**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 here **[ ]** if after your review **NO** constitutional signs or symptoms are documented |
| [ ]  Acute change in mental status from baselineWERE 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):  |
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| **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

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| **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: |  [ ]  |  [ ]  |  [ ]  |

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| **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***

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| Enter any additional comments or information related to urinary tract signs, symptoms or tests: |
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| **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):

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| **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) |  |

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| **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: |

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| **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 |
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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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

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| Enter any additional comments or information related to skin, soft tissue, bone, joint, and mucosal infection signs, symptoms, or tests |
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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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: |  |

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| **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 |

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| **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 |  |

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| **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* infection**[ ]** Gastroenteritis

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| Enter any additional comments or information related to gastrointestinal tract signs, symptoms, or tests |
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| **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):

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| **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 |

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| **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

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| Enter any additional comments or information related to bloodstream Infection, sepsis, blood cultures |
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| **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 testedAntimicrobial 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 |