF)  Single temperature >1.1oC (2oF) over baseline  Term “Fever” is documented, but temperature value is  not recorded  New hypothermia (<34.5oC, or does not register on the thermometer being used) |

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| **Section B: Urinary tract infection signs, symptoms, or tests** |
| **Check here** if after your review **NO** urinary tract signs, symptoms or tests are documented |
| INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY): |
| |  |  | | --- | --- | | **LOCALIZING URINARY SIGNS OR SYMPTOMS** |  | | Acute dysuria (e.g., “burning or pain with urination”) | Gross hematuria | | Acute pain/swelling or tenderness of the testes,  epididymis, or prostate | New or marked increase in frequency | | Purulent discharge around catheter | New or marked increase in urgency | | Acute costovertebral angle pain or tenderness | New or marked increase in incontinence | | Suprapubic pain or tenderness |  |   **INDWELLING URINARY CATHETER** status at the time of urinary sign/symptom onset:  Resident without an indwelling urinary catheter  Resident with an indwelling urinary catheter   |  |  |  |  | | --- | --- | --- | --- | | **URINALYSIS** (U/A or Urine Test or Urine Analysis) | | | | | Was a urinalysis performed | Yes  No | | | | If yes, date performed: | // | | | | If yes, record the following results | Positive | Negative | Not done | | Nitrites: |  |  |  | | Leukocyte esterase: |  |  |  | | >5 White blood cells: |  |  |  |  |  |  |  | | --- | --- | --- | | **URINE CULTURE** | | | | Was a urine collected for culture: | | Yes  No | | If yes, date of specimen collection: | | // | | How the specimen was collected: | | Voided urine sample  Indwelling urinary catheter specimen  Straight (“In-and-out”) catheter  Other………………………………………….  Not documented | | Urine culture result: | | Positive  Negative (no growth)  Result not available | | **If positive**, report the organisms isolated from this specimen | | | |  | Organism name: Use Codes List | Number Colony forming units (CFU)/mL | | 1 |  |  | | 2 |  |  | | 3 |  |  |   **This resident had *documentation of provider suspected or diagnosed urinary tract infection***   |  | | --- | | Enter any additional comments or information related to urinary tract signs, symptoms or tests: | |  | |
| **Section C: Respiratory tract infection signs, symptoms or tests** |
| **Check here**  if after your review **NO** respiratory tract signs, symptoms or tests are documented |
| INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):   |  |  | | --- | --- | | **RESPIRATORY SIGNS AND SYMPTOMS** |  | | Runny nose or sneezing | New / increased cough | | Stuff nose (i.e. congestion) | New/increased sputum production | | Sore throat or hoarseness or difficulty swallowing | Pleuritic chest pain | | Headache or eye pain | Abnormal lung examination (new or changed) | | Swollen or tender glands in the neck (cervical lymphadenopathy) |  |  |  |  | | --- | --- | | **RESPIRATORY X-RAY IMAGINING** | | | Was X-RAY imaging performed | Yes  No | | If yes, date performed: | // | | If yes, record the x-ray findings |  | | X-ray findings not available | | | Negative x-ray findings | | | POSITIVE for pneumonia or a new infiltrate | | | POSITIVE with findings not consistent with pneumonia or a new infiltrate | | | Other findings, specify: | |  |  |  |  | | --- | --- | --- | | **RESPIRATORY DIAGNOSTICS** | | | | Was a respiratory specimen collected for diagnosis: | | Yes  No | | If yes, indicate the specimen source**:** | |  | | If yes, date of specimen collection: | | // | | If yes, record respiratory culture result | | Positive  Negative  Result not available | |  | | | | **If positive**, report the organisms isolated from this specimen | | | |  | Organism name (s): Use code list | | | 1 |  | | | 2 |  | | | 3 |  | |   ***This resident has documentation of provider suspected or diagnosed***  Cold  Pharyngitis  Influenza-like illness  Lower respiratory infection  Pneumonia  Other respiratory tract infection, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | Enter any additional comments or information related to respiratory tract signs, symptoms or testing: | |  | |
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| **Section D: Skin, soft tissue, bone, joint, and mucosal infection signs, symptoms, or tests** |
| **Check here**  if after your review **NO** skin, soft tissue,bone, joint, or mucosal signs, symptoms or tests are documented |
| INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Pus present at the *affected* wound, skin, or soft tissue site  Presence of inflammation at the *affected* wound or skin or soft tissue site  SELECT WHICH OF THE FOLLOWING WERE DOCUMENTED:  Heat at the affected site  Redness at the affected site  Serous drainage at the affected site  Tenderness or pain at the affected site  Swelling at the affected site  A topical antibiotic was applied at *affected* site (e.g., ointment or cream). Name of topical agent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The *affected* site is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |  | | --- | --- | --- | | **CULTURE RELATED TO THE *AFFECTED* WOUND OR SKIN SITE** | | | | Was a wound or skin specimen collected for culture | | Yes  No | | If yes, indicate the specimen source**:** | |  | | If yes, date of specimen collection: | | // | | If yes, record the culture result | | Positive  Negative  Result not available | | If positive, report the organisms isolated from this specimen | | | |  | Organism name (s): Use code list | | 1 |  | | 2 |  | | 3 |  |   ***This resident has documentation of provider suspected or diagnosed***  Wound infection  Cellulitis  Osteomyelitis  Joint infection  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUSPECTED SCABIES:** INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Maculopapular and/or itching rash  Laboratory confirmation (positive scraping or biopsy)  Epidemiological linkage to a case of scabies with lab confirmation  Provider diagnosis of scabies  Scabies other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SUSPECTED FUNGAL SKIN or ORAL/PERIORAL INFECTION:** INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Presence of raises white patches in inflamed mucosa or plaques on oral mucosa  Provider diagnosis of oral candidiasis  Characteristic skin rash or skin lesion  Lab confirmed fungal pathogen from skin scraping or biopsy  Provider diagnosis of fungal skin infection  Fungal other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SUSPECTED HERPES SIMPLEX OR ZOSTER INFECTION:** INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Vesicular rash  Laboratory confirmation of herpes simplex or herpes zoster infection  Provider diagnosis of herpes simplex  Provider diagnosis of herpes zoster infection  Herpes other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *\*\*Section D continues on the next page\*\**  **SUSPECTED CONJUNCTIVITIS (“Pink eye”)**  INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Pus appearing from one or both eyes, present for at least 24 hours  New or increased conjunctival erythema, with or without itching  New or increased conjunctival pain, present for at least 24 hours.  Topical antimicrobial applied to eyes (e.g., ointment or drops)  NO documentation that conjunctivitis symptoms (“pink eye”) symptoms are due of allergic reaction or trauma  Provider diagnosis of conjunctivitis  **SUSPECTED EAR INFECTION**  INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  New drainage from one or both ears  Ear pain  Ear tenderness  Topical antimicrobial applied to ears (e.g., ointment or drops)  Provider diagnosis of an ear infection   |  | | --- | | Enter any additional comments or information related to skin, soft tissue, bone, joint, and mucosal infection signs, symptoms, or tests | |  | |
| **Section E: Gastrointestinal tract infection signs, symptoms or tests** |
| **Check here**  if after your review **NO** gastrointestinal signs, symptoms or tests are documented |
| INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):  Diarrhea  Exceeds or equivalent to: 3 liquid or watery stools in 24-h period  Diarrhea is documented, but frequency and/or time-period not known  Vomiting  Exceeds or equivalent to: 2 episodes in 24-h period  Vomiting is documented but frequency and/or time-period not known  Nausea  Abdominal pain or tenderness  Documentation of a noninfectious cause of diarrhea, vomiting or nausea, Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |  | | --- | --- | --- | | **ABDOMINAL X-RAY IMAGINING** | | | | Was X-RAY imaging performed | Yes  No | | | If yes, date performed: | // | | | If yes, record the following findings |  | | |  | X-ray result not available | | |  | Negative x-ray findings | | |  | POSTIVE for evidence of toxic megacolon | | |  | Positive with findings not consistent with toxic megacolon | | |  | Other findings, specify: |  |  |  |  | | --- | --- | | **STOOL TESTING FOR *CLOSTRIDIUM DIFFICILE* INFECTION** | | | Was an order written for *C. difficle* testing | Yes  No | | If yes, order date: | // | | Was stool collected for *C. difficile* testing: | Yes  No | | If yes, date of specimen collection: | // | | Test type: | NAAT/PCR  EIA  Other (specify):\_\_\_\_\_\_\_\_\_\_\_ | | *C. difficile* test result: | Positive  Negative  Result not available |  |  |  |  |  | | --- | --- | --- | --- | | **STOOL CULTURE FOR PATHOGENS (Bacteria, Parasite, etc.)