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NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

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 physician and/or physicians-in-training or nursing students? ☐ 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, III or higher): _____
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

a. 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

b. If Yes, do you also send out any antimicrobial susceptibility testing? (check one) ☐ Yes ☐ No

Facility Microbiology Laboratory Practices (continued)

*2. For *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex, 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, indicate the methods used at the outside laboratory.

Use the testing codes listed below the table.

(1) Primary	(2) Secondary	Comments
_____	_____	_____
1 = Kirby-Bauer disk diffusion	4 = ThermoFiscer/Sensititre	7 = Gradient Dilution Strip (for example, E test, Liofilchem)
2 = bioMérieux/Vitek	5 = Beckman Coulter/MicroScan	8 = Sent out test, method not known
3 = BD Phoenix	6 = Selux Diagnostics	9 = Other (describe in Comments section)

*3. Does either primary or secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply):

Drug	Tested	Not Tested
Cefiderocol	☐	☐
Ceftazidime-Avibactam	☐	☐
Ceftolozane-Tazobactam	☐	☐
Eravacycline	☐	☐
Plazomicin	☐	☐
Imipenem-Relebactam	☐	☐
Meropenem-Vaborbactam	☐	☐
Aztreonam-Avibactam	☐	☐
Sulbactam-Durlobactam	☐	☐

*4. Has the laboratory implemented revised breakpoints recommended by CLSI for the following:

a. Third Generation Cephalosporin and monobactam (i.e. aztreonam) breakpoints for *Enterobacterales* in 2010 ☐ Yes ☐ No
b. Carbapenem breakpoints for *Enterobacterales* in 2010 ☐ Yes ☐ No
c. Ertapenem breakpoints for *Enterobacterales* in 2012 ☐ Yes ☐ No
d. Carbapenem breakpoints for *Pseudomonas aeruginosa* in 2012 ☐ Yes ☐ No
e. Fluroquinolone breakpoints for *Pseudomonas aeruginosa* in 2019 ☐ Yes ☐ No

Facility Microbiology Laboratory Practices (continued)

f. Fluroquinolone breakpoints for *Enterobacterales* in 2019 ☐ Yes ☐ No

g. Aminoglycoside breakpoints for *Enterobacterales* in 2023 ☐ Yes ☐ No

h. Aminoglycoside breakpoints for *Pseudomonas aeruginosa* in 2023 ☐ Yes ☐ No

i. Piperacillin-tazobactam breakpoints for *Pseudomonas aeruginosa* in 2023 ☐ Yes ☐ No

j. Piperacillin-tazobactam breakpoints for *Enterobacterales* in 2022 ☐ Yes ☐ No

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

5a. If Yes, 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

5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

☐ Nucleic Acid Amplification Test (for example, PCR, Cepheid)
☐ Modified Hodge Test
☐ mCIM/CIM
☐ NG-Test Carba-5 (or other lateral flow assay)
☐ Carba NP
☐ Other (specify):_____

5c. If Yes, which of the following are routinely tested for the presence of carbapenemases: (check all that apply)

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

*6. Does your facility use commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections? Examples of commercially available systems include BioFire FilmArray, Luminex Verigene, etc.

☐ Yes

☐ No [If checked, skip questions 7 and 8]

6a. If Yes, which test panel(s) does your facility use? (check all that apply)

☐ Accelerate PhenoTest BC ☐ BioFire FilmArray BCID ☐ BioFire FilmArray BCID II
☐ Cepheid Xpert MRSA/SA BC ☐ GenMark ePlex BCID-GP ☐ GenMark ePlex BCID-GN
☐ GenMark ePlex BCID-FP ☐ Luminex Verigene BC-GP ☐ Luminex Verigene BC-GN
☐ MALDI-TOF MS directly from positive blood culture (e.g., SepsiTyper)
☐ MALDI-TOF MS based antimicrobial resistance detection
☐ T2Biosystems T2Bacteria ☐ T2Biosystems T2Candida ☐ T2Biosystems T2Resistance
☐ Other Commercial Test(s) (Leave Comment) _____
☐ Other Laboratory Developed Test(s) (Leave Comment) _____

*7. In a scenario where the *mecA* resistance marker and *Staphylococcus aureus* are detected by rapid molecular testing in a blood specimen, select the procedure(s) your facility conducts. (check one)

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☐ Our laboratory does not perform *mecA* testing using rapid molecular methods. [If checked, skip question 7a.]

Facility Microbiology Laboratory Practices (continued)

☐ Culture based phenotypic antimicrobial susceptibility testing is not performed. [If checked, skip question 7a.]

☐ Culture based phenotypic antimicrobial susceptibility testing is performed. A text indicating results of the corresponding rapid molecular testing and/or the interpretation of the rapid molecular testing result is added to the phenotypic test result.

☐ Culture based phenotypic antimicrobial susceptibility testing is performed. No text indicating corresponding rapid molecular testing and/or interpretation is added.

7a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed for a blood specimen to detect drug resistance in *Staphylococcus aureus*, and discordance is found between their results, how are results reported? (check one)

☐ Further testing is not pursued. Results are reported separately.

