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Patient Safety Component—Annual Hospital Survey

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

*required for saving

Tracking #:

Facility ID:

*Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

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

If facility is a Hospital:

*Number of patient days: _____

*Number of admissions: _____

For any Hospital:

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

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

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

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

b. All other inpatient locations: _____

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

*1. Does your facility have its own on-site laboratory that performs bacterial 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

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Facility Microbiology Laboratory Practices (continued)

*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	10 = E test
2 = Vitek (Legacy)	5.2 = MicroScan autoSCAN	12 = Vancomycin agar screen (BHI + vancomycin)
2.1 = Vitek 2	6 = Other broth micro dilution method	13 = Other (describe in Comments section)
3.1 = BD Phoenix	7 = Agar dilution method	
4 = Sensititre		

*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 test for presence of carbapenemase? (this does not include automated testing instrument expert rules) ☐ 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 practices

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

☐ PCR
☐ Modified Hodge Test
☐ mCIM/CIM
☐ E test
☐ Cepheid, BioFire array, Verigene®
☐ MBL Screen
☐ Carba NP
☐ Rapid CARB Blue
☐ Other (specify): _____

If Yes, does the laboratory have a policy to routinely notify any of the following when CP-CRE are detected?

Physician ☐ Yes ☐ No

Infection Control ☐ Yes ☐ No

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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; answers listed are generic antimicrobial susceptibility testing methods and do not imply they are recommended for use in polymyxin susceptibility testing)

☐ Vitek 2
☐ BD Phoenix
☐ Sensititre
☐ MicroScan- WalkAway
☐ MicroScan autoSCAN
☐ Other broth microdilution method
☐ Agar dilution method
☐ E test
☐ Kirby-Bauer disk diffusion
☐ Accelerate Pheno
☐ Other (specify): _____

7*. Which of the following methods are used for yeast identification at your facility's laboratory or at the outside laboratory serving your facility? (check all that apply)

☐ MALDI-TOF MS System (Vitek MS)
☐ MALDI-TOF MS System (Bruker Biotyper)
☐ Vitek-2
☐ BD Phoenix
☐ MicroScan
☐ Non-automated Manual Kit (e.g., API 20C, RapID, Germ Tube, PNA-FISH, etc.)
☐ DNA sequencing
☐ Other (specify) _____

8*. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)

☐ Blood
☐ Other normally sterile body site (e.g.: CSF)
☐ Urine
☐ Respiratory
☐ Other (specify) _____
☐ None are fully identified to the species level

9*. What method is used for antifungal susceptibility testing (AFST) at your facility's laboratory or the outside laboratory serving your facility? (check all that apply)

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

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*10. Antifungal susceptibility testing is performed on fungal isolates in which of the following situations:
Candida albicans:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

Candida glabrata:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

All other *Candida* species:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

Facility Microbiology Laboratory Practices (continued)

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

☐ Enzyme immunoassay (EIA) for toxin

☐ Cell cytotoxicity neutralization assay

☐ Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP)

☐ 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)

*12. Please indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (**SELECT ONE ANSWER**)

☐ MALDI-TOF MS System (Vitek MS)

☐ MALDI-TOF MS System (Bruker Biotyper)

☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)

☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)

☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)

☐ 16S rRNA Sequencing

*13. Please indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (e.g., a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). (**SELECT ALL THAT APPLY**)

☐ MALDI-TOF MS System (Vitek MS)

☐ MALDI-TOF MS System (Bruker Biotyper)

☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)

☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)

☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)

☐ 16S rRNA Sequencing

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

*14. 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: _____

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

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

*16. 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

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

*17. 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

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

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*18. 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

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

*19. 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

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐ Patients admitted to high risk settings

☐ Patients at high risk for transmission

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

*20. 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): _____

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*21. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings? ☐ Yes ☐ No

If yes, in which situations does the facility routinely perform screening testing for MRSA for non-NICU settings? (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): _____

*22.Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings? ☐ Yes ☐ No

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

- ☐ Surveillance testing at admission for all transferred patients
- ☐ Surveillance testing of patients from known MRSA positive mothers
- ☐ Surveillance testing of high-risk patients (e.g. infants born premature)
- ☐ Routine active surveillance testing (i.e., point prevalence surveys)
- ☐ Other (please specify): _____

*23. 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

*24. 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

Facility Neonatal Patient Care Practices and Neonatal Admission Information

(To be completed with input from the NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, and/or Lead Neonatal Nurse Practitioner)*

*25. Was this section completed in collaboration with your facility's neonatal patient care team (i.e. was input sought from at least one of the following neonatal patient care team members: NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner)?