** | | | | | Was a stool specimens collected | | Yes  No | | | If yes, date of specimen collection: | | // | | | If yes, record the culture result | | Positive  Negative  Result not available | | | **If positive**, report the organisms isolated from this specimen | | | | |  | Organism name (s): Use code list |  | | 1 |  | | 2 |  | | 3 |  |  |  | | --- | | **The resident was diagnosed with pseudomembranous colitis by endoscopy, surgery or biopsy**  Yes  No | | If yes, diagnosis date: // |   **The resident has** **documentation of provider *suspected or* diagnosed**  *C. difficile* infectionGastroenteritis   |  | | --- | | Enter any additional comments or information related to gastrointestinal tract signs, symptoms, or tests | |  | |
| **Section F: Bloodstream Infection, sepsis, blood cultures** |
| **Check here**  if after your review **NO** bloodstream infection or sepsis is documented |
| INDICATE WHICH OF THE FOLLOWING WERE DOCUMENTED (SELECT ALL THAT APPLY):   |  |  | | --- | --- | | **BLOOD CULTURE** | | | Was blood collected for culture | Yes  No | | If yes, date of specimen collection: | // | | Blood culture test result: | Positive  Negative  Result unavailable | | **If positive**, indicate if ; | | | A single blood culture with a NHSN-defined recognized pathogen | | | Two or more blood cultures positive for the same NHSN-defined commensal organism | |  |  |  | | --- | --- | | **If positive**, report the organisms isolated from this specimen | | |  | Organism name (s): Use code list | | | 1 |  | | | 2 |  | | | 3 |  | |   ***The resident has documentation of provider suspected or diagnosed***  Bloodstream infection Sepsis     |  | | --- | | Enter any additional comments or information related to bloodstream Infection, sepsis, blood cultures | |  | |
| **Section G: Any other infections or relevant information** |
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| **Section H: Selected Antimicrobial Susceptibilities** |
| **Check here  if NO organisms were isolated or if the organism isolated if NOT one of those listed below - Data collection is now complete** |

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| If one or more of the organism listed below was isolated from a specimen collected, check the box for the organism(s) and report the susceptibility result for the indicated antimicrobial agents. If 2 or more strains of the same organism are identified, enter the susceptibility pattern for the first organism isolated (by date). | | | | | | | | | | | | | | | | | |
| Organism name [code] | | ***OX/METH*** | ***VANC*** | ***LINZ*** | ***TMZ*** | ***AMP*** | ***CEFZN*** | ***AMP-SUL*** | ***PIP-TAZO*** | ***CIPRO*** | ***LEVO*** | ***CEFTRX*** | ***CEFTAZ*** | ***CEFEP*** | ***GENT*** | ***IMI*** | ***MERO*** |
|  | *S. aureus [SA]* |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  |  S   R   N/A |  |  |  |  |  |  |  |  |  |  |
|  | *Enterococcus spp.*  *[ENTFM or ENTFS]* |  S   R   N/A |  S   R   N/A |  S   R   N/A |  |  S   R   N/A |  |  |  |  |  |  |  |  |  |  |  |
|  | *E. coli [EC]* |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
|  | *Klebsiella pneumoniae*  *or oxytoca [KP or KO]* |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
|  | *Proteus mirabilis [PM]* |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
|  | *Enterobacter cloacae [ENC]* |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
|  | *Pseudomonas aeruginosa [PA]* |  |  |  |  |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
|  | *Acinetobacter baumanii [ACBA]* |  |  |  |  |  |  |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |  S   R   N/A |
| S – Susceptible R – Intermediate or resistance N/A – Not available or not tested  Antimicrobial agent abbreviations: AMP=ampicillin, AMP-SUL=ampicillin/sulbactam, CEFZN= cefazolin, CEFEP = cefepime, CEFTAZ=ceftazidime, CEFTRX=ceftriaxone, CIPRO = ciprofloxacin, GENT=gentamicin, IMI=imipenem, LEVO=levofloxacin, LINZ = linezolid, MERO = meropenem OX/METH=oxacillin or methicillin, PIP-TAZO=piperacillin/ tazobactam, TMZ=trimethoprim/sulfamethoxazole, VANC=vancomycin | | | | | | | | | | | | | | | | | |