Case Investigation Form - Expanded

In order for the HAI team to support your facility in conducting a case investigation, please complete the survey below.

REDCap was developed specifically around HIPAA-Security guidlines. All confidentiality information shared in this survey is protected and secure in accordance with HIPPA's compliance requirements.

Thank you!

Facility Name

____

County

◯ Beaver
◯ Box Elder
◯ Cache
◯ Carbon
◯ Daggett
◯ Davis
◯ Duchesne
◯ Emery
◯ Garfield
◯ Grand
◯ Iron
◯ Juab
◯ Kane
◯ Millard
◯ Morgan
◯ Piute
◯ Rich
◯ San Juab
◯ Sanpete
◯ Salt Lake
◯ Sevier
◯ Summit
◯ Tooele
◯ Uintah
◯ Utah
◯ Wasatch
◯ Washington
◯ Wayne
◯ Weber

Please upload a list of the patient's/resident's active and inactive medication list for the past 6 months.

If unable to upload the patient/resident's active and inactive medication list, please upload the resident's Medication Administration Record (MAR) for the past 6 months.

List the patient/resident's comorbidity history

____

projectredcap.org REDCap®

Patient Demographic

	Yes	No
Do you have the patient's demographic information readily available?	◯	◯

Patient Name ______________________

Date of Birth ______________________

Birth sex ______________________

Age ______________________

Race/Ethnicity
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

(Check all that apply)

Mechanical Ventilation

	Yes	No
Did the patient/resident use a mechanical ventilator in the last 6 months?	◯	◯

Was the mechanical ventilation...
- ☐ Present upon admission
- ☐ Currently using mechanical ventilation

Start date of mechanical ventilation ______________________

End date of mechanical ventilation ______________________

Location of mechanical ventilator ______________________

Did the patient/resident have a tracheostomy placed in the last 6 months?
- ◯ Yes
- ◯ No

Date of placement of the tracheostomy ______________________

Date of removal of the tracheostomy ______________________

Did the patient/resident have a endotracheal tube (ET) tube placed in the past 6 months?	◯ Yes ◯ No
Location the endotracheal tube (ET) tube was placed	__________________________
Date of placement of the endotracheal tube (ET) tube	__________________________
Date of removal of the endotracheal tube (ET) tube	__________________________
Did the patient/resident use a CPAP in the last 6 months?	◯ Yes ◯ No
Location of placement of the CPAP	__________________________
Date of placement of the CPAP	__________________________
Date of removal of the CPAP	__________________________
Did the patient/resident use any other respiratory equipment in the last 6 months?	◯ Yes ◯ No
Name of 'other' type of respiratory equipment that the patient/resident has used in the past 6 months	__________________________
Location of placement of the 'other' respiratory equipment	__________________________
Date of placement of the 'other" respiratory equipment	__________________________
Date of removal of the 'other" respiratory equipment	__________________________
If the patient/resident used other respiratory equipment that was not mentioned above, please include the following information for each additional respiratory equipment used: 1. Name of respiratory equipment 2. Location of placement 3. Date of placement 4. Date of removal	________________________________

Indwelling Devices

	Yes	No
Did the patient/resident have any indwelling device(s) in the last 6 months? (e.g. urinary catheter, PICC line, drain, etc.)	◯	◯

Did the patient/resident have a central venous catheter (CVC) placed in the past 6 months?
◯ Yes
◯ No

Which type of central venous catheter (CVC) was used?
☐ PICC line
☐ Tunneled catheter
☐ Implanted port
(check all that apply)

Was the PICC line present upon admission?
◯ Yes
◯ No

Date of placement of the PICC line
____

Date of removal of the PICC line
____

Please include any other additional information about the PICC line:
____

Was the tunneled catheter present upon admission?
◯ Yes
◯ No

Date of placement of the tunneled catheter
____

Date of removal of the tunneled catheter
____

Please include any other additional information about the tunneled catheter:
____

Was the implanted port present upon admission?
◯ Yes
◯ No

Date of placement of the implanted port
____

Date of removal of the implanted port
____

Please include any other additional information about the implanted port:
____

Did the patient/resident have a dialysis catheter placed in the past 6 months?
◯ Yes
◯ No

