# Instructions

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| ***Organization Name:*** |   |
|  |  |
| ***Date Completed:***  |   |
|  |  |
| ***Unit Name:*** |  |
| ***Purpose:*** | To evaluate existing resources and processes and identify areas of improvement to facilitate interventions to reduce the incidence and prevalence of infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA), the primary goal of participation in the AHRQ Safety Program for MRSA Prevention.  |
| ***Outcome:*** | This gap analysis will be completed twice, once at the beginning and once at the end of participation in the AHRQ Safety Program. When completed at the start of the Safety Program, it will be used by the project team to understand needs of participating hospitals and by participating hospitals to prioritize areas for improvement and advocate for institution-level and unit-level resources. When completed at the end of the Safety Program, both the project team and the participating hospitals will use the gap analysis to assess progress in building infrastructure and capacity to sustainably reduce MRSA infections.  |
| ***Instructions:*** | This gap analysis has two parts. The first part addresses infection prevention program structure, activities, and resources and is to be completed by the Infection Prevention Team. The second part addresses infection control activities, specifically those related to MRSA prevention, on the participating unit and should be completed by the Project Lead for the participating unit in collaboration with the infection preventionist working with the unit. For each item, enter answers directly into the data portal in the indicated space. For some items, there will be a dropdown menu to allow you to select your answers.Public reporting burden for the collection of information is estimated to average 1 hour per response. 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: AHRQ Reports Clearance Officer, Attention: PRA, Paperwork Reduction Project (0935-0143), AHRQ, 5600 Fishers Lane, MS 0741A, Rockville, MD 20857.The confidentiality of your responses is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. |

# PART 1: Infection Prevention Program Structure & Resources

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| ***Item Description*** | ***Response*** |
| **INFECTION PREVENTION PROGRAM STRUCTURE AND RESOURCES** |
| **Staffing** |
| Number of infection preventionists (ICP) fulltime equivalents (FTEs) for the hospital |  |
| Is there a hospital epidemiologist? | * No
* Yes, full-time
* Yes, part-time
 |
| How much time does the hospital epidemiologist dedicate to the infection prevention program (% effort of hours/week or FTEs) |  |
| Is the hospital epidemiologist available to the infection prevention program on a daily basis?  | * No
* Rarely
* Usually
* Always
 |
| **Senior Leadership**  |
| To whom does the infection prevention program report (provide position title and department, not a specific name)? |  |
| How often does infection prevention leadership meet with senior leadership? (check all that apply) | * Weekly
* Monthly
* Quarterly
* Annually
* Never
* Other:
 |
| Does senior leadership actively promote/support infection prevention activities? (check all that apply) | * No
* Yes: Infection Control Committee member
* Yes: Provides adequate funding for infection prevention
* Yes: Provides funding for infection prevention member training
* Yes: Promotes infection prevention messages via newsletters, screen savers, etc.
* Yes: Provides back up to the infection prevention program if employees do not follow policies and procedures
* Yes: Other:
 |
| **Data Analysis and Management** |
| Is a data analyst available to assist with obtaining and analyzing infection prevention data? | * No
* Yes, full-time
* Yes, part-time
 |
| Is access to the data analyst adequate to meet program goals? | Yes / No |
| Select existing methods of storing infection data. (check all that apply) | * Paper
* Microsoft Excel or other spreadsheet
* Microsoft Access or other relational database
* Software that is part of the electronic health record system
* Standalone infection prevention software
* Other: (describe)
 |
| Which of the following Infection Prevention data are submitted to CDC/NHSN? (check all that apply) | * MRSA bacteremia
* Central line-associated bloodstream infection (CLABSI)
 |
| **Microbiology** |
| Is there a microbiology laboratory on site? | Yes / No |
| Does the infection prevention team have access to microbiology results as soon as those results are confirmed? | Yes / No |
| Is there a system to alert **the infection control team** about epidemiologically important microbiology results? (check all that apply) | * Yes, cultures or tests positive for methicillin-resistant *Staphylococcus aureus* (MRSA)
* Yes, cultures or tests positive for other epidemiologically important results (e.g. carbapenem resistant Enterobacterales (CRE), *C. difficile,* etc.)
* No, there is no system in place to alert about these organisms
 |
| Is there a system to alert **units** about epidemiologically important microbiology results? (check all that apply) | * Yes, cultures or tests positive for MRSA
* Yes, cultures or tests positive for other epidemiologically important results (e.g. carbapenem resistant Enterobacterales (CRE), C*. difficile,* etc.)
* No, there is no system in place to alert about these organisms
 |
| Does your lab have the capacity to process surveillance cultures either on-site or by sending samples to a reference laboratory? | Yes / No |
| **Interactions with Units** |
| Is an infection preventionist assigned to each intensive care unit in the hospital? | Yes / No |
| Is an infection preventionist assigned to each non-intensive care unit in the hospital? | Yes / No |
| If so, how often does the infection preventionist visit their unit(s) routinely? | * Daily
* At least weekly
* At least monthly
* At least quarterly
* As needed
* Never
 |
| Does the infection preventionist participate in their unit's patient safety/quality improvement meetings? | Yes / No |
| Does the infection preventionist participate in rounds to assess compliance with the following at least quarterly: | Y/N CLASBI prevention bundlesY/N Hand hygieneY/N Isolation precaution compliance Y/N Environment of CareY/N Other:  |

