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

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2015, a facility would complete a 2014 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • P - For profit • NP - Not for profit, including church • GOV - Government • MIL - Military • VA- Veterans Affairs • PHY - Physician owned
Number of patient days	*Required.* Enter the total number of patient days from inpatient locations in your hospital during the last full calendar year. Newborns should be included in this count.
Number of admissions	*Required.* Enter the total number of inpatient admissions, including newborns, for your hospital during the last full calendar year.
Is your hospital a teaching hospital for physicians and/or physicians in training? If Yes, what type?	*Required.* If a teaching hospital, select 'Yes'. Otherwise, select 'No'. *Conditionally Required.* If a teaching hospital, select the type from the options listed: (Note: There is no minimum requirement for the number of students in training to meet these definitions.) • **Major:** Facility has a program for medical students and post-graduate medical training. • **Graduate:** Facility has a program for post-graduate medical training (i.e., residency and/or fellowships). • **Undergraduate:** Facility has a program for medical students only.

Facility Characteristics (continued)	
Number of beds set up and staffed in the following location types (as defined by NHSN)	*Required.* Record the maximum number of beds set up and staffed for the last full calendar year for the bed types listed below. If any bed type is new or has not been available long enough to have a full calendar year's worth of data from which to obtain the maximum number, indicate the maximum number from the number of months available. For definitions of CDC location types, see CDC Locations and Descriptions chapter.
a. ICU	Enter the number of beds in locations designated as intensive care units (ICUs) in the facility. This includes all adult, pediatric, and neonatal levels II/III and III.
b. All other inpatient locations	Enter the number of beds set up and staffed in all other inpatient locations used for overnight stay patients in this hospital. This includes all inpatient beds in the facility, and not just those that are subject to NHSN surveillance.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.

Facility Microbiology Laboratory Practices (continued)	
2. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document the laboratory used during the prior calendar year (i.e., the survey year)	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory during the prior calendar year.
3. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
4. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
6. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.

detect carbapenemase (check all that apply).	

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

Facility Microbiology Laboratory Practices (continued)	
12. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
13. Number of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
14. Does the facility routinely place patients infected or colonized with MRSA in contact precautions when these patients are admitted? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.
15. Does the facility routinely place patients infected or colonized with VRE in contact precautions when these patients are admitted? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.
16. Does the facility routinely place patients infected or colonized with CRE in contact precautions when	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary

these patients are admitted? (check one)	indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.

Infection Control Practices (continued)	
17. Does the facility routinely place patients infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions when these patients are admitted? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select 'Not applicable'.
18. Does the facility routinely perform screening testing (culture or non-culture) for CRE? If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. . If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
19. Does the facility routinely perform screening testing (culture or non-culture) for MRSA? If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all. *Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.
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)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.

Infection Control Practices (continued)	
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)	*Required.* Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used **routinely** (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients.
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?	*Required.* Please select the most appropriate response that indicates approximately how often your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO. If your facility does not receive transferred patients, or does not receive transferred patients with an MDRO, select 'Not applicable'.
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
23. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
24. Is there a leader responsible for outcomes of stewardship activities at your facility? If Yes, what is the position of this leader? (check one)	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes. *Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). . If 'Other' is selected, please specify the position.
25. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.

26. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.

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

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

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

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2015, a facility would complete a 2014 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
Setting/Classification: If classified as "Free-standing", does your LTAC hospital share physical housing with one or more of the following on-site facilities or units? (check all that apply)	*Required.* Select the physical setting of the facility: free-standing or within a hospital. *Conditionally Required.* If facility is classified as free-standing, select one or more of the following facility or unit types that share physical housing with your LTAC: • No (none) • Skilled nursing facility (SNF)/nursing home • Residential facility (assisted living) • Inpatient rehabilitation facility • Neuro-behavioral unit or facility • Other: specify

Facility Characteristics (continued)	
If classified as "Within a hospital", is your LTAC hospital located:	*Conditionally Required.* If facility is classified as within a hospital, indicate 'Yes' or 'No' if it is: • In a building that does not provide acute care services (e.g., psychiatric hospital) • Near (but not within) an acute care hospital Note: These questions are to clarify the physical set-up of each HOSP-LTAC. All separately licensed LTAC hospitals should be enrolled within NHSN as a separate LTAC facility type regardless of the physical setting of the facility.
Number of Patient Days	*Required.* Enter the total number of patient days for your hospital during the last full calendar year.
Number of Admissions	*Required.* Enter the total number of inpatient admissions for your hospital during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day during the last full calendar year. Please round to the nearest whole number.
Numbers of LTAC beds in the following categories (categories should equal total number of beds)	*Required.* Enter the total number of LTAC beds in each on the following categories during the last full calendar year: • Intensive care unit (ICU) or critical care beds • High observation/special care/high acuity beds (not ICU) • Other LTAC beds
Total number of LTAC beds (licensed capacity)	*Required.* The total number of LTAC beds in the facility during the last full calendar year will be automatically summed based on the above counts.
Number of single occupancy rooms	*Required.* Enter the total number of single occupancy rooms during the last full calendar year.
Total number of admissions with one of the following conditions identified on admission (present on admission, not developing during LTAC stay):	*Required.* Enter the total number of admissions with one of the following conditions identified on admission (present on admission, not developing during LTAC stay): (Note: These categories are not mutually exclusive.) • Ventilator dependence • Hemodialysis If helpful for your facility in identifying these conditions on admission, please review a list of ICD-9 and DRG codes commonly associated with these conditions found here: http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx

Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
35. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing? If No, where is your facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
36. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document that the laboratory used during the prior calendar year.	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory during the prior calendar year.
37. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
38. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
39. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.

