Emerging Infections Program
Healthcare-Associated Infections & Antimicrobial Use
Prevalence Survey

Operational Manual

Version 1, June 20, 2013

Primary Team Instructions*

***NOTE:** This document contains only the sections of the complete Operational Manual that are relevant to the Primary Team's responsiblities in this survey. Some sections, appendices, and forms have been removed as they are not relevant to the major activities of the Primary Team. If you have questions about the complete Operational Manual, please contact your EIP Team.*

TABLE OF CONTENTS

References used in preparing this manual:

1) The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol, available at http://www.cdc.gov/nhsn/PDFs/pscManual/PSC-Manual-portfolio.pdf.
2) Operational manual for the Four Country (England, Wales, Northern Ireland, Republic of Ireland) Healthcare Associated Infection Prevalence Survey 2006, Hospital Infection Society and Infection Control Nurses Association. Survey results presented in: Smyth ETM, McIlvenny G, Enstone JE, et al. Four Country Healthcare Associated Infection Prevalence Survey 2006: overview of the results. J Hosp Infect 2008;69:230-48.
3) Operational manual for the Jacksonville Healthcare-Associated Infections Prevalence Survey Pilot 2009, Jacksonville, FL, Version 6, June 29, 2009.
4) Operational manual for the Emerging Infections Program Phase 3 Healthcare-Associated Infections and Antimicrobial Use Prevalence Survey, Version 2a, May 6, 2011.
5) Emerging Infections Program Phase 3 Healthcare-Associated Infections and Antimicrobial Use Prevalence Survey protocol, Version 4a, March 22, 2011.

PREVALENCE SURVEY DESIGN OVERVIEW

This manual contains instructions for performing the Emerging Infections Program (EIP) Healthcare-Associated Infections (HAI)/Antimicrobial Use Prevalence Survey and completing the data collection forms.

The project has been designed as a point prevalence survey, to be conducted on a single day in each participating hospital. Hospital types included in the survey are general, acute care hospitals, including general, acute care, pediatric hospitals. Hospitals were randomly selected and recruited for participation in each EIP site from 3 bed size strata: small, medium, and large. The numbers of hospitals recruited in each of these strata attempted to approximate the distribution of hospitals in these bed size categories across the entire EIP catchment area (combined catchment areas of the 10 EIP sites).

Each participating hospital will select its own survey date. Where possible, all hospital survey dates will occur during the same 4-month period (e.g., May through August).

Prior to the survey date, participating hospitals will assemble a team of hospital staff to perform survey-related activities. This team is called the Primary Team, or PT. During the month prior to the survey, a member of the PT will complete a Healthcare Facility Assessment (HFA). On the survey date, the PT will perform medical record review on a random sample of hospital

inpatients to collect a limited amount of basic information. This basic information includes patient demographic data (e.g., age, gender, etc.), hospitalization dates, height and weight information, presence of selected medical devices, and antimicrobial drug administration. Because this is a point prevalence survey, all data collection will remain restricted to information present (or cultures collected) on or prior to the survey date.

Each EIP site will have a trained team of survey personnel (the EIP Team, or EIPT) that may assist the PT with its data collection, where needed. In some cases, where resources do not permit collection of data on the survey date itself, the PT and/or EIPT may collect the information retrospectively, according to the specific approach developed by the CDC and EIP survey personnel. Information collected on the survey date by the PT will be transmitted to EIPTs within 30 days following the survey date.

The EIPT will identify those patients for whom additional medical record review is needed (i.e. those patients identified as being on antimicrobial drugs or scheduled to receive antimicrobial drugs on the day of the survey or the day prior to the survey). The EIPT will request and review medical records of this subset of patients to collect additional antimicrobial use data and make HAI determinations. EIPTs will enter all survey data into a web-based electronic data management system developed by CDC.

PREVALENCE SURVEY TEAMS

As noted above, primary data collection for the prevalence survey will be conducted by 2 teams: Primary Teams (PTs) and EIP Teams (EIPTs).

The PT is the team that each participating hospital assembles for the purposes of conducting prevalence survey activities. The number, experience, and expertise of team members will vary from hospital to hospital, although it is recommended that the PT leader be an infection preventionist. Other team members will be determined by the PT leader. These individuals may be Registered Nurses or other hospital personnel without specific infection prevention experience, as long as these team members: 1) possess appropriate credentials and permissions to review patient medical records as required by the facility; 2) have participated in prevalence survey training conducted by EIP sites and/or CDC; and 3) receive adequate supervision by the PT leader. The PT will complete the HFA and collect basic demographic and limited clinical data on patients selected for inclusion in the survey. The EIPT may assist the PT in these survey date activities, to the extent determined upon by the PT and EIPT, by providing support or participating in data collection.

The EIPT is the team composed of EIP epidemiologists/surveillance officers and led by the EIP survey coordinator. In some EIP sites, this team may also include other designated, qualified individuals, as deemed appropriate by the EIP survey coordinator. EIPT members will participate in prevalence survey training conducted by CDC. The EIPT will assist the PT with acute care unit mapping to NHSN location codes, patient selection activities, and will also perform retrospective medical record review of patients surveyed by the PT to identify HAIs and to assess antimicrobial use.

PATIENT POPULATION

The prevalence survey will include patients of any age admitted to acute care areas of participating hospitals. Acute care areas of participating hospitals include labor and delivery (LD) units, labor-delivery-recovery-postpartum (LDRP) units, and newborn nurseries housing well

newborns. Newborns rooming in with mothers on LDRP or postpartum (PP) units are also included. There is no required duration of hospitalization for a patient to be included in the study (except in the case of patients on observation status, who are eligible for inclusion in the survey if they have been in the hospital for ≥ 24 hours at the time of the survey).

Do not include patients in the following categories:

- Patients in non-acute care areas of the hospital.
- Patients in non-admission areas of the hospital.
- Patients in skilled nursing care units.
- Patients undergoing same-day treatment or surgery.
- Patients seen as outpatients, whether for 23-hour observation, diagnosis, or therapy (e.g. chemotherapy, dialysis, or cardiac catheterization).
- Patients in the Emergency Department.
- Patients in hospice units.

Ideally, all acute care patients in participating hospitals would be included the survey. However, in many instances this is not practical. Therefore, a random sample of acute care patients from each participating hospital will be included. The process for selecting the random sample of patients is described below. The size of the random sample will depend on the staffed bed size of the hospital:

- Small hospitals will have a target sample size of 75 patients (or all acute care inpatients in circumstances where the acute care patient census on the survey date is <75).
- Medium hospitals will have a target sample size of 75 patients.
- Large hospitals will have a target sample size of 100 patients.

