Instructions for Completion of the Patient Safety Component-Annual Hospital Survey (CDC 57.103)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2014, a facility would complete a 2013 survey.
Facility Characteristics	
Ownership (check one)	*Required.* Select the appropriate ownership of this facility: • P - For profit • NP - Not for profit, including church • GOV - Government • MIL - Military • VA- Veterans Affairs • PHY - Physician owned
If facility is a Hospital: *Section required if facility is enrolled in NHSN as a hospital (e.g., HOSP-GEN, HOSP-ONC, etc.); otherwise, optional.*	
Number of patient days	*Required.* Enter the total number of patient days from inpatient locations in your hospital during the last full calendar year. Newborns should be included in this count.
Number of admissions	*Required.* Enter the total number of inpatient admissions, including newborns, for your hospital during the last full calendar year.
Is your hospital a teaching hospital for physicians and/or physicians in training? If Yes, what type?	*Required.* If a teaching hospital, select 'Yes'. Otherwise, select 'No'. *Conditionally Required.* If a teaching hospital, select the type from the options listed: (Note: There is no minimum requirement for the number of students in training to meet these definitions.) • **Major:** Facility has a program for medical students and post-graduate medical training. • **Graduate:** Facility has a program for post-graduate medical training (i.e., residency and/or fellowships). • **Undergraduate:** Facility has a program for medical students only.

Facility Characteristics (continued)	
Number of beds set up and staffed in the following location types (as defined by NHSN)	*Required.* Record the maximum number of beds set up and staffed for the last full calendar year for the bed types listed below. If any bed type is new or has not been available long enough to have a full calendar year's worth of data from which to obtain the maximum number, indicate the maximum number from the number of months available. For definitions of CDC location types, see CDC Locations and Descriptions chapter.
a. ICU	Enter the number of beds in locations designated as intensive care units (ICUs) in the facility. This includes all adult, pediatric, and neonatal levels II/III and III.
b. All other inpatient locations	Enter the number of beds set up and staffed in all other inpatient locations used for overnight stay patients in this hospital. This includes all inpatient beds in the facility, and not just those that are subject to NHSN surveillance.
If facility is an Ambulatory Surgery Center (ASC): *Section required only if facility is enrolled in NHSN as an ASC (known as AMB-SURG in NHSN); otherwise, select 'No ASC or not operational in this survey year'.*	
Setting	Select the physical setting of this ambulatory surgery center: Within a hospital or Free-standing.
Total number of procedures	Enter the total number of procedures performed in your ambulatory surgery center during the last full calendar year; includes surgical and non-surgical procedures. Procedures are defined as any patient care event that is assigned a CPT code.
Percent of procedures that was surgical	Of the total procedures performed, enter the percentage that was surgical. Surgical procedures are defined using the full definition of an NHSN operative procedure, found in the NHSN SSI Protocol.
What percentage of your ambulatory surgery patients were discharged or transferred to the following places	For each place listed, enter the percentage of patients that were discharged or transferred to these places following their procedure(s): Home/Customary residence; Recovery care center (facility other than this one); Acute care hospital (emergency or inpatient). The total of all three should equal 100%.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
2. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document the laboratory uses.	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory.

Facility Microbiology Laboratory Practices (continued)	
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)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
4. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
6. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply).	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
7. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.

Facility Microbiology Laboratory Practices (continued)	
8. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species? If No, where your facility's antifungal susceptibility testing is performed? (check one).	*Required.* Select 'Yes' if your laboratory performs antifungal susceptibility testing for *Candida* species; otherwise, select 'No'. *Conditionally Required.* If 'No", select one of the choices provided.
9. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)	*Required.* Select from the choices listed the method(s) of antifungal susceptibility testing performed at your facility or an outside laboratory. If 'Other' is selected, please specify.
10. Is antifungal susceptibility testing performed automatically/reflexively for *Candida* spp. cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? If Yes, what antifungal drugs are tested automatically/ reflexively? (check all that apply)	*Required.* Select 'Yes' if your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing for *Candida* species which are from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select from the choices listed the antifungal drugs which are tested automatically/reflexively. If 'Other' is selected, please specify.
11. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. **Note:** "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of C. *difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.

