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Patient Safety Component—Annual Hospital Survey

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

*required for saving

Tracking #:

Facility ID:

*Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

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

☐ Military ☐ Veterans Affairs ☐ Physician owned

If facility is a Hospital:

*Number of patient days: _____

*Number of admissions: _____

For any Hospital:

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

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

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

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

b. All other inpatient locations: _____

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

*1. Does your facility have its own on-site laboratory that performs bacterial antimicrobial susceptibility testing? ☐ Yes ☐ No

1a. If No, where is your facility's antimicrobial susceptibility testing performed? (check one)

☐ Affiliated medical center

☐ Commercial referral laboratory

☐ Other local/regional, non-affiliated reference laboratory

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Assurance of Confidentiality: The 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)).

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Facility Microbiology Laboratory Practices (continued)

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

(1) Primary susceptibility testing and

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

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

Please use the testing codes listed below the table.

Pathogen	**(1) Primary**	**(2) Secondary**	**Comments**
Staphylococcus aureus	_____	_____	_____
Enterobacterales	_____	_____	_____

1 = Kirby-Bauer disk diffusion	5.1 = MicroScan WalkAway	10 = E test
2 = Vitek (Legacy)	5.2 = MicroScan autoSCAN	12 = Vancomycin agar screen (BHI + vancomycin)
2.1 = Vitek 2	6 = Other broth microdilution method	13 = Other (describe in Comments section)
3.1 = BD Phoenix	7 = Agar dilution method	
4 = Sensititre		

*3. Does either the primary or secondary/supplemental antimicrobial susceptibility testing of *Pseudomonas* spp., include ceftolozane-tazobactam? ☐ Yes ☐ No ☐ N/A – no AST performed for *Pseudomonas*

*4. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? *(As of 2020, this includes organisms in the order Enterobacterales.)* ☐ Yes ☐ No

*5. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? *(As of 2020, this includes organisms in the order Enterobacterales.)* ☐ Yes ☐ No

*6. Does the laboratory perform a test for presence of carbapenemase? (this does not include automated testing instrument expert rules) ☐ Yes ☐ No

6a. If Yes, please indicate what is done if carbapenemase production is detected: (check one)

☐ Change susceptible carbapenem results to resistant

☐ Report carbapenem MIC results without an interpretation

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

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Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

6b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

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

6c. If Yes, which of the following are routinely tested for the presence of carbapenemases: (check all that apply)

☐ Enterobacterales spp. ☐ *Pseudomonas aeruginosa* ☐ *Acinetobacter baumannii*

*7. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli* or or *Klebsiella* spp. routinely or using a testing algorithm? ☐ Yes ☐ No

7a. If Yes, please indicate what is done if ESBL is detected: (check one)

- ☐ Change susceptible Cefotaxime/Ceftriaxone/Cefepime results to resistant
- ☐ No changes are made in the interpretation of cephalosporins with a note of ESBL
- ☐ Suppress cephalosporin susceptibility results

*8. Where is yeast identification performed for specimens collected at your facility? (check the most applicable)

- ☐ On-site laboratory
- ☐ Affiliated medical center
- ☐ Commercial referral laboratory
- ☐ Other local/regional, non-affiliated reference laboratory
- ☐ Yeast identification not available (i.e., yeast identification is not performed onsite or at any affiliate/commercial/other laboratory) [If checked, skip questions 9-13)

Answer questions 9–13 for the laboratory that *performs yeast identification for your facility*:

*9. Which of the following methods are used for yeast identification? (check all that apply)

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

*10. Does the laboratory routinely use Chromagar for the identification or differentiation of *Candida* isolates?

☐ Yes ☐ No ☐ Unknown

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Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

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

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

*12. Does the laboratory employ any culture-independent diagnostic tests (CIDT) to identify *Candida* from blood specimens?

☐ Yes ☐ No ☐ Unknown

12a. If yes, which culture-independent diagnostic tests (CIDT) are used to identify *Candida* from blood specimens? (check all that apply)

- ☐ T2Candida Panel
- ☐ BioFire
- ☐ Other, specify: _____
- ☐ Unknown

*13. Are any culture-independent diagnostic tests (CIDT) used to specifically identify *Candida auris* from clinical specimens?