Was the dialysis catheter present upon admission?	◯ Yes ◯ No
Date of placement of the dialysis catheter	_______________
Date of removal of the dialysis catheter	_______________
Please include any other additional information about the dialysis catheter:	_______________
Did the patient/resident have a urinary catheter placed in the past 6 months?	◯ Yes ◯ No
Was the urinary catheter present upon admission?	◯ Yes ◯ No
Date of placement of the urinary catheter	_______________
Date of removal of the urinary catheter	_______________
Please include any other additional information about the urinary catheter:	_______________
Did the patient/resident have a gastrostomy tube placed in the past 6 months?	◯ Yes ◯ No
Was the gastrostomy tube present upon admission?	◯ Yes ◯ No
Date of placement of the gastrostomy tube	_______________
Date of removal of the gastrostomy tube	_______________
Please include any other additional information about the gastrostomy tube:	_______________
Did the patient/resident have a nephrostomy tube placed in the past 6 months?	◯ Yes ◯ No
Was the nephrostomy tube present upon admission?	◯ Yes ◯ No
Date of placement of the nephrostomy tube	_______________
Date of removal of the nephrostomy tube	_______________

Please include any other additional information about the nephrostomy tube:	__________________________________
Did the patient/resident have a nasogastric (NG) tube placed in the past 6 months?	◯ Yes ◯ No
Was the nasogastric (NG) tube present upon admission?	◯ Yes ◯ No
Date of placement of the nasogastric (NG) tube	__________________________________
Date of removal of the nasogastric (NG) tube	__________________________________
Please include any other additional information about the nasogastric (NG) tube:	__________________________________
Did the patient/resident have a peripheral IV placed in the past 6 months?	◯ Yes ◯ No
Was the peripheral IV present upon admission?	◯ Yes ◯ No
Date of placement of the peripheral IV	__________________________________
Date of removal of the peripheral IV	__________________________________
Please include any other additional information about the peripheral IV:	__________________________________
Did the patient/resident have a surgical drain placed in the past 6 months?	◯ Yes ◯ No
Was the surgical drain present upon admission?	◯ Yes ◯ No
Date of placement of the surgical drain	__________________________________
Date of removal of the surgical drain	__________________________________
Please include any other additional information about the surgical drain:	__________________________________
Did the patient/resident have a wound drain placed in the past 6 months?	◯ Yes ◯ No
Was the wound drain present upon admission?	◯ Yes ◯ No

Date of placement of the wound drain ________________

Date of removal of the wound drain ________________

Please include any other additional information about the wound drain: ________________

Dialysis History

Did the patient/resident receive dialysis in the past 6 months? ○ Yes ○ No

Name of the facility that performs the dialysis for the patient/resident? ________________

Type of dialysis ________________

Dialysis start date ________________

Dialysis end date (if applicable) ________________

If the patient/resident received more than one type of dialysis, please list the following information for each type of dialysis:
1. Type
2. Start date(s)
3. End date(s)

____

Surgical Procedure History

Did the patient/resident have any surgical procedure(s) in the last year? ○ Yes ○ No

Type of procedure (including anatomical location) ________________

Type of facility where procedure was performed ________________

Date of procedure ________________

If the patient/resident had more than one procedure in the last year, please include the following information for each procedure:
1. Type of procedure (including anatomical location)
2. Type of facility where the procedure was performed
3. Date of procedure

____

Wound Care History

Did the patient/resident have any wound care in the last 6 months?

○ Yes ○ No

Location of open/recently healed wounds

____

Were antimicrobials used to treat the wound?

○ Yes
○ No

Date of wound onset

____

Date wound healed

____
(Use today's date if the wound is still open)

Facility History

Is this the only encounter the patient/resident has had with your facility?

○ Yes ○ No

Patient/Resident's admission date

____

Patient/Resident's discharge date (if applicable)

____

Has the patient/resident resided in your facility previously to this encounter?

○ Yes
○ No

Please list the following information about each of the patient/resident's previous encounters at your facility:
1. Discharge dates
2. Readmission dates
3. Name of facilities the resident was previously discharged from

____

Did the patient/resident have a carbapenem resistant status upon admissions to your facility?

○ Yes
○ No

How was the patient/resident's carbapenem resistant status communicated to the facility?

☐ Verbally - In person
☐ Verbally - Over the phone
☐ Paperwork
(check all that apply)

Precation Status

	Resident was not on precautions	Resident was on precautions for part of the stay	Resident was on precautions during the whole duration of the stay
Which of the following best describes the amount of time the patient/resident was on precautions at your facility?	◯	◯	◯

Was the patient/resident on Admission Precautions during their stay at your facility?