Facility Microbiology Laboratory Practices (continued)	
40. Does the laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply)?	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
41. Does the laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.
42. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species? If No, where your facility's antifungal susceptibility testing is performed? (check one).	*Required.* Select 'Yes' if your laboratory performs antifungal susceptibility testing for *Candida* species; otherwise, select 'No'. *Conditionally Required.* If 'No", select one of the choices provided.
43. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)	*Conditionally Required.* Select from the choices listed the method(s) of antifungal susceptibility testing performed at your facility or an outside laboratory. If 'Other' is selected, please specify.
44. Is antifungal susceptibility testing performed automatically/reflexively for *Candida* spp. cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)	*Required.* Select 'Yes' if your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing for *Candida* species which are from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select from the choices listed the antifungal drugs which are tested automatically/reflexively. If 'Other' is selected, please specify.

Facility Microbiology Laboratory Practices (continued)	
45. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. Note: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
46. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
47. Number of trained or certified infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
c. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
d. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.

Infection Control Practices (continued)
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).

48. Does the facility routinely place patients infected or colonized with MRSA in contact precautions when these patients are admitted? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.
49. Does the facility routinely place patients infected or colonized with VRE in contact precautions when these patients are admitted? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.
50. Does the facility routinely place patients infected or colonized with CRE in contact precautions when these patients are admitted? (check one)	Required. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.
51. 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)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriacae, select 'Not applicable'.
52. Does the facility routinely perform screening testing (culture or non-culture) for CRE? If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done routinely. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
53. Does the facility routinely perform screening testing (culture or non-culture) for MRSA? If yes, in which situation does the facility routinely perform screening testing	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all. *Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.

for MRSA? (check all that apply)	
54. 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)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.

Infection Control Practices (continued)	
55. 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)	*Required.* Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used **routinely** (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent the transmission of MRSA. Please do not include the use of these agents in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients.
56. 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?	*Required.* Please select the most appropriate response that indicates approximately how often your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO. If your facility does not receive transferred patients, or does not receive transferred patients with an MDRO, select 'Not applicable'.
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
57. Does your facility have a written statement of support from leadership that supports efforts to improve	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches

antibiotic use (antibiotic stewardship)?	staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
58. Is there a leader responsible for outcomes of stewardship activities at your facility?	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes.
If Yes, what is the position of this leader? (check one)	*Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position.
59. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
60. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.
61. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?	*Required.* Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'.
If Yes, has adherence to the policy to document an indication been monitored?	*Conditionally Required.* If 'Yes' to question 28, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.
62. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?	*Required.* Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'.
If Yes, has adherence to facility-specific treatment recommendations been monitored?	*Conditionally Required.* If 'Yes' to question 29, select 'Yes' charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above; otherwise, select 'No'.
63. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	*Required.* Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
64. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?	*Required.* Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
65. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility?	*Required.* Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents and communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.
66. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide?	*Required.* Select 'Yes' if your facility monitors antibiotic use or consumption at the unit, service, and/or facility wide level at least quarterly; otherwise, select 'No'.
If Yes, by which metrics? (Check all that apply)	*Conditionally Required.* If 'Yes', select from the choices of listed antibiotic use metrics. Days of Therapy (also known as Antimicrobial Days) is defined by any amount of a specific antimicrobial agent administered in a calendar day to a particular patient (i.e., each antimicrobial agent administered to a patient counted as one day of therapy). The Defined Daily Dose is the assumed average maintenance dose per day for a drug used for its main indication in adults and is derived from the total number of grams of each antibiotic purchased, dispensed, or administered. If 'Other' is selected, please specify the method(s) or metric(s) used.
If Yes, are facility- and/or unit-specific reports on antibiotic use shared with prescribers?	*Conditionally Required.* Select 'Yes' if facility and/or unit-specific reports on antibiotic use are shared with prescribers (individually, by service line, by medical group, etc.); otherwise, select 'No'.
67. Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?	*Required.* Select 'Yes' if prescribers (individually, by service line, by medical group, etc.) have received feedback based on observed practices through in-person, telephone, written or electronic communication about how they can improve their antibiotic prescribing; otherwise, select 'No'.
68. Has your stewardship program provided education to clinicians and other relevant staff on improving antibiotic use?	*Required.* Select 'Yes' if your facility stewardship program has provided education on how to improve antibiotic use to clinicians and other relevant staff (e.g. Grand Rounds, in-service training, or direct instruction); otherwise, select 'No'.

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

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2015, a facility would complete a 2014 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
How would you describe your licensed inpatient rehabilitation facility? (check one)	*Required.* Select the appropriate classification of your inpatient rehabilitation facility: • Free-standing - The rehabilitation facility functions as a stand-alone facility. Patients receive all required care within the constructs of this facility. The facility may share a building with another healthcare facility, but does not share staff, patients, or policies (such as infection control) with the other healthcare facility. • Healthcare facility based - The rehabilitation facility functions as part of a larger healthcare facility. Patients can be transported from the rehabilitation area to the healthcare facility area on a regular/daily basis for procedures or therapy. The facility may share staff and policies (such as infection control) with the affiliated healthcare facility.
Total number of beds	*Required.* Enter the total number of beds in your inpatient rehabilitation facility during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day in your inpatient rehabilitation facility during the last full calendar year. Please round to the nearest whole number.