OVERVIEW OF SURVEY PROCEDURES FOR PRIMARY TEAMS

1) Each hospital should designate a PT leader in advance of the survey date. The PT leader is responsible for coordinating all prevalence survey activities at that facility and for supervising and organizing the efforts of the PT.
2) Approximately one month prior to the survey date, the PT leader or designee will complete the HFA; this assessment gathers information on hospital characteristics (such as bed size) and infection control and antimicrobial stewardship practices, policies and resources. The PT leader or designee will be responsible for completing the assessment and submitting it to the EIPT, but the PT leader or designee is expected and encouraged to consult with other hospital colleagues/departments to collect all information needed to complete the HFA. The HFA should be completed within 1-2 weeks.
3) In advance of the survey date (e.g., approximately one month prior to the survey date), the PT leader will send a list of the participating facility's acute care inpatient units to the EIPT. The EIPT will work with staff at CDC to map each acute care inpatient unit to the correct NHSN location code (see Appendix 1).
4) The PT leader will submit a list of acute care bed numbers to the EIPT approximately 2-3 weeks in advance of the survey date. This bed number list should, whenever possible, be formatted in Microsoft Excel, with columns for acute care unit name, CDC location code, and bed number. Bed numbers should represent unique hospital beds (and, therefore, in most cases unique patients).
5) Approximately one week prior to the survey, the PT leader will receive a randomly-sorted acute care bed number list from the EIPT. This list should include the following information for each acute care bed number: the hospital unit on which the bed is located,

the CDC location code for that unit, and the CDC ID code assigned to that bed number. The list should also make note of the target sample size for that hospital, based on the hospital's bed size category.

Note for small hospitals: If the number of staffed beds in a small hospital is less than 75, then the goal will be for the PT to survey all patients in that hospital on the survey date. For example, if Hospital CC has 50 staffed beds, Hospital CC would have a sample size goal of 50 patients on the survey date. If 45 eligible acute care patients were in Hospital CC on the morning of the survey date (i.e. 5 beds were empty), the PT should attempt to survey all 45 patients. Also, in hospitals where the number of staffed beds may be greater than 75 but the number of eligible patients on the survey date turns out to be less than 75, the PT should attempt to survey all eligible patients.

6) CDC ID codes should be pre-assigned to bed numbers prior to the survey by the EIPT or the PT. Each code will be a 7-digit, alpha-numeric code starting with the state's two-letter abbreviation, followed by a two-letter facility identifier and 3 numbers (example, CA-AA001). The two-letter facility identifier will be assigned by the EIPT.

   Example of CDC ID code assignment: Hospital AA in CA is a small hospital with a target sample size of 75 patients. The CA EIPT member assigned to Hospital AA provides the PT leader with the hospital two-letter code (AA), and patient numbers from 1 to 75. Therefore, CDC ID codes in Hospital AA will be CA-AA001 through CA-AA075. Hospital BB, also in CA, is a large hospital and therefore has a target sample size of 100. The CA EIPT member gives the Hospital BB PT leader the hospital two-letter code (BB) and patient numbers from 1 to 100. Therefore, Hospital BB's CDC ID codes will be CA-BB001 through CA-BB100.

7) Between 12:00 am and 8:00 am on the morning of the survey date, the PT leader will print out the hospital census for that day. The PT will match the randomly-sorted acute care bed number list with the morning census to identify the patients to be surveyed. For example, if the first bed number on the randomly-sorted bed number list is bed 100 on the 2 North patient care unit, then the PT will use the morning census to identify the patient occupying bed 100 on the 2 North unit. That patient will be included in the survey, unless initial review of the patient's record reveals that the patient is not an acute care patient eligible for inclusion in the survey. Once the randomly-sorted bed numbers are matched to the morning census, the CDC ID codes are used as unique identifiers for the patients occupying those acute care bed numbers randomly selected for inclusion in the survey.
8) The PT and/or EIPT must complete a Patient Information Form (PIF) for each patient included in the minimum sample size goal. The PIF is a 2-page form. Only the first page needs to be completed on the survey date; the second page of the PIF consists of follow up information (e.g., hospital discharge date and outcome date) that will be collected at a later date (and filled out, in most cases, by the EIPT). In the Hospital AA example, a small hospital, the PT needs to complete a PIF for each patient occupying one of the first 75 bed numbers on the randomly-sorted acute care bed number list on the morning of the survey, assuming that each of the patients occupying those 75 bed numbers is eligible for the survey (i.e. are eligible acute care inpatients) and their medical records are available.
9) Special circumstances that may arise include the following: (1) a patient occupying a bed selected for inclusion in the survey is not eligible for the survey; (2) the patient's medical record is unavailable at the time of the survey; and (3) a bed selected for inclusion in the survey is empty at the time of the survey. Circumstance (2) is likely to be a problem

primarily in facilities where PTs need to review paper medical records to complete PIFs. Several special circumstances are addressed below:

a) What if I go to review the medical record of a patient occupying a bed selected for inclusion in the survey, and I discover that the patient is actually a patient on observation status?

Answer: If the patient is an observation-status patient who has been in the hospital for at least 24 hours, include that patient in the survey. If the patient is an observation-status patient who has been in the hospital for < 24 hours, exclude that patient and move on to the next patient/bed number on your list.

b) What should I do if I travel to a unit to review a patient selected for inclusion in the survey, but the patient is off the floor and the medical record is not available?

Answer: In these cases, the PT should make a second attempt to review that patient's chart at a later time on the survey date. If the patient record is still not available on the second attempt, then the PT can skip that patient and not include that patient in the survey.

c) What should I do if a patient selected for inclusion in the survey dies or is discharged from the hospital between the time the morning census was generated and the time I travel to the unit to review the medical record?

Answer: If a patient selected for inclusion in the survey has been discharged or has died between the time the morning census list is generated and the time the PT reviews that patient's medical record on the survey date, the PT may skip that patient and not include that patient in the survey ***if the medical record is not available****. If, however, the patient's record is still available, and it can be confirmed that the patient was in the hospital, was an eligible acute care inpatient, and occupied the selected acute care bed number for some period of time on the survey date, the patient should be included in the survey and a PIF should be completed.*

d) What should I do if a patient selected for inclusion in the survey is transferred to another bed in my hospital between the time the morning census was generated and the time I travel to the unit to review the medical record?

Answer: In this circumstance, you will need to skip that patient. Do not "follow" the patient to their new location in the hospital. Also, if the patient's original bed number (the bed number selected for inclusion in the survey) is now occupied by a different patient than the patient on the morning census list, DO NOT review the record of the patient who is now occupying the bed. You should move to the next acute care bed number and patient on your randomly-sorted bed number list.

e) What should I do if I discover that a bed number selected for inclusion in the survey is empty at the time of the survey?

Answer: You should simply skip that bed number and move on to the next bed number on your list. Of course, you will need to replace that empty bed number with another bed number on your randomly-sorted list, and the process for doing this is described in the answer to the next question.

f) What should I do if I get to my minimum goal sample size on my list, but I realize that I have had to skip a few patients for the reasons noted above (e.g., medical records were not available, beds were empty, etc.), and so I haven't actually completed my minimum goal number of PIFs?