☐ Further testing is not pursued. The phenotypic result is overridden by the rapid molecular test result when an antimicrobial resistance marker is detected.

☐ Further testing is performed to identify the reason for the discordance. Results are modified based on the further analysis.

*8. In a scenario where the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* are detected by rapid molecular testing in a blood specimen, select the procedure(s) your facility conducts. (check one)

☐ Our laboratory does not perform *bla*$_{CTX-M}$ (CTX-M) testing using rapid molecular methods. [If checked, skip question 8a.]

☐ Culture based phenotypic antimicrobial susceptibility testing is not performed. [If checked, skip question 8a.]

☐ Culture based phenotypic antimicrobial susceptibility testing is performed. A text indicating results of the corresponding rapid molecular testing and/or the interpretation of the rapid molecular testing result is added to the phenotypic test result.

☐ Culture based phenotypic antimicrobial susceptibility testing is performed. No text indicating corresponding rapid molecular testing and/or interpretation is added.

8a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed for a blood specimen to detect drug resistance in *Escherichia coli* and discordance is found between their results, how are results reported? (check one)

☐ Further testing is not pursued. Results are reported separately.

☐ Further testing is not pursued. The phenotypic result is overridden by the rapid molecular test result when an antimicrobial resistance marker is detected.

☐ Further testing is performed to identify the reason for the discordance. Results are modified based on the further analysis.

*9. Where is yeast identification performed for specimens collected at your facility? (check one)

☐ On-site laboratory

☐ Affiliated medical center

☐ Commercial referral laboratory

Facility Microbiology Laboratory Practices (continued)

☐ Other local/regional, non-affiliated reference laboratory

☐ Yeast identification not available (specifically, yeast identification is not performed onsite or at any affiliate/commercial/other laboratory) [If checked, skip questions 10-14]

Answer questions 10-14 for the laboratory that performs yeast identification for your facility:

*10. 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 (for example, API 20C, RapID, Germ Tube, PNA-FISH, etc.)
☐ DNA sequencing
☐ Other (specify): _____

*11. Does the laboratory routinely use chromogenic agar for the identification or differentiation of *Candida* isolates?

☐ Yes ☐ No ☐ Unknown

*12. *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 (for example, CSF)
☐ Urine
☐ Respiratory
☐ Other (specify): _____
☐ None are fully identified to the species level

*13. Does the laboratory employ any PCR molecular tests to identify *Candida* from blood specimens?

☐ Yes ☐ No ☐ Unknown

13a. If yes, which PCR molecular tests are used to identify *Candida* from blood specimens? (check all that apply)

☐ T2Candida Panel
☐ BioFire BCID
☐ GenMark ePlex BCID
☐ Other, specify: _____
☐ Unknown

13b. If yes and you get a positive result, does this lab culture the blood to obtain an isolate?

☐ Yes, always
☐ Yes, with clinical order
☐ No
☐ Unknown

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Facility Microbiology Laboratory Practices (continued)

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

- ☐ On-site laboratory
- ☐ Affiliated medical center
- ☐ Commercial reference laboratory
- ☐ Other local/regional, non-affiliated reference laboratory
- ☐ AFST not available (specifically, AFST is not performed onsite or at any affiliate/commercial/other laboratory) [if selected, skip questions 15 -19]

Answer questions 15-19 for the laboratory that performs AFST for your facility:

*15. What methods are used for antifungal susceptibility testing (AFST), **excluding Amphotericin B?** (check all that apply)

- ☐ Broth microdilution with laboratory developed plates
- ☐ YeastOne (Thermo Scientific™ Sensititre™)
- ☐ Gradient diffusion (E test)
- ☐ Vitek (bioMerieux)
- ☐ Other (specify): _____
- ☐ Unknown

*16.What methods are used for antifungal susceptibility testing (AFST) of **Amphotericin B?** (check all that apply)

- ☐ Broth microdilution with laboratory developed plates
- ☐ YeastOne (Thermo Scientific™ Sensititre™)
- ☐ Gradient diffusion (E test)
- ☐ Vitek (bioMerieux)
- ☐ Other (specify): _____
- ☐ Unknown

*17. 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

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

	Performed automatically	Performed with a clinician's order	Not performed	Unknown
Blood	☐	☐	☐	☐
Other normally sterile body site (for example, CSF)	☐	☐	☐	☐
Urine	☐	☐	☐	☐
Respiratory	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐

*19. Is this laboratory developing antibiograms or other reports to track susceptibility trends for *Candida* spp. isolates tested in this laboratory?