Number of patient days	*Required.* Enter the total number of patient days for your facility during the last full calendar year.
Facility Characteristics (continued)	
Average length of stay	*Required.* Enter the average length of stay of patients in your inpatient rehabilitation facility during the last full calendar year. Please round to the nearest whole number.
Indicate the number of admissions with the primary diagnosis for each of the following rehabilitation categories (must sum to the total number of admissions listed below)	*Required.* For your inpatient rehabilitation facility during the last full calendar year, enter the number of admissions with the primary diagnosis for each of the categories listed. • Traumatic spinal cord dysfunction • Non-traumatic spinal cord dysfunction • Stroke • Brain dysfunction (non-traumatic or traumatic) • Other neurologic conditions (e.g. multiple sclerosis, Parkinson's disease, etc) • Orthopedic conditions (incl. fracture, joint replacement, other) • All other admissions
Total number of admissions	*Required.* The total number of admissions will be automatically summed from the categories above. Additionally, enter the total number of admissions that were patients on a ventilator as well as the number that were pediatric admissions.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
69. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing? If No, where is your facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
70. Does the laboratory use CLSI (formerly NCCLS) antimicrobial susceptibility standards? If Yes, specify which version of the M100 document that the laboratory used during the prior calendar year (i.e. the survey year).	*Required.* Select 'Yes' if your laboratory uses CLSI antimicrobial susceptibility standards; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the version used by your laboratory or the referral laboratory during the prior calendar year.

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

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

Facility Microbiology Laboratory Practices (continued)	
80. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)? If Yes, is the antibiogram produced at least annually? If Yes, are data stratified by hospital location? If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)	*Required.* Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'. *Conditionally Required*. If 'Yes', indicate whether the antibiogram is produced at least annually. *Conditionally Required*. If 'Yes', indicate whether antibiogram data are stratified by hospital location. *Conditionally Required*. If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
81. Number of trained or certified infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
e. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
f. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
82. Does the facility routinely place patients infected or colonized with MRSA in contact precautions when these patients are admitted? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.
Infection Control Practices (continued)	
83. Does the facility routinely place patients infected or colonized with VRE in contact precautions when these patients are admitted? (check one)	*Required*. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.

84. Does the facility routinely place patients infected or colonized with CRE in contact precautions when these patients are admitted? (check one)	*Required*. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.
85. 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)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriacae, select 'Not applicable'.
86. Does the facility routinely perform screening testing (culture or non-culture) for CRE? If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *Conditionally required*. If 'Yes', select **all** the situations for which screening testing is done routinely. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
87. Does the facility routinely perform screening testing (culture or non-culture) for MRSA? If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all. *Conditionally required*. If 'Yes', select **all** the situations for which screening testing is done routinely. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.
88. Does the facility routinely use chlorhexidine bathing on any patient to prevent transmission of MDROs in your hospital? (Note: this does not include the use of chlorhexidine in pre-	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO; otherwise, select 'No'. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.

operative patients to prevent surgical site infections)	

Infection Control Practices (continued)	
89. 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)	*Required.* Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used **routinely** (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients.
90. 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?	*Required.* Please select the most appropriate response that indicates approximately how often your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO. If your facility does not receive transferred patients, or does not receive transferred patients with an MDRO, select 'Not applicable'.
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
91. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
92. Is there a leader responsible for outcomes of stewardship activities at your facility? If Yes, what is the position of this leader? (check one)	*Required.* Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on program planning and outcomes. *Conditionally Required.* If 'Yes', specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position.

93. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Required.* Select 'Yes' if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
94. Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Required.* Select 'Yes' if any individual was given salary support at least 4 hours per week (0.1 full-time employees) to engage in duties to improve or monitor antibiotic use that are not part of their general clinical duties; otherwise, select 'No'.
95. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?	*Required.* Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'.
If Yes, has adherence to the policy to document an indication been monitored?	*Conditionally Required.* If 'Yes' to question 28, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.
96. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?	*Required.* Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'.
If Yes, has adherence to facility-specific treatment recommendations been monitored?	*Conditionally Required.* If 'Yes' to question 29, select 'Yes' charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above; otherwise, select 'No'.
97. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	*Required.* Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.
98. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?	*Required.* Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
99. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility?	*Required.* Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents and communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.

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

Instructions for the Outpatient Dialysis Center Practices Survey
(CDC 57.500)
A complete survey is an annual reporting requirement specified in the NHSN Dialysis Event Protocol. Users cannot create Monthly Reporting Plans or submit monthly data for May through December until a survey for that year is completed.
Print a blank survey from:
http://www.cdc.gov/nhsn/forms/57.104_PSOutpatientDialysisSurv_BLANK.pdf
A worksheet is available to calculate answers for patient- and staff-specific questions. Click here to access the worksheet: http://www.....

Complete one survey per center. Surveys are completed for the current year. It is strongly recommended that the survey is completed in February of each year by someone who works in the center and is familiar with current practices within the center. Complete the survey based on the actual practices at the center, not necessarily the center policy, if there are differences.

Survey Question	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will auto-populate in this field.
Survey Year	**Required**. Enter the 4-digit year that the data were collected for this facility. (format: YYYY)
ESRD Network #	**Required**. Enter the 2-digit ESRD Network number that your facility is part of.
A. Dialysis Center Information	
A.1. General	
1. Ownership	**Required.** Select the ownership of your dialysis center (Choose one option only): • Government • Not for profit • For profit
2. Location/Hospital affiliation	**Required.** Select the location/hospital affiliation of your dialysis center (Choose one option only): ○ Freestanding: the dialysis center is not hospital affiliated. ○ Hospital based: the dialysis center is affiliated with a hospital and the building is attached to, or part of, the hospital. ○ Freestanding, but owned by a hospital: the dialysis center is affiliated with a hospital, but the building is not attached to the hospital.

