



Patient Safety Component Annual Facility Survey

OMB No. 0920-0666
Exp. Date: xx-xx-20xx

*Tracking # : _____

*Survey Year: _____

*Facility ID #: _____

*Facility Type: _____

Facility Characteristics:

*Facility ownership (check all that apply): For profit Government Military
 Not for profit, including church Veteran's Affairs
 Physician owned Managed Care Organization

*Is your facility affiliated with a medical school? Yes No
If Yes, check type of affiliation: MAJOR GRADUATE
LIMITED _____

*Number of Patient Days (if facility is not Ambulatory or LTC): _____ *Number of Admissions: _____

If facility is a Hospital:

Number of beds set up and staffed:

- a. ICU beds (including adult, pediatric, and neonatal levels II/III and III): _____
- b. Specialty care beds (including hematology/oncology, bone marrow transplant, solid organ transplant, inpatient dialysis, and long term acute care [LTAC]): _____
- c. All other beds _____

If facility is a Long Term Acute Care Hospital (LTACH):

Setting: _____ Within a hospital _____ Free-standing

Number of beds set up and staffed:

- a. Ventilator beds: _____
- b. High-observation beds: _____
- c. All other beds _____

If facility is an Ambulatory Surgery Center:

Setting: _____ Within a hospital _____ Free-standing

Total Number of procedures: _____ Percent of procedures that are surgical: _____%

What percentage of your ambulatory surgery patients were discharged or transferred to the following places:
_____ % Home/Customary Residence _____ % Recovery Care Center (facility other than this one)
_____ % Acute Care Hospital (Emergency or inpatient)

If facility is a Long Term Care Facility:

Number of Resident Days: _____ Average length of stay: _____

Infection Control Practices

*Number of infection control professionals (ICPs) in facility: _____

Assurance of Confidentiality: This information is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual. **Public Reporting Burden:** This information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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 CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

*Total hours per week performing surveillance: _____
*Total hours per week for infection control activities other than surveillance: _____

Facility Microbiology Laboratory Practices:

1. *Does your facility have its own laboratory that performs antimicrobial susceptibility testing?
 Yes No
 If No, where is your facility's antimicrobial susceptibility testing performed (check one)?
 Affiliated hospital of facility Commercial referral laboratory

2. *Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? Yes No
 If Yes, specify what version of the M100 document the laboratory uses? _____

3. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed). If the laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory.

Please use the testing codes listed below the table.

Pathogen	* (1) Primary	* (2) Secondary	Comments
Coagulase-negative staphylococci	_____	_____	_____
<i>Staphylococcus aureus</i>	_____	_____	_____
<i>Enterococcus</i> spp.	_____	_____	_____
<i>Escherichia coli</i>	_____	_____	_____
<i>Klebsiella pneumoniae</i> or <i>K. oxytoca</i>	_____	_____	_____
<i>Serratia marcescens</i>	_____	_____	_____
<i>Enterobacter</i> spp.	_____	_____	_____
<i>Pseudomonas aeruginosa</i>	_____	_____	_____
<i>Acinetobacter</i> spp.	_____	_____	_____
<i>Stenotrophomonas maltophilia</i>	_____	_____	_____

1 = Kirby-Bauer disk diffusion; 2 = Vitek; 2.1 = Vitek 2; 3 = Sceptor; 3.1 = BD Phoenix; 4 = Sensititre; 5.1 = MicroScan walkaway rapid; 5.2 = MicroScan walkaway conventional; 5.3 = MicroScan auto or touchscan; 6 = Other micro-broth dilution method; 7 = Agar dilution method; 8 = Pasco; 9 = Micromedia; 10 = Etest; 11 = Oxacillin screen (MHA + salt); 12 = Vancomycin agar screen (BHI + vancomycin); 13 = Other (describe in Comments column)

4. *Are staphylococci that test as vancomycin resistant repeated using the same method? Yes No

5. *Does the laboratory confirm vancomycin resistant staphylococci using a second method? Yes No
 If Yes, please select the PRIMARY method used to confirm vancomycin resistance in staphylococci:
 Disk diffusion Etest Vancomycin agar screen plate
 Other, please indicate using method codes in Question 3 above _____

6. *Does the laboratory do either screening or confirmatory testing for extended spectrum β -lactamase (ESBL) production according to CLSI? Yes No

7. *If ESBL production is suspected how do does the laboratory report the results to the clinician (check one)?
 Change susceptible and intermediate interpretations for third generation cephalosporins and aztreonam to resistant
 Suppress the results for third generation cephalosporins and aztreonam for the report
 No changes are made in the interpretations reported to clinicians