Facility Microbiology Laboratory Practices (continued)	
12. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
13. Number of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
14. Does the facility routinely place patients infected or colonized with MRSA in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with MRSA on Contact Precautions at your facility.
15. Does the facility routinely place patients infected or colonized with VRE in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with VRE on Contact Precautions at your facility.
16. Does the facility routinely place patients infected or colonized with CRE in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with CRE on Contact Precautions at your facility.

Infection Control Practices (continued)	
17. Does the facility routinely place patients infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility.
18. Does the facility routinely perform screening cultures for CRE? If Yes, in which situations does the facility routinely perform screening cultures for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** obtains screening cultures from patients for CRE (e.g., rectal, perirectal, or stool cultures); otherwise, select 'No.' *Conditionally required*. If 'Yes', select **all** the situations in which your facility would **routinely** obtain screening cultures from patients for CRE. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
19. Does the facility use chlorhexidine bathing on any patient to prevent transmission of MDROs in your hospital?	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO; otherwise, select 'No'.
20. Are results rapidly communicated (generally within 4 hours) to infection prevention staff and/or clinical staff when MDROs are identified from clinical or screening cultures in the laboratory? If Yes, for which MDROs? (check all that apply)	*Required.* Select 'Yes' if the laboratory that performs clinical culture testing for your facility routinely notifies relevant staff (either the Infection Prevention staff and/or clinical staff) in a timely manner (e.g., within 4 hours) when an MDRO is identified from clinical or surveillance cultures; otherwise, select 'No.' *Conditionally required*. If 'Yes', select all the MDROs for which timely notification of relevant staff is performed by the laboratory. If 'Other' is selected, please specify the MDRO(s) for which this would apply.
21. When a patient with an MDRO is transferred to another facility, does your facility communicate the patient's MDRO status to the receiving facility at the time of transfer?	*Required*. Select 'Yes' if your facility **routinely** communicates the MDRO status of a patient known to be colonized or infected with an MDRO to the receiving facility at the time of patient transfer; otherwise, select 'No'.

Infection Control Practices (continued)	
22. Among patients with an MDRO admitted to your facility from another healthcare facility, what percentage of the time does the facility receive information from the transferring facility about the patient's MDRO status?	*Required.* Enter the estimated percentage of the time that your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO.
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
23. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
24. Is there a leader responsible for outcomes of stewardship activities at your facility? If Yes, what is the position of this leader? (check one)	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes. *Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). More than choice one may be selected. If 'Other' is selected, please specify the position.
25. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
26. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
27. Does your facility have a policy that requires prescribers to document in the medical record or during order entry, a dose, duration, and indication for all antibiotics? If Yes, has adherence to this documentation policy (dose, duration, and indication) been monitored?	*Required.* Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 5, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.
28. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions? If Yes, has adherence to facility-specific treatment recommendations been monitored?	*Required.* Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 6, a. Select 'Yes' charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above; otherwise, select 'No'.
29. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	*Required.* Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.
30. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing (i.e., pre-authorization) at your facility?	*Required.* Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
31. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility?	*Required.* Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents and communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
32. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide? If Yes, by which metrics (Check all that apply) If Yes, are facility- and/or unit-specific reports on antibiotic use shared with prescribers?	Required. Select 'Yes' if your facility monitors antibiotic use or consumption at the unit, service, and/or facility wide level at least quarterly; otherwise, select 'No'. *Conditionally Required*. If 'Yes', select from the choices of listed antibiotic use metrics. Days of Therapy (also known as Antimicrobial Days) is defined by any amount of a specific antimicrobial agent administered in a calendar day to a particular patient (i.e., each antimicrobial agent administered to a patient counted as one day of therapy). The Defined Daily Dose is the assumed average maintenance dose per day for a drug used for its main indication in adults and is derived from the total number of grams of each antibiotic purchased, dispensed, or administered. If 'Other' is selected, please specify the method(s) or metric(s) used. *Conditionally Required*. Select 'Yes' if facility and/or unit-specific reports on antibiotic use are shared with prescribers (individually, by service line, by medical group, etc.); otherwise, select 'No'.
33. Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?	*Required.* Select 'Yes' if prescribers (individually, by service line, by medical group, etc.) have received feedback based on observed practices through in-person, telephone, written or electronic communication about how they can improve their antibiotic prescribing; otherwise, select 'No'.
34. Has your stewardship program provided education to clinicians and other relevant staff on improving antibiotic use?	*Required.* Select 'Yes' if your facility stewardship program has provided education on how to improve antibiotic use to clinicians and other relevant staff (e.g. Grand Rounds, in-service training, or direct instruction); otherwise, select 'No'.