Survey Question	Instructions for Data Collection
3.a. Dialysis services	**Required.** Indicate all dialysis service types that are offered by your facility (Select all that apply): o In-center daytime hemodialysis o In-center nocturnal hemodialysis o Peritoneal dialysis o Home hemodialysis (includes home, home-assisted, and NxStage®[1] patients)
3.b. Patient population	**Required.** Indicate what patient population your center serves. • Adult only • Pediatric only • Mixed: adult and pediatric
4. Hemodialysis Stations	Conditionally required if for question 3, "in-center hemodialysis" was selected. Enter the number of useable in-center hemodialysis stations in your facility.
5. Group/chain	**Required.** Select "Yes" if your facility is part of a group or chain of dialysis centers. Select "No" if your facility is not owned by a group or chain of dialysis centers.
a. Group/chain name	Conditionally required. Enter the name of the dialysis facility group or chain. If owned and managed by two different groups, then indicate the managing company.
6. Data collector	**Required.** Select "Yes" if the person who is primarily responsible for collecting the NHSN survey data performs patient care in the facility. Select "No" if the person who is primarily responsible for collecting these survey data does not perform patient care in the facility.
7. Person in charge of infection control	**Required.** Select "Yes" if there is at least one person at your dialysis center who is designated in charge of infection control. Select "No" if no one at your dialysis center is designated in charge of infection control.
a. Person in charge of infection control description	Conditionally required. Select all the description(s) that best describe the person(s) in charge of infection control in your dialysis facility.
8. Vascular access nurse/coordinator	**Required.** Select "Yes" if there is a dedicated vascular access nurse or coordinator, either full or part-time, at your facility. Select "No" if there is no dedicated vascular access nurse or coordinator.
A.2. Isolation and Screening	

[1] Use of trade names and commercial sources is for identification only and does not imply endorsement.

Survey Question	Instructions for Data Collection
9. Capacity to isolate hepatitis B patients	**Required.** Select "Yes, use hepatitis B isolation room" if a separate room exists where patients positive for hepatitis B virus infection receive hemodialysis. Select "Yes, use hepatitis B isolation area" if a specific section of the hemodialysis clinic is designated as an area for patients positive for hepatitis B virus infection to receive hemodialysis. Select "No hepatitis B isolation" if your facility does not have the capacity to isolate patients who are positive for hepatitis B virus infection.
10. Conditions isolated/cohorted	**Required.** Select all of the conditions for which patients are routinely isolated or cohorted for treatment within your facility. • Select only those conditions that are admitted and isolated by your facility. If your facility would refer the patient with the condition (e.g., Active tuberculosis [TB disease]) elsewhere for dialysis, do not select that condition on the survey. • Select only those conditions for which all patients that are positive for the condition are isolated. If additional criteria are used to isolate some positive patients (e.g., active diarrhea, draining wound), but not all, do not select this condition for the survey. If none of the conditions listed are routinely isolated or cohorted for treatment within your facility, select "No - None."
11. TB screening	**Required**. Select "Yes" if your center routinely screens patients for latent tuberculosis infection (LTBI) upon admission. Select "No" if patients are not routinely screened for TB upon admission.
A.3. Patient Records	
12. Station assignment	**Required.** Select "Yes" if your facility maintains records of patients' hemodialysis station assignment. Select "No" if these records are not maintained.
13. Machine assignment	**Required.** Select "Yes" if your facility maintains records of patients' hemodialysis machine assignment. Select "No" if these records are not maintained.
14. BSI hospitalizations	**Required.** Following a hospitalization, indicate the frequency with which your facility is able to determine whether a bloodstream infection contributed to the patient's hospital admission. Select "N/A – not pursued" only if your facility does not routinely try to determine the cause of hospitalizations.
15. Hospital lab records	**Required.** Following a hospitalization, indicate the frequency with which your facility is able to obtain the patient's hospital microbiology lab records. Select "N/A – not pursued" only if your facility does not routinely request microbiology lab records after a patient is hospitalized.

Survey Question	Instructions for Data Collection
B. Patient and staff census	
16. Operational during first week of February	**Required.** Select "Yes" if your facility was open for hemodialysis treatment during the first week of February (the first seven calendar days of the month) of the survey year. Select "No" if your facility was closed for hemodialysis treatment during the first week of February of the survey year. • If you select "No," proceed to answer subsequent questions about the first week of February and enter zeros for quantitative questions.
17. Number of dialysis patients in 1st week of February	**Required.** Indicate the total number of all the maintenance, non-transient, dialysis patients assigned to your facility during the first week of February (the first seven calendar days of the month) of the survey year (include in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients). The sum of 17.a., 17.b., and 17.c., must be less than or equal to the answer to question 17.
a. In-center hemodialysis	**Conditionally required**. If "in-center hemodialysis" was selected for question 3, then of the patients specified in question 17, indicate how many underwent in-center hemodialysis during the first week of February.
b. Home hemodialysis	**Conditionally required**. If "home hemodialysis" was selected for question 3, then of the patients specified in question 17, indicate how many underwent home hemodialysis during the first week of February. Include home, home-assisted, and NxStage®[2] patients.
c. Peritoneal dialysis.	**Conditionally required**. If "peritoneal dialysis" was selected for question 3, then of the patients specified in question 17, indicate how many underwent peritoneal dialysis during the first week of February.

[2] Use of trade names and commercial sources is for identification only and does not imply endorsement.

