For EIP Team use only: Hospital ID: _____

Form Approved
OMB No. **0920-XXXX**
Exp. Date xx/xx/20xx

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
HEALTHCARE FACILITY ASSESSMENT

Instructions:

1) The hospital should designate one staff person to be responsible for ensuring completion of this assessment and submitting the completed assessment to the EIP Team point of contact. Indicate this information in the table below.
2) The person designated as the individual responsible for ensuring completion of the assessment should consult as needed with other facility departments or colleagues to answer the questions included in the assessment. Indicate this information in the table below.
3) The assessment should be completed using the most up-to-date information available. For example, if total annual discharge information is available from the year 2012 and 2013, the 2013 information should be used.
4) The assessment should be completed and returned to the EIP Team point of contact within 1-2 weeks.

For each section of the assessment, list person(s) and department(s) to contact for information:
This information is for hospital and EIP Team use only; information is not transmitted to the CDC.

Section	Name	Department
1—Individual responsible for ensuring completion of assessment and submission to EIP Team		
2—Hospital data (e.g., total discharges, staffed beds, etc.)		
3—Infection control resource and practice information		
4—Antimicrobial use resource and practice information		

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Section 1: If you are the individual responsible for ensuring completion of this assessment, tell us about yourself:

1) Enter the date you started to complete this assessment: ☐☐/☐☐/☐☐☐☐

2) Which of the following best describes your role in the hospital?
   - ☐ Infection preventionist
   - ☐ Nurse
   - ☐ Physician
   - ☐ Microbiologist
   - ☐ Pharmacist
   - ☐ Administrator
   - ☐ Other (specify): _____

–end of Section 1–

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Section 2: Tell us about your hospital

3) Complete the following table for your hospital, using the most current data available to you:

	Number	What year are data from?
No. of total annual discharges *(If discharges not available, enter total annual admissions and check here: ☐)*		☐2013 ☐Other: _____
No. of total patient rooms		☐2014 ☐2013 ☐Other: _____
No. of single patient rooms		☐2014 ☐2013 ☐Other: _____
No. of acute care licensed beds *(do not include nursing home or skilled nursing facility beds)*		☐2014 ☐2013 ☐Other: _____
No. of acute care staffed beds *(do not include nursing home or skilled nursing facility beds)*		☐2014 ☐2013 ☐Other: _____
Average daily acute care census *(do not include nursing home or skilled nursing facility beds)*		☐2014 ☐2013 ☐Other: _____
No. of intensive care unit beds		☐2014 ☐2013 ☐Other: _____
No. of full time equivalent (FTE) infection preventionists		☐2014 ☐2013 ☐Other: _____
No. of FTE physician hospital epidemiologists		☐2014 ☐2013 ☐Other: _____

4) What is your hospital's "intern/resident to bed ratio" ("IRB") (check one)?

NOTE: This information may be available from one of your hospital's administrative departments, such as the finance department or other department that is responsible for Medicare-related issues. *You are not expected to calculate this ratio yourself.*

"Resident" is defined according to the Code of Federal Regulations (CFR) § 413.75(b): "*resident* means an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board" (http://www.ecfr.gov/cgi-bin/text-idx?w=text&node=42:2.0.1.2.13.6.57.1&idno=4

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☐ The IRB is 0.25 or greater (i.e., there is at least one intern or resident for every 4 hospital beds). *(Skip to question #6)*

☐ The IRB is less than 0.25, but greater than zero. *(Skip to question #6)*
☐ My hospital does not have any interns or residents. *(Skip to question #6)*
☐ I do not know if my hospital has interns or residents. *(Skip to question #6)*
☐ My hospital has interns/residents, but I do not know my hospital's IRB. *(If you do not know the IRB, go to question #5)*

5) If your hospital has interns/residents but you do not know your hospital's IRB, do you know the number of full-time equivalent interns and residents in your hospital (where "interns and residents" are defined as noted above in question #4)?
   ☐ Yes (enter number here: _____, for year _____)
   ☐ No

–end of Section 2–

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Section 3: Tell us about infection control resources and practices in your hospital

6) Does your facility have an infection control team or program with one or more staff members responsible for developing and implementing infection control policies and practices and related activities?
   - ☐ Yes
   - ☐ No *(if "No," skip to question #10)*

7) If your hospital has an infection control team/program, who participates in the infection control team/program (check all that apply)?
   - ☐ Infectious diseases physician
   - ☐ Other physician (not infectious diseases)
   - ☐ Nurse infection preventionist, Certified in Infection Control (CIC®)
   - ☐ Other infection preventionist (not a nurse), Certified in Infection Control (CIC®)
   - ☐ Nurse, not Certified in Infection Control (CIC®)
   - ☐ Other infection preventionist (not a nurse), not Certified in Infection Control (CIC®)
   - ☐ Data analyst
   - ☐ Informatics support staff
   - ☐ Quality or patient safety department staff
   - ☐ Other (specify): _____