- ☐ Yes
- ☐ No
- ☐ N/A, my facility does not provide neonatal patient care services

If N/A was selected in question 25 above, questions 26-30 below do not apply to your facility and should be skipped. If your facility does care for neonates (at any level), please complete questions below.

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Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

*26. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions to Special Care Nurseries (Level II) and Intensive Care Units (Level II/III, Level III, Level IV):

a. Inborn Admissions: _____

b. Outborn Admissions: _____

*27. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions (both inborn and outborn) to Special Care (Level II) and Intensive Care (Level II/III, Level III, Level IV) in each of following birth weight categories:

a. Less than or equal to 750 grams: _____

b. 751-1000 grams: _____

c. 1001-1500 grams: _____

d. 1501-2500 grams: _____

e. More than 2500 grams: _____

*28. Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (e.g. capable of providing sustained life support, comprehensive care for infants born <32 weeks gestation and weighing <1500 grams, a full range of respiratory support that may include conventional and/or high-frequency ventilation)? ☐ Yes ☐ No

*29 Does your facility accept neonates as transfers for any of the following procedures: Omphalocele repair; ventriculoperitoneal shunt; tracheoesophageal fistula (TEF)/esophageal atresia repair; bowel resection/reanastomosis; meningomyelocele repair; cardiac catheterization. ☐ Yes ☐ No

*30. If your facility administers antimicrobials (oral or parenteral) to newborns residing in their mother's room, to which NHSN location(s) is the baby mapped? (Select all that apply)

☐ N/A, my facility requires that newborns be transferred to a higher level of care (i.e. special care nursery or neonatal intensive care unit) in order for antimicrobials to be administered

☐ Level I neonatal unit (well newborn nursery)

☐ Labor and Delivery Ward, Postpartum Ward, or Labor, Delivery, Recovery, Postpartum Suite

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

31*. Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board). ☐ Yes ☐ No

32*. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)

☐ Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues.

☐ Providing opportunities for staff training and development on antibiotic stewardship.

☐ Allocating information technology resources to support antibiotic stewardship efforts.

☐ None of the above

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33*. Our facility has a committee responsible for antibiotic stewardship. ☐ Yes ☐ No

If Yes, membership in our facility's antibiotic stewardship committee includes: (Check all that apply.)

- ☐ Non-infectious diseases trained prescriber(s)
- ☐ Infectious disease physician(s)
- ☐ Pharmacist(s)
- ☐ Nurse(s)
- ☐ Infection preventionist(s)
- ☐ Microbiologist(s)
- ☐ Information technologist(s)
- ☐ A patient representative
- ☐ None of the Above

34*. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes. ☐ Yes ☐ No

If Yes, what is the position of this leader? (Check one.)

- ☐ Physician
- ☐ Pharmacist
- ☐ Co-led by both Pharmacist and Physician
- ☐ Other (please specify):_____

If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)

- ☐ Has antibiotic stewardship responsibilities in their contract or job description
- ☐ Is physically on-site in your facility (either part-time or full-time)
- ☐ Completed an ID fellowship
- ☐ Completed a certificate program or other coursework
- ☐ None of the above

If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)

- ☐ Has antibiotic stewardship responsibilities in their contract or job description
- ☐ Is physically on-site in your facility (either part-time or full-time)
- ☐ Completed a PGY2 ID residency and/or ID fellowship
- ☐ Completed a certificate program or other coursework
- ☐ None of the above

If Physician or Other, is there at least one pharmacist responsible for improving antibiotic use at your facility? ☐ Yes ☐ No

35*. Our facility has a policy or formal procedure for: (Check all that apply.)

☐ Required documentation of indication for antibiotic orders.

If selected: Our stewardship team monitors adherence to the policy or formal procedure for required documentation of indication for all antibiotic orders. ☐ Yes ☐ No

☐ Required documentation of duration for antibiotic orders.

☐ The treating team to review antibiotics 48-72 hours after initial order (i.e., antibiotic time-out).

☐ The stewardship team to review courses of therapy for specific antibiotic agents and provide real-time feedback and recommendations to the treating team (i.e., prospective audit and feedback).

If selected: For which categories of antimicrobials? (Check all that apply.)

☐☐ Cefepime, ceftizidime, or piperacillin/tazobactam

☐☐ Ertapenem, imipenem/cilastatin, or meropenem

☐☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors

☐☐ Colistin or polymyxin B

☐☐ Quinolones

☐☐ Vancomycin

☐☐ Daptomycin, linezolid, or other anti-MRSA agents

☐☐ Anidulafungin, caspofungin, or micafungin

☐☐ Isavuconazole, posaconazole, or voriconazole

☐☐ Amphotericin B and/or lipid-based amphotericin B

☐☐ None of the above

☐☐ Required authorization by the stewardship team before restricted antibiotics on the formulary can be dispensed (i.e., prior authorization).

