HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
HEALTHCARE FACILITY ASSESSMENT

Form Approved
OMB No. 0920-0852
Exp. Date xx/xx/xxxx

For EIP Team use only: CDC Hospital ID: ☐☐-☐☐

Sources of Information (NOT transmitted to CDC):

For each *Section* of the assessment below, list the names of person(s) and department(s) to contact for information.

Section	Description	Person(s)	Department(s)
I.	Information about person responsible for ensuring completion of assessment and submission to EIP Team		
II.	Hospital data		
III.	Infection prevention and control		
IV.	Antimicrobial stewardship		

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I: Information about person responsible for ensuring completion of assessment and submission to EIP Team

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

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

–End of Section 1–

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II. Hospital data

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

Hospital characteristic	Number	What year are data from?
No. of acute care licensed beds *Do not include nursing home or skilled nursing facility beds.*	☐☐☐☐ or ☐ Unknown	☐2018 ☐2019 ☐Other: _____
No. of acute care staffed beds *Do not include nursing home or skilled nursing facility beds.*	☐☐☐☐ or ☐ Unknown	☐2018 ☐2019 ☐Other: _____
No. of full time equivalent (FTE) infection preventionists *Enter the number of FTEs to the nearest hundreth of an FTE. For example, if you have three staff members who each spend 35% of their time on infection prevention, you would enter 1.05 FTE. If you do not have any staff who serve part- or full-time as infection preventionists, check "None." If you do not know if your hospital has any part- or full-time infection preventionists, check "Unknown."*	☐☐.☐☐ or ☐ None ☐ Unknown	☐2018 ☐2019 ☐Other: _____
No. of FTE physician hospital epidemiologists *Enter the number of FTEs to the nearest hundreth of an FTE. For example, if you have two physicians who spends 45% of their time as hospital epidemiologists, you would enter 0.9 FTE. If you do not have any physicians who serve part- or full-time as hospital epidemiologists, check "None." If you do not know if your hospital has any part- or full-time hospital epidemiologists, check "Unknown."*	☐☐.☐☐ or ☐ None ☐ Unknown	☐2018 ☐2019 ☐Other: _____
No. of FTE interns/residents *Enter the number of FTE interns or residents that work in your hospital to the nearest hundredth of an FTE (e.g., 50.25 FTE). If your hospital does not have any interns or residents, check "None" and skip to Question #4. If you do not know if your hospital has interns or residents, check "Unknown."*	☐☐☐.☐☐ or ☐ None ☐ Unknown	☐2018 ☐2019 ☐Other: _____
If your hospital has interns or residents: Provide the official intern/resident to bed ratio (IRB) *If you do not know your hospital's official IRB, check "Unknown".*	☐ <0.25 ☐ ≥0.25 ☐ Unknown	☐2018 ☐2019 ☐Other: _____

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4) For each type of unit in your hospital, check the one ratio that most accurately reflects the average Registered Nurse (RN) to patient ratio during dayshift hours:

Note: "1:1" means one RN for one patient, "1:2" means one RN for every two patients, etc. Check "NA" (not applicable) if your hospital does not have one of the listed unit types.

Adult	
Medical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Surgical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical-surgical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Surgical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical-surgical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Pediatric	
Medical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Surgical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical-surgical critical care unit	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Surgical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA
Medical-surgical ward	☐ 1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ 1:5 ☐ 1:6 ☐ Other, specify:_____ ☐ Unknown ☐ NA

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III. Infection prevention and control

5) Does your facility have an infection control team or program with at least one staff member responsible for developing and implementing infection control policies and practices and related activities?
   - ☐ Yes
   - ☐ No ***(if "No," skip to question #9)***

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

7) If your hospital has an infection control team/program, how long has the infection control team/program been in place (check one)?
   - ☐ < 1 year
   - ☐ 1 – 3 years
   - ☐ 4 – 6 years
   - ☐ 7 – 9 years
   - ☐ ≥ 10 years

8) If your hospital has an infection control team/program, how often does the team/program meet (check one)?
   - ☐ More frequently than monthly
   - ☐ Monthly
   - ☐ Every other month or quarterly
   - ☐ Less than quarterly