Instructions for Completion of the Patient Safety Annual Facility Survey for LTAC (CDC 57.150)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2014, a facility would complete a 2013 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
Setting/Classification: If classified as "Free-standing", does your LTAC hospital share physical housing with one or more of the following on-site facilities or units? (check all that apply) If classified as "Within a hospital", is your LTAC hospital located:	*Required.* Select the physical setting of the facility: free-standing or within a hospital. *Conditionally required.* If facility is classified as free-standing, select one or more of the following facility or unit types that share physical housing with your LTAC: • No (none) • Skilled nursing facility (SNF)/nursing home • Residential facility (assisted living) • Inpatient rehabilitation facility • Neuro-behavioral unit or facility • Other: specify *Conditionally required.* If facility is classified as within a hospital, indicate 'Yes' or 'No' if it is: • In a building that does not provide acute care services (e.g., psychiatric hospital) • Near (but not within) an acute care hospital

Data Field	Instructions for Form Completion
	Note: These questions are to clarify the physical set-up of each HOSP-LTAC. All separately licensed LTAC hospitals should be enrolled within NHSN as a separate LTAC facility type regardless of the physical setting of the facility.
Number of Patient Days	*Required.* Enter the total number of patient days for your hospital during the last full calendar year.
Number of Admissions	*Required.* Enter the total number of inpatient admissions for your hospital during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day during the last full calendar year. Please round to the nearest whole number.
Numbers of LTAC beds in the following categories (categories should equal total number of beds)	*Required.* Enter the total number of LTAC beds in each on the following categories during the last full calendar year: • Intensive care unit (ICU) or critical care beds • High observation/special care/high acuity beds (not ICU) • Other LTAC beds
Total number of LTAC beds (licensed capacity)	*Required.* The total number of LTAC beds in the facility during the last full calendar year will be automatically summed based on the above counts.
Number of single occupancy rooms	*Required.* Enter the total number of single occupancy rooms during the last full calendar year.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
35. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
36. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document the laboratory uses.	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory.
37. For the following organisms please indicate which methods are used for (1) primary susceptibility	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism.

Data Field	Instructions for Form Completion
testing and (2) secondary, supplemental, or confirmatory testing (if performed)	Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
38. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
39. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
40. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply)?	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
41. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.

Data Field	Instructions for Form Completion
42. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species? If No, where your facility's antifungal susceptibility testing is performed? (check one).	*Required.* Select 'Yes' if your laboratory performs antifungal susceptibility testing for *Candida* species; otherwise, select 'No'. *Conditionally Required.* If 'No", select one of the choices provided.
43. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)	*Conditionally Required.* Select from the choices listed the method(s) of antifungal susceptibility testing performed at your facility or an outside laboratory. If 'Other' is selected, please specify.
44. Is antifungal susceptibility testing performed automatically/reflexively for *Candida* spp. cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? If Yes, what antifungal drugs are tested automatically/ reflexively? (check all that apply)	*Required.* Select 'Yes' if your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing for *Candida* species which are from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select from the choices listed the antifungal drugs which are tested automatically/reflexively. If 'Other' is selected, please specify.
45. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. Note: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
46. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified

Data Field	Instructions for Form Completion
obstacle(s) to producing an antibiogram. (Check all that apply)	by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
47. Number of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
c. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
d. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
48. Does your facility perform active surveillance testing (culturing) of new patients on admission for colonization with any of the following multidrug-resistant organisms (MDROs)? (check all that apply)	*Required.* Select from the choices listed, all MDRO(s) for which newly-admitted patients are tested for colonization: • Methicillin-resistant *Staphylococcus aureus* (MRSA) • Vancomycin-resistant *Enterococcus* (VRE) • Carbapenem-resistant Enterobacteriaceae (CRE) • Other multidrug-resistant gram-negative rods • We do not screen new admissions for MDROs
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
49. Does the facility routinely place patients infected or colonized with MRSA in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with MRSA on Contact Precautions at your facility.
50. Does the facility routinely place patients infected or colonized with VRE in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with VRE on Contact Precautions at your facility.
51. Does the facility routinely place patients infected or colonized with CRE in contact precautions? (check	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with CRE on Contact Precautions at your facility.

