Resident ID: ___-___-_____

Nursing Home Prevalence Survey: Resident Infection From

Survey Date: ☐☐/☐☐/☐☐☐☐ Date Form Completed: ☐☐/☐☐/☐☐☐☐ Data Collected by: _____ (initials)

FOR LOCAL USE ONLY, WILL NOT BE TRANSMITTED TO CDC

Resident Name:_____ Medical Record Number: _____

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		

Resident ID: ___-___-_____

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 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/mm^3)
- ☐ Left shift (6% bands or ≥1,500 bands/mm^3)

☐ Fever

SELECT WHICH OF THE FOLLOWING WERE DOCUMENTED:

- ☐ Single temperature >37.8°C (>100°F)
- ☐ Repeated temperatures >37.2°C (99°F)
- ☐ Single temperature >1.1°C (2°F) over baseline
- ☐ Term “Fever” is documented, but temperature value is not recorded

☐ New hypothermia (<34.5°C, or does not register on the thermometer being used)

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):

Resident ID: ___-___-_____

LOCALIZING URINARY SIGNS OR SYMPTOMS

- ☐ Acute dysuria (e.g., "burning or pain with urination")
- ☐ Acute pain/swelling or tenderness of the testes, epididymis, or prostate
- ☐ Purulent discharge around catheter
- ☐ Acute costovertebral angle pain or tenderness
- ☐ Suprapubic pain or tenderness
- ☐ Gross hematuria
- ☐ New or marked increase in frequency
- ☐ New or marked increase in urgency
- ☐ New or marked increase in incontinence

INDWELLING URINARY CATHETER status at the time of urinary sign/symptom onset:

☐ Resident <u>without</u> an indwelling urinary catheter ☐ Resident <u>with</u> 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:

Resident ID: ___-___-_____

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
- ☐ Stuff nose (i.e. congestion)
- ☐ Sore throat or hoarseness or difficulty swallowing
- ☐ Headache or eye pain
- ☐ Swollen or tender glands in the neck (cervical lymphadenopathy)
- ☐ New / increased cough
- ☐ New/increased sputum production
- ☐ Pleuritic chest pain
- ☐ Abnormal lung examination (new or changed)

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:

Resident ID: ___-___-_____

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):

Resident ID: ___-___-_____

- [ ] 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

Resident ID: ___-___-_____

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

Resident ID: ___-___-_____

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* infection ☐ Gastroenteritis

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

Resident ID: ___-___-_____

Resident ID: ___-___-_____

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

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