Form Approved
OMB No. 0920-0666
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Patient Safety Component—Annual Hospital Survey

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/57_103-TOI.pdf

*required for saving	Tracking #:
Facility ID:	*Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

☐ For profit ☐ Not for profit, including church ☐ Government
☐ Military ☐ Veterans Affairs ☐ Physician owned

If facility is a Hospital:

*Number of patient days: _____

*Number of admissions: _____

For any Hospital:

*Is your hospital a teaching hospital for physicians and/or physicians-in-training? Yes No

If Yes, what type: ____ Major ____ Graduate ____ Undergraduate

*Number of beds set up and staffed in the following location types (as defined by NHSN):

a. ICU (including adult, pediatric, and neonatal levels II/III and III): _____

b. All other inpatient locations: _____

Facility Microbiology Laboratory Practices (completed with input from Microbiology Laboratory Lead)

*1. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing?

☐ Yes ☐ No

If No, where is your facility's antimicrobial susceptibility testing performed? (check one)

☐ Affiliated medical center ☐ Commercial referral laboratory ☐ Other local/regional, non-affiliated reference laboratory

*2. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards?

☐ Yes ☐ No

If Yes, specify the version of the M100 document that the laboratory used during the prior calendar year (i.e., the survey year): M100- S_____

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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).

If your laboratory does not perform susceptibility testing, please indicate the methods used at the outside laboratory.

Please use the testing codes listed below the table.

Pathogen	(1) Primary	(2) Secondary	Comments
Staphylococcus aureus	_____	_____	_____
Enterococcus spp.	_____	_____	_____
Enterobacteriaceae	_____	_____	_____
Pseudomonas aeruginosa	_____	_____	_____
Acinetobacter spp.	_____	_____	_____

1 = Kirby-Bauer disk diffusion	5.1 = MicroScan walkaway rapid	10 = E test
2 = Vitek (Legacy)	5.2 = MicroScan walkaway conventional	12 = Vancomycin agar screen (BHI + vancomycin)
2.1 = Vitek 2	5.3 = MicroScan auto or touchscan	13 = Other (describe in Comments section)
3.1 = BD Phoenix	6 = Other micro-broth dilution method	
4 = Sensititre	7 = Agar dilution method	

*4. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? ☐ Yes ☐ No

*5. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? ☐ Yes ☐ No

*6. Does the laboratory perform a special test for presence of carbapenemase? ☐ Yes ☐ No

If Yes, please indicate what is done if carbapenemase production is detected: (check one)

☐ Change susceptible carbapenem results to resistant

☐ Report carbapenem MIC results without an interpretation

☐ No changes are made in the interpretation of carbapenems, the test is used for epidemiological or infection control purposes

If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

☐ PCR ☐ MBL screen

☐ Modified Hodge Test ☐ Carba NP

☐ E test ☐ Other (specify): _____

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Facility Microbiology Laboratory Practices (continued)

*7. Does the laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? ☐ Yes ☐ No

If Yes, please indicate methods: (check all that apply)

☐ Vitek (Legacy) ☐ MicroScan walkaway rapid ☐ Agar dilution method
☐ Vitek 2 ☐ MicroScan walkaway conventional ☐ E test
☐ BD Phoenix ☐ MicroScan auto or touchscan ☐ Other (specify): _____
☐ Sensititre ☐ Other micro-broth dilution method

*8. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species?

☐ Yes ☐ No

If No, where is your facility's antifungal susceptibility testing performed? (check one)

☐ Affiliated medical center ☐ Commercial referral laboratory
☐ Other local/regional, non-affiliated reference laboratory ☐ Not offered by my facility

9. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)

☐ Broth macrodilution ☐ Broth microdilution ☐ YeastOne colorimetric microdilution ☐ E test
☐ Vitek 2 card ☐ Disk diffusion ☐ Other (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?

☐ Yes ☐ No

If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)

☐ Fluconazole ☐ Itraconazole ☐ Voriconazole ☐ Caspofungin
☐ Micafungin ☐ Anidulafungin ☐ Flucytosine ☐ Other

*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)

☐ Enzyme immunoassay (EIA) for toxin
☐ Cell cytotoxicity neutralization assay
☐ Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP)
☐ Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm)
☐ GDH plus NAAT (2-step algorithm)
☐ GDH plus EIA for toxin, followed by NAAT for discrepant results
☐ Toxigenic culture (*C. difficile* culture followed by detection of toxins)
☐ Other (specify): _____

("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.)

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Facility Microbiology Laboratory Practices (continued)

*12. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)?

☐ Yes ☐ No

If Yes, is the antibiogram produced at least annually?

☐ Yes ☐ No

If Yes, are data stratified by hospital location?

