D2. Explanation for Program Changes or Adjustments 2024

National Healthcare Safety Network (NHSN)
OMB Control No. 0920-0666
Revision Request September 2024

57.103 Patient Safety Component--Annual Hospital Survey

NHSN Patient Safety Component (PSC) Annual Survey collects facility-level data from the previous calendar year and is completed by all facilities enrolled in the NHSN Patient Safety Component. The Annual Survey data is used to calculate healthcare associated infection (HAI) Standardized Infection Ratio (SIR) risk adjustment models and track HAI incidence in facilities. The data is also used to support decision making, program planning, and research across CDC. The SIR is available for use for CMS Quality Reporting for select HAI and facility types, state health departments, other organizations, or groups (i.e., Leapfrog) and CDC in national surveillance reports. The survey is collected electronically on an annual basis via the NHSN application.

By updating the PSC Annual Survey, NHSN is ensuring improved relevance, enhanced data quality, alignment with industry standards and regulations, increased efficiency, and expanded analysis capabilities within CDC.

Type of Change	Changed From	Changed To	Justification	Impact to Burden
Revision	*2. For the following organisms, 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.*** **Pathogen** / **(1) Primary** / **(2) Secondary** / **Comments** *Enterobacterales* _____ _____ _____ *Pseudomonas aeruginosa* _____ _____ _____ *Acinetobacter baumanni* complex _____ _____ _____ 1 = Kirby-Bauer disk diffusion; 4 = Sensititre; 7 = Agar dilution method 2 = Vitek (Legacy); 5.1 = MicroScan WalkAway; 10 = Gradient Dilution Strip (for example E test) 2.1 = Vitek 2; 5.2 = MicroScan autoSCAN; 13 = Other (describe in Comments section) 3.1 = BD Phoenix; 6 = Other broth microdilution method	*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)	Simplified the question to have facilities respond only 1 time (not per organism). Updated the response options to reflect currently used lab tests	0.5 minute decrease
revision	*3. Does either primary or secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply): **Drug** / ***Organism tested:*** *Enterobacterales* / *Pseudomonas aeruginosa* / *Acinetobacter baumanni* Cefiderocol ☐ ☐ ☐ Ceftazidime-Avibactam ☐ ☐ ☐ Ceftolozane-Tazobactam ☐ ☐ ☐ Colistin ☐ ☐ ☐ Delafloxacin ☐ ☐ ☐ Eravacycline ☐ ☐ ☐ Imipenem-Relebactam ☐ ☐ ☐ Meropenem-Vaborbactam ☐ ☐ ☐	*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 ☐ ☐	Simplified the question to have facilities respond only 1 time per drug (not per organism). Updated the response options to reflect drugs of interest.	No change
revision	*4. Has the laboratory implemented revised breakpoints recommended by CLSI for the following: a. Third Generation Cephalosporin and monobactam (i.e. aztreonam) breakpoints	*4. Has the laboratory implemented revised breakpoints recommended by CLSI for the following: a. Third Generation Cephalosporin and monobactam (i.e. aztreonam)	to monitor the uptake of up-to-date CLSI breakpoints among clinical laboratories	0.5 minute increase

	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 f. Fluroquinolone breakpoints for *Enterobacterales* in 2019 ◻ Yes ◻ No	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 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	and interpret antimicrobial surveillance data which reuse hospital interpretations of antimicrobial susceptibility testing results. The additional organism-drug combos are the those that CLSI recently updated the breakpoints on.	
Revision	*5. Does the laboratory test bacterial isolates for presence of carbapenemase? (this does not include automated testing instrument expert rules) ◻ 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	Grammar update	No change
Revision	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ NAAT (for example, PCR) ◻ MLB Screen ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM ◻ Rapid CARB Blue ◻ E test ◻ CARBA 5 ◻ Cepheid, BioFire, Verigene, Genmark, etc ◻ Other _____	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ Nucleic Acid Amplification Test (for example, PCR, Cepheid) ◻ NG-Test Carba-5 (or other lateral flow assay) ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM ◻ Other_____	Update of tests to more accurately reflect tests in use.	No change
Deletion of question	*9. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli Klebsiella pneumoniae*, *Klebsiella oxytoca*, or *Proteus mirabilis* routinely or using a testing algorithm? ◻ Yes ◻ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of	9a. If Yes, indicate what is done if ESBL is detected: (check one) ◻ Change	N/A	not needed anymore	0.5 minute