*Answer: Let's consider an example, You are a PT member in Hospital BB, considered a large hospital for the purposes of the prevalence survey. You know that your minimum sample size goal for the prevalence survey is 100 patients. You have reached the 100th acute care bed number on your randomly-sorted bed number list, and you realize that you have only been able to complete 95 PIFs, since 3 patients' medical records were not available and 2 bed numbers were empty. In this case, you should simply continue **in order** down your randomly-sorted acute care bed number list until you are able to complete 5 more PIFs. That will give you your minimum goal sample size of 100. It is very important to continue down your randomly-sorted list **in order**—do not skip around on your list to select the replacement bed numbers.*

10) The PT leader should ensure that all PIFs are completed, ideally on the day of the survey whenever possible. If the form is completed on the survey date, the PT leader should ensure that the time of data collection is recorded in the appropriate space at the top of the PIF. If the PIFs cannot be completed on the survey date, it is acceptable for PTs and/or EIPTs to complete the PIFs retrospectively, as long as data collection is restricted to information present up until 5:00 pm (17:00 hours) on the survey date. For example, if the PT is completing Patient X's PIF two weeks after the survey date, and the PT determines that a urinary catheter was not present until 7 pm on the survey date, the PIF "Urinary catheter" item within the "Devices" section of the form would be checked "No," since the catheter was not in place until after 5 pm. In circumstances where data collection is performed retrospectively, this should be indicated at the top of the PIF by checking the "Data collection done retrospectively" box.
11) The PT leader should maintain the linkages between CDC ID codes and patient identifiers until the EIPT notifies the PT leader that project activities are complete and the linkages can be destroyed. The PT leader can maintain the linkages by making sure to fill out the top portion of the Data Collection Form (the "Identifiers" section), making a copy of each PIF, and storing these PIF copies in a secure location at the participating facility, according to local institutional review board (IRB) and/or facility regulations.
12) The PT leader should submit all original, completed PIFs to the EIPT within 30 days after the survey date, keeping in mind that PIFs contain patient identifiers. All necessary precautions, according to each participating facility's and/or state's requirements, should be taken to ensure patient privacy and confidentiality.

DATA COLLECTION

NOTE regarding sources of data: This project relies on existing data sources (e.g., medical records, nursing records, and laboratory reports). There is no direct interaction with patients. Patients will not be interviewed. Acceptable sources of data include: electronic or paper medical records, radiology or laboratory reports, census lists, lists of patients with selected medical devices, etc. It is acceptable to consult with healthcare providers (such as the Charge Nurse) on inpatient units to obtain information regarding patients with selected medical devices.

There is one healthcare facility information form completed by the PTs:

1) Healthcare Facility Assessment (HFA), completed one time by the PT leader or designee approximately one month before the survey date.

There is one patient-level survey form completed by the PTs (and/or the EIPTs in some cases):

2) Patient Information Form (PIF), completed by PTs and/or EIPTs for all surveyed patients. The first page is completed by the PTs and/or EIPTs, ideally on the survey date; the second page (follow up information) will in most cases be completed by EIPTs through a retrospective medical record review process.

There are additional forms completed by the EIPTs:

3) Antimicrobial Use Form, completed by EIPTs for patients identified on PIFs as being on antimicrobial agent(s) or scheduled to receive antimicrobial agents;
4) HAI Form, completed by EIPTs for patients identified on PIFs as being on antimicrobial agent(s), and identified on Antimicrobial Use Forms as receiving antimicrobial agent(s) for treatment of active infection or for unknown rationale.
5) Antimicrobial use assessment/audit forms, completed by EIPTs to gather information regarding the appropriate use of antimicrobial agents.

The PT role in survey data collection is described in more detail below.

Primary Teams

Data Collection Tools

Hospital characteristics will be collected on the HFA; the HFA should be completed using blue or black ink. Patient data collection should be completed using the PIF, using black or blue ink. Record dates, identification numbers, and codes where indicated. When making a selection(s) among two or more answer choices, place an "**X"** in the appropriate box(es).

Timeline for Completing HFA and PIFs

Each hospital will select a single survey date. Ideally, all participating hospitals will conduct their surveys during the same 4-month period (e.g., May through August). The HFA should be completed and submitted to the EIPT during the month prior to the survey date. Surveys should be conducted on a weekday, Monday through Friday, during normal working hours. The PT is strongly encouraged to complete its patient-level data collection activities on the survey date; however, when necessary data collection by the PT can be completed retrospectively, following a standard approach developed by CDC and EIP staff. ALL data collection must remain restricted to information present (or cultures collected) on or prior to the survey date. PTs will provide their completed PIFs to the EIPT within 30 days of the survey date.

Data Collected

The HFA is completed once, prior to the survey. It is divided into several sections. The person completing the HFA is asked to record the date on which the HFA was started, and his/her role in the hospital. There is a section about hospital characteristics, a section about infection control, and a section about antimicrobial stewardship. No hospital identifiers should be recorded on the form. The EIPT will provide each hospital with a unique code to record at the top of each form. This code will be submitted to the CDC, along with information recorded on the HFA.

The PTs (and/or EIPTs) will complete the PIF (first page) for every patient included in the survey. The PIF is divided into 5 sections: Identifiers, Demographic information, Height and weight, Devices, and Antimicrobials. Identifiers are collected and kept at the local hospital.

Identifiers are also provided to the EIPT so that the EIPT can complete its data collection activities. Patient identifiers such as name, date of birth, and medical record number are not transmitted to CDC. Dates such as admission date and survey date are transmitted to CDC. Detailed instructions about how to answer each item in the PIF are provided below.

Patient Confidentiality Protection

All eligible patients included in the study will be assigned a unique study identification code (called the "CDC ID"). This code does not incorporate personally identifying information. Each code will be a 7-digit, alpha-numeric code starting with the state's two-letter abbreviation, followed by a two-letter facility identifier and 3 numbers (example, CA-AA001). The two-letter facility identifier will be assigned by the EIPT. CDC ID codes will be assigned prior to review of medical records. If bed numbers included in the random sample are not occupied, or patients are subsequently found to be ineligible for inclusion in the study, CDC ID codes will not be re-used or re-assigned to other patients.

The linkages between patient identifiers and CDC ID codes will be maintained at the appropriate participating hospitals and EIP sites until the conclusion of project activities, at which time the linkages should be destroyed. Data collected during the course of the study, whether identifiable or de-identified, must be stored in secure locations according to local and/or state regulations. Participating hospitals and EIP sites will obtain institutional review board (IRB) approval to perform the prevalence survey, where such approval is necessary.

