Tables of Instructions

Table 1. Instructions for Completion of the Healthcare Personnel Safety Monthly Reporting Plan Form (CDC 57.203)

This form collects data on which modules and which months (if any) the facilities intend to participate in NHSN Healthcare Personnel Safety (HPS) Component. This form should be completed for every month that the facility will participate in the HPS component.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Month/Year	Required. Enter the month and year for the surveillance plan being recorded.
No NHSN Healthcare Personnel Safety Modules Followed this Month	Conditionally required. Check this box if you do not plan to follow any of the NHSN Healthcare Personnel Safety Modules during the month and year selected.
Healthcare Personnel Exposure Modules	
Blood/Body Fluid Exposure Only	Conditionally required. Check this box if you plan to follow blood/body fluid exposures only, without following exposure management during the month and year selected.
Blood/Body Fluid Exposure with Exposure Management	Conditionally required. Check this box if you plan to follow blood/body fluid exposure with exposure management during the month and year selected.
Influenza Exposure Management	Conditionally required. Check this box if you plan to follow influenza exposure management (i.e., antiviral chemoprophylaxis and/or treatment) only, without following influenza vaccination.
Healthcare Personnel Vaccination Module	
Influenza Vaccination with Exposure Management/Treatment	Conditionally required. Check this box if you plan to follow influenza vaccination (either seasonal and/or non-seasonal vaccine) with exposure management (i.e., antiviral chemoprophylaxis and/or treatment) during the month and year selected.

Table 2. Instructions for Completion of the Healthcare Worker Demographic Data Form (CDC 57.204)

This form must be completed for all HCP who have information recorded in HPS component of NHSN (e.g., exposure to blood or body fluid or influenza vaccination.) Alternatively, data for all or selected personnel can be imported from the facility's personnel database at facility enrollment.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
HCW ID #	Required. Enter the healthcare worker's (HCW) alphanumeric identification number. This identifier is unique to the healthcare facility.
Social Security #	Optional. Enter the HCW's Social Security Number.
Secondary ID #	Optional. Enter the HCW's secondary ID number. This could be the employee's medical record # or some other unique identifier.
HCW Name: Last, First, Middle	Optional. Enter demographic information for the HCW.
Street Address City State Zip Code	
Home Phone	
E-mail Address	
Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Born in the U.S.?	Optional. Select Yes, No, or Unknown.
Ethnicity	Optional. Select one ethnicity of the HCW.
Race	Optional. Select the race of the HCW. Check all that apply.
Work Phone	Optional. Enter the work phone number of the HCW.
Start Date	Required. Enter the date the HCW began employment or affiliation with the facility (use format: mm/dd/yyyy).
Work Status	Required. Select Active, Inactive, or No longer affiliated.
Type of Employment	Required. Select from Full-time, Part-time, Contract, Volunteer, Other (please specify).

Data Field	Instructions for Data Collection
Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. For example, a radiology technician who spends most of his/her time performing portable x-rays throughout the facility works at multiple locations. In general, most interns/residents are not considered to work at a single location because they rotate every month or every few months. For HCP who do not work at least 75% of the time at a single location, the work location code for 'float' should be entered. Location codes must be customized to the facility and set up prior to entering HCW records. The work location must be mapped to a CDC Location (http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf).
Department	Optional. Enter the department in which the HCW works (facility defined).
Supervisor	Optional. Enter the name of the HCW's supervisor (facility defined).
Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. These must be customized to the facility and set up prior to entering HCW records. The occupation must be mapped to a CDC Occupation Code.
Title	Conditionally required. Required only for HCP designated as Influenza Vaccinators if the facility intends on using NHSN to fulfill federal recordkeeping requirements for administration of vaccine covered by the Vaccine Injury Compensation Program. Enter the HCW's job title.
Clinical specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, select the appropriate clinical specialty.
Performs direct patient care	Conditionally required. Required only when the HCW has influenza vaccination and/or influenza chemoprophylaxis/treatment records. Select Y (Yes) if the HCW provides direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select N (No).
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information about the HCW. This information cannot be analyzed.

Table 3. Instructions for Completion of the Exposures to Blood/Body Fluids Form (CDC 57.205)