8) If your hospital has an infection control team/program, how long has the infection control team/program been in place (check one)?
   - ☐ Less than 1 year
   - ☐ Between 1 and 3 years
   - ☐ Between 4 and 6 years
   - ☐ Between 7 and 9 years
   - ☐ 10 or more years

9) If your hospital has an infection control team/program, how often does the team/program meet (check one)?
   - ☐ More frequently than monthly
   - ☐ Monthly
   - ☐ [illegible]

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10) Is there a committee in your hospital that reviews infection control-related activities (such as reports, policies and procedures, etc., developed by the infection control team/program)?
   - ☐ Yes

☐ No *(if "No," skip to question #13)*

11) If there is a committee in your hospital that reviews infection control-related activities, indicate the members represented on the committee (check all that apply):
- ☐ Facility executive leaders (e.g., CEO, COO) or board members
- ☐ Nursing leaders or administrators
- ☐ Medical/physician leaders or administrators
- ☐ Quality department
- ☐ Pharmacy department
- ☐ Environmental services
- ☐ Unit managers or supervisors
- ☐ Physician staff
- ☐ Nursing staff
- ☐ Other (specify): _____

12) If there is a committee in your hospital that reviews infection control-related activities, how frequently does this committee meet (check one)?
- ☐ More frequently than monthly
- ☐ Monthly
- ☐ Every other month or quarterly
- ☐ Less than quarterly

13) For each HAI surveillance statement below, check YES or NO to indicate what is currently being done in your hospital (at the time of this assessment, or during the 6 months prior to this assessment):

	YES	NO
My hospital performs surveillance for one or more types of HAIs, in one or more inpatient locations, in compliance with local, state and/or	☐	☐
For EIP Team use only: Hospital ID: _____ rms surveillance for one or more types of HAIs not currently included in any local, state or federal reporting requirements.	☐	☐
My hospital tracks rates or standardized infection ratios (SIR) of HAIs over time to identify trends (e.g., monthly, quarterly, annually, etc.).	☐	☐
My hospital creates HAI summary reports (e.g., trends).	☐	☐
My hospital shares HAI surveillance data with hospital leaders (e.g., CEO, COO, Chief Medical Officer, Chief Nursing Officer, department heads).	☐	☐

	YES	NO
My hospital shares HAI surveillance data with individual patient unit managers.	☐	☐
My hospital shares HAI surveillance data with frontline providers.	☐	☐

14) For each infection control policy statement below, check YES or NO to indicate whether a policy is in place in your hospital at the time of this assessment:

	YES	NO
My hospital has a hand hygiene policy.	☐	☐
My hospital has an Isolation Precautions policy.	☐	☐
My hospital has a policy on cleaning and disinfection of shared medical equipment.	☐	☐
My hospital has an environmental cleaning policy.	☐	☐

15) For each statement about monitoring adherence to infection control policy, check YES or NO to indicate what is currently being done in your hospital (at the time of this assessment, or during the 6 months prior to this assessment):

	YES	NO
My hospital measures adherence to hand hygiene policies in at least one patient care area.	☐	☐
My hospital measures adherence to Isolation Precautions among staff (e.g., the percentage of those who comply with wearing of gloves or donning of gowns).	☐	☐
g practices to are followed.	☐	☐
My hospital shares adherence rates to specific policies (e.g., hand hygiene) with relevant staff.	☐	☐
All hospital units, services and/or staff members are held accountable for complying with infection control policies (e.g., there are positive consequences for good compliance, and/or negative consequences for poor compliance).	☐	☐

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16) When does your hospital require staff members to participate in training on infection control topics (check all that apply)?

- ☐ Staff members are required to participate in training at the time of new employee orientation.
- ☐ Staff members are required to participate in training on an as-needed basis, when specific infection control issues arise.
- ☐ Staff members participate in required training on a regular basis, as follows (check one):
    - ☐ More frequently than once per month
    - ☐ Once per month
    - ☐ Every other month or quarterly
    - ☐ Twice per year
    - ☐ Once per year
- ☐ My hospital does not require staff members to participate in infection control training.
- ☐ Other (specify): _____

17) For each multidrug-resistant organism (MDRO) management statement below, check YES or NO to indicate what is being done in your hospital at the time of this assessment:

	YES	NO
My hospital has a mechanism to identify, on admission, patients previously infected or colonized with the following MDROs:		
Methicillin-resistant *Staphylococcus aureus* (MRSA):	☐	☐
Vancomycin-resistant *Enterococcus* (VRE):	☐	☐
Carbapenem-resistant Enterobacteriaceae (CRE):	☐	☐
Clostridium difficile:	☐	☐