Data Field	Instructions for Form Completion
one)	
52. Does the facility routinely place patients infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility.
53. Does the facility routinely perform screening cultures for CRE? If Yes, in which situations does the facility routinely perform screening cultures for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** obtains screening cultures from patients for CRE (e.g., rectal, perirectal, or stool cultures); otherwise, select 'No.' *Conditionally required*. If 'Yes', select **all** the situations in which your facility would **routinely** obtain screening cultures from patients for CRE. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
54. Does the facility use chlorhexidine bathing on any patient to prevent transmission of MDROs in your hospital?	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO; otherwise, select 'No'.
55. Are results rapidly communicated (generally within 4 hours) to infection prevention staff and/or clinical staff when MDROs are identified from clinical or screening cultures in the laboratory? If Yes, for which MDROs? (check all that apply)	*Required.* Select 'Yes' if the laboratory that performs clinical culture testing for your facility routinely notifies relevant staff (either the Infection Prevention staff and/or clinical staff) in a timely manner (e.g., within 4 hours) when an MDRO is identified from clinical or surveillance cultures; otherwise, select 'No.' *Conditionally required*. If 'Yes', select all the MDROs for which timely notification of relevant staff is performed by the laboratory. If 'Other' is selected, please specify the MDRO(s) for which this would apply.
56. When a patient with an MDRO is transferred to another facility, does your facility communicate the patient's MDRO status to the receiving facility at the time of transfer?	*Required*. Select 'Yes' if your facility **routinely** communicates the MDRO status of a patient known to be colonized or infected with an MDRO to the receiving facility at the time of patient transfer; otherwise, select 'No'.
57. Among patients with an MDRO admitted to your facility from another	*Required.* Enter the estimated percentage of the time that your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO.

Data Field	Instructions for Form Completion
healthcare facility, what percentage of the time does the facility receive information from the transferring facility about the patient's MDRO status?	
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
58. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
59. Is there a leader responsible for outcomes of stewardship activities at your facility? If Yes, what is the position of this leader? (check one)	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes. *Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). More than choice one may be selected. If 'Other' is selected, please specify the position.
60. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
61. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.
62. Does your facility have a policy that requires prescribers to document in the medical record or during order entry, a dose, duration, and indication for all antibiotics?	*Required.* Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 5, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.

Data Field	Instructions for Form Completion
If Yes, has adherence to this documentation policy (dose, duration, and indication) been monitored?	
63. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions? If Yes, has adherence to facility-specific treatment recommendations been monitored?	*Required.* Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 6, a. Select 'Yes' charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above; otherwise, select 'No'.
64. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	*Required.* Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.
65. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing (i.e., pre-authorization) at your facility?	*Required.* Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
66. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility?	*Required.* Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents and communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.
67. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide? If Yes, by which metrics (Check all that apply) If Yes, are facility- and/or unit-specific reports on antibiotic use shared with	Required. Select 'Yes' if your facility monitors antibiotic use or consumption at the unit, service, and/or facility wide level at least quarterly; otherwise, select 'No'. *Conditionally Required*. If 'Yes', select from the choices of listed antibiotic use metrics. Days of Therapy (also known as Antimicrobial Days) is defined by any amount of a specific antimicrobial agent administered in a calendar day to a particular patient (i.e., each antimicrobial agent administered to a patient counted as one day of therapy). The Defined Daily Dose is the assumed average maintenance dose per day for a drug used for its main indication in adults and is derived from the total number of grams of each antibiotic purchased, dispensed, or administered. If 'Other' is selected, please specify the method(s) or metric(s)

Data Field	Instructions for Form Completion
prescribers?	used. *Conditionally Required*. Select 'Yes' if facility and/or unit-specific reports on antibiotic use are shared with prescribers (individually, by service line, by medical group, etc.); otherwise, select 'No'.
68. Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?	*Required.* Select 'Yes' if prescribers (individually, by service line, by medical group, etc.) have received feedback based on observed practices through in-person, telephone, written or electronic communication about how they can improve their antibiotic prescribing; otherwise, select 'No'.
69. Has your stewardship program provided education to clinicians and other relevant staff on improving antibiotic use?	*Required.* Select 'Yes' if your facility stewardship program has provided education on how to improve antibiotic use to clinicians and other relevant staff (e.g. Grand Rounds, in-service training, or direct instruction); otherwise, select 'No'.