- ☐ Yes
- ☐ No
- ☐ Unknown

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Facility Microbiology Laboratory Practices (continued)

*20. 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) (for example, 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): _____

*21. Which of the following methods serve as the primary method used for bacterial identification at your facility? (check one)

- ☐ MALDI-TOF MS System (Vitek MS)
- ☐ MALDI-TOF MS System (Bruker Biotyper)
- ☐ Automated Instrument (for example, Vitek, MicroScan, Phoenix, etc.)
- ☐ Non-automated Manual Kit (for example, API 20C, biochemicals)
- ☐ Rapid Identification (for example, NAAT/PCR, Gene Xpert, etc.)
- ☐ 16S rRNA Sequencing
- ☐ Other (specify): _____
- ☐ None

*22. Which of the following methods serve as the secondary or backup method used for bacterial identification at your facility? (for example, a secondary method if the primary method fails to give an identification, or if the primary method is unavailable). (check one)

- ☐ MALDI-TOF MS System (Vitek MS)
- ☐ MALDI-TOF MS System (Bruker Biotyper)
- ☐ Automated Instrument (for example, Vitek, MicroScan, Phoenix, etc.)
- ☐ Non-automated Manual Kit (for example, API 20C, biochemicals)
- ☐ Rapid Identification (for example, NAAT/PCR, Gene Xpert, etc.)
- ☐ 16S rRNA Sequencing
- ☐ Other (specify): _____
- ☐ None

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

*23. 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: _____

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

Infection Control Practices (continued)

*25. 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

25a. If Yes, 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

*26. 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

26a. If Yes, 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. 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

27a. If Yes, 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

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

Infection Control Practices (continued)

*28. 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

28a. If Yes, 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

*29. 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

29a. 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 (for example, 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 (for example, within 6 months) overnight hospital stay outside the United States
  ☐ Patients admitted to high-risk settings (for example, ICU)
  ☐ Other high-risk patients (specify): _____
☐ Surveillance testing of all patients in the facility or in a specific high-risk settings (for example, ICU) at pre-specified intervals (for example, weekly point prevalence survey)
☐ Other (specify): _____

29b. If Yes, what method is routinely used by the lab conducting CRE testing of screening swabs from your facility? (check all that apply)

☐ Culture-based methods

☐ PCR
☐ Other (specify): _____

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

☐ Yes ☐ No

Infection Control Practices (continued)

30a. If Yes, in which situations does the facility routinely perform screening testing for *Candida auris*? (check all that apply)

☐ Surveillance testing at admission for all patients
☐ Surveillance testing of epidemiologically-linked patients of newly identified *Candida auris* patients (for example, point prevalence surveys in response to a case, patients in the same room or unit as a case)
☐ 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 (for example, within 6 months) overnight hospital stay outside the United States
  ☐ Patients admitted to high-risk settings (for example, ICU)
  ☐ Other high-risk patients (specify): _____
☐ Surveillance testing of all patients in the facility or in a specific high-risk setting (for example, ICU) at pre-specified intervals (for example, weekly point prevalence survey)
☐ Other (specify): _____

30b. If Yes, what method is routinely used by the lab conducting *Candida auris* testing of screening swabs from your facility?

☐ Culture-based methods
☐ PCR
☐ Other (specify): _____

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

31a. 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 (for example, admitted from long-term acute care [LTAC] or long-term care facility [LTCF], or dialysis patients)
☐ Surveillance testing at admission of patients admitted to high-risk settings (for example, ICU)
☐ Surveillance testing of pre-operative patients to prevent surgical site infections
☐ Other (specify): _____

*32. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings? ☐ Yes ☐ No ☐ N/A, facility does not have a NICU

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32a. 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 patients
- ☐ Surveillance testing at admission for all transferred patients
- ☐ Surveillance testing of patients from known MRSA positive mothers
- ☐ Surveillance testing of high-risk patients (for example, infants born premature)
- ☐ Routine active surveillance testing (specifically, point prevalence surveys)
- ☐ Other (specify): _____

Infection Control Practices (continued)

*33. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients to prevent infection or transmission of MDROs at your facility?

☐ Yes ☐ No ☐ N/A, Children's Hospital

33a. If yes, indicate which patients: (select all that apply)

☐ ICU patients:
- ○ All ICU patients
- ○ Subset of ICU patients
  - ☐ Patients with central venous catheter or midline catheters
  - ☐ Others, specify:_____

☐ Patients outside the ICU:
- ○ All patients outside the ICU
- ○ Subset of patients outside the ICU
  - ☐ Patients with central venous catheter or midline catheters
  - ☐ Others, specify:_____

☐ Pre-operatively for patients undergoing surgery

*34. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal anti-staphylococcal 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

34a. If yes, indicate which patients: (select all that apply)

☐ ICU patients:
- ☐ All ICU patients
- ☐ ICU patients who are known to be colonized or infected with MRSA
- ☐ ICU patients with central venous catheters or midline catheters

☐ Patients outside the ICU:
- ☐ Patients who are known to be colonized or infected with MRSA
- ☐ Patients with central venous catheters or midline catheters

☐ Pre-operatively for patients undergoing surgery

Facility Neonatal or Newborn Patient Care Practices and Admissions Information

*35. Does your facility provide neonatal or newborn patient care services at any level (specifically, does your facility provide delivery services, Level 1 well newborn care, Level II special care, or neonatal intensive care)?

- ☐ Yes
- ☐ No

If No was selected in question 35 above, questions 36-40 below do not apply to your facility and should be skipped. If your facility does care for neonates or newborns (at any level), 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.

*36. 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: _____

Neonatal or Newborn Patient Care Practices and Admissions (continued)

*37. 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: _____

*38. Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (for example, 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)?