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	YES	NO
My hospital has policies that specifically address the implementation of Isolation Precautions that are used in addition to Standard Precautions for patients infected or colonized with the following MDROs:		
Methicillin-resistant *Staphylococcus aureus* (MRSA):	☐	☐
Vancomycin-resistant *Enterococcus* (VRE):	☐	☐
Carbapenem-resistant Enterobacteriaceae (CRE):	☐	☐
Clostridium difficile:	☐	☐
My hospital has policies that specifically address the discontinuation of Isolation Precautions that are used in addition to Standard Precautions for patients infected or colonized with the following MDROs:		
Methicillin-resistant *Staphylococcus aureus* (MRSA):	☐	☐
Vancomycin-resistant *Enterococcus* (VRE):	☐	☐
Carbapenem-resistant Enterobacteriaceae (CRE):	☐	☐
Clostridium difficile:	☐	☐
My hospital has a process for communicating with other facilities about patients colonized or infected with the following MDROs at the time of transfer:		
Methicillin-resistant *Staphylococcus aureus* (MRSA):	☐	☐
Vancomycin-resistant *Enterococcus* (VRE):	☐	☐
Carbapenem-resistant Enterobacteriaceae (CRE):	☐	☐
Clostridium difficile:	☐	☐
My hospital has a strategy for identifying appropriate roommate selection for patients admitted with the following MDROs who cannot be placed in a private room:		
Methicillin-resistant *Staphylococcus aureus* (MRSA):	☐	☐
Vancomycin-resistant *Enterococcus* (VRE):	☐	☐
Carbapenem-resistant Enterobacteriaceae (CRE):	☐	☐
Clostridium difficile:	☐	☐

18) Which of the following *Clostridium difficile* infection control practices are performed in your hospital (check all that apply)?

☐ Patients with suspected *C. difficile* infection (i.e., patients who are having symptoms typical of *C. difficile* infection and who have risk factors for *C. difficile* infection but who do not yet have a positive diagnostic test confirming *C. difficile* infection) are placed on Contact Precautions.

- ☐ Patients with active *C. difficile* infection (i.e., patients who have tested positive for *C. difficile* and are having symptoms) are placed on Contact Precautions.
- ☐ All patients with active *C. difficile* infection (i.e., patients who have tested positive for *C. difficile* and are having symptoms) are placed in private rooms.
- ☐ None of the above

19) If your hospital does <u>not</u> have a sufficient number of private rooms available, what does your hospital do with patients who are identified with active *C. difficile* infection (check all that apply)?
- ☐ Place with other *C. difficile* infection patients (cohort)
- ☐ Place with other patients but use separate commodes/bathrooms
- ☐ Place with other patients sharing bathrooms
- ☐ Other (specify):_____
- ☐ Not applicable (all rooms in my hospital are private rooms, or there is always a sufficient number of private rooms available)

20) For patients with active *C. difficile* infection, what is the preferred method of hand hygiene used in your hospital (check one)?
- ☐ Soap and water
- ☐ Alcohol hand gel
- ☐ Not specified (i.e., both available but neither preferred)
- ☐ Other (specify): _____

21) In what settings and/or patients does your hospital routinely perform MRSA surveillance testing (culture or PCR) on admission for the purpose of detecting MRSA colonization (active surveillance) (check all that apply)?
- ☐ Hospital-wide
- ☐ In one or more intensive care units
- ☐ In one or more non-intensive care units
- ☐ In one or more specific patient populations (e.g., patients undergoing cardiac surgery, dialysis, recent hospital discharge, etc…)
- ☐ Other (specify): _____
- ☐ None of the above

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nely use chlorhexidine bathing (check all that apply)?
- ☐ In one or more intensive care units
- ☐ In one or more <u>non</u>-intensive care units
- ☐ In one or more specific patient populations (e.g., patients undergoing cardiac surgery)
- ☐ In patients who are current MRSA carriers

- ☐ In patients who are past MRSA carriers
- ☐ In patients who are not known to be current or past MRSA carriers
- ☐ Other (specify): _____
- ☐ None of the above

23) In what settings and/or patients does your hospital routinely use mupirocin (check all that apply)?

