Facility ID: ____-_____

Healthcare Facility Assessment (HFA) Form: Nursing Home

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

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		☐

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"?	☐	☐