question	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			decrease
Revision	*14. Does the laboratory employ any molecular tests to identify *Candida* from blood specimens? □ Yes □ No □ Unknown	*13. Does the laboratory employ any PCR molecular tests to identify *Candida* from blood specimens? □ Yes □ No □ Unknown	Revised question wording to increase clarity.	No change
Revision	14a. If yes, which molecular tests are used to identify *Candida* from blood specimens? (check all that apply) □ T2Candida Panel □ BioFire BCID □ GenMark ePlex BCID □ Other, specify: _____ □ 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	Revised question wording to increase clarity.	No change
Revision	*16. What method is 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	*15. What methods are used for antifungal susceptibility testing (AFST), excluding Amphotericin B? (check all that apply)	Grammar update	No change
Revision	*17. What method is 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	*16. What methods are used for antifungal susceptibility testing (AFST) of Amphotericin B? (check all that apply)	Grammar update	No change
Revision	*22. 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 (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.) □ 16S rRNA Sequencing	*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	Updated question to more accurately reflect what we'd like facilities to answer.	No change

	□ Other (specify): _____ □ None	□ Other (specify): _____ □ None		
revision	*23. Indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (for example, 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 (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, 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	Updated question to more accurately reflect what we'd like facilities to answer.	No change
Revision	*33. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings? □ Yes □ No	*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	adding a N/A option as not all hospitals have a NICU	No change
Deletion of question	*36. 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 (specifically, my facility does **not** provide delivery services, Level 1 well newborn care, Level II special care, or neonatal intensive care)	N/A	Not needed anymore	0.5 minute decrease
Added new question	N/A	*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	We don't use the data on whether input was sought so felt that portion could go. We do, however, need to know whether neonatal care is provided for the skip pattern.	0.5 minute increase
Deletion of question	*42. 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	N/A	Not needed anymore	0.5 minute decrease

	□ No			
Deletion of question	45a. If Prospective audit and feedback is selected: For which categories of antimicrobials? 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	NA	Not needed anymore	0.5 minute decrease
Deletion of question	45c. If Preauthorization is selected: For which categories of antimicrobials? 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 □ Colistin or polymyxin B □ Anidulafungin, caspofungin, or micafungin □ Isavuconazole, posaconazole, or voriconazole □ Amphotericin B and/or lipid-based amphotericin B □ None of the above	N/A	Not needed anymore	0.5 minute decrease

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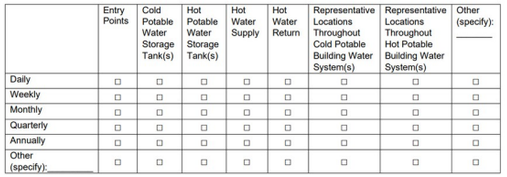
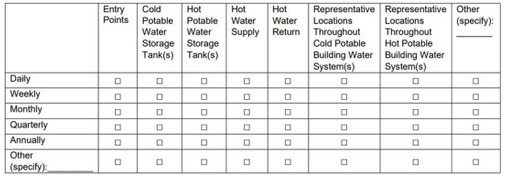
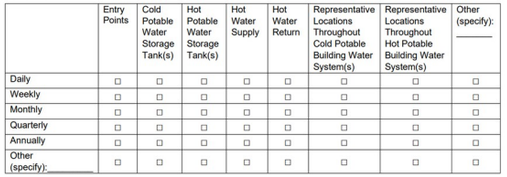
Deletion of question	48b. If 'Nurses track antibiotic duration of therapy' is selected: Is that information available at the bedside (for example, on a whiteboard in the room)? □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	55. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	56. Our facility accesses targeted remote stewardship expertise (for example, tele-stewardship to obtain facility-specific support for our antibiotic stewardship efforts). □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	57. 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	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	58. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply) □ Pharmacy director □ Executive leadership (for example, CEO, CMO) □ Pharmacy & therapeutics □ Hospital board □ Patient safety □ Other (specify): _____ □ Quality improvement □ None	N/A	Not needed anymore	0.5 minute decrease
Revision	59b. If Yes: This program or committee includes the following healthcare personnel: (Check all that apply; check at least one) □ Physician □ Quality improvement staff member □ Nurse □ Case manager □ Pharmacist □ Microbiology laboratory staff member □ Advanced practice provider (for example, Physician Assistant, Nurse Practitioner □ Discharge planner □ Social worker □ 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 □ Quality improvement staff member □ Nurse □ Case manager □ Pharmacist □ Microbiology staff member or Laboratory staff member □ Advanced practice provider (for example, Physician Assistant, Nurse Practitioner □ Discharge planner □ Hospital Epidemiologist or Infection prevention professional □ Patients/families/caregivers □ Phlebotomist □ Outpatient clinicians □ Social worker □ None of the above	Changes made reflect the final draft of the hospital sepsis core elements document.	No change
Revision	61. 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	*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	Changes made reflect the final draft of the hospital sepsis core elements document.	No change