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| **Surveillance** |
| ***Epidemiologically Significant Bacteria*** |
| **Methicillin-resistant *Staphylococcus aureus* (MRSA)** |
| Are patients who are colonized or infected with MRSA identified by the infection control team as soon as those microbiology results are confirmed?  | Yes / No |
| If yes, are these patients placed on contact isolation precautions? | * Yes, all patients
* Yes, patients in select units
* No
* N/A
 |
| Is active surveillance for MRSA performed (e.g., obtaining nasal swabs for culture at regular intervals for culture or MRSA testing by other means)? (check all that apply) | * Yes, all patients
* Yes, patients in all ICUs
* Yes, patients in select ICUs
* Yes, patients on all floor units
* Yes, patients on select floor units
* No
 |
| If yes, with what frequency does active surveillance occur? (check all that apply) | * On admission
* Weekly
* Upon discharge
* Other:
 |
| If yes, are rates of hospital-acquired transmissions calculated (e.g., patients who have negative surveillance cultures on admission and develop MRSA colonization infection subsequently during the admission)? | Yes / No |
| If yes, are rates fed back to units? | Yes / No |
| If yes, indicate frequency:  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Is surveillance for MRSA bacteremia LabID events performed? | Yes / No |
| If yes, are data on MRSA bacteremia LabID events fed back to units? | Yes / No |
| If yes, indicate frequency:  | * Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| **Carbapenem-resistant Enterobacterales (CRE)** |
| Are patients who are colonized or infected with CREs identified as soon as microbiology results are confirmed by the infection control team?  | Yes / No |
| If yes, are these patients placed in contact precautions? | * N/A
* Yes, all patients
* Yes, patients in select units
* No
 |
| ***Device Related HAIs*** |
| **Central line-associated bloodstream infection (CLABSI)** |
| Is surveillance performed? | Yes / No |
| If yes, is it done via manual chart review only, electronically by extracting data from the electronic health record or billing codes without chart review, or a combination of chart review and electronic data extraction? | * Via manual chart review only
* Electronically by extracting data from the electronic health record or billing codes without chart review
* A combination of both chart review and electronic data extraction from the electronic health record or billing codes
 |
| Are the data fed back to units? | Yes / No |
| If yes, indicate frequency:  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| ***Hand Hygiene and Personal Protective Equipment***  |
| Does the infection prevention program have a surveillance program in place to assess compliance with hand hygiene? | Yes / No |
| If yes, what are the elements of the program? (check all that apply) | * Secret observations by unit staff
* Secret observations by individual not from the unit
* Direct observations followed by immediate feedback
* An electronic monitoring system
* Other (specify):
 |
| Is feedback regarding hand hygiene compliance provided to units? | Yes / No |
| If yes, indicate frequency:  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Does the infection prevention program assess compliance with isolation precautions and use of personal protective equipment? | Yes / No |
| If yes, indicate how compliance with isolation precautions and use of personal protective equipment is monitored (check all that apply) | * Ongoing observation on the units
* Unit self-assessments
* Periodic observation assessment (e.g. quarterly, semi-annually)
* Other:
 |
| Is feedback regarding compliance with isolation precautions and use of personal protective equipment provided to units? | Yes / No |
| If yes, indicate frequency:  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| ***Environmental Cleaning*** |
| Does the infection prevention program, quality improvement, or environmental services have a surveillance program in place to assess compliance with cleaning of high-touch surfaces?  | Yes / No |
| If yes, indicate how compliance with cleaning of high touch surfaces is monitored (check all that apply). | * Ongoing observation on the units
* Checklists for cleaning surfaces and items:
* Marking surfaces with fluorescent dye or other marker to assess removal
* ATP or other rapid detection of surface contamination
* Other:
 |