*39. 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

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

*40. 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?
☐ 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

40a. 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)

*41. 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 (for example, IT support, training for stewardship team) to support antibiotic stewardship efforts.

Antibiotic Stewardship Practices (continued)

- ☐ 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 (for example, a written policy or statement approved by the board).
- ☐ Ensuring that staff from key support departments and groups (for example, IT and hospital medicine) are contributing to stewardship activities.
- ☐ None of the above

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

42a. If Yes, what is the position of this leader? (Check one.)

- ☐ Physician
- ☐ Pharmacist
- ☐ Co-led by both Pharmacist and Physician
- ☐ Other (for example, RN, PA, NP, etc.; specify):_____

42b. 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 job description, or performance review
- ☐ 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 other training(s) (for example, conferences or online modules) on antibiotic stewardship
- ☐ None of the above

42c. If 'Has antibiotic stewardship responsibilities in their contract or job description' is selected (for physician (co) leader): What percentage of time for antibiotic stewardship activities is specified in the **physician** (co) leader's **contract or job description**? (Check one.)

- ☐ 1-10%
- ☐ 11-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%
- ☐ Not specified

42d. If Physician or Co-led is selected: **In an average week**, what percentage of time does the **physician** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)

- ☐ 1-10%
- ☐ 11-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

42e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)

Antibiotic Stewardship Practices (continued)

- ☐ Has antibiotic stewardship responsibilities in their contract, job description, or performance review
- ☐ 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 other training(s) (for example, conferences or online modules) on antibiotic stewardship
- ☐ None of the above

42f. 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)

- ☐ 1-10%
- ☐ 11-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%
- ☐ Not specified

42g. If 'Pharmacist' or 'Co-led' is selected: **In an average week**, what percentage of time does the **pharmacist** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one)

- ☐ 1-10%
- ☐ 11-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

42h. 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

42i. 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

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

- ☐ Prospective audit and feedback for specific antibiotic agents

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43a. If Prospective audit and feedback is selected: Our antibiotic stewardship program monitors prospective audit and feedback interventions (for example, by tracking antibiotic use, types of interventions, acceptance of recommendations).

☐ Yes ☐ No

☐ Preauthorization for specific antibiotic agents.

43b. If Preauthorization is selected: Our antibiotic stewardship program monitors preauthorization interventions (for example, 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 (for example, community-acquired pneumonia, urinary tract infection, skin and soft tissue infection)

43c. If Facility-specific treatment recommendations is selected: For which common clinical conditions?

☐ Community-acquired pneumonia
☐ Urinary tract infection

Antibiotic Stewardship Practices (continued)

☐ Skin and soft tissue infection
☐ None of the above

43d. 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 (for example, community-acquired pneumonia, urinary tract infection, skin and soft tissue infection).

☐ Yes ☐ No

43e. If Yes: For which common clinical conditions?

☐ Community-acquired pneumonia
☐ Urinary tract infection
☐ Skin and soft tissue infection
☐ None of the above

☐ None of the above

*44. 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 (for example, bloodstream) infections
☐ Review of planned outpatient parenteral antibiotic therapy (OPAT)
☐ The treating team to review antibiotics 48-72 hours after initial order (specifically, antibiotic time-out).
☐ Assess and clarify documented penicillin allergy

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

☐ None of the above

44a. If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' is selected: Our stewardship program monitors adherence in using the shortest effective duration of antibiotics at discharge for common clinical conditions (for example, community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.

☐ Yes ☐ No

*45. 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 (for example, hospital-approved protocol)
- ☐ Alerts to providers about potentially duplicative antibiotic spectra (for example, multiple antibiotics to treat anaerobes)
- ☐ Automatic antibiotic stop orders in specific situations (for example, surgical prophylaxis)
- ☐ None of the above

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

☐ Yes ☐ No

Antibiotic Stewardship Practices (continued)

46a. 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.
- ☐ None of the above

*47. 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 (specifically, purchasing costs), at least quarterly
- ☐ Antibiotic use in some other way, at least annually (specify): _____
- ☐ None of the above

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

- ☐ Individual, prescriber-level reports
- ☐ Unit- or service-specific reports
- ☐ None of the above

48a. 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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

*51. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) at least annually? (Check all that apply.)

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

Antibiotic Stewardship Practices (continued)

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

☐ Yes ☐ No

52a. 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

Sepsis Management and Practices

*53. Our facility has a program or committee charged with monitoring and improving sepsis care and/or outcomes.