DATA VALIDATION

Data validation may be conducted by an Evaluation Team (EVALT) of independent, expert infection preventionists. Whether or not validation is performed will depend upon the availability of resources. The EVALT will retrospectively review a 10-20% random sample of surveyed patients in each EIP site. The EIPT, with input from CDC, will determine the random sample of patients to be reviewed by the EVALT. The EVALT will review patients' medical records on site in each hospital, although in some cases hospitals may choose to grant EVALT members remote access to electronic health record systems. The EVALT will fulfill all requirements mandated by participating institutions related to HIPAA, confidentiality and other special requirements for access to hospitals and to patients' medical records. In some instances the EVALT members may require the assistance of EIPTs to fulfill specific hospital requirements and conduct survey activities. In other instances it is possible that the EVALT will work directly with PTs in hospitals to meet requirements and conduct survey activities. The EVALT will record CDC ID codes and admission dates on data collection forms, but will not record identifiers such as names or medical record numbers on forms. The EVALT will collect data using the PIF, the Antimicrobial Use Form, the HAI Form, and the antimicrobial use assessment/audit forms. The EVALT will enter its data into the electronic data management system. The timeline for EVALT activities may begin after and/or extend beyond the timeline for EIPT data collection and entry activities.

DETAILED INSTRUCTIONS FOR COMPLETING SURVEY FORMS

General points:

The Healthcare Facility Assessment (HFA) consists of 10 pages, divided into Sections 1 through 4. Instructions for completion of the assessment are provided on the HFA. EIPTs may be consulted for clarification of any items included in the HFA.

The Patient Information Form (PIF) consists of 2 pages. Data collection on the first page is divided into 5 sections: Identifiers (Section I), Demographic information (Section II), Weight and height (Section III), Devices (Section IV), and Antimicrobials (Section V). Identifiers are at the top of page 1. The information in Section I will be shared with the EIP site but not with CDC. Data entered in Sections II through V will be entered into the electronic data management system and shared with CDC. Data collection on the second page consists of one follow-up information section (Section VI). The information in this section will be collected in most cases by EIPTs through retrospective medical record review, although PTs may also be contacted to assist in providing information on discharge dates and outcome for surveyed patients. This information will be entered into the electronic data management system and shared with CDC.

INSTRUCTIONS FOR COMPLETING THE PATIENT INFORMATION FORM

Page 1

Data Field	***Instructions***
CDC ID	Record CDC identification code.
Survey Date	Enter the date in mm/dd/yyyy format.
Data collector initials	Enter data collector's initials.
If data collected on survey date, enter data collection time:	For PIFs completed on the survey date (this is the ideal approach), the data collector should record the time of day on the survey date when the patient's data were reviewed and the form completed.
Data collection done retrospectively	Check this box only in those circumstances where the PIF is NOT completed on the survey date. If this box is checked, then all data entered onto the first page of this form should be based on information present up until 5 pm on the survey date. No information present after 5 pm should be used in completing the first page of the form.

Page 1, Section I. Identifiers – *information in Section I is not submitted to CDC*

Data Field	***Instructions***
Patient name	Enter last name, first name, middle initial.
Date of birth	Enter in mm/dd/yyyy format.
Hospital name	Enter the name of the hospital.
Hospital unit name	Enter the name of the hospital unit on which the patient is housed at the time of the survey.
Room no.	Enter the number of the room occupied by the patient at the time of the survey.
Medical record no.	Enter the medical record number.

Page 1, Section II. Demographic information

Data Field	***Instructions***
Age	Record the patient's age on the survey date. Age may be noted on the medical record "face sheet." If patient's age less than 30 days, indicate age in days. If patient's age is 30 days to 11 months, indicate age in months. If patient is 12 months or older, indicate age in years. Examples: 34 days of age should be coded as Age=1 and the box for "months" should be checked. 14

	months of age should be coded as Age=1 and the box for “years” should be checked.
Admission date	Enter the date the patient was admitted to the hospital. Use mm/dd/yyyy format. Admission date may be noted on the medical record “face sheet.”
Gender	Check the appropriate box. M=male. F=female. Gender may be noted on the medical record “face sheet.” An “Unknown” box is provided for rare instances where gender is not known.
CDC location code	The CDC location code identifies the type of inpatient unit on which the patient is housed on the survey date. CDC location codes appear in Appendix 1. Hospital units should be mapped to the appropriate CDC location codes in advance of the survey date. The CDC location code for the unit of each bed number selected for inclusion in the survey should appear on the randomly-sorted bed number list that the EIPT provides to the PT to use on the survey date. Record this code on the PIF. Only one CDC location should be recorded on the PIF. If bed numbers from heterogeneous units (those units with multiple patient types, and with no single patient type comprising 80% or more of the unit’s population) are included on the randomly sorted bed number list, and there are multiple possible CDC location codes that could potentially be assigned, depending upon the type of patient occupying the bed on the day of the survey, you should select the single most appropriate code based on the type of patient or the clinical service to which the patient was admitted. For example, Bed 100 on Unit 6 East is included in the survey. 6 East is a unit with the following patient types: 30% general medicine, 40% orthopedic surgery, 30% hematology/oncology. On the randomly-sorted bed number list, the CDC location column has the following entry: “W-M or W-ORT or SCA-HONC.” You should evaluate the medical record for the patient in Bed 100 on the day of the survey and record ONE CDC location code based on the patient type or clinical service. If the patient is admitted to the medical service for treatment of pneumonia, for example, you would record only “W-M” on the PIF.
Race	Race of patient as noted in the medical record. Race may be noted on the medical record “face sheet.” Multiple boxes can be checked. Do not make assumptions based on name or native language. If race is unknown, please check “unknown”. The minimum categories for the Federal statistics of race data are defined as follows: • American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. • Asian: A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian subcontinent. Can include the following: Cambodia, China, Japan, Korea,

	Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”. • Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • White: A person having origins in any of the original peoples of Europe, the Middle East, or North Asia. Note: “Race” instructions modified from 2010 EIP 2010 MRSA Case Report Form Instructions, revised 4/13/2010. (see OMB Standards for Data on Race and Ethnicity, as published in 1997 Federal Register, http://www.whitehouse.gov/omb/fedreg_1997standards/)
Ethnicity	Ethnicity of patient as noted in medical record. Ethnicity may be indicated on the medical record “face sheet.” Indicate ethnicity EVEN IF race is already indicated. Hispanic or Latino ethnicity indicates a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. For example, many whites are also Hispanic or Latino. Do not make assumptions based on name or native language. If not noted or unsure, check "unknown." *Note: Some institutions combine race/ethnic coding. For example, they might define a person’s race as “Hispanic or Latino”. In this case race would be coded “unknown” on the DCF, and ethnicity would be “Hispanic or Latino”. Note: “Ethnicity” instructions modified from 2010 EIP 2010 MRSA Case Report Form Instructions, revised 4/13/2010. (see OMB Standards for Data on Race and Ethnicity, as published in 1997 Federal Register, http://www.whitehouse.gov/omb/fedreg_1997standards/)

Page 1, Section III. Weight and height

Data Field	***Instructions***
For infants in neonatal locations (e.g., CC:NURS, CCS:NURS, S:NURS, W:NURS, W:LDRP): Birthweight	For infants in locations that typically house newborns (including those listed on the form), record the birthweight in pounds and ounces or in grams. If the birthweight is not known, check the “Birthweight unknown” box.
For other patients: BMI OR Height and Weight	For patients who are not infants in neonatal locations, record the Body Mass Index (BMI, if available) during the 7 days prior to the survey date or on the survey date. If multiple BMIs are available

	during the 7 days prior to the survey date or on the survey date, record the BMI that is closest to the survey date. If BMI is not available during the 7 days prior to the survey date or on the survey date, record the patient's height and weight. You may use any height measurement available in the medical record from the date of admission through the survey date. For weight, record weight during the 7 days prior to the survey date or on the survey date, using the weight value closest to the survey date. Height may be recorded in feet and inches, or in centimeters (or "Height unknown" may be checked if no height is available from admission through the survey date). Weight may be recorded in pounds and ounces, or in grams (or "Weight unknown" may be checked if no weight is available during the 7 days prior to the survey date or on the survey date).

