Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

hpsc

HALT 2016: HPSC Questionnaire

One HPSC Questionnaire to be completed per participating facility – The information provided will be used to ensure that the results of your LTCF are analysed in the correct category

Please liaise with the Director of Nursing/General Manager of your LTCF when completing this questionnaire

Please bring this completed HPSC Questionnaire to your HALT training day

Your facility's name and address:____

____

Your HALT facility study number (given to you by HPSC): ___________________________________

A. Please select one option from the list below that best describes the care type of the majority (>75%) of residents in your facility. If your LTCF participated in a previous HALT survey, it is very important that the care type which you pick for 2016 matches the care type which was picked for the prior HALT survey(s), provided your LTCF still cares for the same category of resident. If you are unsure, please contact the HALT coordinating team HALT@hpsc.ie

	FACILITY TYPE	**HALT LTCF CATEGORY**	**TICK APPROPRIATE BOX**
1	**General nursing home where majority of your residents (>75%) are expected to have a length-of-stay greater than 12 months**	GN>12m	
2	**Mixed care type LTCF* where majority of your residents (>75%) are expected to have a length-of-stay greater than 12 months**	Mixed>12m	
3	**LTCF (either general nursing home or mixed care type) where majority of your residents (>75%) are expected to have a length-of-stay less than 12 months**	LTCF<12m	
4	**Psychiatric long-term care facility**	Psychiatric	
5	**Intellectually disabled long-term care facility**	Intellectually disabled	
6	**Physically disabled long-term care facility**	Physically disabled	
7	**Rehabilitation long-term care facility**	Rehabilitation	
8	**Palliative care facility**	Palliative care	
9	**Other care type (not specified in 1 to 8):** please specify care type below ______________________________	Other	

**Mixed care type = None of the other categories alone fits a description for >75% of your residents (e.g., your facility cares for a mixture of general nursing home type residents, intellectual disability residents, palliative care residents etc.)*

B. If a designated infection prevention and control nurse (IPCN), with formal IPC training provides cover to your facility, please complete the table below. This information is important, so that the ratio of IPCN resource for LTCF beds in Ireland can be estimated

Name of your LTCF's trained IPCN	
E-mail address or telephone number of your trained IPCN	
Number of hours your trained IPCN spends in your LTCF each week	

An infection prevention and control link nurse would not be counted as a designated IPCN. Please do not provide contact information for IPC link nurses.

C. Hand hygiene compliance auditing: Tick the boxes that apply to your LTCF

C.i	**Was at least one formal documented audit of compliance with hand hygiene carried out in your LTCF during 2015?**	**YES**	**NO**
C.ii	**Was there a formal hand hygiene training session delivered to staff of your LTCF during 2015?**	**YES**	**NO**
C.iii	**Was there a formal hand hygiene training session delivered to staff of your LTCF during 2014?**	**YES**	**NO**

D. Please note that you will also need to find out the volume of alcohol hand rub/gel/foam consumed in your LTCF in 2015, as this is a question on the HALT institutional questionnaire

Please ensure that one completed HPSC questionnaire is brought along to your HALT training day

Thank you for your assistance