☐ Yes ☐ No

53a. If Yes: The responsibilities of this committee include the following: (Check all that apply; check at least one)

- ☐ Developing and updating hospital sepsis guidelines
- ☐ Developing and updating hospital sepsis order sets
- ☐ Monitor and review compliance with Centers for Medicare & Medicaid SEP-1 measure
- ☐ Monitor and review effectiveness of early sepsis identification strategies

- ☐ Monitoring and reviewing management of patients with sepsis
- ☐ Monitor and review outcomes among patients with sepsis
- ☐ Monitor and review antimicrobial use in sepsis in conjunction with antimicrobial stewardship or infectious disease staff
- ☐ Providing education to hospital staff on sepsis
- ☐ Setting annual goals for sepsis management and/or outcomes
- ☐ None of the above

53b. If Yes: This program or committee includes the following healthcare personnel: (Check all that apply; check at least one)

- ☐ Physician
- ☐ Nurse
- ☐ Pharmacist
- ☐ Advanced practice provider (for example, Physician Assistant, Nurse Practitioner
- ☐ Hospital Epidemiologist or Infection prevention professional
- ☐ Phlebotomist
- ☐ Social worker
- ☐ Quality improvement staff member
- ☐ Case manager
- ☐ Microbiology staff member or Laboratory staff member
- ☐ Discharge planner
- ☐ Patients/families/caregivers
- ☐ Outpatient clinicians
- ☐ None of the above

Sepsis Management and Practices (continued)

53c. If Yes:, This program or committee includes representatives from the following locations or services (Check all that apply; check at least one)

- ☐ Antimicrobial Stewardship
- ☐ Critical Care / Intensive Care (excluding Neonatal Intensive Care)
- ☐ Data Analytics
- ☐ Emergency Medicine
- ☐ Hospital Medicine
- ☐ Infectious Diseases
- ☐ Information Technology
- ☐ Laboratory
- ☐ Neonatal Intensive Care
- ☐ Obstetrics/Labor and Deliver
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ None of the above

*54. Our facility has one leader or two co-leaders responsible for sepsis program or committee management and outcomes. (Check one)

- ☐ Yes
- ☐ No (we have no designated leaders)
- ☐ No (we have more than 2 leaders)

54a. If yes selected in 54: What is the professional background of the sepsis program or committee leaders(s)?

- ☐ Advanced practice provider (APP)
- ☐ Nurse

- ☐ Physician
- ☐ None of the above

54b. If Yes selected in 54: Did the sepsis program leader(s) participate in responding to these questions? (Check one)

- ☐ Yes
- ☐ No

54c. If APP selected in #54a: What percentage of the APP leader's effort is specified for sepsis activities? If there are two APP leaders, please indicate the sum of their combined effort if it were applied towards a single APP. (Check one)

- ☐ 0% (Sepsis activities are voluntary with no specified effort)
- ☐ 1 to 10%
- ☐ 11 to 25%
- ☐ 26 to 50%
- ☐ More than 50%
- ☐ Not specified

Sepsis Management and Practices (continued)

54d. If nurse selected in #54a.: What percentage of the nurse leader's effort is specified for sepsis activities? If there are two nurse leaders, please indicate the sum of their combined effort if it were applied towards a single nurse. (Check one)

- ☐ 0% (Sepsis activities are voluntary with no specified effort)
- ☐ 1 to 10%
- ☐ 11 to 25%
- ☐ 26 to 50%
- ☐ More than 50%
- ☐ Not specified

54e. If physician selected in #54a.: What percentage of the physician leader's effort is specified for sepsis activities? If there are two physician leaders, please indicated the sum of their combined effort if it were applied towards a single physician.

- ☐ 0% (Sepsis activities are voluntary with no specified effort)
- ☐ 1 to 10%
- ☐ 11 to 25%
- ☐ 26 to 50%
- ☐ More than 50%
- ☐ Not specified

*55. Facility leadership has demonstrated commitment to improving sepsis care by: (Check all that apply; check at least one.)

- ☐ Providing sepsis program leader(s) with sufficient specified time to manage the hospital sepsis program.
- ☐ Providing sufficient resources, including data analytics and information technology support, to operate the program effectively.

- ☐ Ensuring that relevant staff from key clinical groups and support departments have sufficient time to contribute to sepsis activities.
- ☐ Appointing a senior leader to serve as an executive sponsor for the sepsis program.
- ☐ Identifying sepsis as a facility priority and communicating this priority to hospital staff.
- ☐ Having a sepsis coordinator who oversees day-to-day implementation of sepsis program activities
- ☐ None of the above.

*56. Our facility uses the following approaches to assist in the identification of sepsis upon presentation to the hospital: (Check all that apply; check at least one.)

- ☐ Manual screening for clinical instability (e.g., MEWS, NEWS score)
- ☐ Electronic health record (EHR)-based screening for clinical instability
- ☐ Manual screening for sepsis criteria
- ☐ Electronic Health Record (HER)-based screening for sepsis criteria
- ☐ None of the above

*57. Our facility uses the following approaches to assist in identification of sepsis throughout hospitalization: (Check all that apply; check at least one.)

- ☐ Manual screening for clinical instability (e.g., MEWS, NEWS score)
- ☐ Electronic health record (EHR)-based screening for clinical instability
- ☐ Manual screening for sepsis criteria
- ☐ Electronic Health Record (EHR)-based screening for sepsis criteria
- ☐ None of the above

Sepsis Management and Practices (continued)

*58. Our facility uses the following approaches to promote evidence-based management of patients with sepsis: (Check all that apply; check at least one.)