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9) Is there a committee in your hospital that reviews infection control-related activities (such as reports, policies and procedures, etc)?
   - ☐ Yes
   - ☐ No ***(if "No," skip to question #12)***

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

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

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

	YES	NO	UNKNOWN
My hospital performs surveillance for one or more types of HAIs, in one or more inpatient locations, in compliance with local, state and/or federal reporting requirements.	☐	☐	☐
In addition to required HAI reporting, my hospital performs surveillance for one or more types of HAIs not currently included in any local, state, or federal reporting requirements.	☐	☐	☐

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	YES	NO	UNKNOWN
My hospital tracks rates or standardized infection ratios (SIR) of HAIs over time to identify trends (e.g., monthly, quarterly, annually, etc.).	☐	☐	☐
My hospital creates HAI summary reports (e.g., trends).	☐	☐	☐
My hospital shares HAI surveillance data with hospital leaders (e.g., CEO, COO, Chief Medical Officer, Chief Nursing Officer, department heads).	☐	☐	☐
My hospital shares HAI surveillance data with individual patient unit managers.	☐	☐	☐
My hospital shares HAI surveillance data with frontline providers (e.g., nurses, physicians, etc.).	☐	☐	☐

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

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

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

	YES	NO	UNKNOWN
My hospital measures adherence to hand hygiene policies in at least one patient care area.	☐	☐	☐
My hospital measures adherence to Isolation Precautions among staff (e.g., the percentage of those who comply with wearing of gloves or donning of gowns).	☐	☐	☐
My hospital monitors/observes environmental cleaning practices to ensure consistent cleaning and disinfection practices are followed.	☐	☐	☐

	YES	NO	UNKNOWN
My hospital shares adherence rates to specific policies (e.g., hand hygiene) with relevant staff.	☐	☐	☐
All hospital units, services and/or staff members are held accountable for complying with infection control policies (e.g., there are positive consequences for good compliance, and/or negative consequences for poor compliance).	☐	☐	☐

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

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

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

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

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

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17) What is the primary testing method for *Clostridioides difficile (C. difficile)* used most often by your hospital's laboratory or the outside laboratory where your hospital'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): _____

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

- ☐ Patients with suspected *C. difficile* infection (i.e., patients who are having symptoms typical of *C. difficile* infection and who have risk factors for *C. difficile* infection but who do not yet have a positive diagnostic test confirming *C. difficile* infection) are placed on Contact Precautions.
- ☐ Patients with active *C. difficile* infection (i.e., patients who have tested positive for *C. difficile* and are having symptoms) are placed on Contact Precautions.
- ☐ All patients with active *C. difficile* infection (i.e., patients who have tested positive for *C. difficile* and are having symptoms) are placed in private rooms.
- ☐ Other (specify):_____
- ☐ None of the above

19) If your hospital does <u>not</u> have a sufficient number of private rooms available, what does your hospital do with patients who are identified with active *Clostridioides difficile (C. difficile)* infection (check all that apply)?

- ☐ Place with other *C. difficile* infection patients (cohort)
- ☐ Place with other patients but use separate commodes/bathrooms
- ☐ Place with other patients sharing bathrooms
- ☐ Other (specify):_____
- ☐ NA (all rooms in my hospital are private rooms, or there is always a sufficient number of private rooms available)

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20) For patients with active *Clostridioides difficile (C. difficile)* infection, what is the preferred method of hand hygiene used in your hospital (check one)?

- ☐ Soap and water
- ☐ Alcohol hand gel
- ☐ Not specified (i.e., both available but neither preferred)
- ☐ Other (specify): _____

21) In what settings and/or patients does your hospital routinely perform Methicillin-resistant *Staphylococcus aureus* (MRSA) surveillance testing (culture or PCR) on admission for the purpose of detecting MRSA colonization (active surveillance) (check all that apply)?

- ☐ Hospital-wide
- ☐ In one or more intensive care units
- ☐ In one or more non-intensive care units
- ☐ In one or more specific patient populations (e.g., patients undergoing cardiac surgery, dialysis, recent hospital discharge, etc.)
- ☐ Other (specify): _____
- ☐ None of the above

22) In what settings and/or patients does your hospital routinely use chlorhexidine bathing (check all that apply)?