	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. □ None of the above.	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.		
revision	*64. 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 □ None of the above	*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	Changes made reflect the final draft of the hospital sepsis core elements document.	No change
Revision	*69. Describe your facility’s use of manual chart review for sepsis performance evaluation and improvement: (Check one.) □ We review all sepsis hospitalizations □ We review all sepsis hospitalizations with adverse outcomes (e.g., all hospitalizations with in-hospital mortality) □ We review a sample of sepsis hospitalizations (e.g., a random sample) □ We do not complete routine chart reviews of sepsis hospitalizations	*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.	Facilities have other methods besides manual. We wanted this question to be more inclusive of other electronic means.	0.5 minute increase
Deletion of a	*71. Clinicians receive feedback regarding their care of specific patients with sepsis: (Check	N/A	Incorporated into another	0.5 minute

question	all that apply; check at least one) ◻ Yes, positive feedback is provided for good sepsis care ◻ Yes, constructive feedback is provided for areas of improvement ◻ Neither of the above		question	decrease
revision	77b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply) 	70b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Revision	77d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply) 	70d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Revision	77f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply) 	70f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Revision	77h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply)	70h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply)	Added “N/A” column for those who do not test certain locations	No change

	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): _____
Daily	□	□	□	□	□	□	□	□
Weekly	□	□	□	□	□	□	□	□
Monthly	□	□	□	□	□	□	□	□
Quarterly	□	□	□	□	□	□	□	□
Annually	□	□	□	□	□	□	□	□
Other (specify):_____	□	□	□	□	□	□	□	□

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):_____	□	□	□	□	□	□	□

revision	77j. If Yes, where an how frequently does your facility perform Legionella testing? (check all that apply)	70j. If Yes, where an how frequently does your facility perform Legionella testing? (check all that apply)	Added “N/A” column for those who do not test certain locations	No change

	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): _____
Daily	□	□	□	□	□	□	□	□
Weekly	□	□	□	□	□	□	□	□
Monthly	□	□	□	□	□	□	□	□
Quarterly	□	□	□	□	□	□	□	□
Annually	□	□	□	□	□	□	□	□
Other (specify):_____	□	□	□	□	□	□	□	□

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):_____	□	□	□	□	□	□	□

Revision	77l. If Yes, where an how frequently does your facility perform Pseudomonas testing? (check all that apply)	70l. If Yes, where an how frequently does your facility perform Pseudomonas testing? (check all that apply)	Added “N/A” column for those who do not test certain locations	No change

	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): _____
Daily	□	□	□	□	□	□	□	□
Weekly	□	□	□	□	□	□	□	□
Monthly	□	□	□	□	□	□	□	□
Quarterly	□	□	□	□	□	□	□	□
Annually	□	□	□	□	□	□	□	□
Other (specify):_____	□	□	□	□	□	□	□	□

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):_____	□	□	□	□	□	□	□

Added new question	N/A	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. □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.	provide data (baseline and annually) on VTE prevention practices in hospitals/facilities and help identify gaps between evidence-based guidelines for VTE prevention and implementation of those guidelines in practice. The baseline data would also be helpful in the evaluation of future VTE prevention initiatives.	1.0 minute increase

		□ 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.		
Added new question	N/A	*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	For the purposes of the Consensus Based Entity measure endorsement process, validity testing demonstrates the measure score (in our case, the SIR) correctly reflects the quality of care provided, adequately identifying differences in quality. The goal of these questions is to correlate process measures (for example, implementation of HAI prevention strategies) with the outcome measures of the NHSN SIRs.	2.0 minute increase

		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 □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		
Added new question	N/A	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): _____ □CAUTI (check all that apply) □Documentation of daily assessment for indwelling urinary	For the purposes of the Consensus Based Entity measure endorsement process, validity testing demonstrates the measure score (in our case, the SIR) correctly reflects the quality of care provided, adequately identifying differences in quality. The goal of these questions is to correlate process measures (for example, implementation of HAI prevention strategies) with the outcome measures of the NHSN SIRs.	3.0 minute increase