◯ Yes
◯ No

Please list all the dates the patient/resident was on Admission Precautions

____

Was the patient/resident on Contact Precautions during their stay at your facility?

◯ Yes
◯ No

Please list all the dates the patient/resident was on Contact Precautions

____

Was the patient/resident on Droplet Precautions during their stay at your facility?

◯ Yes
◯ No

Please list all the dates the patient/resident was on Droplet Precautions

____

Was the patient/resident on Standard Precautions during their stay at your facility?

◯ Yes
◯ No

Please list all the dates the patient/resident was on Standard Precautions

____

Was the patient/resident on Enhanced Barrier Precautions (EBP) during their stay at your facility?

◯ Yes
◯ No
(EBPs are only implemented in LTCF settings)

Please list all the dates the patient/resident was on Enhanced Barrier Precautions (EBPs)

____

Lab Lookbacks

	Yes	No
Has your team performed a 6-month lab lookback to identify any other patients/residents in the facility with matching positive isolates?	◯	◯

Does the patient/resident have a history of any of the following prior lab lookbacks?

- ☐ Carbapenem-resistant Acinetobacter (CRA)
- ☐ Carbapenem-resistant Enterobacterales (CRE)
- ☐ Carbapenem-resistant Pseudomonas aeruginosa (CRPA)
- ☐ Candida auris
- ☐ Other organisms resistant to carbapenems (e.g. Elizabethkingia anophelis, etc.)

(check all that apply)

Date(s) of Carbapenem-resistant Acinetobacter (CRA) labs ______________________________

Date(s) of Carbapenem-resistant Enterobacterales (CRE) labs ______________________________

Date(s) of Carbapenem-resistant Pseudomonas aeruginosa (CRPA) labs ______________________________

Date(s) of Candida auris labs ______________________________

Name(s) of other organisms that the patient/resident has a history of resistant to carbapenems (e.g. Elizabethkingia anophelis, etc.) labs ______________________________

Date(s) of other organisms resistant to carbapenems (e.g. Elizabethkingia anophelis, etc.) labs ______________________________

Roommate History

	Patient/resident in private room since admission	Patient/resident in shared room since admission	Patient/resident in shared room for part of the stay
Did the patient/resident have a private or shared room while residing at your facility?	◯	◯	◯

Did the patient/resident have a room with a shared (Jack/Jill) bathroom?

- ◯ Yes
- ◯ No

Date(s) that the patient/resident had a private room while at your facility ______________________________

Date(s) that the patient/resident had a shared room while at your facility

____

Other Healthcare Visits

	Dialysis	Therapy (PT, OT, ST)	Urology	Wound care/clinic	Out-patient visits	In-patient stays	Other healthcare related service(s)	The resident did not utilize any out of the facility services
Does the patient/resident have a history of utilizing any of the following services outside of the facility in the past 6 months: (check all that apply)	☐	☐	☐	☐	☐	☐	☐	☐

Please list the receiving facility name and date(s) of the healthcare visit for when the patient/resident received dialysis services

____

Please list the receiving facility name and date(s) of the healthcare visit for when the patient/resident received therapy (PT, OT, ST) services

____

Please list the receiving facility name and date(s) of the healthcare visit for when the patient/resident received urology services

____

Please list the receiving facility name and date(s) of the healthcare visit for when the patient/resident received wound care/clinic services

____

Please list the receiving facility name and date(s) of the healthcare visit for when the patient/resident received out-patient visits

____

Please list the receiving facility name, date(s) of the healthcare visit or the date of transfer to an inpatient stay

____

Please list the receiving facility name and date(s) of any other healthcare visit that the patient/resident received

____

Travel History

	Yes	No
Did the patient/resident travel outside the country in the past year?	◯	◯

Please list the following information regarding the patient/resident's travel outside the country in the past year:
1. Location of area(s) traveled
2. Date(s)
3. Duration

____

Did the patient/resident receive any medical care outside the country in the past 6 months?

◯ Yes
◯ No

Please list the following information regarding the patient/resident's medical care that was received outside the country in the last 6 months:
1. Type of medical care received
2. Location of area(s) traveled
3. Date(s)

____