☐ Yes ☐ No

If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)

- ☐ The laboratory data are difficult to access
- ☐ Limited or no information technology tool for data analysis
- ☐ Limited personnel time for data analysis
- ☐ Limited personnel skills for data analysis
- ☐ Limited interest in an antibiogram from staff who prescribe antibiotics
- ☐ Our institution does not have enough isolates of any or most species (i.e., < 30 isolates per species) to produce an antibiogram
- ☐ Other (please specify): _____

Infection Control Practices
(completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)

*13. Number of infection preventionists (IPs) in facility: _____

a. Total hours per week performing surveillance: _____

b. Total hours per week for infection control activities other than surveillance: _____

*14. Does the facility routinely place patients infected or colonized with MRSA in contact precautions when these patients are admitted? (check one)

- ☐ Yes, all infected or colonized patients
- ☐ Yes, only all infected patients
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ Yes, only those admitted to high-risk settings (e.g., ICU)
- ☐ No
- ☐ Not applicable: my facility never admits these patients

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Infection Control Practices
(completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)

*15. Does the facility routinely place patients infected or colonized with VRE in contact precautions when these patients are admitted? (check one)

- ☐ Yes, all infected or colonized patients
- ☐ Yes, only all infected patients
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ Yes, only those admitted to high-risk settings (e.g., ICU)
- ☐ No
- ☐ Not applicable: my facility never admits these patients

*16. Does the facility routinely place patients infected or colonized with CRE in contact precautions when these patients are admitted? (check one)

- ☐ Yes, all infected or colonized patients
- ☐ Yes, only all infected patients
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ Yes, only those admitted to high-risk settings (e.g., ICU)
- ☐ No
- ☐ Not applicable: my facility never admits these patients

*17. Does the facility routinely place patients infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions when these patients are admitted? (check one)

- ☐ Yes, all infected or colonized patients
- ☐ Yes, only all infected patients
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ Yes, only those admitted to high-risk settings (e.g., ICU)
- ☐ No
- ☐ Not applicable: my facility never admits these patients

*18. Does the facility routinely perform screening testing (culture or non-culture) for CRE?

☐ Yes ☐ No

If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)

- ☐ Surveillance cultures at admission of all patients
- ☐ Surveillance cultures of epidemiologically-linked patients of newly identified CRE patients (e.g., roommates)
- ☐ Surveillance cultures at admission of high-risk patients (e.g., admitted from LTAC or LTCF)
- ☐ Surveillance cultures at admission of patients admitted to high-risk settings (e.g. ICU)
- ☐ Other (please specify): _____

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Infection Control Practices (continued)

*19. Does the facility routinely perform screening testing (culture or non-culture) for MRSA?

☐ Yes ☐ No

If yes, in which situations does the facility routinely perform screening testing for MRSA? (check all that apply)

☐ Surveillance cultures at admission of all patients

☐ Surveillance cultures at admission of high-risk patients (e.g., admitted from LTAC or LTCF)

☐ Surveillance cultures at admission of patients admitted to high-risk settings (e.g. ICU)

☐ Surveillance cultures of pre-operative patients to prevent surgical site infections

☐ Other (please specify): _____

*20. Does the facility routinely use chlorhexidine bathing on any patient to prevent transmission of MDROs in your facility? (Note: this does not include the use of chlorhexidine in pre-operative patients to prevent surgical site infections)

☐ Yes ☐ No

*21. Does the facility routinely use topical chlorhexidine and intranasal mupirocin on any patients to prevent transmission of MRSA in the facility? (Note: this does not include the use of these agents in pre-operative patients to prevent surgical site infections)

☐ Yes ☐ No

*22. Among patients with an MDRO admitted to your facility from another healthcare facility, please estimate how often your facility receives information from the transferring facility about the patient's MDRO status?

☐ All the time

☐ More than half of the time

☐ About half of the time

☐ Less than half of the time

☐ None of the time

☐ Not applicable: my facility does not receive transferred patients with an MDRO

Antibiotic Stewardship Practices (completed with input from Physician and Pharmacist Stewardship Champions)

*23. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?

☐ Yes ☐ No

*24. Is there a leader responsible for outcomes of stewardship activities at your facility?

☐ Yes ☐ No

If Yes, what is the position of this leader: (check one)

☐ Physician ☐ Co-led by both Pharmacist and Physician

☐ Pharmacist ☐ Other (please specify): _____

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Antibiotic Stewardship Practices (continued)

*25. Is there at least one pharmacist responsible for improving antibiotic use at your facility?

☐ Yes ☐ No

*26. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?

☐ Yes ☐ No

*27. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?

☐ Yes ☐ No

If Yes, has adherence to the policy to document an indication been monitored?

☐ Yes ☐ 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?

☐ Yes ☐ No

If Yes, has adherence to facility-specific treatment recommendations been monitored?

☐ Yes ☐ 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)?

☐ Yes ☐ No

*30. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?

☐ Yes ☐ 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?

☐ Yes ☐ No

*32. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide?

☐ Yes ☐ No

If Yes, by which metrics? (Check all that apply)

☐ Days of Therapy (DOT) ☐ Purchasing Data

☐ Defined Daily Dose (DDD) ☐ Other (please specify): _____

If Yes, are facility- and/or unit- or service-specific reports on antibiotic use shared with prescribers?

☐ Yes ☐ No

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Antibiotic Stewardship Practices (continued)

*33. Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?

☐ Yes ☐ No

*34. Has your stewardship program provided education to clinicians and other relevant staff on improving antibiotic use?

☐ Yes ☐ No