		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 □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): _____		
Added new question	N/A	*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	For the purposes of the Consensus Based Entity measure endorsement process, validity testing demonstrates the measure score (in our case, the SIR) correctly reflects the quality of care provided, adequately identifying differences in quality. The goal of these questions is to correlate process measures (for example, implementation of HAI prevention strategies) with the outcome measures of the NHSN SIRs.	1.0 minute increase

		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 □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		

57.122 HAI Progress Report State Health Department Survey

D2. Explanation for Program Changes or Adjustments 2024

To collect information from all states and territory health departments on healthcare associated infection (HAI) reporting requirements and data validation activities that were in place during the 2023 calendar year. Information collected from this survey is used to populate technical tables in the annual release of the National and State Healthcare Associated Infection Progress Report. The report helps identify the progress that is being made in the prevention of HAIs at the state and national level. Information from the survey is juxtaposed with state level data that monitors the number of facilities reporting and number of total HAI events. Understanding whether the state has validated their HAI data or has a state mandate to report such HAI data, is very helpful when interpreting the state-level HAI incidence data presented in CDC's report. Data collection form will be electronic via REDCap.

Type of Change	Changed From	Changed To	Justification	Impact to Burden
New		Name State/Province Email address	To ensure one form is completed per state. If there are multiple submissions per state, we may need to contact the completers to resolve.	Increase
Revision to questions 1-27, 30-35	2017	2023	Update to calendar year of data collection interest	None
Revision to questions 1-26	'legislative'	'legislation'	Updated for consistency across data collection	None
Revision to response options for questions 1-20, 23-26	'No mandate (e.g., legislative or state-required mandate at any facility types)'	'No reporting mandates (e.g., legislation or policy) for any facility types'	Updated for specificity/clarity and consistency across this response option	None
Revision to questions 2-26	'mandate…'	'reporting requirement…'	Updated for specificity/clarity	None
Revision to questions 5,6,13-16,19,20	Removed 'Inpatient Rehabilitation Facility (IRF)' as response option		Response option is not applicable	Decrease
Revision to questions 7,8	Removed 'Critical Access Hospital (CAH)' as response option		Response option is not applicable	Decrease
Revision to question 21	Did your state have a mandate (e.g., legislation or policy including reportable conditions) for acute care hospitals (ACH) to report SSI data to NHSN from any of the following procedure types at any time during 2017? (check all that apply)?	Did your state have a reporting requirement (e.g., legislation or policy including reportable conditions) for acute care hospitals (ACH) to report SSI data to NHSN from any of the following procedure types at any time during 2023? If your state has no mandates, please only respond to the first option.	Updated for specificity/clarity and consistency across this response option	None
Revision to	Removed response options 'APPY', XLAP	Added response options 'CHOL', 'FX'	Procedure options updates	None

question 21			given change in HAI reporting trends	
Revision to question 21,22	Column header 'Was this reporting mandate in effect on January 1, 2017?'	Column header 'This mandate was in effect on January 1, 2023'	Changed question to statement to reduce confusion	None
Revision to question 22	Did your state have a mandate (e.g., legislation legislative or state-required mandate) for critical access hospitals (CAH) to report inpatient SSI data to NHSN from any of the following procedure types during 2017? (check all that apply)?	Did your state have a reporting requirement (e.g., legislation or state-required mandate) for critical access hospitals (CAH) to report **SSI** data to NHSN from any of the following procedure types during 2023? If your state has no mandates, please only respond to the first option.	Updated for specificity/clarity and consistency across this response option	None
Revision to question 22	Removed response options 'AAA', 'APPY', 'CARD', 'CBGB/CBGC', 'CSEC', 'FUSN', HPRO'		Procedure options not applicable for facility type	Decrease
Revision to question 23-26	Did your state have a mandate (e.g., legislative state-required mandate) for healthcare facilities to report….	Did your state have a reporting requirement (e.g., legislation or policy including reportable conditions) for healthcare facilities to report…	Updated for consistency with similar questions	None
New		(27) Did your state use the NHSN External Validation Toolkit to perform validation on 2023 NHSN data prior to June 1, 2024? Yes/No	To evaluate use of CDC materials when conducting HAI data validation	Increase
New		(28) Please select the HAI(s) that were validated using the NHSN External Validation Toolkit CLABSI, CAUTI, SSI-COLO, SSI-HYST, MRSA LabID Event, C. difficile LabID Event, or None	To evaluate use of CDC materials when conducting HAI data validation	Increase
New		(29) Please select the facility type(s) that were validated using the NHSN External Validation Toolkit Acute Care Hospital (ACH), Critical Access Hospital (CAH), Long Term Acute Care Facility (LTAC), Inpatient Rehabilitation Facility (IRF), or None	To evaluate use of CDC materials when conducting HAI data validation	Increase
Revision to question 30,31 instructions	(Please select a response for each HAI listed below)	Check all that apply. If your state has [no access to any data listed] or [performs no data quality of any HAI's listed], please only respond to the first option.	Instructions updated to match format updates to response table	None
Revision to questions 30, 31,33,35 response table	Each data cell listed by facility type and performance type	Facility types moved as header and performance question moved to first row	Increase readability of table	None
Revision to question 31 table row	No data quality checks performed for any facility type for HAIs listed below	No data quality checks performed for any facility type for HAIs listed below	Updated for specificity/clarity	None