Survey Question	Instructions for Data Collection
18. Number of staff in 1st week of February	**Required**. Indicate the total number of patient care staff (including full time, part time, and affiliated with) who worked in your center during the first week of February (the first seven calendar days of the month) of the survey year. *Include only those staff persons whose role involves direct contact with dialysis patients or equipment*. • Count each person as 1, even if they work part-time. • If a person works at more than one facility, they are counted as 1 at each facility. • Include physicians who see patients in the facility. • Include patient care staff who are normally present during the year, but were absent this week due to vacation or other leave. • Include per diem staff only if they are consistently part of facility staffing. • If your facility was not operational during the 1st week of February, enter 0.
a.-h. Occupational categories	Conditionally required if answer to question 18 is equal to 1 or more. Of the total number of patient care staff specified in question 18, indicate the number per occupational category. The sum of the occupational categories 18.a. – 18.h. must equal the number of patient care staff indicated in question 18.
C. Vaccines	
19. a. Patients received hepatitis B vaccine	Conditionally required if answer to question 17 is equal to 1 or more. Of all maintenance, non-transient patients indicated in question 17 (a.-c.), indicate how many have ever received at least 3 doses of hepatitis B vaccine. • Do not count patients who are in the process of completing the hepatitis B vaccine series. • Include all patients who have received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses to complete the series. • Include patients with documentation of having received 3 or more doses, even if they were not vaccinated at your facility. • If no patients received 3 or more doses of the hepatitis B vaccine, enter 0.

Survey Question	Instructions for Data Collection
b. All hemodialysis patients who received influenza vaccine	Conditionally required if answer to question 17 is equal to 1 or more. Of all maintenance, non-transient patients indicated in question 17 (a.-c.), indicate how many received the influenza (flu) vaccine for this flu season (September or later). • This question refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2015, count flu vaccinations for the 2014-2015 flu season. • Include patients who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If no patients received the influenza vaccine for the current/most recent flu season, enter 0.
c. Patients received pneumococcal vaccine	Conditionally required if answer to question 17 is equal to 1 or more. Of the total number of maintenance, non-transient patients indicated in question 17, indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. • If no patients received the pneumococcal vaccine ever, enter 0.
20a. Number of in-center hemodialysis patients vaccinated against hepatitis B	Conditionally required. Of the total number of maintenance, non-transient *hemodialysis* patients indicated in question 17a, indicate how many ever received at least 3 doses of hepatitis B vaccine. • Do not count patients who are in the process of completing the series. • Include all hemodialysis patients who received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses. • Include patients who have documentation of having a complete hepatitis B vaccine series, even if not received at your facility. • If no in-center hemodialysis patients received at least 3 doses of the hepatitis B vaccine, enter 0.

Survey Question	Instructions for Data Collection
b. In-center hemodialysis patients received influenza vaccine	Conditionally required if answer to question 17a is 1 or greater. Of all these maintenance, non-transient, in-center patients indicated in question 17a, indicate how many received the influenza (flu) vaccine for this flu season (September 2014 or later). • This question refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2015, count flu vaccinations for the 2014-2015 flu season. • Include patients who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If no maintenance, non-transient patients receiving in-center hemodialysis reported receiving the influenza vaccine for the current/most recent flu season, enter 0.
c. In-center hemodialysis patients received at least one dose of pneumococcal vaccine ever	Conditionally required if answer to question 17a is equal to 1 or more. Of the total number of maintenance, non-transient patients indicated in question 17a, indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. If no patients received the pneumococcal vaccine ever, enter 0.
21. a. Patient care staff who received hepatitis B vaccine	Conditionally required. Of the patient care staff members counted in question 18, indicate how many have ever received at least 3 doses of hepatitis B vaccine. • Do not count staff members who are in the process of completing the series. • Include all staff members who received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses. • Include patient care staff members who report having received at least 3 doses of hepatitis B vaccine (or for whom there is documentation) even if not received at your facility. • If none of the patient care staff members indicated in question 18 have received at least 3 doses of the hepatitis B vaccine ever, enter 0.

Survey Question	Instructions for Data Collection
b. Patient care staff who received influenza vaccine	Conditionally required. Of the patient care staff members counted in question 18, indicate how many received the flu vaccine for the current/most recent flu season. • This refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2014, count flu vaccinations for the 2014-2015 flu season. • Include patient care staff members who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If none of the patient care staff members indicated in question 18 have received the influenza vaccine for the current/most recent flu season, enter 0.
22. Vaccine standing orders	**Required.** Select "Yes" if your facility uses standing orders to allow nurses to administer some or all of the vaccines mentioned in questions 19, 20, and 21 to patients without a specific physician order. These vaccines include: • Hepatitis B vaccine • Influenza vaccine for the current/most recent flu season • Pneumococcal vaccine Select "No" if there are no standing orders for any of the mentioned vaccines.
23. Type of pneumococcal vaccine(s)	**Required.** Choose only one type of pneumococcal vaccine offered to your facility's patients: ○ Polysaccharide: pneumococcal polysaccharide vaccine, called PPSV23 or Pneumovax®.[3] ○ Conjugate: pneumococcal conjugate vaccine, called PCV13 or Prevnar® 13.[3] If type of vaccine offered is unknown, select "Offered, but type unknown." If pneumococcal vaccine is not offered, select "Not offered."

D.	Hepatitis B and C
D.1.	Hepatitis B - Complete this section even if your facility does not treat hepatitis B surface antigen (HBsAg) positive patients.

[3] Use of trade names and commercial sources is for identification only and does not imply endorsement.