Information for all blood/body fluid exposures should be recorded using this form. The variables to be entered depend upon whether the facility selects the exposure event only reporting or exposure reporting and management.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the application.	Required	Required
Exposure Event #	The exposure event number will be auto-generated by the application.	Required	Required
HCW ID	Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.	Required	Required
♦HCW Name: Last, First, Middle	Enter the HCW's name.	Optional	Optional
♦Gender	Indicate the gender of the HCW by checking F (Female) or M (Male).	Required	Required
♦Date of Birth	Enter the date of birth of the HCW using the format: mm/dd/yyyy.	Required	Required
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
Clinical Specialty	If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.	Conditionally required	Conditionally required
Exposure Type	The default setting is auto-entered by the application as Blood/Body Fluids.	Required	Required
Section I – General Exposure Information			
1. Did the exposure occur at this facility	Choose Y (Yes) or N (No).	Required	Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
1a. If No, specify the name of facility in which exposure occurred	If the exposure did not occur at the reporting facility, enter the name of the facility where the event occurred.	Conditionally required	Conditionally required
2. Date of exposure	Enter date of exposure in mm/dd/yyyy format.	Required	Required
3. Time of exposure	Enter the time the exposure occurred and whether it was AM or PM.	Required	Required
4. Number of hours on duty	Enter the number of hours the HCW had been on duty when the exposure occurred.	Optional	Optional
5. Is exposed person a temp/agency employee?	Choose Y (Yes) or N (No).	Optional	Optional
6. Location where exposure occurred	Choose the appropriate code for the physical location where the event took place. (This is customized to the facility).	Required	Required
7. Type of Exposure	Check the appropriate exposure type. Check all that apply.	Required	Required
7a. Percutaneous: Did the exposure involve a clean, unused needle or sharp object?	If Type of Exposure was Percutaneous, then check this item. If percutaneous is checked, then select Yes or No to indicate whether the exposure involved a clean, unused needle or sharp object. If the incident involved a clean, unused needle or sharp object you may not need to report this as an exposure (see your protocol for more information). If not, check No and complete Q8, Q9 and Section II. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required Conditionally required	Conditionally required Conditionally required
7b. Mucous membrane	If Type of Exposure was Mucous Membrane, then check this item and complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
7c. Skin:	If Type of Exposure was Skin, then check this item.	Conditionally required	Conditionally required
Was skin intact?	If Skin is checked, then indicate Y (Yes), N (No) or (U) Unknown for whether the skin remained intact during the exposure. If the answer is No, complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
7d. Bite	If Type of Exposure was Bite, then check this item and complete Q9 and Section IV. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
8. Type of fluid/tissue involved in exposure	Select the Type of fluid/tissue from the list.	Required	Required
	If Solutions or Body fluids are checked, indicate whether visibly bloody or not visibly bloody. For Body Fluids, indicate the primary body fluid type implicated in the exposure from the list.	Conditionally required	Conditionally required
	If Other is selected for either the Type of Fluid/Tissue involved in the exposure or the Body Fluid Type, please specify the type. (Make sure it is not a body fluid that is already listed in the box on the right side of the form).	Conditionally required	Conditionally required
9. Body site of exposure	Check body site of exposure from the list. Check all sites that were exposed.	Required	Required
	If the Body site of exposure was (Other), please specify the site.	Conditionally required	Conditionally required
Section II – Percutaneous Injury			
1. Was the needle or sharp object visibly contaminated with blood prior to exposure?	Choose Y (Yes) or N (No).	Required	Required
2. Depth of the injury (check one)	Indicate the depth of the injury from the needle or sharp object using the list provided. Exposures that are not obviously superficial (e.g., scratch) or deep (e.g., "muscle contracted" or "touched bone"), should be classified as moderate.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
3. What needle or sharp object caused the injury?	Select one of the following categories: Device, Non-Device Sharp Object, or Unknown Sharp Object. If you select Device in the application you will be provided with a **Device** button that will take you to a screen to enter manufacturer, model, etc. Once a device has been entered you will be able to select it from the drop down list.	Conditionally required	Conditionally required
	If a Non-Device Sharp is selected, please describe the item or object.	Conditionally required	Conditionally required
	Within Devices, there are six categories: *Hollow-bore needles, Suture needles, Other solid sharps, Glass, Plastic, Non-sharp safety devices, and Other devices*.		
	If Other known device is selected, please specify.	Conditionally required	Conditionally required
4. Manufacturer and model	Enter the brand name and model of the device used. If the brand and model are unknown, generic device descriptors can be entered.	Conditionally required	Conditionally required
5. Did the needle or other sharp object involved in the injury have a safety feature?	Choose Y (Yes) or N (No). If Yes, answer 5a and 5b. If No, skip to Q6.	Conditionally required	Conditionally required
5a. If Yes, indicate the type of safety feature	If above is Y (Yes), choose one item from the list of safety devices.	Conditionally required	Conditionally required
5b. If the device had a safety feature, when did the injury occur?	Choose the timing of the injury event with relation to the use of the safety device. Check one item from the list provided.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
6. When did the injury occur? (check one) Before use of the item During use of the item After use of item, before disposal During or after disposal Unknown	Choose the timing of the injury event from the list provided. Injuries that occurred prior to intended use and usually involve clean needles or sharp objects. It may also include injuries that occurred with a clean device that passed through bloody gloves. Injuries that occurred during the use of the needle or sharp object. It also includes surgical or other invasive procedures with many steps. Injuries that occurred while in transit to disposal, cleaning instrument or recapping. Injuries that occurred during or after the process of disposal or because of improper disposal of a needle or other sharp object. Time of injury relative to the use of the device or object is unknown.	Conditionally required	Conditionally required
7. For what purpose or activity was the sharp device being used?	Choose from the lists provided. If Other specify the purpose in the space provided. Select Unknown if injury was a result of contact with discarded or uncontrolled sharps, or in circumstances where the intent of device or object use is unknown or cannot be ascertained.	Conditionally required	Conditionally required
8. What was the activity at the time of injury?	Choose the activity being performed at the time of injury involving the sharp object or needle. If the activity being performed at the time of the injury was different than the purpose indicated in Q7, select the activity at the time the actual injury event took place.	Conditionally required	Conditionally required
9. Who was holding the device at the time the injury occurred?	Select one answer.	Conditionally required	Conditionally required
10. What happened when the injury occurred?	Choose one item from the list. If Other, please record details in the space provided.	Conditionally required	Conditionally required
Section III – Mucous Membrane and/or Skin Exposure			