D2. Explanation for Program Changes or Adjustments 2024

Revision to question 33	Has your state health department completed an external audit (medical record review of any HAI, or a review of laboratory records for MRSA or *C. difficile* LabID Events) of 2017 NHSN data from any of the following facility types prior to August 1, 2018?	Has your state health department or partner organization completed an external audit (medical record review of any HAI, or a review of laboratory records for MRSA or *C. difficile* LabID Events) of 2023 NHSN data from any of the following facility types prior to June 1, 2024?	External audits may be completed by parties outside of the state health department.	None
Deletion	(34) Which HAIs and facility types were validated during the external audit? (Please answer all fields)		Question not needed given data table already allowed reporting by the facility types. This question was redundant.	None
Revision to question 35	Please select the HAIs for each facility that had a state mandate (e.g., legislation or policy) to conduct an external audit of NHSN data during 2017. (Please answer all fields)	Please select the required HAIs for each facility type that had a state mandate (e.g., legislation or policy including reportable conditions) to conduct an external audit of NHSN data during 2023. If your state does not have a mandate to conduct an annual external audit, please skip this question.	Updated for consistency with similar questions	None
Revision to question 35		If you need space to clarify or comment on any of your survey responses, please do so here	Not required. Respondent can provide any additional details relevant if desired. These data will be reviewed and appropriate follow-up as needed	None

57.137 Long-Term Care Facility Component – Annual Facility Survey
The NHSN Annual Facility survey for long-term care facilities (LTCFs) is required for facilities that currently, or plan to, report healthcare associated infections (urinary tract infections), laboratory-identified events for C. difficile

and/or multidrug resistant organisms, and/or prevention process measures. There are four new questions that will be added to the Annual Facility Survey effective January 2025. The new questions will provide additional information about the facility Infection Preventionist (IP) role.				
Type of Change	**Changed From**	**Changed To**	**Justification**	**Impact to Burden**
Addition of a new question: Question #5	Variable/question not currently on form	*5. In addition to the Infection Preventionist (IP) role, how many other roles is the IP responsible for? Select all that apply: ❑ Director of Nursing ❑ Assisted Director of Nursing ❑ Registered Nurse or Licensed Practical Nurse (clinical) ❑ Administrator Other _____	To obtain additional information about the Infection Preventionist role at the facility.	Increase to burden because it is an additional question. Estimated average 2 minutes to complete question.
Addition of a new question: Question #6	Variable/question not currently on form	*6. If your Infection Preventionist (IP) has more than 1 role (as reported above), what percentage of their time is dedicated to the IP role? (Check one) ❑ <25% of their time ❑ ~25-50% of their time ❑ >50% of their time We have a full-time position for an IP	To obtain additional information about the Infection Preventionist role at the facility.	Increase to burden because it is an additional question. Estimated average 2 minutes to complete question.
Addition of a new question: Question #7	Variable/question not currently on form	*7. What formal training has your Infection Preventionist received? Select all that apply	To obtain additional information about the Infection Preventionist role at the facility.	Increase to burden because

		❑ None ❑ Infection Prevention Training Course through CDC ❑ Infection Prevention Training Course through State Health Department Other		it is an additional question. Estimated average 2 minutes to complete question.
Addition of a new question: Question #8	Variable/question not currently on form	*8. How many times in the past year have you had to find a new employee to take over the Infection Preventionist (IP) role? In other words, how many times has this position “turned over”? (Check one) ❑ Did not turn over the IP role in the past year ❑ Once ❑ Twice ❑ Three Four or more	To obtain additional information about the Infection Preventionist role at the facility.	Increase to burden because it is an additional question. Estimated average 2 minutes to complete question.
Revision: Shift existing questions down.	#5 - #25	Change numbering to #9- #29	Question numbers are shifted down to accommodate the four new questions.	No burden change