**Supplemental Interventions Relevant to MRSA Prevention:**

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| **Ventilator-associated events (VAE) (including ventilator-associated pneumonia)**  |
| Do units admit or care for patients receiving mechanical ventilation? | Yes / No*(If No, then skip this section)* |
| Is VAE surveillance performed? | Yes / No |
| If yes, with what frequency? | * Quarterly
* One quarter per year
* Two quarters per year
* Other:
 |
| If yes, is it done via chart review, electronically, or a combination of chart review and electronic? | * Via chart review
* Electronically
* A combination of both
 |
| Are the data fed back to units? | Yes / No |
| If yes, indicate frequency | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| **Antimicrobial stewardship activities** |
| Does the hospital have an antibiotic stewardship (AS) program or processes to reduce use of unnecessary antibiotics? | Yes / No |
| If yes, indicate which of the following antimicrobial stewardship interventions are implemented: (select all that apply) | * Pre-prescription approval
* Daily time out by team to assess antibiotic use
* Post-prescription review and feedback by the AS program
* Rounds with the AS program
* Order sets for common infectious disease syndromes
* Activities to reduce the use of vancomycin
* Activities to reduce the use of fluoroquinolones
* Other:
 |

# PART 2: Unit Level Infection Prevention Activities

*Please indicate which of the following strategies are implemented for patients* ***in the participating unit****.*