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
1. Estimate the amount of blood/body fluid exposure	Select the estimated amount of blood or body fluid involved in the mucous membrane or skin exposure. Indicate Unknown if unable to estimate the amount.	Conditionally required	Conditionally required
2. Activity/event when exposure occurred	Select the activity or event at the time mucous membrane or skin exposure occurred.	Conditionally required	Conditionally required
	If Other is selected record details of the activity or event in the space provided.	Conditionally required	Conditionally required
3. Barriers used by the worker at the time of exposure	Check all that apply.	Conditionally required	Conditionally required
	If Other is selected, list other barriers in the space provided.	Conditionally required	Conditionally required
Section IV – Bite			
1. Wound description	Select the description of the bite wound from the list provided.	Conditionally required	Conditionally required
2. Activity/event when exposure occurred	Choose the activity or event when the bite occurred.	Conditionally required	Conditionally required
	If Other, specify the event in the space provided.	Conditionally required	Conditionally required
Sections V – IX are required when following the protocols for Exposure Management			
Section V – Source Information			
1. Was the source patient known?	Choose Y (Yes) if the source of the exposure (patient) is known. Otherwise, select N (No).	Optional	Required
2. Was HIV status known at time of exposure?	Indicate Y (Yes) if the source patient's serostatus was known at the time of exposure.	Optional	Required
3. Check the test results for the source patient: **Hepatitis B** HbsAg HBeAg Total anti-HBc anti-HBs **Hepatitis C** anti-HCV EIA anti-HCV suppl PCR-HCV RNA **HIV** HIV EIA, ELISA Rapid HIV Confirmatory HIV	Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused and NT=Not tested. Indicate the results of any tests performed prior to the exposure (as found in the medical record) or performed immediately after the exposure. If the source is not known, check U. If the source refuses to be tested, check R. Not all tests listed on the form need to be offered after all exposures.	Optional	Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
Section VI – For HIV Infected Source			
1. Stage of Disease	Indicate the stage of HIV disease of the source patient. Use CDC surveillance definitions. For end stage AIDS and acute HIV illness, use definitions as defined in the protocol.	Optional	Conditionally required
2. Is the source patient taking anti-retroviral drugs?	Indicate if the source patient is was taking anti-retroviral drugs at the time of the exposure, Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
2a. If Yes, indicate drug(s)	If the source patient was taking anti-retroviral drugs at the time of the exposure, list them here. Drug codes are listed in Chapter 7 and will be in a drop down list in the application.	Optional	Conditionally required
3. Most recent CD4 count Date	If available, indicate the most recent CD4 count in mm^3 for the source patient. Enter the month and year of the test for the source patient.	Optional	Conditionally required
4. Viral Load Date	If available, indicate the most recent HIV viral load (# of copies per ml) or Undetectable for the source patient. Enter the month and year of the test.	Optional	Conditionally required
Section VII: Initial Care Given to Healthcare Worker			
1. HIV postexposure prophylaxis Offered? Taken?	 Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were offered to the HCW following this exposure. Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were taken by the HCW. If Yes is selected, complete Post-Exposure Prophylaxis/Treatment form (CDC form 57.206).	 Optional Optional	 Required Required
2. HBIG given? Date administered	Choose Y (Yes), N (No), or U Unknown) for whether Hepatitis B immunoglobulin was given. Enter date HBIG prophylaxis pertaining to this exposure was administered. Use mm/dd/yyyy format.	Optional Optional	Required Conditionally Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
3. Hepatitis B vaccine given?	Choose Y (Yes), N (No), or U. (Unknown) for whether Hepatitis B vaccine was given.	Optional	Required
Date first dose administered	Enter date of first dose of Hepatitis B vaccine (mm/dd/yyyy format). This and subsequent doses to complete the HBV series should be recorded in the HCW's file.	Optional	Conditionally Required
4. Is the HCW pregnant?	Indicate the pregnancy status of HCW. Choose Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
4a. If yes, which trimester?	Check 1 (1st trimester), 2 (2nd trimester), or 3 (3rd trimester) at the time of exposure. If stage of pregnancy is unknown, check U.	Optional	Conditionally required
Section VIII – Baseline Lab Testing			
Was baseline testing performed on the HCW?	Choose Y (Yes) or N (No) or U (Unknown). Baseline lab tests should be performed within 2 weeks of exposure date (either before or after).	Optional	Required
HIV EIA HIV confirmatory HepC anti-HCV EIA HepC anti-HCV-supp HepC PCR HCV RNA HepB HBsAg HepB IgM anti-Hbc HepB Total anti-Hbc HepB Anti-HBs	Enter the dates for each test performed and the result (Use codes: P= Positive, N= Negative, I=Indeterminate, U=Unknown, R=Refused).	Optional	Conditionally required
ALT Amylase Blood glucose Hematocrit Hemoglobin Platelets Blood cells in urine WBC Creatinine Other	Additional baseline laboratory tests may be completed to document potential physiologic changes associated with a blood/body fluid exposure. Enter the date (in mm/dd/yyyy format) and result, using the specified units.	Optional	Optional
Section IX – Follow-up			
1. Is it recommended that the HCW return for follow-up of this exposure?	Choose Y (Yes) or N (No).	Optional	Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
1a. If Yes, will follow-up be performed at this facility?	Choose Y (Yes) or N (No).	Optional	Conditionally Required
Section X – Narrative			
In the worker's words, how did the injury occur?	Enter the narrative of the HCW's description of how the injury occurred.	Optional	Optional
Section XI – Prevention			
In the worker's words, what could have prevented the injury?	Enter the narrative of the HCW's assessment of how the injury might have been prevented.	Optional	Optional
Custom Fields	Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.	Optional	Optional
Comments	Enter any additional information about the HCW. This information cannot be analyzed.	Optional	Optional

