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: _____

a. *Total hours per week ICPs perform surveillance: _____

b. *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	_____	_____	_____
Staphylococcus aureus	_____	_____	_____
Enterococcus spp. _____	_____	_____	
Escherichia coli _____	_____	_____	
Klebsiella pneumoniae or *K. oxytoca*	_____	_____	_____
Serratia marcescens	_____	_____	_____
Enterobacter spp. _____	_____	_____	
Pseudomonas aeruginosa	_____	_____	_____
Acinetobacter spp. _____	_____	_____	
Stenotrophomonas maltophilia	_____	_____	_____

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 ß-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