- ☐ In one or more intensive care units
- ☐ In one or more non-intensive care units
- ☐ In one or more specific patient populations (e.g., patients undergoing cardiac surgery)
- ☐ In patients who are current MRSA carriers
- ☐ In patients who are past MRSA carriers
- ☐ In patients who are not known to be current or past MRSA carriers
- ☐ Other (specify): _____
- ☐ None of the above

–end of Section 3–

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Section 4: Tell us about antimicrobial use resources and practices in your hospital

24) Does your hospital have a multidisciplinary team focused on promoting appropriate antimicrobial use (antimicrobial stewardship)?
☐Yes
☐No *(If "No," skip to question #29)*

25) If your hospital has an antimicrobial stewardship team, who participates in the stewardship team (check all that apply)?
☐ Infectious diseases physician
☐ Other physician (not infectious diseases)
☐ Infectious diseases pharmacist
☐ Pharmacist (without specialized infectious diseases training)
☐ Microbiologist
☐ Infection preventionist
☐ Data analyst
☐ Informatics support staff
☐ Other (specify): _____

26) If your hospital has an antimicrobial stewardship team, how long has the team been in place (check one)?
☐ Less than 1 year
☐ Between 1 and 3 years
☐ Between 4 and 6 years
☐ Between 7 and 9 years
☐ 10 or more years

27) If your hospital has an antimicrobial stewardship team, how often does the team meet (check one)?
☐ More frequently than monthly
☐ Monthly
☐ Every other month or quarterly
☐ Less than quarterly

28) If your hospital has an antimicrobial stewardship team, what support does the team receive

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☐ Partial salary support for one or more team members
☐ Formal recognition as a hospital committee
☐ Other support (specify): _____

☐ No formal support from administration

29) For each statement listed below, whether you have an antimicrobial stewardship team or not, check YES or NO based on practices or policies in place in your hospital <u>at the time of this assessment</u>:

	YES	NO
My hospital has a defined formulary of antimicrobial agents, and prescribing is generally restricted to those agents on the formulary.	☐	☐
My hospital requires pre-authorization or approval of selected antimicrobials by an infectious diseases physician, pharmacist or other hospital staff member.	☐	☐
Use of selected antimicrobials is reviewed or audited on a daily or weekly basis by an infectious diseases physician, pharmacist, or other hospital staff member.	☐	☐
Results of audits/reviews of antimicrobial use are provided directly to prescribers, through in-person, telephone, or electronic communications	☐	☐
Automatic stop orders (e.g., after 2-3 days, subject to documentation of the need for ongoing therapy) are in place for selected antimicrobials.	☐	☐
My hospital has guidelines for switching from parenteral to oral antimicrobials.	☐	☐
My hospital has guidelines for surgical prophylaxis.	☐	☐
My hospital has guidelines for first-line antimicrobial therapy for common infections (e.g., community-acquired pneumonia, urinary tract infections, etc.).	☐	☐
Providers have access to hospital information technology support for prescribing antimicrobials.	☐	☐
Providers are required to document (in the medical record or in the computerized provider order entry system) the indication for	☐	☐
For EIP Team use only: Hospital ID: _____ cord or in the computerized provider order entry system) the anticipated duration of antimicrobial therapy.	☐	☐
Prescribers are required to participate in a training/educational program or session on appropriate antimicrobial use at least annually.	☐	☐

	YES	NO
My hospital produces a hospital-wide antibiogram (i.e., antimicrobial susceptibility data aggregated across the entire facility, rather than broken down by patient units) at least annually, and makes the antibiogram available to prescribers.	☐	☐
My hospital produces a patient unit-specific antibiogram at least annually, and makes the antibiogram available to prescribers.	☐	☐

30) Is antimicrobial consumption monitored in your hospital?
- ☐ Yes
- ☐ No *(If "No," hospital assessment is complete)*

31) If antimicrobial consumption is monitored in your hospital, in what settings are antimicrobial consumption patterns monitored (check all that apply)?
- ☐ Hospital-wide
- ☐ On specific patient care units
- ☐ Other (specify): _____

32) If antimicrobial consumption is monitored in your hospital, what are the data sources for monitoring antimicrobial consumption (check all that apply)?
- ☐ Purchasing data (e.g., grams or dollars per patient per day)
- ☐ Ordering data from the pharmacy or computerized provider order entry system
- ☐ Dispensed data from the pharmacy information system
- ☐ Administered data from paper or electronic medication administration records
- ☐ Unknown

33) If antimicrobial consumption is monitored in your hospital, what are the measures used to monitor antimicrobial consumption (check all that apply)?
- ☐ Defined Daily Dose (DDD)
- ☐ Days of Therapy (DOT)
- ☐ Length of Therapy (LOT)
- ☐ Grams or dollars
- ☐ Other (specify)

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34) If antimicrobial consumption is monitored in your hospital, who in the hospital is antimicrobial consumption data reported to (check all that apply)?
- ☐ Antimicrobial stewardship team
- ☐ Administrators
- ☐ Front line providers or clinical leaders

☐ Other (specify): _____

–end of Section 4–

The Healthcare Facility Assessment is now complete. Thank you!