Table 4. Instructions for Completion of the Healthcare Personnel Postexposure Prophylaxis Form (CDC 57.206)

Use this form if HIV postexposure prophylaxis (PEP) was administered to a healthcare worker following a blood or body fluid exposure.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
MedAdmin ID#	Required. Medical administration number. Data will be auto-entered by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of Birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Infectious Agent	Required. Enter HIV on form. Select HIV in the application.
Exposure Event #	Required. The Exposure event number will be auto-entered by the system. Use the Link/Unlink button to find any exposures for the entered HCW, select, and link the exposure for which PEP is being administered. PEP records cannot be saved unless they are linked to an exposure. PEP records entered from the Blood and Body Fluid Exposure Form will automatically be linked to that exposure.
Initial PEP	**Indication: Prophylaxis**
Time between exposure and 1st dose	Required. Enter the number of hours between the exposure and when the 1st dose of PEP was administered.
Drug	Required. Enter any drugs prescribed for prophylaxis. See Chapter 7 in the protocol for a list of individual drug codes.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Required. Enter the date the initial PEP regimen commenced (mm/dd/yyyy format). The start date will apply to all drugs selected as the initial PEP regimen. The date started must be on or after the exposure date.
Date Stopped	Required. Enter the date the initial PEP regimen was stopped (mm/dd/yyyy format). Note: If any drug(s) of a drug regimen are discontinued, the entire regimen is considered 'stopped.' If select drugs in the regimen continue to be used as prophylaxis (and if other drugs are added) enter them as drugs under a PEP change with a new start date.
Reason for Stopping	Required. Indicate the primary reason for stopping the initial PEP regimen by selecting the appropriate choice.

Data Field	Instructions for Data Collection
PEP Change 1	**Indication: Prophylaxis**
Drug	Required. Enter drugs prescribed for a second prophylaxis regimen. Note that the second PEP regimen may contain drugs that were included in the first regimen.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Conditionally required. Enter the date the second PEP regimen was started using mm/dd/yyyy format.
Date Stopped	Conditionally required. Enter the date the second PEP regimen was stopped using mm/dd/yyyy format. Note: If any drug(s) of a drug regimen are discontinued, the regimen is considered 'stopped.' Whatever drugs in the regimen are continued (and if other drugs are added) will constitute a new regimen and should be entered as such.
Reason for Stopping	Conditionally required. Indicate the primary reason for stopping this PEP regimen by selecting the appropriate choice.
PEP Change 2	**Indication: Prophylaxis**
Drug	Conditionally required. Enter drugs prescribed for a third prophylaxis regimen. Note that the third PEP regimen may contain drugs that were included in previous regimens.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Conditionally required. Enter the date the new PEP regimen was started using mm/dd/yyyy format.
Date Stopped	Conditionally required. Enter the date the new PEP regimen was stopped using mm/dd/yyyy format. Note: If any drug(s) of a drug regimen are discontinued, the regimen is considered 'stopped.' Whatever drugs in the regimen are continued (and if other drugs are added) will constitute a new regimen and should be entered as such.
Reason for Stopping	Conditionally required. Indicate the primary reason for stopping this PEP regimen by selecting the appropriate choice.
Adverse Reactions	
Signs or symptoms of adverse reactions to post-exposure prophylaxis	Optional. Indicate any adverse signs/symptoms the HCW experienced while receiving postexposure prophylaxis. You may select up to six. If Other is selected, briefly specify details of adverse reaction.
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. This information cannot be analyzed.