☐ Yes ☐ No ☐ Unknown

13a. If yes, which culture-independent diagnostic tests (CIDT) are used to identify *Candida auris* from clinical specimens? (check all that apply)

- ☐ T2Cauris Panel
- ☐ PCR
- ☐ Other, specify: _____
- ☐ Unknown

*14. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check the most applicable)

- ☐ On-site laboratory
- ☐ Affiliated medical center
- ☐ Commercial referral laboratory
- ☐ Other local/regional, non-affiliated reference laboratory
- ☐ AFST not available (i.e., AFST is not performed onsite or at any affiliate/commercial/other laboratory) [if selected, skip questions 15-17]

Answer questions 15–17 for the laboratory that *performs AFST for your facility*:

*15. What method is used for antifungal susceptibility testing (AFST)? (check all that apply)

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

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Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

15a. If Vitek is used for AFST, which *Candida* species do you test with it? (check all that apply)

- ☐ *C. albicans*
- ☐ *C. glabrata*
- ☐ *C. parapsilosis*
- ☐ Other *Candida* spp.

*16. AFST is performed for which of the following antifungal drugs? (check all that apply)

- ☐ Fluconazole
- ☐ Voriconazole
- ☐ Itraconazole
- ☐ Posaconazole
- ☐ Micafungin
- ☐ Anidulafungin
- ☐ Caspofungin
- ☐ Amphotericin B
- ☐ Flucytosine
- ☐ Other, specify: _____
- ☐ Unknown

*17. AFST is performed on fungal isolates in which of the following situations? (check only one box per row)

	Performed automatically/ reflexively	Performed with a clinician's order	Not performed	Unknown
Blood	☐	☐	☐	☐
Other normally sterile body site (e.g., CSF)	☐	☐	☐	☐
Urine	☐	☐	☐	☐
Respiratory	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐

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

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

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Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

*19. Please indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (check one)

- ☐ MALDI-TOF MS System (Vitek MS)
- ☐ MALDI-TOF MS System (Bruker Biotyper)
- ☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)
- ☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)
- ☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)
- ☐ 16S rRNA Sequencing

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

- ☐ MALDI-TOF MS System (Vitek MS)
- ☐ MALDI-TOF MS System (Bruker Biotyper)
- ☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)
- ☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)
- ☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)
- ☐ 16S rRNA Sequencing

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

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

a. Total hours per week performing surveillance: _____

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

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

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

- ☐ Yes
- ☐ No
- ☐ Not applicable: my facility never admits these patients

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Patient Safety Component—Annual Hospital Survey

Infection Control Practices (continued)

23a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- ☐ All infected and all colonized patients
- ☐ Only all infected patients
- ☐ Only infected or colonized patients with certain characteristics (check all that apply)
  - ☐ Patients admitted to high risk settings
  - ☐ Patients at high risk for transmission

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

- ☐ Yes
- ☐ No
- ☐ Not applicable: my facility never admits these patients

24a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- ☐ All infected and all colonized patients
- ☐ Only all infected patients
- ☐ Only infected or colonized patients with certain characteristics (check all that apply)
  - ☐ Patients admitted to high risk settings
  - ☐ Patients at high risk for transmission

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

- ☐ Yes
- ☐ No
- ☐ Not applicable: my facility never admits these patients

25a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- ☐ All infected and all colonized patients
- ☐ Only all infected patients
- ☐ Only infected or colonized patients with certain characteristics (check all that apply)
  - ☐ Patients admitted to high risk settings
  - ☐ Patients at high risk for transmission

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Patient Safety Component—Annual Hospital Survey

Infection Control Practices (continued)

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

☐ Yes

☐ No

☐ Not applicable: my facility never admits these patients

26a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

☐ All infected and all colonized patients

☐ Only all infected patients

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

☐ Patients admitted to high risk settings

☐ Patients at high risk for transmission

*27. Does the facility routinely perform screening testing (culture or non-culture) for CRE? *This includes screening for patients at your facility performed by public health laboratories and commercial laboratories.*

☐ Yes ☐ No

27a. If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)

☐ Surveillance testing at admission for all patients

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

☐ Surveillance testing at admission of high-risk patients (check all that apply)