D2. Explanation for Program Changes or Adjustments 2024

57.150 LTAC Annual Survey

NHSN PSC Annual Survey collects facility-level data from the previous calendar year and is completed by all facilities enrolled in the NHSN Patient Safety Component. The Annual Survey data is used to calculate HAI Standardized Infection Ratio (SIR) risk adjustment models and track HAI incidence in facilities. The data is also used to support decision making, program planning, and research across CDC. The SIR is available for use for CMS Quality Reporting for select HAI and facility types, state health departments, other organizations, or groups (i.e., Leapfrog) and CDC in national surveillance reports. It will be collected electronically once annually via the NHSN application.

D2. Explanation for Program Changes or Adjustments 2024

National Healthcare Safety Network (NHSN)
OMB Control No. 0920-0666
Revision Request September 2024

By updating the PSC Annual Survey, we ensure improved relevance, enhanced data quality, alignment with industry standards and regulations, increased efficiency, and expanded analysis capabilities within the CDC.

Type of Change	Changed From	Changed To	Justification	Impact to Burden
Revision	*2. For the following organisms, 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.* Pathogen | (1) Primary | (2) Secondary | Comments *Enterobacterales* _____ *Pseudomonas aeruginosa* _____ *Acinetobacter baumanni* complex _____ 1 = Kirby-Bauer disk diffusion; 4 = Sensititre; 7 = Agar dilution method 2 = Vitek (Legacy); 5.1 = MicroScan WalkAway; 10 = Gradient Dilution Strip (for example E test) 2.1 = Vitek 2; 5.2 = MicroScan autoSCAN; 13 = Other (describe in Comments section) 3.1 = BD Phoenix; 6 = Other broth microdilution method	*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)	Simplified the question to have facilities respond only 1 time (not per organism). Updated the response options to reflect currently used lab tests	0.5 minute decrease
revision	*3. Does either primary or secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply): Organism tested: Drug | *Enterobacterales* | *Pseudomonas aeruginosa* | *Acinetobacter baumanni* Cefiderocol ☐ ☐ ☐ Ceftazidime-Avibactam ☐ ☐ ☐ Ceftolozane-Tazobactam ☐ ☐ ☐ Colistin ☐ ☐ ☐ Delafloxacin ☐ ☐ ☐ Eravacycline ☐ ☐ ☐ Imipenem-Relebactam ☐ ☐ ☐ Meropenem-Vaborbactam ☐ ☐ ☐	*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 ☐ ☐	Simplified the question to have facilities respond only 1 time per drug (not per organism). Updated the response options to reflect drugs of interest.	No change
revision	*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	*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	to monitor the uptake of up-to-date CLSI breakpoints among clinical laboratories and interpret antimicrobial surveillance data which reuse hospital interpretations of antimicrobial susceptibility testing results. The additional organism-drug combos are the those that CLSI recently	0.5 minute increase

	f. Fluroquinolone breakpoints for *Enterobacterales* in 2019 ◻ Yes ◻ No	e. Fluroquinolone breakpoints for Pseudomonas aeruginosa in 2019 ◻ Yes ◻ No 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	updated the breakpoints on.	
revision	*5. Does the laboratory test bacterial isolates for presence of carbapenemase? (this does not include automated testing instrument expert rules) ◻ 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	Grammar update	No change
	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ NAAT (for example, PCR) ◻ MLB Screen ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM ◻ Rapid CARB Blue ◻ E test ◻ CARBA 5 ◻ Cepheid, BioFire, Verigene, Genmark, etc	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ Nucleic Acid Amplification Test (for example, PCR, Cepheid) ◻ NG-Test Carba-5 (or other lateral flow assay) ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM	Update of tests to more accurately reflect tests in use.	No change
Deletion of question	*9. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli Klebsiella pneumoniae*, *Klebsiella oxytoca*, or *Proteus mirabilis* routinely or using a testing algorithm? ◻ Yes ◻ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	9a. If Yes, 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	N/A	not needed anymore	0.5 minute decrease