Table 5: Instructions for Completion of Follow-Up Laboratory Testing Form (CDC 57.207)

This form should be completed for HCP who have additional laboratory testing done as a result of blood or body fluid exposures. These tests would occur after baseline laboratory testing had been completed.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Lab #	Required. The lab testing ID number will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Exposure Event #	Required. The user is required to link the laboratory follow-up record to a blood and body fluid exposure record using the Link feature within the application. Once the exposure is selected and submitted, the form will display the message "Lab is Linked." Laboratory records must be linked to an exposure.
Lab Results	
Lab Test	Required (At least one laboratory test and date are required). Select lab test from dropdown menu: HIV EIA HIV confirmatory HepC anti-HCV EIA HepC anti-HCV-supp HepC PCR HCV RNA HepB HBsAg HepB IgM anti-Hbc HepB Total anti-Hbc HepB Anti-HBs ALT Amylase Blood glucose Hematocrit Hemoglobin Platelets Blood cells in urine WBC Creatinine Other
Date	Required. Indicate date of test using mm/dd/yyyy format.
Result	Conditionally required. Select one of the result codes: Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused)
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. This information cannot be analyzed.

Table 6. Instructions for Completion of the Pre-season Survey on Influenza Vaccination Programs for Healthcare Personnel Form (CDC 57.211)

This form is used to report plans for the facility's influenza vaccination campaign. In addition, denominator data regarding the target vaccination population (i.e., number of FTEs, PTEs, contractors, volunteers, others) are collected. This form should be completed at the beginning of the vaccination season.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Date Entered	Required. The month and year that the pre-season survey was filled out.
For Season	Required. Years of the vaccination season for which survey was completed entered in the format: yyyy – yyyy. Vaccination season is 9/1 of the current year to 8/31 of the following year.
Vaccination campaign for: Seasonal influenza subtype, Non-seasonal influenza subtype, Both	Required. Select the influenza subtype for the campaign described in this survey. Select "Both" if your vaccination campaign and target populations are the same for both influenza subtypes. If your campaign and/or target populations will be different for seasonal and non-seasonal influenza subtypes, complete a separate pre-season survey for each subtype.
1. Which personnel groups do you plan to include in your annual influenza vaccination program?	Required. Check the personnel group you plan to include.
2. Which of the following types of employees do you plan to include in your annual influenza vaccination program? (Check all that apply)	Required. Check each type of employee you plan to include in your influenza vaccination program. For each type of employee you checked, enter the estimated number of employees. This should be the estimated number of employees in each category who you intend on vaccinating during the season.
3. At what cost will you provide influenza vaccine to your healthcare workers?	Required. Check one cost category that best describes your plan for providing influenza vaccinations for the majority of the personnel group specified above.
4. Will influenza vaccination be available during all work shifts (including nights and weekends)?	Required. Check Yes or No.
5. Which of the following methods do you plan to use this influenza season to deliver vaccine to your healthcare workers?	Required. Check all methods that you plan to use to deliver influenza vaccination this season.

Data Field	Instructions for Data Collection
6. Which of the following strategies do you plan to use to promote/enhance healthcare worker influenza vaccination at your facility?	Required. Check all strategies you plan to use in order to promote or enhance influenza vaccination at your facility.
7. Do you plan to conduct any formal educational programs on influenza and influenza vaccination for your healthcare workers?	Required. Check Yes or No.
8. If you plan to conduct formal educational programs on influenza and influenza vaccination, will your healthcare workers be required to attend?	Conditionally required if you plan on conducting formal education programs (i.e., you checked Yes for Question 7). Check Yes or No.
9. Will you require healthcare workers who receive off-site influenza vaccination to provide documentation of their vaccination status?	Required. Check Yes or No.
10. Will you required signed declination statements from healthcare workers who refuse influenza vaccination?	Required. Check Yes or No.
11. Vaccine information statement edition date	Required. Enter the edition date for the official vaccine information statement (VIS) for the seasonal and non-seasonal influenza vaccines that you will be distributing to your employees at ONSITE vaccinations. VISs can be found on the CDC website at http://www.cdc.gov/vaccines/pubs/vis/. Enter the VIS edition date of the primary type of vaccine (e.g., inactivated) that your facility will be using. If the pre-season survey reflects "Both" seasonal and non-seasonal influenza vaccines, then enter the edition dates for both vaccines. This date will be used to auto-fill the HCW vaccination records that are entered for the applicable edition dates. You can edit the date on the vaccination record to reflect a secondary type of vaccine (e.g., live attenuated). The edition dates are required if you plan to use NHSN to satisfy federal record-keeping requirements for the administration of vaccine covered by the Vaccine Injury Compensation Program.
Comments	Optional. Enter any additional information about the HCW. This information cannot be analyzed.