☐ Patients admitted from long-term acute care (LTAC) or long-term care facility (LTCF)

☐ Patients with recent (e.g., within 6 months) overnight hospital stay outside the United States

☐ Patients admitted to high-risk settings (e.g., ICU)

☐ Other high-risk patients (please specify): _____

☐ Other (please specify): _____

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

28a. If yes, in which situations does the facility routinely perform screening testing for MRSA for non-NICU settings? (check all that apply)

☐ Surveillance testing at admission for all patients

☐ Surveillance testing at admission of high-risk patients (e.g., admitted from long-term acute care [LTAC] or long-term care facility [LTCF])

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

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

☐ Other (please specify): _____

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Patient Safety Component—Annual Hospital Survey

Infection Control Practices (continued)

*29. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings?

☐ Yes ☐ No

29a. If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)

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

*30. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients? ☐ Yes ☐ No ☐ N/A, Children's Hospital

30a. If yes, please indicate which patients: (select all that apply)

- ☐ ICU patients:
  - O All ICU patients
  - O Subset of ICU patients
- ☐ Patients outside the ICU:
  - O All patients outside the ICU
  - O Subset of patients outside the ICU
- ☐ Pre-operatively for patients undergoing surgery

*31. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal antistaphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens? ☐ Yes ☐ No ☐ N/A, Children's Hospital

31a. If yes, please indicate which patients: (select all that apply)

- ☐ ICU patients:
  - O All ICU patients
  - O ICU patients who are known to be colonized or infected with MRSA
- ☐ Patients outside the ICU who are known to be colonized or infected with MRSA
- ☐ Patients outside the ICU with central venous catheters or midline catheters
- ☐ Pre-operatively for patients undergoing surgery
- ☐ Other ICU patients, please specify: _____
- ☐ Other non-ICU patients, please specify: _____

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Patient Safety Component—Annual Hospital Survey

Facility Neonatal or Newborn Patient Care Practices and Admissions Information

*32. Was this section completed in collaboration with your facility's neonatal or newborn patient care team? For example, was input sought from a neonatal or newborn patient care team member, such as a NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner?

☐ Yes

☐ No

☐ N/A, my facility does not provide neonatal or newborn patient care services at any level (i.e., my facility does **not** provide delivery services, Level 1 well newborn care, Level II special care, or neonatal intensive care)

If N/A was selected in question 32 above, questions 33–37 below do not apply to your facility and should be skipped. If your facility does care for neonates or newborns (at any level), please complete questions below. *Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*

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

a. Inborn Admissions: _____

b. Outborn Admissions: _____

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

a. Less than or equal to 750 grams: _____

b. 751-1000 grams: _____

c. 1001-1500 grams: _____

d. 1501-2500 grams: _____

e. More than 2500 grams: _____

*35. Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (e.g., capable of providing sustained life support, comprehensive care for infants born <32 weeks gestation and weighing <1500 grams, a full range of respiratory support that may include conventional and/or high-frequency ventilation)?

☐ Yes ☐ No

*36. Does your facility accept neonates as transfers for any of the following procedures: Omphalocele repair; ventriculoperitoneal shunt; tracheoesophageal fistula (TEF)/esophageal atresia repair; bowel resection/reanastomosis; meningomyelocele repair; cardiac catheterization?

☐ Yes ☐ No

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Patient Safety Component—Annual Hospital Survey

Neonatal or Newborn Patient Care Practices and Admissions (continued)

To help us better understand your facility's practices and protocols for administering antimicrobials to newborns, please answer the following questions:

*37. If babies are roomed with their mother in a labor and delivery or postpartum ward and are administered oral or parenteral antimicrobials, such as ampicillin, what location is the medication administration attributed to in the electronic medication administration record (eMAR) system and/or bar code medication administration (BCMA) system?
Please ask your clinical pharmacist to review the eMAR system and/or BCMA system to determine this and select all that apply:

☐ a. Level I Well Newborn Nursery

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

☐ c. My facility requires that babies receiving antimicrobials **intravenously** (IV) are transferred out of their mother's room in order for IV antimicrobials to be administered (babies receiving oral or intramuscular antimicrobials may remain in their mother's room for antimicrobial administration)