- ☐ Hospital guideline or care pathway for management of sepsis
- ☐ Hospital order set for management of sepsis
- ☐ Structured template for documentation of sepsis treatment
- ☐ Standardized process for verbal hand-off of sepsis treatment
- ☐ Sepsis Response Team
- ☐ Rapid Response Team with training in sepsis management
- ☐ Use of “Code Sepsis” protocol for facilitating prompt recognition and team-based care of sepsis
- ☐ None of the above

*59. Our facility uses the following approaches to promote rapid antimicrobial delivery to patients with sepsis: (Check all that apply; check at least one.)

- ☐ Stocking of common antimicrobials in locations outside the pharmacy
- ☐ Immediate processing of new antimicrobial orders in patients with sepsis
- ☐ Orders that default to ordering immediate administration of new antimicrobials

- ☐ Pharmacists on-site in key locations outside the pharmacy
- ☐ None of the above

*60. Our facility uses the following approaches to facilitate recovery after sepsis hospitalization: (Check all that apply; check at least one.)

- ☐ Communicating a patient's sepsis diagnosis and care plan to the patient's primary care physician
- ☐ Providing contact information for a clinical staff at the hospital to addresses post-discharge questions and/or troubleshoot post-discharge issues
- ☐ Contacting patients within 2 days of discharge by clinical staff to follow-up on discharge instructions, symptoms, and/or issues
- ☐ Screening patients for new functional and/or cognitive impairment after sepsis and referring patients to relevant evaluation or support services
- ☐ Reconciling and optimizing medications prior to hospital discharge
- ☐ Screening patients for social vulnerability and referring to available support services as needed
- ☐ None of the above

*61. Our facility uses the following approaches to ensure that all patients hospitalized with sepsis (or their family or caregivers), are educated on their diagnosis of sepsis, the underlying infection, and signs and symptoms of new infection or sepsis. (Check all that apply; check at least one.)

- ☐ Direct 1:1 education on sepsis from a healthcare personnel
- ☐ Written educational material about sepsis
- ☐ Pre-recorded video material about sepsis
- ☐ None of the above are used routinely

Sepsis Management and Practices (continued)

*62. Our facility tracks the following hospital sepsis metrics: (Check all that apply; check at least one.)

- ☐ Hospital sepsis epidemiology (e.g., number and characteristics of sepsis hospitalizations)
- ☐ Hospital sepsis treatment (e.g., time-to-antibiotics, type, and volume of fluid delivery)
- ☐ Hospital sepsis outcomes (e.g., mortality, length of hospitalization)
- ☐ Progress towards achieving hospital goals for sepsis treatment and/or outcomes
- ☐ Use of hospital sepsis tools (e.g., how often sepsis order-set is used)
- ☐ Usability or acceptability of hospital sepsis tools (e.g., clinician acceptance)
- ☐ Impact of hospital sepsis tools (e.g., impact on sepsis alert or order-set on treatment or outcomes)
- ☐ None of the above

*63. Describe your facility's use of chart review for sepsis performance evaluation and improvement: (Check all that apply.)

- ☐ We routinely review some or all sepsis hospitalizations to influence clinical care in real-time.

- ☐ We routinely review some or all sepsis hospitalization within 48 hours to provide positive feedback to individual clinicians on areas where care excelled.
- ☐ We routinely review some or all sepsis hospitalization within 48 hours to provide constructive feedback to individual clinicians on areas where care could be improved.
- ☐ We routinely review some or all sepsis hospitalizations to evaluate performance or to inform quality improvement work (e.g., root-cause analysis).
- ☐ We review charts for other purposes.
- ☐ We do not complete routine chart reviews of sepsis hospitalizations.

*64. Sepsis treatment and/or outcome data are reported to unit-based or service-based leadership at following frequency: (Check one)

- ☐ Continuously (e.g., a sepsis dashboard that updates in real-time)
- ☐ At least monthly
- ☐ At least quarterly
- ☐ At least annually
- ☐ Not reported or reported less often than annually

64a. [If Q64 has one of the following answers selected: “continuously”, “at least monthly”, “at least quarterly”, or “at least annually”] Feedback data provided to clinician and/or unit-based leadership on sepsis treatment and outcomes includes the following elements at least annually: (Check all that apply; check at least one)

- ☐ Unit-specific or service-specific data
- ☐ Clinician-specific data
- ☐ Benchmarking or comparative data (i.e., comparison to other similar units or hospitals)
- ☐ Temporal trends (i.e., how treatment or outcomes have changed overtime)
- ☐ None of the above

Sepsis Management and Practices (continued)

*65. Our facility provides education on sepsis to the following groups as part of their hiring or onboarding process: (Check all that apply; check at least one)

- ☐ APPs
- ☐ Certified nursing assistants
- ☐ Nurses
- ☐ Patient care technicians
- ☐ Physicians
- ☐ Trainees (for example, medical students, residents, nursing students)
- ☐ None of the above

*66. Our facility provides sepsis education to the following groups at least annually, for example through lectures, staff meetings, etc.: (check all that apply; check at least one)

- ☐ APPs
- ☐ Certified nursing assistants
- ☐ Nurses
- ☐ Patient care technicians
- ☐ Physicians
- ☐ None of the above

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

*67. Does your facility have a water management program (WMP) to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas,* nontuberculous mycobacteria, and fungi)?