Page 1, Section IV. Devices *(in place on the survey date)*

NOTE: Information on devices (urinary catheters, ventilators and central lines) may be found in nursing notes and patients' daily flowsheets (e.g., sheets that include information on vital signs, fluid balance, nursing assessments, etc.). Progress notes and procedure notes may also contain information on device use. Ventilator information may be found in respiratory therapy notes and in intensive care unit flowsheets in sections documenting the patient's respiratory status. Finally, some record systems (particularly electronic record systems) may have a specific location where information on the presence and status of medical devices is recorded.

Data Field	***Instructions***
Urinary catheter	Check "yes" if the patient has an indwelling urethral catheter (also called a Foley catheter) on the survey date. Otherwise, check "no." Check "no" for patients who receive intermittent catheterization or "straight" catheterization. Check "no" for patients with nephrostomy tubes or suprapubic catheters. A urinary catheter is defined in Appendix 3 as "A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a closed collection system; also called a Foley catheter; does not include straight in-and-out catheters."
Ventilator	Check "yes" if the patient has a device to assist or control respiration continuously through a tracheostomy or by endotracheal intubation on the survey date. A ventilator is defined in Appendix 3 as "A device to assist or control respiration continuously, inclusive of the weaning period, through a tracheostomy or by endotracheal intubation. NOTE: Lung expansion devices such as intermittent positive pressure breathing (IPPB); nasal positive end-expiratory pressure (PEEP); continuous nasal positive airway pressure (CPAP, hypoCPAP) are not considered ventilators unless delivered via tracheostomy or endotracheal intubation (e.g., ET-CPAP)."
Central line	Check "yes" if the patient has a central line in place on the survey date. A central line is defined as follows in Appendix 3 as: "An intravascular catheter that terminates at or close to the

	heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line infections: aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, and femoral veins. NOTE: Neither the location of the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of these vessels or in or near the heart to qualify as a central line. NOTE: An introducer is considered an intravascular catheter, and depending on the location of its tip, may be a central line. NOTE: Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are <u>not</u> considered central lines, because fluids are not infused, pushed, nor withdrawn through such devices. NOTE: In neonates, the umbilical artery/vein is considered a great vessel. NOTE: The following devices are <u>not</u> considered central lines: extracorporeal membrane oxygenation (ECMO), femoral arterial catheters, and intraaortic balloon pump (IABP) devices. If the patient has a central line, check "yes," and indicate using the check boxes provided whether the patient has a Peripherally Inserted Central Catheter (PICC) in place, whether the patient has a femoral line in place, whether the patient has another type of central line in place, or whether the patient has a central line in place for which the type is unknown (central line noted but type not documented in the medical record). If the patient has more than one line type, check as many boxes as apply. For example, if a patient has a PICC inserted in the left upper extremity and a triple lumen catheter in the right internal jugular vein, you would check the "PICC" box and the "Other central line" box.

Page 1, Section V. Antimicrobials

Data field	***Instructions***
Antimicrobials administered or scheduled to be administered on the survey date:	See Appendix 2 for the definition of "antimicrobial agent" for the purposes of this survey. This question should be answered for every patient included in the survey. Use the Medication Administration Record (MAR) (including the Emergency Department MAR and the inpatient MAR) and operating room flow sheets (on which surgical prophylaxis antibiotics may be recorded) to determine whether patients are on antimicrobials or not. Check "yes" if the patient was administered or was scheduled to be administered at least one dose of an antimicrobial agent <u>on the survey date</u>. Acceptable antimicrobial agents are those that appear in Appendix 4 that are administered (or are scheduled to be administered) by any of the following routes: IV, IM, orally, enterally, or via inhalation. See Appendix 3 for a description

	of antimicrobial agents and routes of administration that are excluded from this survey.
Antimicrobials administered or scheduled to be administered on the day before the survey date:	See Appendix 2 for the definition of "antimicrobial agent" for the purposes of this survey. This question should be answered for every patient included in the survey. Use the Medication Administration Record (MAR) (including the Emergency Department MAR and the inpatient MAR) and operating room flow sheets (on which surgical prophylaxis antibiotics may be recorded) to determine whether patients are on antimicrobials or not. Check "yes" if the patient was administered or was scheduled to be administered at least one dose of an antimicrobial agent on the day before the survey date. Acceptable antimicrobial agents are those that appear in Appendix 2 that are administered (or are scheduled to be administered) by any of the following routes: IV, IM, orally, enterally, or via inhalation. See Appendix 2 for a description of antimicrobial agents and routes of administration that are excluded from this survey.

Page 2: Keep in mind that this page is typically completed by the EIPTs during a retrospective medical record review process in the weeks and months following the survey dates. The PTs may be asked to assist in gathering hospital discharge and outcome information.

Record the CDC ID and data collector initials at the top of the form.

Page 2, Section VI. Follow up information

Data field	***Instructions***
Enter date of follow-up data collection	This should be the date on which the discharge date and outcome was assessed. For example, if the PT gathers this information and transmits it to the EIPT, then the date recorded here should be the date on which the PT determined the discharge date and outcome (not the date on which the EIPT recorded that information on the PIF).
Hospital discharge date	The date of discharge from the survey hospitalization, entered as mm/dd/yyyy. This should be assessed up to 90 days following the survey date. If the date is unknown, chedck "Unknown." If the patient is still in the hospital 90 days following the survey date, check "Still in hospital."
Patient outcome at time of hospital discharge	Indicate whether the patient was alive at discharge ("Survived"), dead ("Died"), or if the outcome is unknown or the patient is still in the hospital 90 days after the survey date.

WHAT TO DO WITH COMPLETED FORMS

Primary Teams:

1) Copy each PIF.
2) Submit the original PIFs to the EIPT according to arrangements made with the EIPT, in accordance with local and/or state guidelines and with all necessary precautions taken to protect patient identifiers.

3) Store copies of PIFs in a secure location at the survey hospital in the care of the PT, in accordance with local and/or state guidelines.
4) Once the EIPT has been notified by CDC that project activities are complete, the forms may be destroyed as long as this is in accordance with local guidelines. In some instances, IRBs may require that forms be maintained for longer periods of time. Check with your IRB for further information.

