



## Patient Safety Monthly Reporting Plan

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\*required for saving

Facility ID: \_\_\_\_\_ \*Month/Year: \_\_\_\_\_ / \_\_\_\_\_

No NHSN Patient Safety Modules Followed this Month

### Device-Associated Module

Locations	CLABSI	VAE	CAUTI	CLIP	PedVAP	PedVAE
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Procedure-Associated Module

Procedures	SSI	
	IN	OUT
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

### Antimicrobial Use and Resistance Module

Locations	Antimicrobial Use	Antimicrobial Resistance
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

**Assurance of Confidentiality:** The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).  
 CDC 57.106(Front) Rev. 5, v9.2

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<b>MDRO and CDI Module</b>									
+Locations (Circle one)		Specific Organism Type		<sup>‡</sup> LabID Event All Specimens		<sup>‡</sup> LabID Event Blood specimens only			
FacWideIN	FacWideOUT	_____		<input type="checkbox"/>		<input type="checkbox"/>			
FacWideIN	FacWideOUT	_____		<input type="checkbox"/>		<input type="checkbox"/>			
FacWideIN	FacWideOUT	_____		<input type="checkbox"/>		<input type="checkbox"/>			
FacWideIN	FacWideOUT	_____		<input type="checkbox"/>		<input type="checkbox"/>			
<b>Process and Outcome Measures</b>									
Locations	Specific Organism Type	Infection Surveillance	<sup>§</sup> AST Timing	<sup>§</sup> AST Eligible	Incidence	Prevalence	LabID Event	HH	GG
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+ FacWideIN = Facility-wide Inpatient  
 FacWideOUT = Facility-wide Outpatient  
 NHx = Only patients tested are those who have no documentation at the admitting facility in the previous 12 months of MDRO-colonization or infection at the time of admission.  
<sup>‡</sup> LabID Event = Laboratory-identified Event  
<sup>§</sup> For AST, circle one choice to indicate time of testing and one choice to indicate type of patients eligible for testing.  
 Timing: Adm = Admission  
 Both = Both Admission and Discharge/Transfer  
 Patients Eligible: All patients tested