Table 7. Instructions for Completion of the Healthcare Worker Influenza Vaccination Form (CDC 57.209)

This form is used to collect information on whether an individual HCW received or declined the influenza vaccine, and the details of that vaccination. A separate form must be filled out for each vaccination dose. For example, if a HCW received 1 dose of seasonal influenza vaccine and 2 doses of non-seasonal influenza vaccine, there should be three separate vaccination forms. A pre-season survey (CDC 57.211), an annual facility survey (CDC 57.200), and a monthly reporting plan for the month of vaccination (CDC 57.203) must be completed before vaccination records can be entered in NHSN.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).
+Data elements that are carried forward from one vaccination record to the next during batch data entry.

Data Field	Instructions for Data Collection
+Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Vaccination ID #	Required. The vaccination ID number is a unique NSHN locator number for that specific vaccination record that will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Clinical Specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.
♦Performs direct patient care	Required. Select Yes if the HCW provides direct patient care (i.e., hands on, face to face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select No.
+Type of vaccination	Required. Influenza is pre-filled on form and auto-entered by the application.
+Influenza subtype (years)	Required. Select seasonal vaccine or non-seasonal (e.g., 2009 H1N1) vaccine. For either subtype specify the vaccination years during which this vaccination date (or the date the vaccination was offered) falls. For NHSN purposes, the vaccination year is 9/1 of the first year to 8/31 of the following year.

Data Field	Instructions for Data Collection
+Do you plan to use this information to satisfy federal record-keeping requirements for the administration of vaccine covered by the Vaccine Injury Compensation Program?	Required. Check Yes or No. If you select Yes, information on the person administering the vaccine (i.e., the vaccinator) will be required per federal record-keeping requirements.
+Vaccine administered Reasons for declining due to personal reasons:	Required. Select the appropriate location of vaccine administration (ONSITE or OFFSITE). If the HCW declined vaccination, indicate primary reason for declination. Check "Declined due to medical contraindications" if the HCW has severe allergy to chicken eggs or other vaccine components or has developed Guillain-Barre´ syndrome within 6 weeks of getting an influenza vaccine. Select "Declined due to personal reasons" for all other reasons. Conditionally required. If the HCW declined influenza vaccination for personal reasons, select the reason(s) for declining.
+Date of vaccination	Conditionally required – Date is required if the vaccination was administered ONSITE or OFFSITE. Enter the vaccination date using mm/dd/yyyy format. If the exact date of an OFFSITE vaccination is unknown, use the 15th of the month: mm/15/yyyy. The HCW cannot receive two doses of the same vaccine on the same day.
+Product	Conditionally required if vaccine was administered ONSITE. Select the product used in this vaccination. For a NON-SEASONAL vaccine, please select "Other" and specify the name of the NON-SEASONAL vaccine. Optional if vaccine was administered OFFSITE.
+Manufacturer	Conditionally required if vaccine was administered ONSITE. Manufacturer will be auto-entered by the application based on the product that is selected. For a NON-SEASONAL vaccine, specify the manufacturer of the vaccine. Optional if vaccine was administered OFFSITE.
+Lot number	Conditionally required if vaccine was administered ONSITE. Enter the lot number of the vaccine administered to the HCW. Optional if vaccine was administered OFFSITE.
+Type of influenza vaccine	Conditionally required if vaccine was administered ONSITE. Type of influenza vaccine will be auto-entered by the application based on the product that is selected. Select either "Live attenuated" or "Inactivated vaccine." Optional if vaccine was administered OFFSITE.
+Route of administration	Conditionally required if vaccine was administered ONSITE. Route of administration will be auto-entered by the application based on the product that is selected. In rare instances, where some products may be administered subcutaneously (SUBQ), you can manually change the route of administration. Optional if vaccine was administered OFFSITE.