Note: Section I "Identifiers" of the PIF will not be shared with CDC or entered into the CDC data management system.

APPENDIX 1: CDC PATIENT LOCATIONS

Note: Location list, codes and descriptions are subject to change to maintain consistency with locations defined in the National Healthcare Safety Network. Here is the link to current NHSN location types: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf.

Note: Instructions for location mapping may be found at: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf.

CDC Patient Location/Service	*Code*	*Description*
Inpatient Adult Critical Care		
Burn Critical Care	CC-B	Critical care area specializing in the care of patients with significant/major burns.
Medical Cardiac Critical Care	CC-C	Critical care area specializing in the care of patients with serious heart problems that do not require heart surgery.
Medical Critical Care	CC-M	Critical care area for patients who are being treated for nonsurgical conditions.
Medical/Surgical Critical Care	CC-MS	An area where critically ill patients with medical and/or surgical conditions are managed.
Neurologic Critical Care	CC-N	Critical care area specializing in treating life-threatening neurological diseases.
Neurosurgical Critical Care	CC-NS	Critical care area specializing in the surgical management of patients with severe neurological diseases or those at risk for neurological injury as a result of surgery.
ONC Medical Critical Care	CC-ONC-M	Critical care area for the care of oncology patients who are being treated for nonsurgical conditions related to their malignancy.
ONC Surgical Critical Care	CC-ONC-S	Critical care area for the evaluation and management of oncology patients with serious illness before and/or after cancer-related surgery.
ONC Medical-Surgical Critical Care	CC-ONC-MS	Critical care area for the care of oncology patients with medical and/or surgical conditions related to their malignancy.
Prenatal Critical Care	CC-PNATL	Critical care area specializing in the management of the pregnant patient with complex medical or obstetric problems requiring a high level of care to prevent the loss of the fetus and to protect the

		life of the mother.
Respiratory Critical Care	CC-R	Critical care area for the evaluation and treatment of the patient with severe respiratory conditions.
Surgical Cardiothoracic Critical Care	CC-CT	Critical care area specializing in the care of patients following cardiac and thoracic surgery.
Surgical Critical Care	CC-S	Critical care area for the evaluation and management of patients with serious illness before and/or after surgery.
Trauma Critical Care	CC-T	Critical care area specializing in the care of patients who require a high level of monitoring and/or intervention following trauma or during critical illness related to trauma.
Neonatal Units[i]		
Well Baby Nursery (Level I)	W-NURS	Hospital area for evaluation and postnatal care of healthy newborns. May include neonatal resuscitation and stabilization of ill newborns until transfer to a facility at which specialty neonatal care is provided.
Step down Neonatal ICU (Level II)	S-NURS	Special care nursery for care of preterm infants with birth weight $\geq$1500g. Includes resuscitation and stabilization of preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided.
Neonatal Critical Care(Level II/III)	CCS-NURS	Combined nursery housing both Level II and III newborns and infants.
Neonatal Critical Care (Level III)	CC-NURS	A hospital neonatal intensive care unit (NICU) organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness. Level III is subdivided into 3 levels differentiated by the capability to provide advanced medical and surgical care. NOTE: The categories of Level III below are classifications from the American Academy of Pediatrics, Definitions of hospital-based newborn services[1]. These classifications are **all** considered Level III nurseries in NHSN.

		Level IIIA – Hospital or state-mandated restriction on type and/or duration of mechanical ventilation. Level IIIB – No restrictions on type or duration of mechanical ventilation. No major surgery. Level IIIC – Major surgery performed on site (e.g., omphalocele repair, tracheoesophageal fistula or esophageal atresia repair, bowel resection, myelomeningocele repair, ventriculoperitoneal shunt). No surgical repair of serious congenital heart anomalies that require cardiopulmonary bypass and /or ECMO for medical conditions. Level IIID – Major surgery, surgical repair of serious congenital heart anomalies that require cardiopulmonary bypass, and/or ECMO for medical conditions.
Pediatric Critical Care		
Pediatric Burn Critical Care	CC-BPED	Critical care area specializing in the care of patients ≤ 18 years old with significant/major burns
Pediatric Cardiothoracic Critical Care	CC-CTPED	Critical care area specializing in the care of patients ≤ 18 years old following cardiac and thoracic surgery.
Pediatric Medical Critical Care	CC-MPED	Critical care area for patients ≤ 18 years old who are being treated for nonsurgical conditions. In the NNIS system, this was called Pediatric ICU (PICU).
Pediatric Medical/Surgical Critical Care	CC-MSPED	An area where critically ill patients ≤ 18 years old with medical and/or surgical conditions are managed.
Pediatric Neurology Critical Care	CC-NPED	Critical care area for patients ≤ 18 years old specializing in treating life-threatening neurological diseases.
Pediatric Neurosurgical Critical Care	CC-NSPED	Critical care area specializing in the surgical management of patients ≤ 18 years old with severe neurological diseases or those at risk for neurological injury as a result of surgery.
ONC Pediatric Critical Care	CC-ONCPED	Critical care area for the care of oncology patients ≤18 years old who are being treated for surgical or nonsurgical conditions related to their malignancy.

Pediatric Respiratory Critical Care	CC-RPED	Critical care area for the evaluation and treatment of the patients ≤ 18 years old with severe respiratory conditions.
Pediatric Surgical Critical Care	CC-SPED	Critical care area for the evaluation and management of patients ≤ 18 years old with serious illness before and/or after surgery.
Pediatric Trauma Critical Care	CC-TPED	Critical care area specializing in the care of patients ≤ 18 years old who require a high level of monitoring and/or intervention following trauma or during critical illness related to trauma.
Inpatient Specialty Care Areas		
Inpatient Acute Dialysis Unit	SCA-DIAL	Hospital specialty care area for patients who require acute dialysis as a temporary measure.
Solid Organ Transplant SCA	SCA-SOTP	Hospital specialty area for the postoperative care of patients who have had a solid organ transplant (e.g., heart/lung, kidney, liver, pancreas)
Pediatric Dialysis SCA	SCA-DIALPED	Hospital specialty care area for patients ≤ 18 years old who require acute dialysis as a temporary measure.
Pediatric Solid Organ Transplant SCA	SCA-SOTPPED	Hospital specialty area for the postoperative care of patients ≤ 18 years old who have had a solid organ transplant (e.g., heart/lung, kidney, liver, pancreas).
Adult Wards		
Antenatal Care Ward	W-ANT	Hospital area for observation, evaluation, treatment or surgery of high risk pregnancy patients.
Behavioral Health/Psych Ward	W-BHV	Area for the evaluation and treatment of patients with acute psychiatric or behavioral disorders.
Inpatient Burn Ward	W-B	Hospital area for evaluation and treatment of patients who have burns.
Inpatient Ear/Nose/Throat Ward	W-ENT	Hospital area for the evaluation, treatment, or surgery of patients with ear, nose, or throat disorders
Inpatient Gastrointestinal Ward	W-GI	Hospital area for evaluation, treatment or surgery of patients with disorders of the gastrointestinal tract.
Inpatient Gerontology Ward	W-GNT	Hospital area for the evaluation, treatment or surgery of patients with age-related diseases.
Inpatient Genitourinary Ward	W-GU	Hospital area for the evaluation, treatment or surgery of patients with disorders of the genitourinary system.