24.	a. In-center HD patients with HBV infection during 1st week of February	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 17a, indicate how many were hepatitis B virus surface antigen (i.e., HBsAg) positive in the first week of February (i.e., the first seven calendar days of the month). This is a measure of prevalence of hepatitis B virus infection among patients in your facility during this period.
	a.i. In-center HD patients with HBV infection upon admission	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 24a, indicate how many were hepatitis B virus surface antigen (i.e., HBsAg) positive when they were first admitted to your facility (i.e., they had hepatitis B virus infection upon admission). This is a measure of prevalence of hepatitis B virus infection among your incoming patients.
	b. In-center HD patients acquired HBV infection in 12 months prior to February	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 17a, indicate how many converted from hepatitis B virus surface antigen (i.e., HBsAg), negative to positive, during the 12 months prior to February (i.e., they acquired HBV infection in the past year). Do not include patients who were antigen positive before they were first dialyzed in your center (i.e., patients specified in question 24a.i). This is a measure of annual incidence of hepatitis B virus infection among patients in your facility.
25.	Hepatitis B reverse seroconverted	**Required.** Indicate whether one or more hemodialysis patients had evidence of reverse seroconversion of hepatitis B virus.
D.2.	Hepatitis C	
26.	Hepatitis C antibody admission screening	**Required.** Select "Yes" if your facility screens hemodialysis patients for hepatitis C antibody (anti-HCV) upon admission. Select "No" if your facility does not screen hemodialysis patients for hepatitis C antibody (anti-HCV) upon admission.
27.	Hepatitis C antibody screening at times other than admission	**Required.** Select "Yes" if your facility screens hemodialysis patients for hepatitis C antibody (anti-HCV) at any time other than upon admission. Select "No" if your facility does not screen hemodialysis patients for hepatitis C antibody (anti-HCV) at any other times than upon admission. Select "No" if hepatitis C testing is diagnostic only.
	a. Hepatitis C antibody screening frequency	Conditionally required. If answered yes to question 26, indicate the frequency of non-admission hepatitis C antibody (anti-HCV) screening. ○ Twice annually: screening is two times per year, after admission. ○ Annually: if screening is once per year, any time after admission. Otherwise, select "Other" and specify the frequency of post-admission HCV screening.

28. a. In-center HD patients with HCV infection during 1st week of February	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 17a, indicate how many were hepatitis C virus antibody (i.e., anti-HCV) positive in the first week of February (the first seven calendar days of the month). If your facility does not screen for hepatitis C antibody, respond by counting patients with records of known history of HCV infection. This is a measure of prevalence of hepatitis C virus infection among your patients.
a.i. In-center HD patients with HCV infection upon admission	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 27a, indicate how many were hepatitis C antibody (anti-HCV) positive when they were first admitted to your facility (i.e., they had hepatitis C virus infection upon admission). If your facility does not screen for hepatitis C antibody, respond to the question counting patients with records of known history of HCV infection. (Note: if your facility does not screen for hepatitis C upon admission, respond by counting patients with records of known history of HCV infection.) This is a measure of prevalence of hepatitis C virus infection among your patients.
b. In-center HD patients acquired HCV infection in 12 months prior to February	**Required**. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 17a, indicate how many converted from hepatitis C antibody (i.e., anti-HCV) negative to positive during the 12 months prior to February (i.e., they acquired HCV infection in the past year). Do not include patients who were antibody positive before they were first dialyzed in your center (i.e., patients specified in question 27a.i). If your facility does not screen for hepatitis C antibody, respond by counting patients with records of known history of HCV infection. This is a measure of annual incidence of hepatitis C virus infection among your patients.
E. Dialysis Policies and Practices	
E.1. Dialyzer Reuse	
29. Dialyzer reuse	**Required.** Select "Yes" if dialyzers are reused for any patients. Select "No" if dialyzers are never reused. o Facilities that use non-disposable dialyzers for more than one patient treatment should answer "Yes" to this question. o All facilities with a dialyzer reuse program would answer "Yes" to this question.
a. In-center hemodialysis patients participate in dialyzer reuse	Conditionally required if the response to 17 is greater than or equal to 1. Indicate the number of in-center hemodialysis patients who participate in dialyzer reuse.

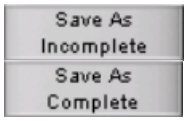
b. R.O. water testing	Conditionally required if the center reuses dialyzers for any patients. Indicate whether the reverse osmosis (R.O.) water is tested for both culture and endotoxin whenever a reuse patient has a pyrogenic reaction.
c. Dialyzer refrigeration	Conditionally required if the center reuses dialyzers for any patients. Indicate approximately how many reuse dialyzers are refrigerated prior to reprocessing.
d. Dialyzer reuse limit	Conditionally required. If there is a limit on the number of times a dialyzer can be reused at your facility, select "Yes" and indicate the maximum number of times dialyzers may be reused. Otherwise select "No limit as long as dialyzer meets certain criteria."
e. Sealed (non-removable) header caps	Conditionally required if the center reuses dialyzers for any patients. Indicate approximately how many reuse dialyzers have sealed (non-removable) header caps.
f. Dialyzer reprocessing location	Conditionally required. Indicate whether dialyzers are reprocessed at your facility, if they are transported to an off-site facility for reprocessing, or if they are reprocessed both at your facility and off-site.
i. Dialyzer header cleaning	Conditionally required if dialyzers are reprocessed at the facility. Select all dialyzer header cleaning methods in use. If there is no header cleaning step, select "No separate header cleaning step performed."
ii. Automated or manual reprocessing	Conditionally required if dialyzers are reprocessed at the facility. Indicate whether reprocessing occurs using an automated process or is completed manually by hand.
E.2. Dialysate	
30. Type of dialysate	**Required.** Choose only one type of dialysate that is used for in-center hemodialysis patients at your center. o Ultrapure: dialysate with a viable microbial count less than 0.1 CFU/ml and an endotoxin level less than 0.03 EU/ml. o Conventional: dialysate that does not meet the ultrapure definition above.
31. Culture and endotoxin tests after pyrogenic reactions	**Required.** Select "Yes" only if your facility routinely tests a patient's dialysate for both culture and endotoxin whenever a patient has a pyrogenic reaction. Select "No" if testing dialysate for both culture and toxin is not routine practice. If there has never been a pyrogenic reaction among your patients, respond based on facility policy.
E.3. Priming Practices	
32. Waste Handling Option (WHO) ports	**Required.** A waste handling option (WHO) port is a feature of some hemodialysis machines that is designed to dispose of any saline that is flushed through the dialyzer before the machine is used for a patient. Select "Yes" if your facility uses WHO ports. Select "No" if the hemodialysis machines at your facility do not have WHO ports or if WHO ports are present, but not used.