Data Field	Instructions for Data Collection
Adverse reaction to the vaccine	Conditionally required if vaccine was administered ONSITE. Select Yes if the HCW had an adverse reaction attributable to the vaccine; otherwise select No. Select "Don't know" if it is unknown whether the HCW experienced an adverse reaction. Optional if vaccine was administered OFFSITE.
If Yes, check all that apply	Conditionally required if vaccine was administered ONSITE. Select all adverse reactions that apply. If Other is checked, please specify the reaction the HCW experienced. Optional if vaccine was administered OFFSITE.
+Which vaccine information statement, including edition date, was provided to the vaccinee?	Conditionally required if vaccine was administered ONSITE. Vaccine information statement type will be auto-entered by the application based on the product that is selected. Optional if vaccine was administered OFFSITE.
+Edition date [of Vaccine Information Statement (VIS)]	Conditionally required if vaccine was administered ONSITE. The edition date of the primary VIS will be auto-entered by the application based on the answer to Question 11 on the Pre-season Survey. If another vaccine is administered, you can edit the edition date to reflect the secondary VIS. Optional if vaccine was administered OFFSITE.
Vaccinator ID	Conditionally required for ONSITE vaccinations if NHSN will be used to satisfy federal record-keeping requirements for the administration of vaccine (You checked Yes to the Federal record-keeping question). Enter the HCW ID # of the person administering the vaccine.
♦Name, Last First Middle	Conditionally required for ONSITE vaccinations if NHSN will be used to satisfy federal record-keeping requirements for the administration of vaccine. Enter the vaccinator's first and last names. Middle name is optional.
Work address, City, State, Zip code	Conditionally required for ONSITE vaccinations. The vaccinator's work address will be auto-entered by the application from data entered on the Facility form.
♦Title	Conditionally required for ONSITE vaccinations if NHSN will be used to satisfy federal record-keeping requirements for the administration of vaccine. Enter the vaccinator's job title which does not have to match a CDC occupation Code.
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. This information cannot be analyzed.

Table 8. Instructions for Completion of the Healthcare Worker Influenza Antiviral Medication Administration Form (CDC 57.210)

This form should be completed when an HCW receives antiviral medications as influenza treatment or as chemoprophylaxis against influenza infection. It is used to collect information on which antiviral medications were administered, when, and what (if any) adverse reactions were experienced by the HCW.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Med Admin ID #	Required. The medication administration ID number will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of Birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Clinical Specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.
♦Performs direct patient care	Required. Select Yes if the HCW provides direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select No.
Infectious agent	Required. Auto-filled on hard copy form. Select Influenza in application.
For season	Required. Select the vaccination season. Specify the year(s) during which this chemoprophylaxis or treatment date falls. For NHSN purposes, the vaccination "season" is 9/1 of the first year to 8/31 of the second year.
#	Required. Indicate up to 10 antiviral medications given using sequential numbers starting with 1.
Indication	Required. Select Prophylaxis or Treatment as appropriate.
Influenza subtype	Required. Select the influenza subtype for which the HCW is receiving antiviral medications (for post-exposure chemoprophylaxis or for treatment). Select Unknown, if you do not know the specific subtype necessitating antiviral medication use.
Antiviral medication	Required. Enter the code of the antiviral medication that was administered to the HCW using the codes listed at the bottom of the form.
Start date	Required. Enter the start date of the antiviral using mm/dd/yyyy format.

Data Field	Instructions for Data Collection
Stop date	Conditionally required. Enter the stop date of the antiviral using mm/dd/yyyy format.
Adverse reactions?	Required. Check Yes if the HCW had a severe adverse reaction attributable to the influenza antiviral medication; otherwise check No. If it is unknown whether or not the HCW experienced any adverse reactions, check Don't Know.
Adverse reactions to antiviral medication #1…#10	Conditionally required. If the HCW had a severe adverse reaction, check all reactions that apply for each medication administered. Please correlate the antiviral medication # with the antiviral medication on page 1. If an adverse reaction is not listed, check Other and specify the adverse reaction in the space provided. All Other adverse reactions should be included if the reactions were severe enough to affect daily activities and/or resulted in the discontinuation of the antiviral medication.
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. This information cannot be analyzed.