Inpatient Gynecology Ward	W-GYN	Hospital area for the evaluation, treatment, or surgery of female patients with reproductive tract disorders.
Inpatient Jail Unit	W-J	Overnight stay patient care area of a hospital or correctional facility used only for those who are in custody of law enforcement during their treatment.
Labor and Delivery Ward	W-LD	Hospital area where women labor and give birth.
Labor, Delivery, Recovery, Postpartum Room (LDRP)	W-LDRP	Hospital suite used for labor, delivery, recovery and post partum (LDRP) – all within the same suite.
Inpatient Medical Ward	W-M	Hospital area for the evaluation and treatment of patients with medical conditions or disorders.
Inpatient Medical/Surgical Ward	W-MS	Hospital area for the evaluation of patients with medical and/or surgical conditions.
Inpatient Neurology Ward	W-N	Hospital inpatient area where patients with neurological disorders are evaluated and treated.
Inpatient Neurosurgical Ward	W-NS	Hospital area for care of patients whose primary reason for admission is to have neurosurgery or to be cared for by a neurosurgeon after head or spinal trauma.
ONC Leukemia Ward	W-ONC-LEUK	Area for the evaluation and treatment of patients with leukemia.
ONC Lymphoma Ward	W-ONC-LYMPH	Area for the evaluation and treatment of patients with lymphoma.
ONC Leukemia/Lymphoma Ward	W-ONC-LL	Area for the evaluation and treatment of patients with leukemia and/or lymphoma.
ONC Solid Tumor Ward	W-ONC-ST	Area for the evaluation and treatment of oncology patients with solid tumors.
ONC Hematopoietic Stem Cell Transplant Ward	W-ONC-HSCT	Area for the care of patients who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders.
ONC General Hematology/Oncology Ward	W-ONC-HONC	Area for the evaluation and treatment of patients with cancer and/or blood disorders.

Inpatient Ophthalmology Ward	W-OPH	Hospital area for care of patients whose primary reason for admission is to have eye surgery or to be cared for by an ophthalmologist after eye trauma.
Inpatient Orthopedic Trauma Ward	W-TORT	Hospital inpatient area where patients with orthopedic injuries or disorders are evaluated and treated.
Inpatient Orthopedic Ward	W-ORT	Hospital area for evaluation, treatment or surgery on bones, joints, and associated structures by an orthopedist.
Inpatient Plastic Surgery Ward	W-PLS	Hospital area for the care of patients who have reconstructive surgery performed by a plastic surgeon.
Inpatient Postpartum Ward	W-PP	Hospital area for the patient who is recovering from childbirth.
Inpatient Pulmonary Ward	W-PULM	Hospital area where patients with respiratory system conditions or disorders are evaluated and treated.
Inpatient Rehabilitation Ward	W-REHAB	Hospital area for evaluation and restoration of function to patients who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, or catastrophic events resulting in complete or partial paralysis.
Inpatient Surgical Ward	W-S	Hospital area for evaluation and treatment of patients who have undergone a surgical procedure.
Stroke (Acute) Unit	W-STRK	Hospital area for evaluation, stabilization and treatment of patients who have experienced an acute stroke.
Telemetry Unit	W-TELE	Hospital area dedicated to providing evaluation and treatment of patients requiring continuous cardiac monitoring.
Inpatient Vascular Surgery Ward	W-VS	Hospital area for evaluation and treatment of patients who have undergone vascular surgery.
Pediatric Wards		
Adolescent Behavioral Health Ward	W-BHV-ADOL	Hospital area for evaluation and treatment of patients between the ages of 13 and 18 with acute psychiatric or behavioral disorders.
ONC Pediatric Hematopoietic Stem Cell Transplant Ward	W-ONC-HSCTPED	Area for the care of patients ≤18 years old who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders.
ONC Pediatric General Hematology/Oncology Ward	W-ONC-HONCPED	Area for the evaluation and treatment of patients ≤18 years old with cancer

		and/or blood disorders.
Pediatric Behavioral Health	W-BHVPED	Hospital area for evaluation and management of patients ≤18 years old with acute psychiatric or behavioral disorders.
Inpatient Pediatric Burn Ward	W-BPED	Hospital area specializing in the evaluation and treatment of patients ≤18 years who have tissue injury caused by burns.
Inpatient Pediatric Ear, Nose, Throat	W-ENTPED	Hospital area for evaluation and management of patients ≤18 years old with disorders of the ear, nose and/or throat.
Inpatient Pediatric Genitourinary	W-GUPED	Hospital inpatient area where patients ≤ 18 years old with disorders of the genitourinary system are evaluated and treated.
Inpatient Medical Pediatric Ward	W-MPED	Hospital inpatient area where patients ≤ 18 years old with medical conditions or disorders are evaluated and treated.
Inpatient Pediatric Med/Surg Ward	W-MSPED	Hospital inpatient area where patients ≤ 18 years old with medical and/or surgical conditions are managed.
Inpatient Pediatric Neurology Ward	W-NPED	Hospital inpatient area where patients ≤ 18 years old with neurological disorders are evaluated and treated.
Inpatient Pediatric Neurosurgical Ward	W-NSPED	Hospital area for care of patients ≤ 18 years old whose primary reason for admission is to have neurosurgery or to be cared for by a neurosurgeon after head or spinal trauma.
Inpatient Pediatric Orthopedic Ward	W-ORTPED	Hospital area where patients ≤ 18 years old with orthopedic injuries or disorders are evaluated and treated.
Inpatient Pediatric Rehabilitation Ward	W-REHABPED	Hospital area for evaluation and restoration of function to patients ≤18 years old who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, or catastrophic events resulting in complete or partial paralysis.
Inpatient Pediatric Surgical Ward	W-SPED	Hospital area for evaluation and treatment of patients ≤ 18 years old who have undergone a surgical procedure.
Step Down Units		