33.	Bled onto machine	**Required.** Select "Yes" if any patients in your facility are "bled onto the hemodialysis machine," a process where blood is allowed to reach or almost reach the prime waste receptacle or WHO port. Select "No" if patients are not bled onto their machines.
E.4.	Injection Practices	
34.	Form of erythropoiesis stimulating agent	**Required.** Select one form of erythropoiesis stimulating agent (ESA) that is most often used in your facility. "Single-dose" (also known as "single-use") and "multi-dose" refer to specific manufacturer designations that are printed on the product packaging/label, not the dosing practice in use. Please refer to the ESA's label to determine if the product most frequently used in your facility is labeled "single-dose" or "multi-dose." If ESA is not used, select "N/A."
	a. ESA single-dose vial or syringe	Conditionally required. Select "Yes" if ESA from a single-dose vial or syringe is ever administered to more than one patient. Select "No" if ESA from a single-dose vial or syringe is never administered to more than one patient.
35.	Medication preparation location	**Required.** Select one location where medications are most commonly drawn into syringes to prepare for patient administration.
36.	Technician IV med administration	**Required.** Select "Yes" if technicians ever administer any IV medications or infusates, such as heparin or saline, to patients. Select "No" if technicians never administer IV medications to patients.
E.5.	Antibiotic Use	
37.	a.-d. Appropriate antibiotic use	**Required.** Select "Yes" only for those practices that have been implemented for the purpose of "appropriate antibiotic use." If antibiotics are restricted, but for another purpose (e.g., cost management), select "No." Select "No" if there are no antimicrobial restrictions in your center. o Have a written policy on antibiotic use: any written plan to guide and determine the present and future decisions about appropriate antibiotic use. o Formulary restrictions: the existence of rules that limit the use of certain types of antimicrobials. o Antibiotic use approval process: a mechanism exists to ensure specific criteria are met before antibiotics are administered. o Automatic stop orders for antibiotics: in the absence of a physician's review and order for continuation, antibiotics are automatically discontinued after a specified period.
38.	Antibiotics before cultures	**Required.** Indicate the frequency with which antibiotics are administered to a patient for a suspected bloodstream infection before blood cultures are drawn.

39.	Infection prevention initiatives	**Required.** Select "Yes" if your facility participates in any national or regional infection prevention initiatives. This includes infection prevention initiatives directed by your ESRD Network.
	a. Initiative types	Conditionally required. If responded "Yes" to question 37, indicate the primary focus of the initiative. If involved in more than one initiative, indicate the primary focus of each initiative.
40.	CDC-recommended core interventions for BSI prevention in dialysis settings	**Required.** Select "Yes, all" if your facility follows all nine CDC-recommended Core Interventions for BSI prevention in dialysis settings for all of your in-center hemodialysis patients. Select "Yes, some" if your facility follows more than 1 but not all nine CDC-recommended core interventions. Select "No, none" if none of the nine core interventions are implemented among all of your hemodialysis patients. Select "Don't know" if you are uncertain about whether all nine CDC-recommended core interventions are followed for all of your facility's hemodialysis patients.
41.	Hand hygiene audits	**Required.** Select "Yes" if your facility performs hand hygiene audits monthly, or more frequently. Select "No" if your facility does not perform hand hygiene audits, or if the audits are performed less often than monthly.
42.	Vascular access care and catheter access practice observation	**Required.** Select "Yes" if your facility performs vascular access care observations and catheter access observations quarterly, or more frequently. Select "No" if your facility does not perform vascular access care observations and catheter access observations, or if the observations are performed less often than quarterly.
43.	Vascular access care and catheter access practice competency	**Required.** Select "Yes" if your facility performs staff competency assessments for vascular access care and catheter accessing annually, or more frequently. Select "No" if your facility does not perform staff competency assessments for vascular access care and catheter accessing, or if the assessments are performed less often than yearly.
E.7.	Peritoneal Dialysis	
44.	Peritoneal dialysis catheter antimicrobial ointment	**Required.** Select "Yes" if antimicrobial ointment is routinely applied to **peritoneal dialysis catheter exit sites** during dressing changes. Select "No" if antimicrobial ointment is not routinely applied to the **peritoneal dialysis catheter exit site** during dressing changes. Select "N/A" if your facility does not have a procedure in place to routinely apply antimicrobial ointment to peritoneal dialysis catheter exit sites.
	a. Peritoneal dialysis catheter antimicrobial ointment type	Conditionally required. Select one antimicrobial ointment that is most commonly applied to the peritoneal dialysis catheter exit site during dressing changes.
F.	**Vascular Access**	
F.1.	General Vascular Access Information	