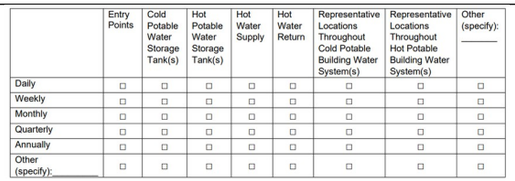
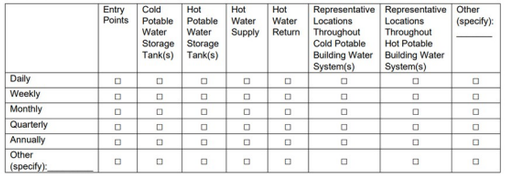
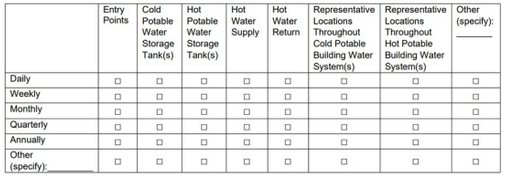
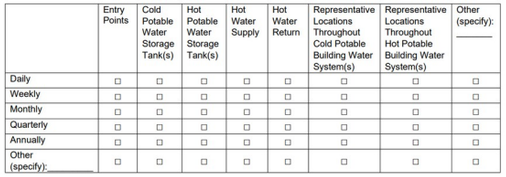
Revision	*14. Does the laboratory employ any molecular tests to identify *Candida* from blood specimens? □ Yes □ No □ Unknown	*13. Does the laboratory employ any PCR molecular tests to identify *Candida* from blood specimens? □ Yes □ No □ Unknown	Revised question wording to increase clarity.	No change
Revision	14a. If yes, which molecular tests are used to identify *Candida* from blood specimens? (check all that apply) □ T2Candida Panel □ BioFire BCID □ GenMark ePlex BCID □ Other, specify: _____ □ 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	Revised question wording to increase clarity.	No change
Revision	*16. What method is 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	*15. What methods are used for antifungal susceptibility testing (AFST), excluding Amphotericin B? (check all that apply)	Grammar update	No change
Revision	*17. What method is 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	*16. What methods are used for antifungal susceptibility testing (AFST) of Amphotericin B? (check all that apply)	Grammar update	No change
revision	*22. 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 (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.) □ 16S rRNA Sequencing	*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): _____	Updated question to more accurately reflect what we'd like facilities to answer.	No change

	□ Other (specify): _____ □ None	□ None		
revision	*23. Indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (for example, 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 (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, 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	Updated question to more accurately reflect what we'd like facilities to answer.	No change
Deletion of question	*35. 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	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	38a. If Prospective audit and feedback is selected: For which categories of antimicrobials? 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	N/A	Not needed anymore	0.5 minute decrease

	□ Anidulafungin, caspofungin, or micafungin □ Isavuconazole, posaconazole, or voriconazole □ Amphotericin B and/or lipid-based amphotericin B □ None of the above			
Deletion of question	38c. If Preauthorization is selected: For which categories of antimicrobials? 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 □ Colistin or polymyxin B □ Anidulafungin, caspofungin, or micafungin □ Isavuconazole, posaconazole, or voriconazole □ Amphotericin B and/or lipid-based amphotericin B □ None of the above	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	41b. If 'Nurses track antibiotic duration of therapy' is selected: Is that information available at the bedside (for example, on a whiteboard in the room)? □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	48. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	49. Our facility accesses targeted remote stewardship expertise (for example, tele-stewardship to obtain facility-specific support for our antibiotic stewardship efforts). □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	50. 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	N/A	Not needed anymore	0.5 minute decrease