Instructions for Completion of the Patient Safety Annual Facility Survey for IRF (CDC 57.151)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2014, a facility would complete a 2013 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
How would you describe your licensed inpatient rehabilitation facility? (check one)	*Required.* Select the appropriate classification of your inpatient rehabilitation facility: • Free-standing - The rehabilitation facility functions as a stand-alone facility. Patients receive all required care within the constructs of this facility. The facility may share a building with another healthcare facility, but does not share staff, patients, or policies (such as infection control) with the other healthcare facility. • Healthcare facility based - The rehabilitation facility functions as part of a larger healthcare facility. Patients can be transported from the rehabilitation area to the healthcare facility area on a regular/daily basis for procedures or therapy. The facility may share staff and policies (such as infection control) with the affiliated healthcare facility.
Total number of beds	*Required.* Enter the total number of beds in your facility during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day in your facility during the last full calendar year. Please round to the nearest whole number.
Number of patient days	*Required.* Enter the total number of patient days for your facility during the last full calendar year.

Data Field	Instructions for Form Completion
Average length of stay	*Required.* Enter the average length of stay of patients in your facility during the last full calendar year. Please round to the nearest whole number.
Indicate the number of admissions with the primary diagnosis for each of the following rehabilitation categories (must sum to the total number of admissions listed below)	*Required.* For your facility during the last full calendar year, enter the number of admissions with the primary diagnosis for each of the categories listed. • Traumatic spinal cord dysfunction • Non-traumatic spinal cord dysfunction • Stroke • Brain dysfunction (non-traumatic or traumatic) • Other neurologic conditions (e.g. multiple sclerosis, Parkinson's disease, etc) • Orthopedic conditions (incl. fracture, joint replacement, other) • All other admissions
Total number of admissions	*Required.* The total number of admissions will be automatically summed from the categories above. Additionally, enter the total number of admissions that were patients on a ventilator as well as the number that were pediatric admissions.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
70. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
71. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document the laboratory uses.	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory.
72. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.

Data Field	Instructions for Form Completion
73. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
74. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
75. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply)?	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
76. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.
77. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species? If No, where your facility's antifungal susceptibility testing is performed? (check one).	*Required.* Select 'Yes' if your laboratory performs antifungal susceptibility testing for *Candida* species; otherwise, select 'No'. *Conditionally Required.* If 'No", select one of the choices provided.
78. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that	*Conditionally Required.* Select from the choices listed the method(s) of antifungal susceptibility testing performed at your facility or an outside laboratory. If 'Other' is selected, please specify.

Data Field	Instructions for Form Completion
apply)	
79. Is antifungal susceptibility testing performed automatically/reflexively for *Candida* spp. cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? If Yes, what antifungal drugs are tested automatically/ reflexively? (check all that apply)	*Required.* Select 'Yes' if your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing for *Candida* species which are from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select from the choices listed the antifungal drugs which are tested automatically/reflexively. If 'Other' is selected, please specify.
80. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. Note: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
81. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
82. Number of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required

Data Field	Instructions for Form Completion
	to be considered an "IP" on this survey.
e. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
f. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
83. Does your facility perform active surveillance testing (culturing) of new patients on admission for colonization with any of the following multidrug-resistant organisms (MDROs)? (check all that apply)	*Required.* Select from the choices listed, all MDRO(s) for which newly-admitted patients are tested for colonization: • Methicillin-resistant *Staphylococcus aureus* (MRSA) • Vancomycin-resistant *Enterococcus* (VRE) • Carbapenem-resistant Enterobacteriaceae (CRE) • Other multidrug-resistant gram-negative rods • We do not screen new admissions for MDROs
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
84. Does the facility routinely place patients infected or colonized with MRSA in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with MRSA on Contact Precautions at your facility.
85. Does the facility routinely place patients infected or colonized with VRE in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with VRE on Contact Precautions at your facility.
86. Does the facility routinely place patients infected or colonized with CRE in contact precautions? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with CRE on Contact Precautions at your facility.
87. Does the facility routinely place patients infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility.
88. Does the facility routinely perform screening cultures	*Required.* Select 'Yes' if your facility **routinely** obtains screening cultures from patients for CRE (e.g., rectal, perirectal, or stool cultures); otherwise, select 'No.'