45.	a.-e. Hemodialysis access types	**Required.** Of the total number of maintenance, non-transient in-center and home hemodialysis patients indicated in questions 17a and 17b, indicate how many patients received hemodialysis through each access type during the first week of February (the first seven calendar days of the month). • Note: this question requires a different counting process than the Denominators for Outpatient Dialysis form: count all accesses that were used for hemodialysis during the week.
F.2.	**Arteriovenous (AV) Fistulas or Grafts**	
46.	Graft/fistula cleanser used before prep	**Required.** Indicate whether the graft/fistula site is most often cleansed with soap and water, or alcohol-based handrub, prior to prepping the area for puncture. Select "Other" and specify if a different cleanser is used. Select "Nothing" if a cleanser is not used to cleanse the fistula or graft site for cannulation.
47.	Graft/fistula puncture prep	**Required.** To prep the graft or fistula for puncture, select one antiseptic/disinfectant that is most often used to prep the area.
	a. Graft/fistula puncture prep form	Conditionally required. If you responded to question 45 with an answer other than "Nothing," indicate the form of the antiseptic/disinfectant used to prep grafts or fistulas for puncture. Select "N/A" if you answered "Nothing" to question 45.
48.	Buttonhole cannulation	**Required.** Buttonhole cannulation is a technique where a patient's fistula is regularly accessed by inserting a blunt needle (cannula) into the fistula at the same location each time using an established track. Indicate if "All," "Most," "Some," or "None" of your fistula patients undergo buttonhole cannulation.
	a. Buttonhole patients	Conditionally required. If you responded "All," "Most," or "Some" to question 46, of these patients whose fistulae are accessed via the buttonhole cannulation technique, indicate whether they are in-center hemodialysis patients only, home hemodialysis patients only, or both.
	b. Buttonhole cannulation performed by	Conditionally required. Among the in-center hemodialysis patients, indicate whether buttonhole cannulation is most often performed by a nurse, the patient, or a technician. Otherwise, select "Other" and specify who most often performs buttonhole cannulation.
	d. Buttonhole site prep	Conditionally required. Indicate what buttonhole sites are most commonly prepped with prior to cannulation.
	b. Buttonhole antimicrobial ointment	Conditionally required. Select "Yes" if antimicrobial ointment is applied at the buttonhole cannulation site to prevent infections. Select "No" if antimicrobial ointment is not used at the buttonhole cannulation site to prevent infections.

F.3. Hemodialysis Catheters If there are no patients with hemodialysis catheters, refer to facility policy to answer the following questions.		
49.	Catheter hub prep	**Required.** Prior to accessing hemodialysis catheters, select one product that is most commonly used to prep the catheter hubs. Select "Other" and specify what product is most commonly used to prep the catheter hubs if it is not listed. Otherwise, if no product is used to prep the catheter hubs, select "Nothing."
	a. Catheter hub prep form	Conditionally required. If a product is used to prep the catheter hubs, indicate the form of the antiseptic/disinfectant used to prep catheter hubs prior to accessing hemodialysis catheters.
50.	Catheter hub scrub	**Required.** Select "Yes" if catheter hubs are routinely scrubbed after the cap is removed, but before the catheter is accessed. Select "No" if scrubbing catheter hubs is not routine practice or if the process is not appropriately implemented.
51.	Catheter exit site prep	**Required.** When a catheter exit site dressing is changed, select one antiseptic/disinfectant that is most often used to prep the area.
	a. Catheter exit site prep form	Conditionally required. Indicate the form of the antiseptic/disinfectant used to prep catheter exit sites when the dressing is changed.
52.	Catheter exit site antimicrobial ointment	**Required.** Select "Yes" if antimicrobial ointment is routinely applied to the hemodialysis catheter exit site during dressing changes. Select "No" if antimicrobial ointment is not routinely applied to the hemodialysis catheter exit site during dressing changes.
	a. Catheter exit site antimicrobial ointment type	Conditionally required. If responded "Yes" to question 50, select one antimicrobial ointment that is most commonly applied to the hemodialysis catheter exit site during dressing changes, indicate the type of ointment that is most commonly used.
53.	Hemodialysis catheter care staff	**Required.** Select one job classification that describes the staff members who most often perform hemodialysis catheter care (i.e., accesses catheters or changes dressings) in your center. Select "Other" and specify the job classification if the staff members who most often who perform hemodialysis catheter care in your facility are not nurses or technicians.
54.	Antimicrobial lock solutions to prevent infection	**Required.** Indicate whether antimicrobial lock solutions are used to prevent hemodialysis catheter infections for all catheter patients in your facility, for some catheter patients in your facility, or for none of the catheter patients in your facility.
	a. Antimicrobial lock solutions	Conditionally required. If you indicated that antimicrobial lock solutions are used for all or some catheter patients in your facility, select one type of antimicrobial lock solution that is most commonly used in your facility.

55. Closed connector luer access devices	**Required.** Select "Yes" if closed connector devices are used on hemodialysis catheters in your facility. Select "No" if closed connector devices are not used on hemodialysis catheters in your facility.
a. Closed connector luer access device type	Conditionally required. If you answered "Yes" to question 53, indicate the type of closed connector device used on hemodialysis catheters in your center.
b. Closed connector luer access device patients	Conditionally required. If you answered "Yes" to question 53, indicate for which patients they are used (e.g. home hemodialysis patients, in-center hemodialysis patients, or both).
56. Other antimicrobial/ antiseptic products	**Required.** Select all of the applicable antimicrobial/antiseptic products that are used for hemodialysis catheters in your facility.
Comments	Optional. Use this field to add any additional information about the dialysis survey necessary to interpret your responses. If the character limit is inadequate, please email your comments to the NHSN Helpdesk at nhsn@cdc.gov.
Save as … 	A complete survey is an annual reporting requirement specified in the NHSN Dialysis Event Surveillance Protocol. Users are prevented from creating Monthly Reporting Plans and submitting monthly data for April through December until a survey for that year has been "Saved as Complete." Surveys can be saved as complete as early as February 8 each year.

For additional assistance, email the NHSN Helpdesk (nhsn@cdc.gov) and include "Dialysis" in the subject line.