☐ d. My facility requires that babies receiving oral **and/or** intramuscular antimicrobials are transferred out of their mother's room in order for antimicrobials to be administered

☐ e. N/A my facility does not provide delivery services

37a. If answer choice **c.** or **d.** was selected above, to which neonatal unit would a baby be transferred in order to receive oral or parenteral antimicrobials (select all that apply):

☐ Level I Well Newborn Nursery separate from the mother's room

☐ Level II Special Care Nursery

☐ Level II/III or higher Neonatal Intensive Care Unit

Antibiotic Stewardship Practices

(completed with input from Physician and Pharmacist Stewardship Leaders)

*38. Did the antibiotic stewardship leader(s) participate in responding to these questions? (Check one.)

☐ Yes, pharmacist lead

☐ Yes, physician lead

☐ Yes, both pharmacist and physician leads

☐ Yes, other lead

☐ No

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Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

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

☐ Providing stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions.

☐ Allocating resources (e.g., IT support, training for stewardship team) to support antibiotic stewardship efforts.

☐ Having a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission.

☐ Presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually.

☐ Ensuring the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually.

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

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

☐ Providing a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board).

☐ Ensuring that staff from key support departments and groups (e.g., IT and hospital medicine) are contributing to stewardship activities.

☐ None of the above

*40. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes. ☐ Yes ☐ No

40a. If Yes, what is the position of this leader? (Check one.)

☐ Physician

☐ Pharmacist

☐ Co-led by both Pharmacist and Physician

☐ Other (e.g., RN, PA, NP, etc.; please specify):_____

40b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)

☐ Has antibiotic stewardship responsibilities in their contract or job description

☐ Is physically on-site in your facility (either part-time or full-time)

☐ Completed an ID fellowship

☐ Completed a certificate program on antibiotic stewardship

☐ Completed training courses (e.g., conferences or online modules) on antibiotic stewardship

☐ None of the above

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Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

40c. If 'Has antibiotic stewardship responsibilities in their contract or job description' is selected (for physician (co) leader): What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's **contract or job description**? (Check one.)

☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Not specified

40d. If Physician or Co-led is selected: **In an average week**, what percent time does the **physician** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)

☐ 1-25%
☐ 26-50%
☐ Not specified
☐ 76-100%
☐ Not specified

40e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)

☐ Has antibiotic stewardship responsibilities in their contract or job description
☐ Is physically on-site in your facility (either part-time or full-time)
☐ Completed a PGY2 ID residency and/or ID fellowship
☐ Completed a certificate program on antibiotic stewardship
☐ Completed training courses (e.g., conferences or online modules) on antibiotic stewardship
☐ None of the above

40f. If 'Has antibiotic stewardship responsibilities in their contract or job description' is selected (for pharmacist (co) leader): What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's **contract or job description**? (Check one)

☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Not specified

40g. If 'Pharmacist' or 'Co-led' is selected: **In an average week**, what percent time does the **pharmacist** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one)

☐ 1-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Not specified

40h. If Pharmacist or Other is selected: Does your facility have a designated physician who can serve as a point of contact and support for the non-physician leader?

☐ Yes ☐ No

40i. If a pharmacist is not the leader or co-leader for the program, is there at least one pharmacist responsible for improving antibiotic use at your facility?

☐ Yes ☐ No

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Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

*41. Our facility has the following priority antibiotic stewardship interventions: (Check all that apply)

☐ Prospective audit and feedback for specific antibiotic agents

41a. If Prospective audit and feedback is selected: For which categories of antimicrobials? Please answer for the following categories of antimicrobials, *whether or not* they are on formulary. (Check all that apply)

☐ Cefepime, ceftazidime, or piperacillin/tazobactam

☐ Vancomycin (intravenous)

☐ Ertapenem, imipenem/cilastatin, or meropenem

☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, imipenem-cilastatin/relebactam, or cefiderocol

☐ Fluoroquinolones

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

☐ Eravacycline or omadacycline

☐ Lefamulin

☐ Aminoglycosides

☐ Colistin or polymyxin B

☐ Anidulafungin, caspofungin, or micafungin

☐ Isavuconazole, posaconazole, or voriconazole

☐ Amphotericin B and/or lipid-based amphotericin B

☐ None of the above

41b. If Prospective audit and feedback is selected: Our antibiotic stewardship program monitors prospective audit and feedback interventions (e.g., by tracking antibiotic use, types of interventions, acceptance of recommendations).