Table 9. Instructions for Completion of the Post-season Survey on Influenza Vaccination Programs for Healthcare Personnel Form (CDC 57.212)

This form is used to report the facility's implemented influenza vaccination campaign. This survey will capture any changes that occurred to the facilities' vaccination strategy and/or target vaccination population during the vaccination season. This form should be completed at the conclusion of the vaccination season.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Date Entered	Required. The month and year that the post-season survey was filled out.
For Season	Required. Years of the vaccination season for which the survey was completed, entered in the format: yyyy – yyyy. Vaccination season is 9/1 of the current year to 8/31 of the following year.
Vaccination campaign for: Seasonal influenza subtype, Non-seasonal influenza subtype, Both.	Required. Select the influenza subtype for the campaign described in this survey. If your campaign and target populations were the same for both influenza vaccination subtypes and you completed a single pre-season survey, select Both. If your campaign and target populations were different for seasonal vs. non-seasonal subtypes, you should complete a separate post-season survey for each.
1. Which personnel groups did you include in your annual influenza vaccination program this past season?	Required. Check the personnel group(s) you included in your campaign or program.
2. Which of the following types of employees did you include in your annual influenza vaccination program this past season? (Check all that apply)	Required. Check each type of employee you included in your influenza vaccination program. Data for each type of employee that you checked for the pre-season survey will be auto-entered into the post-season survey. If your target vaccination population changed over the course of the season, you can edit the number.
3. At what cost did you provide influenza vaccine to your healthcare workers?	Required. Check one cost category that best describes how you provided influenza vaccinations to the majority of the personnel group specified above.
4. Did you provide influenza vaccination during all work shifts (including nights and weekends)?	Required. Choose Yes or No.
5. Which of the following methods did you use during influenza season to deliver vaccine to your healthcare workers?	Required. Check all methods that you used to deliver influenza vaccination this season.

Data Field	Instructions for Data Collection
6. Which of the following strategies did you use to promote/enhance healthcare worker influenza vaccination at your facility?	Required. Check all strategies you used in order to promote or enhance influenza vaccination at your facility.
7. Did you conduct any formal educational programs on influenza and influenza vaccination for your healthcare workers?	Required. Indicate if you conducted formal educational programs on influenza and influenza vaccination for your HCP.
8. If you conducted formal educational programs on influenza and influenza vaccination, did you require your healthcare workers to attend?	Conditionally required if you conducted formal education programs (you checked Yes for Question 7). Check Yes or No.
9. Did you require healthcare workers who received off-site influenza vaccination to provide documentation of their vaccination status?	Required. Check Yes or No.
10. Did you require signed declination statements from healthcare workers who refused influenza vaccination?	Required. Check Yes or No.

Table 10. Instructions for Completion of Healthcare Personnel Safety Component Facility Survey Form (CDC 57.200)

This form must be completed once a year by any facility using the Healthcare Personnel Safety Component.

Data Field	Instructions for Data Collection/Entry
Tracking #	Required. The NHSN-assigned Tracking # will be auto-entered by the application.
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Survey year	Required. Enter the year of the survey using the format: yyyy.
Total beds set up and staffed	Required. Enter the number of all active beds across specialties and intensive care units.
Patient admissions	Required. Enter the number of patients, excluding newborns, admitted for inpatient service.
Inpatient days	Required. Enter the number of adult and pediatric days of care, excluding newborn days of care, rendered during a specified reporting period.
Outpatient encounters	Required. Enter the number of visits by patients who are not admitted as inpatients to the hospital while receiving medical, dental, or other services.
Number of hours worked by all employees	Optional. Number of hours worked is available from OSHA300 reporting logs. The value can also be calculated by identifying the number of full time employees working in your facility within a year, multiply by the number of work hours for one full time employee in a year (typically ranges from 2000-2100 hours per year). Add in overtime hours and total hours worked by part-time, temporary, and contracted staff.
Number of HCWs	Required. HCWs are all persons who work in the hospital. Similar to the AHA survey, calculate the number of attending physicians by including only those who are active or associate staff. Do not include courtesy, consulting, honorary, provisional, or other attending physicians in this number. If you cannot determine the exact number for a particular category, please estimate it. If the facility does not have any HCP in a specific occupation, the user may enter 0. This is the denominator when used to calculate rates of particular exposure events per HCW.
Number of FTEs	Required. A subset of total number of HCP. FTEs are all HCP whose regularly scheduled workweek is 35 hours or more. To calculate the number of FTE's add the number of FTEs to ½ the number of part-time HCP (e.g., 2 part-time HCP = 1 FTE). If you cannot determine the exact number for a particular category, please estimate it. If the facility does not have any FTEs in a specific occupation, the user may enter 0. This is the denominator used to calculate rates of particular exposure events per FTE.

REFERENCES

The following CDC/PHS publications provide recommendations for management and follow-up of blood and body fluid exposures to HBV, HCV, and HIV:

- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. (MMWR, June 29, 2001 / 50(RR11); 1-42)*
- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis (PEP regimens have been changed). (MMWR, September 30, 2005 / 54(RR09); 1-17)*

The following CDC/PHS publication provides recommendations for the immunization of HCP:

- *A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. (MMWR, December 8, 2006 / 55(RR16); 1-25)*
- *Influenza Vaccination of Health-care Personnel. (MMWR, February 24, 2006 / 55(RR02); 1-16)*
- *Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP). (MMWR, July 29, 2009 / 58(Early Release); 1-52)*