

**REQ-2023-078 Supplementary material**

• **Annex 1. Resident Transfer Sheet**

This form must be filled in for the transfer with the information communicated before or during the transfer.

Surname	Name	Date of birth	Medical history:

Referring Centre	Unit to which he/she is derived	Phone:

Centre of origin	Contact Name	Phone	E-mail
Nurse/Unit			
Doctor			
Director			
Infection Control			

Does the person* currently have an infection, colonisation OR a positive culture history of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonisation or history	Active infection or treatment
Methicillin Resistant <i>Staphylococcus aureus</i> (MRSA)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Vancomycin-Resistant <i>Enterococcus</i> (VRE)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Clostridioides difficile</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Multi-resistant <i>Acinetobacter</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Extended-spectrum beta-lactamase (ESBL)-producing Enterobacteriaceae (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Carpabenem-resistant Enterobacteriaceae (CRE)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Multi-resistant <i>Pseudomonas aeruginosa</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Candida auris</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Others, (e.g. scabies, norovirus, influenza):	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

**Does the person currently have any of the following?**

(None)

- |   |  |
|---|--|
| <input type="checkbox"/> Cough (Start date: __/__/__)     | <input type="checkbox"/> Central line/PICC line (Start date: __/__/__)   |
| <input type="checkbox"/> Diarrhoea (Start date: __/__/__) | <input type="checkbox"/> Haemodialysis catheter (Start date: __/__/__)   |
| <input type="checkbox"/> Vomiting (Start date: __/__/__)  | <input type="checkbox"/> Urinary catheter (Start date: __/__/__)         |
| <input type="checkbox"/> Urinary or faecal incontinence   | <input type="checkbox"/> Suprapubic catheter (Start date: __/__/__)      |
| <input type="checkbox"/> Open wound requiring healing     | <input type="checkbox"/> Percutaneous gastrostomy (Start date: __/__/__) |
| <input type="checkbox"/> Drainage (origin):               | <input type="checkbox"/> Tracheostomy                                    |



- Annex 3. Institution's Data Collection Sheet

Cumulative Incidence (CI) and Incidence Density (ID) Calculation

Name of Centre: \_\_\_\_\_ Observation Days: \_\_\_\_\_

Total number of beds: \_\_\_\_\_ Total Number of Residents \_\_\_\_\_

% Occupancy: \_\_\_\_\_

Total Medical Staff: \_\_\_\_\_ Total Nursing Staff: \_\_\_\_\_

Total Number of Residents catheterised: \_\_\_\_\_

CI Bladder Catheterisation (# Residents Catheterised/Total # Residents): \_\_\_\_\_

ID Catheterisation (1- [CI/(Observation Days x Total Residents)]): \_\_\_\_\_

Total Number of residents with pressure injuries and/or MASD: \_\_\_\_\_

CI pressure and/or moisture injuries (# Residents with Pressure injuries and/or MASD/Total # Residents): \_\_\_\_\_

ID pressure injuries and/or MASD (1- [CI/(Observation Days x Total Residents)]): \_\_\_\_\_

\_\_\_\_\_

Total Number of residents on antibiotic treatment: \_\_\_\_\_

CI ATB (# Residents with ATB /Total # Residents): \_\_\_\_\_

ID ATB (1- [CI/(Observation Days x Total Residents)]): \_\_\_\_\_

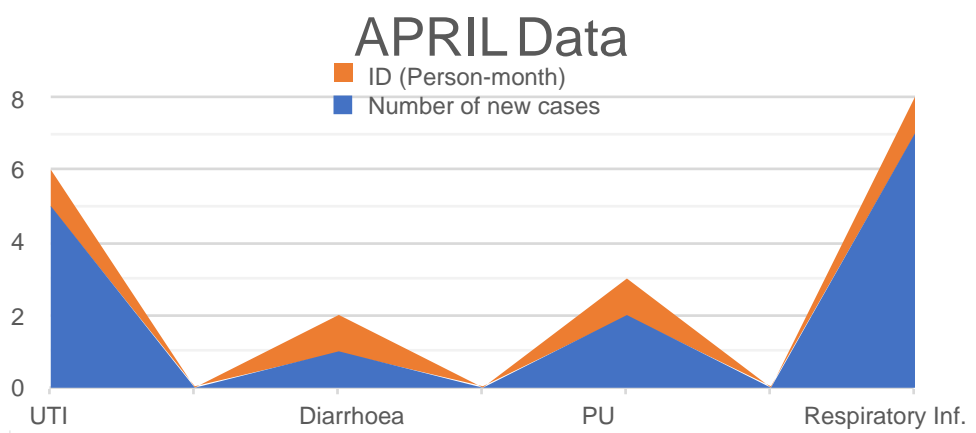
Total Number of residents with diarrhoea: \_\_\_\_\_

CI Diarrhoea (# Residents with Diarrhoea/Total # Residents): \_\_\_\_\_

ID Diarrhoea (1- [CI/(Observation Days x Total Residents)]): \_\_\_\_\_

- Annex 4. Electronic Data Sheet

Institution	XXXX				
Total Number of Residents	100				
Observation Days	30				
Types of care provided	Basics				
	UTI	Diarrhoea	PU	Respiratory	
Number of new cases	5	1	2	7	
Total number of persons	100	100	100	100	
Period	30	30	30	30	
CI	0.05	0.01	0.02	0.07	
ID	0.00166667	0.00033333	0.00066667	0.00233333	
ID (Person-month)	0.99833333	0.99966667	0.99933333	0.99766667	



- Annex 5. Telephone list of Contacts

We consider it necessary for every nursing home to have a telephone list with contacts of interest, accessible to all employees of the institution.

Institution	Phone	Contact Person
Referral Hospital:		
Pharmacy of the Referral hospital:		
Referral Health Centre:		
Reference Microbiology Laboratory:		
Public Health:		
Social Work:		
Liaison Nurse or Residence Case Manager:		
Reference Community Pharmacy:		

## Other reference documents.

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