☐ Yes ☐ No

67a. 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/Leadership
- ☐ Other (specify): _____

*68. Has your facility ever conducted an environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure)? This may include a description of building water systems using text or basic diagrams that map all water supply sources, treatment systems, processing steps, control measures, and end-use points.

☐ Yes ☐ No

Facility Water Management Program (WMP) (continued)

68a. 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)

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

☐ Yes ☐ No

69a. 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)

*70. Does your facility regularly monitor the following parameters in the building water system(s)?

Disinfectant (such as residual chlorine): ☐ Yes ☐ No

70a. 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

70b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

Facility Water Management Program (WMP) (continued)

Water Temperature: ☐ Yes ☐ No

70c. If Yes, does your facility have a plan for corrective actions when water temperatures are not within acceptable limits as determined by the water management program? ☐ Yes ☐ No

70d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐

Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

Water pH: ☐ Yes ☐ No

70e. If Yes, does your facility have a plan for corrective actions when water pH is not within acceptable limits as determined by the water management program? ☐ Yes ☐ No

70f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

Facility Water Management Program (WMP) (continued)

Heterotrophic plate count (HPC) testing: ☐ Yes ☐ No

70g. 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

70h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Potable Water Storage	☐	☐	☐	☐	☐	☐	☐

Tank(s)							
Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

Specific environmental *Legionella* testing: ☐ Yes ☐ No

70i. If Yes, does your facility have a plan for corrective actions when environmental tests for *Legionella* are not within acceptable limits as determined by the water management program? ☐ Yes ☐ No

70j. If Yes, where an how frequently does your facility perform *Legionella* testing? (check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

Facility Water Management Program (WMP) (continued)

Specific environmental *Pseudomonas* testing: ☐ Yes ☐ No

70k. If Yes, does your facility have a plan for corrective actions when environmental tests for *Pseudomonas* are not within acceptable limits as determined by the water management program?

☐ Yes ☐ No

70l. If Yes, where an how frequently does your facility perform *Pseudomonas* testing? (check all that apply)

Location	Daily	Weekly	Monthly	Quarterly	Annually	Other (specify): _____	N/A
Entry Points	☐	☐	☐	☐	☐	☐	☐
Cold Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐

Hot Potable Water Storage Tank(s)	☐	☐	☐	☐	☐	☐	☐
Hot Water Supply	☐	☐	☐	☐	☐	☐	☐
Hot Water Return	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Cold Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Representative Locations Throughout Hot Potable Building Water System(s)	☐	☐	☐	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐	☐	☐	☐

*71. Does your facility water management program address measures to prevent transmission of pathogens from wastewater premise plumbing to patients?

☐ Yes ☐ No ☐ N/A, my facility does not have a water management program

Venous Thromboembolism (VTE) Practices

*72. Our facility uses the following venous thromboembolism (VTE) prevention practices (select all that apply, and select at least one)

- ☐ Our facility has a VTE prevention policy.
- ☐ Our facility has a multidisciplinary team that addresses VTE prevention.
- ☐ Our facility has a facility-wide VTE prevention protocol that includes VTE and bleeding risk assessments linked to clinical decision support for appropriate VTE prophylaxis options.
  - Our facility has embedded the VTE prevention protocol in admission order sets.
    - a. Yes ☐ No
- ☐ Our facility provides VTE prevention education for clinicians annually.
- ☐ Our facility provides VTE prevention education for patients during their stay at our facility.
- ☐ Our facility performs audits to determine whether patients are on risk-appropriate VTE prophylaxis and provides clinician feedback for quality improvement.
- ☐ Our facility tracks the incidence of VTE that develops during a patient's stay at our facility (VTE not present on admission).
- ☐ Our facility does not use any of the above VTE prevention practices.

Prevention Practices

*73. Our facility utilizes a checklist or bundle for prevention of the following HAIs. (Check all that apply)

☐ CLABSI

At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.

- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other

☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

☐ CAUTI

At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other
- ☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

☐ CDI LabID Event

At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other
- ☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

☐ MRSA Bacteremia LabID Event

At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other
- ☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

Validity Testing (continued)

☐ COLO SSI

At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN

☐ Other
☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

☐ HYST SSI
At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? Check one.
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Yearly
☐ PRN
☐ Other
☐ Not regularly monitored/measured

Is checklist/bundle adherence shared routinely with the clinical team?
☐ Yes ☐ No ☐ Unknown

*74. Did your facility (or any part of your facility) implement a **new** HAI prevention strategy **within the last calendar year**? *The following prevention strategies are examples from HAI prevention guidance documents (for example, 2022 SHEA/IDSA/APIC Practice Recommendations - Compendium of Strategies) and are supported by varying levels of evidence.
☐ Yes ☐ No ☐ Unknown

If yes, check all HAIs that apply.