☐ Yes ☐ No

☐ Preauthorization for specific antibiotic agents.

41c. If Preauthorization is selected: For which categories of antimicrobials? Please only answer for categories of antimicrobials that are *on formulary*. (Check all that apply)

☐ Cefepime, ceftazidime, or piperacillin/tazobactam

☐ Vancomycin (intravenous)

☐ Ertapenem, imipenem/cilastatin, or meropenem

☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, imipenem-cilastatin/relebactam, or cefiderocol

☐ Fluoroquinolones

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

☐ Eravacycline or omadacycline

☐ Lefamulin

☐ Aminoglycosides

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Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

☐ Colistin or polymyxin B

☐ Anidulafungin, caspofungin, or micafungin

☐ Isavuconazole, posaconazole, or voriconazole

☐ Amphotericin B and/or lipid-based amphotericin B

☐ None of the above

41d. If Preauthorization is selected: Our antibiotic stewardship program monitors preauthorization interventions (e.g., by tracking which agents are requested for which conditions).

☐ Yes ☐ No

☐ Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions (e.g., community acquired pneumonia, urinary tract infection, skin and soft tissue infection).

41e. If Facility-specific treatment recommendations is selected: Our stewardship program monitors adherence to our facility's treatment recommendations for antibiotic selection for common clinical conditions (e.g., community acquired pneumonia, urinary tract infection, skin and soft tissue infection).

☐ Yes ☐ No

☐ None of the above

*42. Our facility has a policy or formal procedure for other interventions to ensure optimal use of antibiotics: (Check all that apply.)

☐ Early administration of effective antibiotics to optimize the treatment of sepsis

☐ Treatment protocols for *Staphylococcus aureus* bloodstream infection

☐ Stopping unnecessary antibiotic(s) in new cases of *Clostridioides difficile* infection (CDI)

☐ Review of culture-proven invasive (e.g., bloodstream) infections

☐ Review of planned outpatient parenteral antibiotic therapy (OPAT)

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

☐ Assess and clarify documented penicillin allergy

☐ Using the shortest effective duration of antibiotics at discharge for common clinical conditions (e.g. community-acquired pneumonia, urinary tract infections, skin and soft tissue infections)

☐ None of the above

42a. If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' is selected: Our stewardship program monitors adherence to use of shortest effective duration of antibiotics at discharge for common clinical conditions (e.g. community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.

☐ Yes ☐ No

Continued >>

Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

*43. Our facility has in place the following specific 'pharmacy-based' interventions: (Check all that apply)

☐ Pharmacy-driven changes from intravenous to oral antibiotics without a physician's order (e.g., hospital-approved protocol)

☐ Alerts to providers about potentially duplicative antibiotic spectra (e.g., multiple antibiotics to treat anaerobes)

☐ Automatic antibiotic stop orders in specific situations (e.g., surgical prophylaxis)

☐ None of the above

*44. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use.

☐ Yes ☐ No

44a. If Yes is selected: Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)

☐ Nurses receive training on appropriate criteria for sending urine and/or respiratory cultures.

☐ Nurses initiate discussions with the treating team on switching from intravenous to oral antibiotics.

☐ Nurses initiate antibiotic time-out discussions with the treating team.

☐ Nurses track antibiotic duration of therapy

44b. If 'Nurses track antibiotic duration of therapy' is selected: Is that information available at the bedside (e.g., on a whiteboard in the room)?

☐ Yes ☐ No

*45. Our stewardship program monitors: (Check all that apply.)

☐ Antibiotic resistance patterns (either facility- or region-specific), at least annually

☐ *Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually

☐ Antibiotic use in days of therapy (DOT) per 1000 patient days or days present, at least quarterly

☐ Antibiotic use in defined daily doses (DDD) per 1000 patient days, at least quarterly

☐ Antibiotic expenditures (i.e., purchasing costs), at least quarterly

☐ Antibiotic use in some other way, at least annually (please specify): _____

☐ None of the above

*46. Our stewardship team provides the following reports on antibiotic use to prescribers, at least annually: (Check all that apply.)