Adult Step Down Unit	STEP	Hospital area for adult patients that are hemodynamically stable who can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks.
Pediatric Step Down Unit	STEP-PED	Patients ≤ 18 years old that are hemodynamically stable who can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks.
ONC Step Down Unit (all ages)	STEP-ONC	Area for oncology patients who are hemodynamically stable and can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurologic and neurovascular checks.
Mixed Acuity Units		
Mixed Acuity Unit	MIX-ADULT	Hospital area for the evaluation and treatment of adult patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step-down type care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of his care, from critical care through lower levels of care)
Pediatric Mixed Acuity Unit (NOTE: If patients are of mixed age, use Mixed Age, Mixed Acuity Ward, designation found in Inpatient Adult Ward section)	MIX-PED	Hospital area for the evaluation and treatment of patients ≤ 18 years old whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step-down type care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of his care, from critical care through lower levels of care).
Mixed Age, Mixed Acuity Unit	MIX-ALL	Hospital area for the evaluation and treatment of a mixture of adult and

		pediatric patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step-down type care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of his care, from critical care through lower levels of care)
ONC Mixed Acuity Unit	MIX-ONC	Area for the evaluation and treatment of a mixture of adult and pediatric oncology patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step-down type care, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of care, from critical care through lower levels of care).
Long-term Acute Care		
LTAC ICU	CC-LTAC	Critical care area specializing in the evaluation, treatment, and management of patients that require high observance/acuity and/or special care that are suffering medically complex conditions or who have suffered recent catastrophic illness or injury and require an extended stay in an acute care environment.
LTAC Ward	W-LTAC	Hospital area for the evaluation and treatment of patients suffering medically complex conditions or who have suffered recent catastrophic illness or injury, and require an extended stay in an acute care environment.
LTAC Pediatric ICU	CC-LTACPED	Critical care area specializing in the evaluation, treatment, and management of patients <= 18 years old that require high observance/acuity and/or special care that are suffering medically complex conditions or who have suffered recent catastrophic illness or injury and require an extended stay in an acute care

		environment.
LTAC Pediatric Ward	W-LTACPED	Hospital area for the evaluation and treatment of patients <=18 years old, suffering medically complex conditions or who have suffered recent catastrophic illness or injury, and require an extended stay in an acute care environment.

[1]Definitions of Hospital-Based Newborn Services Used for Survey Performed by Section on Perinatal Pediatrics American Academy of Pediatrics website: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/5/1341/T1 , accessed, July 8,2008.

APPENDIX 2: ANTIMICROBIAL AGENT LIST

Note: Use this list when checking whether the patient is "on antimicrobials" on the Patient Information Form.

This list is subject to change at any time.

Definition of an antimicrobial agent: A systemic (oral, enteral, or parenteral) or inhaled antimicrobial agent found in the list presented in the Appendix below. Antimicrobial agents administered via the following routes are EXCLUDED: topical (to the skin), to the ear, to the eye, to the nasal mucosa, intravaginal, per rectum, intraperitoneal, intrathecal, intraventricular. Antimicrobial agents administered via irrigation (such as in the operating room) are also excluded. Medications used for the treatment of Human Immunodeficiency Virus (HIV), Hepatitis C and Hepatitis B virus infections are excluded, with the exception of ribavirin. If ribavirin is being administered to a surveyed patient for treatment of Hepatitis C, the data collector should not document ribavirin on the Antimicrobial Use Form. However, other infection-related uses of ribavirin should be documented in the Antimicrobial Use Form.

5-FC
Abelcet
acyclovir
amantadine
Ambisome
amikacin
Amikin
amoxicillin
amoxicillin/clavulanic acid
amoxicillin, clarithromycin, lansoprazole
Amoxil
amphotericin B cholesteryl sulfate complex
amphotericin B deoxycholate
amphotericin B lipid complex
amphotericin B liposome
Amphotec
ampicillin
ampicillin/sulbactam
Ancef
Ancobon
anidulafungin
Augmentin
Avelox
Azactam
azithromycin
aztreonam
Bactrim
Biaxin
Bio-Statin

Bismuth subcitrate, metronidazole, tetracycline
Bismuth subsalicylate, metronidazole, tetracyline
Cancidas
caspofungin
Cayston
Ceclor
Cedax
cefaclor
cefadroxil
cefazolin
cefdinir
cefditoren
cefepime
cefixime
Cefizox
Cefotan
cefotetan
cefotaxime
cefoxitin
cefpodoxime
cefprozil
ceftibuten
Ceftin
ceftaroline
ceftazidime
ceftizoxime
ceftriaxone

cefuroxime
Cefzil
cephalexin
chloramphenicol
cidofovir
Cipro
ciprofloxacin
Claforan
clarithromycin
Cleocin
clindamycin
clotrimazole
colistin
colistimethate sodium
colistin/polymyxin B
Cotrimaxozole
Cubicin
Cytovene
dapsone
daptomycin
dicloxacillin
Dificid
Diflucan
Doribax
doripenem
doxycycline
Duricef
Dynapen
Eraxis
ertapenem
EryPed
Ery-Tab
Erythrocin
erythromycin
erythromycin ethylsuccinate and sulfisoxazole acetyl
ethambutol
Factive
famciclovir
Famvir
Fasigyn
fidaxomicin
Flagyl
Floxin
fluconazole

flucytosine
Flumadine
Fortaz
foscarnet
Foscavir
fosfomycin
Fungizone
ganciclovir
Garamycin
gemifloxacin
gentamicin
griseofulvin
Helidac
Hiprex
imipenem
Invanz
isoniazid
isoniazid and rifampin
isoniazid, pyrazinamide, and rifampin
itraconazole
kanamycin
Kantrex
Keflex
Ketek
ketoconazole
Lamisil
Levaquin
levofloxacin
linezolid
Macrobid
Macrodantin
Maxipime
Mefoxin
meropenem
Merrem
methenamine
metronidazole
micafungin
miconazole
Minocin
minocycline
Monurol
Moxatag
moxifloxacin
Mycamine

Mycelex
Mycobutin
Mycostatin
nafcillin
Nallpen
neomycin
Nilstat
nitrofurantoin
Nizoral
norfloxacin
Noroxin
Noxafil
nystatin
ofloxacin
Omnipen
Omnicef
Oravig
oseltamivir
oxacillin
penicillin G
penicillin G benzathine
penicillin G benzathine and penicillin G procaine
penicillin G procaine
penicillin V
pentamidine isethionate
peramivir
piperacillin
piperacillin/tazobactam
polymyxin B
posaconazole
pyrazinamide
Prevpac
Priftin
Primaxin
Primsol
Principen
Proquin XR
Pylera
quinupristin/dalfopristin
Raniclor
Relenza
ribavirin
rifabutin
Rifadin

Rifamate
rifampin
rifapentine
Rifater
rifaximin
Rimactane
rimantadine
Rocephin
Septra
spectinomycin
Spectracef
Sporanox
streptomycin
sulfisoxazole
sulfamethoxazole/trimethoprim
Suprax
Symmetrel
Synercid
Tamiflu
Tazicef
Teflaro
telavancin
telithromycin
terbinafine
tetracycline
ticarcillin/clavulanate
tigecycline
Timentin
Tindamax
tinidazole
Tobi
tobramycin
trimethoprim
trimethoprim/sulfamethoxazole
Trimox
Trobicin
Tygacil
Unasyn
Unipen
Urex
valacyclovir
Valcyte
valganciclovir
Valtrex
vancomycin

Vancocin
Vantin
Vfend
Vibativ
Vistide
voriconazole
Xifaxan
zanamivir
Zinacef
Zithromax
Zmax
Zosyn
Zovirax
Zyvox