☐ CLABSI (check all that apply)
☐ Documentation of daily assessment for central line necessity
☐ Bundling of central line insertion supplies to ensure efficient access to supplies in convenient location for aseptic central line insertion
☐ Use of chlorhexidine-containing dressings for central lines in patients >2 months of age
☐ Use of antiseptic-containing caps/covers for central line ports
☐ Use of antiseptic- or antimicrobial-impregnated central lines
☐ Other (specify): _____

Validity Testing (continued)

☐ CAUTI (check all that apply)
☐ Documentation of daily assessment for indwelling urinary catheter necessity

☐ Bundling of indwelling urinary catheter insertion supplies in convenient location to ensure efficient access to supplies for aseptic indwelling urinary catheter insertion

- ☐ Implementation of a nurse-driven indwelling urinary catheter removal protocol or implementation of automatic stop orders requiring review of current indications and renewal of order for continuation of an indwelling urinary catheter
- ☐ Process for consideration of bladder management alternatives to indwelling urethral catheterization in selected patients when appropriate
- ☐ Incorporation of appropriate indications for urine culturing into electronic medical record system, as part of standardized institutional protocol for diagnostic stewardship
- ☐ Other (specify): _____

☐ CDI LabID Event (check all that apply)

- ☐ Use of an EPA-registered (EPA List K) sporicidal disinfectant for environmental cleaning/disinfection or use of additional disinfection of CDI patient rooms with no-touch technologies (for example, UV light disinfection)
- ☐ Establish process in collaboration with environmental services to routinely assess adequacy of room cleaning
- ☐ Restriction of antibiotics with the highest risk for CDI (for example, fluoroquinolones, carbapenems, 3rd and 4th generation cephalosporins)
- ☐ Implementation of laboratory protocol to ensure testing of only appropriate specimens (for example, unformed stool) or a clinical decision support system to help reduce unnecessary *Clostridioides difficile* testing
- ☐ Implementation of laboratory alert system to immediately report positive *C. difficile* results to clinical care providers and infection control personnel
- ☐ Other (specify): _____

☐ MRSA Bacteremia LabID Event (check all that apply)

- ☐ Process for monitoring and validation of compliance of daily CHG bathing in applicable patient populations (for example, adult ICU patients)
- ☐ Process for multidisciplinary review of occurrences of hospital-onset MRSA bacteremia (for example, root cause analysis) to assess modifiable risk factors
- ☐ Establish process in collaboration with environmental services to routinely assess adequacy of room cleaning
- ☐ Implementation of a laboratory-based alert system that immediately notifies clinical care providers and infection control personnel of new MRSA-colonized and/or MRSA-infected patients
- ☐ Implementation of universal gowns and gloves upon entry into adult ICU patient rooms, regardless of MRSA status
- ☐ Other (specify): _____

☐ COLO SSI (check all that apply)

- ☐ Use of combination of parenteral and oral antimicrobial prophylaxis with mechanical bowel prep, unless contraindicated, prior to elective colorectal surgery
- ☐ Monitor compliance with antimicrobial prophylaxis guidelines being appropriately provided
- ☐ Use of impervious plastic wound protectors for GI surgery

Validity Testing (continued)

- ☐ Implementation of preoperative warming for at least 30 minutes prior to surgery to prevent intraoperative hypothermia
- ☐ Use of negative pressure dressings in patients who may benefit
- ☐ Use of antiseptic-impregnated sutures

☐ Other (specify): _____

☐ HYST SSI (check all that apply)
- ☐ Use antiseptic-containing preoperative vaginal preparatory agents for patients undergoing elective hysterectomy
- ☐ Monitor compliance with antimicrobial prophylaxis guidelines being appropriately provided
- ☐ Implementation of preoperative warming for at least 30 minutes prior to surgery to prevent intraoperative hypothermia
- ☐ Use of negative pressure dressings in patients who may benefit
- ☐ Use of antiseptic-impregnated sutures
- ☐ Other (specify): _____

*75. Does your facility provide training and/or education on HAI prevention to healthcare personnel as it relates to their role?

☐ Yes ☐ No ☐ Unknown

If yes, check all HAIs that apply.

☐ CLABSI

At what frequency is training or education is provided? Check all that apply.
- ☐ Upon hire
- ☐ When new product or processes are implemented
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other

☐ CAUTI

At what frequency is training or education is provided? Check all that apply.
- ☐ Upon hire
- ☐ When new product or processes are implemented
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other

☐ CDI LabID Event

At what frequency is training or education is provided? Check all that apply.
- ☐ Upon hire
- ☐ When new product or processes are implemented
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other

☐ MRSA Bacteremia LabID Event

At what frequency is training or education is provided? Check all that apply.
- ☐ Upon hire
- ☐ When new product or processes are implemented

Validity Testing (continued)
- ☐ Quarterly
- ☐ Yearly

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- ☐ PRN
- ☐ Other

☐ COLO SSI

At what frequency is training or education is provided? Check all that apply.

- ☐ Upon hire
- ☐ When new product or processes are implemented
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other

☐ HYST SSI

At what frequency is training or education is provided? Check all that apply.

- ☐ Upon hire
- ☐ When new product or processes are implemented
- ☐ Quarterly
- ☐ Yearly
- ☐ PRN
- ☐ Other