☐ Individual, prescriber-level reports

☐ Unit- or service-specific reports

☐ None of the above

46a. If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' is selected: Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.

☐ Yes ☐ No

Continued >>

Patient Safety Component—Annual Hospital Survey

Antibiotic Stewardship Practices (continued)

*47. Our facility distributes an antibiogram to prescribers, at least annually

☐ Yes ☐ No

*48. Information on antibiotic use, antibiotic resistance, and stewardship efforts is reported to hospital staff, at least annually.

☐ Yes ☐ No

*49. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually? (Check all that apply.)

☐ Prescribers

☐ Nursing staff

☐ Pharmacists

☐ None of the above

*50. Are patients provided education on important side effects of prescribed antibiotics?

☐ Yes ☐ No

50a. If 'Yes' is selected: How is education to patients on side effects shared? (Check all that apply.)

☐ Discharge paperwork

☐ Verbally by nurse

☐ Verbally by pharmacist

☐ Verbally by physician

☐ None of the above

Optional Antibiotic Stewardship Practices Questions

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

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

51. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.

☐ Yes ☐ No

52. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship to obtain facility-specific support for our antibiotic stewardship efforts

☐ Yes ☐ No

53. Our stewardship program works with the microbiology laboratory to implement the following interventions: (Check all that apply)

☐ Selective reporting of antimicrobial susceptibility testing results

☐ Placing comments in microbiology reports to improve prescribing

☐ None of the above

Continued >>

Patient Safety Component—Annual Hospital Survey

Optional Antibiotic Stewardship Practices (continued)

54. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)

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

Facility Water Management Program (WMP) (Completed with input from WMP team members.)

*55. Has your facility ever conducted an environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens (e.g., *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? This may include a basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points.

☐ Yes ☐ No

55a. If Yes, when was the most recent assessment conducted? (Check one)

- ☐ Within the most recent year (< 1 year ago)
- ☐ Between 1 and 3 years ago (≥ 1 year and ≤ 3 years)
- ☐ More than 3 years ago (> 3 years)

*56. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness? An example WICRA tool can be accessed at https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf

☐ Yes ☐ No

56a. If Yes, when was the most recent assessment conducted? (Check one)

- ☐ Within the most recent year (< 1 year ago)
- ☐ Between 1 and 3 years ago (≥ 1 year and ≤ 3 years)
- ☐ More than 3 years ago (> 3 years)

*57. Does your facility have a water management program (WMP) to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens?

☐ Yes ☐ No

57a. If Yes, who is represented on your facility WMP team? (Check all that apply)

- ☐ Hospital Epidemiologist/ Infection Preventionist
- ☐ Hospital Administrator/Leadership
- ☐ Facilities Manager/ Engineer
- ☐ Maintenance Staff
- ☐ Equipment/Chemical Acquisition/Supplier
- ☐ Environmental Services
- ☐ Compliance/ Safety Officer
- ☐ Risk/Quality Management Staff
- ☐ Infectious Disease Clinician
- ☐ Consultant
- ☐ Laboratory Staff
- ☐ Other (please specify): _____

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Patient Safety Component—Annual Hospital Survey

Facility Water Management Program (WMP) (continued)

*58. Does your facility regularly monitor the following parameters in the building water system(s)? (Check all that apply)

Disinfectant (such as residual chlorine):	☐ Yes	☐ No
58a. If Yes, does your facility have a plan for corrective actions when disinfectant(s) are not within acceptable limits as determined by the water management program?	☐ Yes	☐ No
Temperature:	☐ Yes	☐ No
58b. If Yes, does your facility have a plan for corrective actions when temperatures are not within acceptable limits as determined by the water management program?	☐ Yes	☐ No
Heterotropic plate counts:	☐ Yes	☐ No
58c. If Yes, does your facility have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by the water management program?	☐ Yes	☐ No
Specific environmental testing for *Legionella:*	☐ Yes	☐ No
58d. If Yes, does your facility have a plan for corrective actions when environmental testing for *Legionella* are not within acceptable limits as determined by the water management program	☐ Yes	☐ No