If selected: For which categories of antimicrobials? (Check all that apply.)

☐ Cefepime, ceftizidime, or piperacillin/tazobactam

☐ Ertapenem, imipenem/cilastatin, or meropenem

☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors

- ☐ Colistin or polymyxin B
- ☐ Quinolones
- ☐ Vancomycin
- ☐ Daptomycin, linezolid, or other anti-MRSA agents
- ☐ Anidulafungin, caspofungin, or micafungin
- ☐ Isavuconazole, posaconazole, or voriconazole
- ☐ Amphotericin B and/or lipid-based amphotericin B
- ☐ None of the above

☐ None of the above

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36*. Providers have access to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. ☐ Yes ☐ No

If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. ☐ Yes ☐ No

37*. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response). ☐ Yes ☐ No

38*. Our stewardship team monitors: (Check all that apply.)

- ☐ Antibiotic resistance patterns (either facility- or region-specific)
- ☐ *Clostridioides difficile*
- ☐ Antibiotic use in days of therapy (DOT) per 1000 patient days or days present, at least quarterly
- ☐ Antibiotic use in defined daily doses (DDD) per 1000 patient days, at least quarterly
- ☐ Antibiotic expenditures (i.e., purchasing costs), at least quarterly
- ☐ Antibiotic use in some other way (please specify): _____
- ☐ None of the above

If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually. ☐ Yes ☐ No

If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve ☐ Yes ☐ No

their antibiotic prescribing, at least annually.

39*. Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.)

- ☐ Updates to facility leadership on antibiotic use and stewardship efforts.
- ☐ Outcomes for antibiotic stewardship interventions to staff.
- ☐ None of the above

40*. Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.)

- ☐ Prescribers
- ☐ Nursing staff
- ☐ Pharmacists
- ☐ None of the above

Optional Antibiotic Stewardship Practices Questions

Responses to the following questions are not required to complete the annual survey.

Please provide additional information about your facility's antibiotic stewardship activities and leadership.

41. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. ☐ Yes ☐ No

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42. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific support for our antibiotic stewardship efforts. ☐ Yes ☐ No

43. Our facility has a clinical decision support tool embedded in the electronic health record for antibiotic use or stewardship interventions available to prescribers. ☐ Yes ☐ No

44. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities. ☐ Yes ☐ No ☐ Not applicable, our facility does not use cascade and/or selective reporting

45. Our stewardship team monitors compliance with appropriate surgical prophylaxis. ☐ Yes ☐ No

46. If you selected 'Yes' to question 34 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)

- ☐ Pharmacy director
- ☐ Pharmacy & therapeutics
- ☐ Patient safety
- ☐ Quality improvement
- ☐ Executive leadership (e.g., CEO, CMO)
- ☐ Board of directors
- ☐ Other (please specify): _____
- ☐ None

47. If you selected 'Physician' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the **physician** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- ☐ 1-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

48. If you selected 'Pharmacist' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the **pharmacist** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- ☐ 1-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

49. If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's contract or job description? (Check one.)

- ☐ 1-25%

 26-50%

 51-75%

 76-100%

 Not specified

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50. If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's contract or job description? (Check one.)

 26-50%

 51-75%

 76-100%

 Not specified

Water Management Program (prevent legionella)

(*Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)

51. Have you performed an assessment of the water systems in your facility to identify areas of risk for growth and transmission of Legionella and other opportunistic waterborne pathogens? (e.g. pseudomonas, acinetobacter, burkholderia, and nontuberculous mycobacteria) ☐ Yes ☐ No

If Yes, when? (Check one)

☐ ≤ 1 year ago ☐ ≥ 1-3 years ago

☐ ≥ 3 years ago ☐ Other (please specify): _____

52. Has your hospital established a team specifically for the purpose of developing and implementing a water management program to prevent the growth and transmission of Legionella and other waterborne pathogens? ☐ Yes ☐ No

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

- ☐ Hospital Epidemiologist/ Infection Preventionist
- ☐ Compliance Officer
- ☐ Hospital Administrator
- ☐ Risk/Quality Management Staff
- ☐ Facilities Manager/ Engineer
- ☐ Infectious Disease Clinician

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

Disinfectant (such as residual chlorine):	☐ Yes	☐ No
If Yes, do you have a plan for corrective actions when the following parameters 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 the following parameters are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No

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(Question 53 continued.)

If Yes, do you have a plan for corrective actions when the following parameters 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 the following parameters are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No