Data Field	Instructions for Form Completion
for CRE? If Yes, in which situations does the facility routinely perform screening cultures for CRE? (check all that apply)	*Conditionally required*. If 'Yes', select **all** the situations in which your facility would **routinely** obtain screening cultures from patients for CRE. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
89. Does the facility use chlorhexidine bathing on any patient to prevent transmission of MDROs in your hospital?	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO; otherwise, select 'No'.
90. Are results rapidly communicated (generally within 4 hours) to infection prevention staff and/or clinical staff when MDROs are identified from clinical or screening cultures in the laboratory? If Yes, for which MDROs? (check all that apply)	*Required.* Select 'Yes' if the laboratory that performs clinical culture testing for your facility routinely notifies relevant staff (either the Infection Prevention staff and/or clinical staff) in a timely manner (e.g., within 4 hours) when an MDRO is identified from clinical or surveillance cultures; otherwise, select 'No.' *Conditionally required*. If 'Yes', select all the MDROs for which timely notification of relevant staff is performed by the laboratory. If 'Other' is selected, please specify the MDRO(s) for which this would apply.
91. When a patient with an MDRO is transferred to another facility, does your facility communicate the patient's MDRO status to the receiving facility at the time of transfer?	*Required*. Select 'Yes' if your facility **routinely** communicates the MDRO status of a patient known to be colonized or infected with an MDRO to the receiving facility at the time of patient transfer; otherwise, select 'No'.
92. Among patients with an MDRO admitted to your facility from another healthcare facility, what percentage of the time does the facility receive information from the transferring facility about the patient's MDRO status?	*Required.* Enter the estimated percentage of the time that your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO.
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar*	

Data Field	Instructions for Form Completion
year.	
93. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
94. Is there a leader responsible for outcomes of stewardship activities at your facility? If Yes, what is the position of this leader? (check one)	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes. *Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). More than choice one may be selected. If 'Other' is selected, please specify the position.
95. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
96. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.
97. Does your facility have a policy that requires prescribers to document in the medical record or during order entry, a dose, duration, and indication for all antibiotics? If Yes, has adherence to this documentation policy (dose, duration, and indication) been monitored?	*Required.* Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 5, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.
98. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?	*Required.* Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'. *Conditionally Required.* If 'Yes' to question 6, a. Select 'Yes' charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above;

Data Field	Instructions for Form Completion
If Yes, has adherence to facility-specific treatment recommendations been monitored?	otherwise, select 'No'.
99. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	*Required.* Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.
100. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing (i.e., pre-authorization) at your facility?	*Required.* Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
101. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility?	*Required.* Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents and communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.
102. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide? If Yes, by which metrics (Check all that apply) If Yes, are facility- and/or unit-specific reports on antibiotic use shared with prescribers?	Required. Select 'Yes' if your facility monitors antibiotic use or consumption at the unit, service, and/or facility wide level at least quarterly; otherwise, select 'No'. *Conditionally Required*. If 'Yes', select from the choices of listed antibiotic use metrics. Days of Therapy (also known as Antimicrobial Days) is defined by any amount of a specific antimicrobial agent administered in a calendar day to a particular patient (i.e., each antimicrobial agent administered to a patient counted as one day of therapy). The Defined Daily Dose is the assumed average maintenance dose per day for a drug used for its main indication in adults and is derived from the total number of grams of each antibiotic purchased, dispensed, or administered. If 'Other' is selected, please specify the method(s) or metric(s) used. *Conditionally Required*. Select 'Yes' if facility and/or unit-specific reports on antibiotic use are shared with prescribers (individually, by service line, by medical group, etc.); otherwise, select 'No'.
103. Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?	*Required.* Select 'Yes' if prescribers (individually, by service line, by medical group, etc.) have received feedback based on observed practices through in-person, telephone, written or electronic communication about how they can improve their antibiotic prescribing; otherwise, select 'No'.

Data Field	Instructions for Form Completion
104. Has your stewardship program provided education to clinicians and other relevant staff on improving antibiotic use?	*Required.* Select 'Yes' if your facility stewardship program has provided education on how to improve antibiotic use to clinicians and other relevant staff (e.g. Grand Rounds, in-service training, or direct instruction); otherwise, select 'No'.