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| ***Item*** | ***Response*** |
| Is the participating unit an intensive care unit (ICU)? | * Yes, the participating unit is an ICU
* No, the participating unit is **not** an ICU but it is a step-down or intermediate care unit.
* No, the participating unit is **not** an ICU.
* The participating unit is a mixed unit that cares for both ICU and non-ICU patients.
 |
| Are routine MRSA nasal surveillance cultures performed in the unit? | Yes / No |
| If yes, indicate frequency (check all that apply) | * On admission
* Weekly
* Monthly
* Upon discharge
* Other:
 |
| If yes, is there a system in place to monitor compliance? (Please choose all that apply.) | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Are patients infected or colonized with MRSA placed on contact isolation precautions? | Yes / No |
| If yes, is there a system in place to monitor compliance? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? (check all that apply) | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Is chlorhexidine (CHG) treatment (bathing) utilized for **all** patients | Yes / No |
| If yes to chlorhexidine (CHG) bathing for all patients, indicate frequency. | * Daily
* Every other day
* Weekly
* Other:
 |
| If yes to CHG bathing for all patients, estimate the percentage of patients who receive the treatment. | * 100%
* 75-99%
* 50-74%
* 25-49%
* <25%Select: 100% / 75-99% / 50-74% / 25-49% / <25%
 |
| If yes to CHG bathing all patients, is there a system in place to monitor compliance? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes to monitoring compliance with CHG bathing, how often is feedback about compliance provided to the unit?  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| If no to CHG bathing of all patients, is CHG treatment (bathing) used for patients with central lines or epidural catheters?  | Yes / No |
| If yes to CHG bathing for patients with central lines or epidural catheters, indicate frequency. | * Daily
* Every other day
* Weekly
* Other:
 |
| If yes to CHG bathing for patients with central lines or epidural catheters, estimate the percentage of patients with central lines or epidural catheters who receive the treatment. | * 100%
* 75-99%
* 50-74%
* 25-49%
* <25%
 |
| If yes to CHG bathing for patients with central lines or epidural catheters, is there a system in place to monitor compliance? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes to CHG bathing for patients with central lines or epidural catheters, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Is nasal MRSA decolonization performed for all patients in the unit? | * Yes, with Mupirocin
* Yes, with iodophor
* No
 |
| If yes, is there a system in place to monitor compliance? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| If nasal decolonization is not performed for all patients on the unit, is nasal decolonization performed for patients with MRSA infection or colonization? | * Yes, with Mupirocin
* Yes, with iodophor
* No
 |
| If yes, is there a system in place to monitor compliance? (Please choose all that apply.) | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Does this unit participate in a hand hygiene monitoring and feedback program? | Yes / No |
| If yes, who does the monitoring? (check all that apply) | * Staff from the unit
* Staff from another unit
* Staff from infection prevention
* “Secret shoppers” unknown to the unit
* An electronic system
* Other (please specify):
 |
| If yes, how often is feedback about compliance provided to the unit?  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Does the unit focus on implementation of evidence-based practices for prevention of central line associated bloodstream infection (CLABSI) prevention bundle at the time of central line insertion? | Yes / No |
| If yes, indicate which of the following elements are included: (check all that apply) | * Aseptic technique
* Maximal sterile barrier precautions
* CHG for skin preparation
* Avoidance of the femoral site
* Application of a sterile dressing
 |
|  If yes, is there a system in place to monitor compliance for some or all of these elements? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Does the unit focus on implementation of evidence-based practices for prevention of central line associated bloodstream infection (CLABSI) during central line maintenance? | Yes / No |
| If yes, indicate which of the following elements are included: (check all that apply) | * Scrub the hub with friction before each use with an appropriate antiseptic
* Use sterile devices to access catheter
* Replace dressing that are wet, soiled or loose
* Routine sterile dressing changes
* Change administration sets with recommended frequency based on circumstances
* CHG bathing treatment for patients with central lines
* Daily assessment for line necessity to remove central line as soon as possible
* Other:
 |
| If yes, is there a system in place to monitor compliance for some or all of these elements? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit?  | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |
| Does the unit have a process for monitoring the environmental cleaning of high touch surfaces for daily and discharge cleaning? | Yes / No |
| If yes, indicate which of the following are used to monitor the cleaning of high touch surfaces: (select all that apply) | * Observations of cleaning
* Application of fluorescent gel markers with follow up to see if markers are removed with cleaning
* Assessment of surface contamination using ATPase
* Other (please specify):
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |

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| **Supplemental Items Relevant to MRSA Prevention:** |
| Is there a processes for training unit staff in appropriate blood culture collection? | * Yes
* No
* Blood cultures not collected by unit staff
 |
| Is there a protocol for limiting use of central lines to obtain blood cultures? | Yes / No |
| Is there a process to promote best practices for obtaining blood cultures only when indicated? | Yes / No |
| Is feedback provided to the unit regarding blood culture contamination rates? | Yes / No |
| For ICUs:Does the unit focus on implementation of a ventilator associated pneumonia (VAP) prevention bundle? | Yes / No |
| If yes, indicate which of the following elements are included. (select all that apply) | * Elevation of the head of the bed to 30-45 degrees
* Daily sedation vacation
* Daily assessment of readiness to wean
* Oral care with CHG
* Use of subglottic secretion drainage
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| If yes, is there a system in place to monitor compliance? | * Yes, the unit measures compliance
* Yes, infection prevention measures compliance
* Yes, both the unit and infection prevention measure compliance
* No
 |
| If yes, how often is feedback about compliance provided to the unit? | * Weekly
* Monthly
* Quarterly
* Other:
* Feedback not provided
 |