Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2019
www.cdc.gov/nhsn

Patient Safety Component—Annual Facility Survey for LTAC

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/TOI-57.150-LTAC.pdf

*required for saving | Tracking #:

*Facility ID: | *Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

☐ For profit ☐ Not for profit, including church ☐ Government ☐ Veterans Affairs

*Affiliation (check one): ☐ Independent ☐ Multi-facility organization (specialty hospital network) ☐ Hospital system

*Setting/classification: ____ Free-standing ____ Within a hospital

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)?

☐ No
☐ Skilled nursing facility (SNF)/nursing home
☐ Residential facility (assisted living)
☐ Inpatient rehabilitation facility
☐ Neuro-behavioral unit or facility
☐ Other (please specify: _____)

If classified as "Within a hospital," is your LTAC hospital located:
In a building that does not provide acute care services (e.g., psychiatric hospital)? ☐ Yes ☐ No
Near (but not within) an acute care hospital? ☐ Yes ☐ No

In the previous calendar year, indicate:

*Number of patient days: _____

*Number of admissions: _____

*Average daily census: _____

*Numbers of LTAC beds in the following categories (categories should equal total):

a. Intensive care unit (ICU) or critical care beds: _____
b. High observation/special care/high acuity beds (not ICU): _____
c. General LTAC beds: _____

*Total number of LTAC beds (licensed capacity): _____

*Number of single occupancy rooms: _____

* 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.)

If helpful for your facility in identifying these conditions on admission, please review a list of ICD-10 and DRG codes commonly associated with these conditions found here:
http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx

a. Ventilator dependence: _____
b. Hemodialysis: _____

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

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

☐ Yes ☐ No

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

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

*2. For the following organisms please indicate which methods are used for:

(1) primary susceptibility testing and

(2) secondary, supplemental, or confirmatory testing (if performed).

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

Please use the testing codes listed below the table.

Pathogen	(1) Primary	(2) Secondary	Comments
Staphylococcus aureus	_____	_____	_____
Enterobacteriaceae	_____	_____	_____

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

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

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

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

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

☐ Change susceptible carbapenem results to resistant

☐ Report carbapenem MIC results without an interpretation

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

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

☐ PCR ☐ MBL screen

☐ Modified Hodge Test ☐ Carba NP

☐ E test ☐ Other (specify): _____

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Facility Microbiology Laboratory Practices (continued)

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

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

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

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

☐ Yes ☐ No

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

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

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

☐ Broth macrodilution ☐ Broth microdilution ☐ YeastOne colorimetric microdilution ☐ E test
☐ Vitek 2 card ☐ Disk diffusion ☐ Other (specify): _____

*9. Is antifungal susceptibility testing performed automatically/reflexively without needing a specific order or request for susceptibility testing from the clinician for the below *Candida* species when cultured from normally sterile body sites (such as blood)?

Candida albicans: ☐ Yes ☐ No

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

☐ Fluconazole ☐ Voriconazole ☐ Anidulafungin/Caspofungin/Micafungin

Candida glabrata: ☐ Yes ☐ No

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

☐ Fluconazole ☐ Voriconazole ☐ Anidulafungin/Caspofungin/Micafungin

Candida parapsilosis: ☐ Yes ☐ No

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

☐ Fluconazole ☐ Voriconazole ☐ Anidulafungin/Caspofungin/Micafungin

Other *Candida* species: ☐ Yes ☐ No

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

☐ Fluconazole ☐ Voriconazole ☐ Anidulafungin/Caspofungin/Micafungin

☐ Automatic testing is not performed for any *Candida* species

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Facility Microbiology Laboratory Practices (continued)

*10. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)

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

("Other" should not be used to name specific laboratories, reference laboratories, or the brand names of C. difficile tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.)

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

☐ Yes ☐ No

If Yes, is the antibiogram produced at least annually?

☐ Yes ☐ No

If Yes, are data stratified by hospital location?

☐ Yes ☐ No

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

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

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

*12. . Number or fraction of infection preventionists (IPs) in facility: _____

a. Total hours per week performing surveillance: _____

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

*13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility: _____

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

*14. Is it a policy in your facility that patients infected or colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)

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

*15. Is it a policy in your facility that patients infected or colonized with VRE are routinely placed in contact precautions while these patients are in your facility? (check one)

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

*16. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)

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

*17. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)

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

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Patient Safety Component—Annual Facility Survey for LTAC

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

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

☐ Yes ☐ No

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

☐ Surveillance testing at admission for all patients

☐ Surveillance testing of epidemiologically-linked patients of newly identified CRE patients (e.g., roommates)

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

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

☐ Other (please specify): _____

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

☐ Yes ☐ No

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

☐ Surveillance testing at admission for all patients

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

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

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

☐ Other (please specify): _____

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

☐ Yes ☐ No

*21. Does the facility routinely use a combination of topical chlorhexidine AND intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)

☐ Yes ☐ No

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

☐ All the time

☐ More than half of the time

☐ About half of the time

☐ Less than half of the time

☐ None of the time

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

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Physician ☐ Co-led by both Pharmacist and Physician

☐ Pharmacist ☐ Other (please specify): _____

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

*28. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?

☐ Yes ☐ No

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

☐ Yes ☐ No

*29. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?

☐ Yes ☐ No

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

☐ Yes ☐ No

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Antibiotic Stewardship Practices (continued)

*31. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers at your facility?

☐ Yes ☐ No

If Yes, what type of feedback is provided to prescribers? (check all that apply)

☐ Feedback on antimicrobial route and/or dosage

☐ Feedback on the selection of antimicrobial therapy and/or duration of therapy

☐ Other (please specify) : _____

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

☐ Yes ☐ No

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

☐ Days of Therapy (DOT) ☐ Purchasing Data

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

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

☐ Yes ☐ No

*33. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use?

☐ Yes ☐ No

Facility Water Management and Monitoring Program

34. Have you ever conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (e.g. *Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? ☐ Yes ☐ No

If Yes, when was the most recent assessment conducted? (Check one)

☐ ≤ 1 year ago ☐ ≥ 1-3 years ago ☐ ≥ 3 years ago

35. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens? ☐ Yes ☐ No

If Yes, who is represented on the team? (Check all that apply)

☐ Hospital Administrator
☐ Hospital Epidemiologist/ Infection Preventionist
☐ Consultant
☐ Facilities Manager/ Engineer
☐ Maintenance Staff
☐ Infectious Disease Clinician
☐ Risk/Quality Management Staff
☐ Compliance Officer
☐ Equipment/ Chemical Supplier
☐ Other (specify): _____

36. Do you regularly monitor the following parameters in your building's water system? (Check all that apply)

Disinfectant (such as residual chlorine) ☐ Yes ☐ No

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If Yes, do you have a plan for corrective actions when disinfectants are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No
Temperature ☐ Yes ☐ No		
If Yes, do you have a plan for corrective actions when temperatures are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No
Heterotrophic plate counts ☐ Yes ☐ No		
If Yes, do you have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No
Specific tests for *Legionella* ☐ Yes ☐ No		
If Yes, do you have a plan for corrective actions when Specific tests for *Legionella* are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No