**Healthcare Facility Assessment (HFA) Form: Nursing Home**

Form Approved

OMB No. 0920-XXXX

Exp. Date xx/xx/20xx

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| **Instructions:**  1) The nursing home team lead is responsible for ensuring completion of this assessment and submitting it to the EIP Team point of contact.  2) To ensuring accurate completion of the assessment consult as needed with other facility colleagues to answer the questions included in the assessment.  3) The assessment should be completed using the most up-to-date information available.  4) The assessment should be completed and returned to the EIP Team point of contact within 1-2 weeks.  If you are the individual responsible for ensuring completion of this assessment**, please tell us which of the following best describes your role at the nursing home?**  Medical director (physician)  Other physician  Director of nursing  Infection prevention and control officer (IPCO)  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Section A: Facility Size** |
| **1.** What is your facility’s capacity? (please fill in the following):   |  |  |  |  | | --- | --- | --- | --- | |  | | Number | Don’t know | | 1a. | Total number of facility beds: |  |  | | 1b. | Number that are PEDIATRIC beds (age <21): |  |  | | 1c. | Total number of resident rooms |  |  | | 1d. | Number that are SINGLE rooms: |  |  | | 1e. | Average daily census |  |  |   Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX). |
| **Section B: Primary & Clinical Services Provided** |
| **2.** Which of the following primary service types are provided in your facility?   |  |  |  |  | | --- | --- | --- | --- | |  | Yes | No | Don’t Know | | Long-term general nursing |  |  |  | | Long-term dementia |  |  |  | | Skilled nursing/short-term (subacute) rehabilitation |  |  |  | | Long-term psychiatric (non-dementia) |  |  |  | | Ventilator |  |  |  | | Bariatric |  |  |  | | Hospice/Palliative |  |  |  | | Other primary services please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **3.** Which of the following clinical services are available in your facility (please check all that apply):   |  |  |  |  | | --- | --- | --- | --- | |  | Yes | No | Don’t Know | | IV infusions using central lines |  |  |  | | Hemodialysis (provided in your facility) |  |  |  | | Management of residents with a tracheostomy |  |  |  | | Dedicated facility staff to provide wound care |  |  |  | | Dedicated facility staff to perform blood draws |  |  |  | | 24-hour a day on-site supervision by an RN |  |  |  | |
| **Section C: Medical Care and Coordination** |
| **4a.** Which providers provide resident medical care in your facility (check all that apply):  *Physicians provide medical care for residents*  *Non-physician clinical providers*  *Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Don’t Know |
| **4b.** If *Non-physician clinical providers is checked*, how many days per week are they present in your facility?  \_\_\_\_\_\_\_\_\_\_\_ days per week |
| **5.** How many attending physicians currently provide resident medical care in your facility?  \_\_\_\_\_\_\_\_\_\_ physicians |
| **6.** On average, how many days per week is the medical director present on-site in your facility?  \_\_\_\_\_\_\_\_\_\_\_ days per week |
| **Section D: Infection control resources and practices** |
| **7a.** What is the highest level of professional training of the designated IPCO in your facility?  CNA  LPN  RN  MD  Other, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No individual primarily responsible for IC (skip to question 8a) |
| **7b.** How long has this individual been in that position at your facility?  \_\_\_\_\_\_years |
| **7c.** How many years of experience do they have doing infection control-related work?  \_\_\_\_\_\_\_years |
| **7d.** Has this person received any specific infection control training?  APIC/Certification in Infection Control (CIC)  State or Regional training course with certificate  SHEA Long Term/Post-Acute Care Training course  Other IC training, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No specific infection control training |
| **7e.** Is the IPCO a full-time role for this individual?  Yes  No Don’t Know |
| **7f.** If No, please indicate which of the activities listed below also are performed by that individual (please check all that apply):  Administration (i.e., Director of Nursing [DON])  Quality manager  Staff education/staff development  Employee health  Direct resident care  Other, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **8a.** Is there a team or committee in your facility that reviews infection control-related activities (e.g., reports, policies, and procedures)?  Yes  No Don’t Know |
| **8b.** If YES, how frequently does this committee meet?  Annually  Quarterly  Monthly  Weekly  Other, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **9**. For each statement below check YES or NO for the policies and procedures in place at your facility:   |  |  |  | | --- | --- | --- | |  | Yes | No | | Our facility performs surveillance for one or more types of infection |  |  | | Our facility shares infection surveillance data with the medical director |  |  | | Our facility shares infection surveillance data with resident care staff |  |  | | Our facility has a hand hygiene policy |  |  | | Our facility has an Isolation or Contact Precautions policy |  |  | | Our facility has an environmental cleaning policy |  |  | |
| **Section E: Antimicrobial Use Resources and Practices** |
| |  |  | | --- | --- | | 10. For each statement check YES or NO for the policies and procedures in place at your facility: | Yes No | | Our facility reviews antibiotic use and resistance data in quality assurance/performance improvement committee meetings |  | | Our facility has written statements from leadership in support of improving antibiotic use that is shared with staff, residents and families |  | | Our facility has an individual responsible for overseeing activities to improve the use of antibiotics.  If yes, what is the position/title of this individual? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Our facility medical director reviews antibiotic use data |  | | Our facility has access to a pharmacist with specialized infectious diseases or antibiotic stewardship training, who provides guidance and expertise on antibiotic use (on-staff or by consultation) |  | | Our facility has access to an infectious disease physician, who provides guidance on antibiotic stewardship activities (on-staff or by consultation) |  | | Our facility requires providers to document the dose and route of antibiotics |  | | Our facility requires providers to document the anticipated duration of antibiotics, including a start date, end date, and the planned days of therapy |  | | Our facility requires providers to document the indication of antibiotic, including the rationale and treatment site |  | | Our facility provides medical personnel (physicians and non-physician clinical providers) with resources to guide their decisions about antibiotic use (e.g., treatment algorithms, clinical practice guidelines) |  | | Our facility requires providers to perform a follow-up assessment (an antibiotic “time-out”) 2-3 days after a new antibiotic start to determine whether it is still indicated and appropriate |  | | Our facility has a defined formulary of antimicrobial agents, and prescribing is generally restricted to the agents listed on the formulary |  | | Our facility routinely (weekly, monthly, quarterly) receives reports of antibiotic use (e.g., new orders of antibiotic treatment) from the pharmacy service |  | | Our facility receives a summary report of antibiotic resistance from the laboratory (e.g., antibiogram) |  | | Our facility provides feedback on antibiotic prescribing practices to medical personnel (physicians and non-physician clinical providers) |  | | Our facility provides training on appropriate antibiotic use to nursing personnel (e.g., aides, LPNs, RNs) |  | | Our facility provides education to residents and family about antibiotic use |  | | Our facility has a copy of “CDC’s Core Elements of Antibiotic Stewardship in Nursing Homes”? |  | |
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