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

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

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

–End of Section 3–

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IV. Antimicrobial stewardship

24) Does your hospital have a multidisciplinary team focused on promoting appropriate antimicrobial use (antimicrobial stewardship)?

- ☐ Yes
- ☐ No ***(If "No," skip to question #29)***

25) If your hospital has an antimicrobial stewardship team, who participates in the stewardship team (check all that apply)?

- ☐ Infectious diseases physician
- ☐ Other physician (not infectious diseases)
- ☐ Infectious diseases pharmacist
- ☐ Pharmacist (without specialized infectious diseases training)
- ☐ Microbiologist
- ☐ Infection preventionist
- ☐ Data analyst
- ☐ Informatics support staff
- ☐ Other (specify): _____

26) If your hospital has an antimicrobial stewardship team, how long has the team been in place (check one)?

- ☐ < 1 year
- ☐ 1 – 3 years
- ☐ 4 – 6 years
- ☐ 7 – 9 years
- ☐ ≥ 10 years

27) If your hospital has an antimicrobial stewardship team, how often does the team meet (check one)?

- ☐ More frequently than monthly
- ☐ Monthly
- ☐ Every other month or quarterly
- ☐ Less than quarterly

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28) If your hospital has an antimicrobial stewardship team, what support does the team receive from hospital administration (check all that apply)?

- ☐ Full salary support for one or more team members
- ☐ Partial salary support for one or more team members
- ☐ Formal recognition as a hospital committee
- ☐ Other (specify): _____
- ☐ No formal support from administration

29) For each statement listed below, regardless of whether you have an antimicrobial stewardship team, check YES, NO, or UNKNOWN based on practices or policies in place in your hospital at the time of this assessment:

	YES	NO	UNKNOWN
My hospital has a defined formulary of antimicrobial agents, and prescribing is generally restricted to those agents on the formulary.	☐	☐	☐
My hospital requires pre-authorization or approval of selected antimicrobials by an infectious diseases physician, pharmacist or other hospital staff member.	☐	☐	☐
Use of selected antimicrobials is reviewed or audited on a daily or weekly basis by an infectious diseases physician, pharmacist, or other hospital staff member.	☐	☐	☐
Results of audits/reviews of antimicrobial use are provided directly to prescribers, through in-person, telephone, or electronic communications	☐	☐	☐
Automatic stop orders (e.g., after 2-3 days, subject to documentation of the need for ongoing therapy) are in place for selected antimicrobials.	☐	☐	☐
My hospital has guidelines for switching from parenteral to oral antimicrobials.	☐	☐	☐
My hospital has a system that automatically alerts prescribers and/or member(s) of antimicrobial stewardship team in situations where therapy might be unnecessarily duplicative.	☐	☐	☐
My hospital has guidelines for surgical prophylaxis.	☐	☐	☐

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	YES	NO	UNKNOWN
My hospital has guidelines for first-line antimicrobial therapy for common infections (e.g., community-acquired pneumonia, urinary tract infections, etc.).	☐	☐	☐
My hospital monitors prescribers' adherence to guidelines (drug, dose, duration, and indication) in specific patient care units or hospital-wide.	☐	☐	☐
Providers have access to hospital information technology support for prescribing antimicrobials.	☐	☐	☐
Providers are required to document (in the medical record or in the computerized provider order entry system) the indication for antimicrobial prescriptions.	☐	☐	☐
Providers are required to document (in the medical record or in the computerized provider order entry system) the anticipated duration of antimicrobial therapy.	☐	☐	☐
My hospital provides training/educational session on appropriate antimicrobial use to prescribers at least annually	☐	☐	☐
My hospital requires prescribers to participate in a training/ educational session on appropriate antimicrobial use at least annually.	☐	☐	☐
My hospital produces a hospital-wide antibiogram (i.e., antimicrobial susceptibility data aggregated across the entire facility, rather than broken down by patient units) at least annually, and makes the antibiogram available to prescribers.	☐	☐	☐
My hospital produces a patient unit-specific antibiogram at least annually, and makes the antibiogram available to prescribers.	☐	☐	☐

30)Is antimicrobial consumption monitored in your hospital?

☐ Yes

☐ No ***(If "No," STOP as Healthcare Facility Assessment is complete)***

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

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

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

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

–End of Section 4–