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 2017, a facility would complete a 2016 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. 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.
3. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae	*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'.

recommended by CLSI as of 2010?	
4. 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'.
5. 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 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.

Facility Microbiology Laboratory Practices (continued)	
6. 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.
7. 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.
8. 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.

9. Is antifungal susceptibility testing performed automatically/reflexively for any of the following *Candida* species cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? Check all species and corresponding drugs for which automatic testing is done.	*Required.* Select the appropriate *Candida* species and drugs for which your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician. If antifungal susceptibility testing is not performed automatically on *Candida* species, select "Automatic testing is not performed for any *Candida* species".
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)	*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)	
11. 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.*	
12. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number or fraction 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.
13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
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. 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)	*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. Is it a policy in your facility that patients infected or colonized with VRE are	*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

routinely placed in contact precautions while these patients are in your facility? (check one)	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. 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)	*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'.
Infection Control Practices (continued)	
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)	*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 patients 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 surgical site infections (SSIs)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent SSIs. 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 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)	*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 dialysis patients or 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 or to prevent infection in dialysis 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 a known 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 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 leadership activities?	*Required.* Select 'Yes' if any individual was given salary support (any amount) to serve as a leader of the stewardship program; 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? If Yes, has adherence to the policy to document an indication been monitored?	*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'. *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	*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'.

susceptibility, to assist with antibiotic selection for common clinical conditions? 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 at your facility? If yes, what type of feedback is provided to prescribers?	*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'. *Conditionally required.* Select the type of feedback that is provided to prescribers.

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. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use?	*Required.* Select 'Yes' if your facility 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 2017, a facility would complete a 2016 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	*Required.* Enter the total count of patients identified on admission or upon initial assessment and review of patient during admission with the following conditions (Note: these categories are not mutually exclusive). • Ventilator dependence • Hemodialysis For a list of ICD-9, ICD-10, and DRG codes associated with these conditions please review this spreadsheet: 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.*	
1. 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.
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)	*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.
3. 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'.
4. 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)	
5. 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.
6. 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.
7. 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.
8. 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.
9. Is antifungal susceptibility testing performed automatically/reflexively for any of the following *Candida* species cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? Check all species and corresponding drugs for	*Required.* Select the appropriate *Candida* species and drugs for which your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician. If antifungal susceptibility testing is not performed automatically on *Candida* species, select "Automatic testing is not performed for any *Candida* species".

which automatic testing is done.	
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)	*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.
11. 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.*	
12. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number or fraction 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.
13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.

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).	
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)	*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. 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	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. Is it 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)	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'.
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)	*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'.
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 patients 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 surgical site infections (SSIs)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or 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 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)	*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 dialysis patients or 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 or to prevent infection in dialysis 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 a known 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'.
Antibiotic Stewardship Practices (continued)	
24. Is there a leader responsible for 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 leadership activities?	*Required.* Select 'Yes' if any individual was given salary support (any amount) to serve as a leader of the stewardship program; otherwise, select '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? If Yes, has adherence to the policy to document an indication been monitored?	*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'. *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'.
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 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'.
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'.
Antibiotic Stewardship Practices (continued)	
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 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'.
If yes, what type of feedback is provided to prescribers?	*Conditionally required.* Select the type of feedback that is provided to prescribers.
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. Has your facility provided education to clinicians and	*Required.* Select 'Yes' if your facility 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'.

other relevant staff on improving antibiotic use?	

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 2017, a facility would complete a 2016 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 inpatient rehabilitation facility during the last full calendar year.
Facility Characteristics (continued)	
Average length of stay	*Required.* Enter the average number of days that patients stay 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.*	
1. 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.

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)	*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.
3. 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'.
4. 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'.
5. 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.
6. 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)	
7. 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.
8. 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.
9. Is antifungal susceptibility testing performed automatically/reflexively for any of the following *Candida* species cultured from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician? Check all species and corresponding drugs for which automatic testing is done.	*Required.* Select the appropriate *Candida* species and drugs for which your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician. If antifungal susceptibility testing is not performed automatically on *Candida* species, select "Automatic testing is not performed for any *Candida* species".
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)	*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)	
11. 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.*	
12. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number or fraction 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.
13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
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. 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)	*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)	

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)	*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. 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)	*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'.
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)	*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 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.
19. Does the facility routinely perform screening testing (culture or non-culture) for MRSA? If yes, in which situation does the facility routinely	*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.

perform screening testing for MRSA? (check all that apply)	*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 patients 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 surgical site infections (SSIs)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or 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 SSIs. 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 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)	*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 dialysis patients or 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 or to prevent infection in dialysis 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 a known 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	*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

supports efforts to improve antibiotic use (antibiotic stewardship)?	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 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'.

Antibiotic Stewardship Practices (continued)	
26. Does your facility provide any salary support for dedicated time for antibiotic stewardship leadership activities?	*Required.* Select 'Yes' if any individual was given salary support (any amount) to serve as a leader of the stewardship program; otherwise, select '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? If Yes, has adherence to the policy to document an indication been monitored?	*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'. *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'.
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? If Yes, has adherence to facility-specific treatment	*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'.

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'.
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 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'.
If yes, what type of feedback is provided to prescribers?	*Conditionally required.* Select the type of feedback that is provided to prescribers.
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. Has your facility provided education to clinicians and	*Required.* Select 'Yes' if your facility 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'.

other relevant staff on improving antibiotic use?	