

8. Do you have any questions about toileting trials or incontinence management that were not answered during the CAPTA course?

- Yes
- No

If yes, please explain:

Tell us about your experience with the course.

9. The course includes 6 live webinars. How many of these did you attend?

Total sessions

10. Did you review or watch any of the recorded webinars?

- Yes; how many? _____
- No

11. In your opinion, were the individual webinars, which lasted 40 minutes:

- Too long; how long should each teleconference have been? _____ minutes
- Just the right length
- Too short? How long should each teleconference have been? _____ minutes
- No opinion/no response

12. The course offered 6 webinars. In your opinion, was this number:

- Too many; how many teleconferences should we have offered? _____ number
- Just right
- Too few; How many teleconferences should we have offered? _____ number
- No opinion/no response

13. Webinars were typically offered every two weeks during this project. In your opinion, should we have held the webinars:

- As we did; no change to the schedule
- Once a month
- Every week
- Another period; please specify: _____
- No opinion/no response

14. Would you participate in a similar webinar-based course if the training topic were of interest to your and/or your facility?

- Yes
- No
- Don't know/no response

15. Would you recommend this course on toileting trials to your colleagues?

- Yes
- No
- Don't know/no response

16. What is your preferred way of learning about toileting trials?

- A webinar curriculum like the one just completed
- An online-only curriculum
- An in-person 1-day training program offered offsite
- Other (please write in) _____

17. What did you like most about this webinar course?

18. What did you like least about this webinar course, or what could be improved?

19. Is there anything we didn't ask about that you would like to share with us or that you think we should know?

20. Did the course exhibit promotional bias for any pharmaceutical agents? Yes No

Please tell a little about yourself:

Nursing Home Name: _____

Your Name: _____ (for CE purposes)

Your Position:

<input type="checkbox"/>	Administrator	<input type="checkbox"/>	Licensed Practical Nurse (LPN)
<input type="checkbox"/>	Director of Nursing or Assistant DON	<input type="checkbox"/>	Medical Director
<input type="checkbox"/>	Certified Nursing Assistant (CNA)	<input type="checkbox"/>	Nurse Practitioner (NP)
<input type="checkbox"/>	MDS Coordinator	<input type="checkbox"/>	Physician Assistant (PA)
<input type="checkbox"/>	Educator / Staff Developer	<input type="checkbox"/>	Registered Nurses (RN)
<input type="checkbox"/>	Social Work	<input type="checkbox"/>	Other