D2. Explanation for Program Changes or Adjustments 2024

<table>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Deletion of question</td><td>51. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply)
□ Pharmacy director
□ Executive leadership (for example, CEO, CMO)
□ Pharmacy & therapeutics
□ Hospital board
□ Patient safety
□ Other (specify): _____
□ Quality improvement
□ None</td><td>N/A</td><td>Not needed anymore</td><td>0.5 minute decrease</td></tr>
<tr><td>Revision</td><td>55b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply)
<table><tr><th></th><th>Entry Points</th><th>Cold Potable Water Storage Tank(s)</th><th>Hot Potable Water Storage Tank(s)</th><th>Hot Water Supply</th><th>Hot Water Return</th><th>Representative Locations Throughout Cold Potable Building Water System(s)</th><th>Representative Locations Throughout Hot Potable Building Water System(s)</th><th>Other (specify): _____</th></tr><tr><td>Daily</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Weekly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Monthly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Quarterly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Annually</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Other (specify):_____</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr></table></td><td>49b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply)
<table><tr><th>Location</th><th>Daily</th><th>Weekly</th><th>Monthly</th><th>Quarterly</th><th>Annually</th><th>Other (specify): _____</th><th>N/A</th></tr><tr><td>Entry Points</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Cold Potable Water Storage Tank(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Potable Water Storage Tank(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Water Supply</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Water Return</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Representative Locations Throughout Cold Potable Building Water System(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Representative Locations Throughout Hot Potable Building Water System(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Other (specify):_____</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr></table></td><td>Added “N/A” column for those who do not test certain locations</td><td>No change</td></tr>
<tr><td>Revision</td><td>55d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply)
<table><tr><th></th><th>Entry Points</th><th>Cold Potable Water Storage Tank(s)</th><th>Hot Potable Water Storage Tank(s)</th><th>Hot Water Supply</th><th>Hot Water Return</th><th>Representative Locations Throughout Cold Potable Building Water System(s)</th><th>Representative Locations Throughout Hot Potable Building Water System(s)</th><th>Other (specify): _____</th></tr><tr><td>Daily</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Weekly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Monthly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Quarterly</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Annually</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Other (specify):_____</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr></table></td><td>49d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply)
<table><tr><th>Location</th><th>Daily</th><th>Weekly</th><th>Monthly</th><th>Quarterly</th><th>Annually</th><th>Other (specify): _____</th><th>N/A</th></tr><tr><td>Entry Points</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Cold Potable Water Storage Tank(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Potable Water Storage Tank(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Water Supply</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Hot Water Return</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Representative Locations Throughout Cold Potable Building Water System(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Representative Locations Throughout Hot Potable Building Water System(s)</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr><tr><td>Other (specify):_____</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td><td>□</td></tr></table></td><td>Added “N/A” column for those who do not test certain locations</td><td>No change</td></tr>
<tr><td>Revision</td><td>55f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply)</td><td>49f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply)</td><td>Added “N/A” column for those who do not test certain locations</td><td>No change</td></tr>
</table>

				
Revision	55h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply) 	49h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Revision	55j. If Yes, where an how frequently does your facility perform Legionella testing? (check all that apply) 	49j. If Yes, where an how frequently does your facility perform Legionella testing? (check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Revision	55l. If Yes, where an how frequently does your facility perform Pseudomonas testing? (check all that apply) 	49l. If Yes, where an how frequently does your facility perform Pseudomonas testing? (check all that apply) 	Added “N/A” column for those who do not test certain locations	No change
Added new question	N/A	51. 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.	provide data (baseline and annually) on VTE prevention practices in hospitals/facilities and help identify gaps	1.0 minute increase

		□ 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. □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.	between evidence-based guidelines for VTE prevention and implementation of those guidelines in practice. The baseline data would also be helpful in the evaluation of future VTE prevention initiatives.	
Added new question	N/A	*52. 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		2.0 minute increase

		□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 □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		
Added new question	N/A	53. 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		3.0 minute increase

		□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): _____ □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 □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): _____		
Added new question	N/A	*54. 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		1.0 minute increase

		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 □Quarterly □Yearly □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		
57.151 Rehab Annual Survey				

D2. Explanation for Program Changes or Adjustments 2024

NHSN PSC Annual Survey collects facility-level data from the previous calendar year and is completed by all facilities enrolled in the NHSN Patient Safety Component. The Annual Survey data is used to calculate HAI Standardized Infection Ratio (SIR) risk adjustment models and track HAI incidence in facilities. The data is also used to support decision making, program planning, and research across CDC. The SIR is available for use for CMS Quality Reporting for select HAI and facility types, state health departments, other organizations, or groups (i.e., Leapfrog) and CDC in national surveillance reports. It will be collected electronically once annually via the NHSN application.

By updating the PSC Annual Survey, we ensure improved relevance, enhanced data quality, alignment with industry standards and regulations, increased efficiency, and expanded analysis capabilities within the CDC.

Type of Change	Changed From	Changed To	Justification	Impact to Burden
Revision	*2. For the following organisms, 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.* **Pathogen** / **(1) Primary** / **(2) Secondary** / **Comments** *Enterobacterales* _____ _____ _____ *Pseudomonas aeruginosa* _____ _____ _____ *Acinetobacter baumanni* complex _____ _____ _____ 1 = Kirby-Bauer disk diffusion; 4 = Sensititre; 7 = Agar dilution method 2 = Vitek (Legacy); 5.1 = MicroScan WalkAway; 10 = Gradient Dilution Strip (for example E test) 2.1 = Vitek 2; 5.2 = MicroScan autoSCAN; 13 = Other (describe in Comments section) 3.1 = BD Phoenix; 6 = Other broth microdilution method	*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)	Simplified the question to have facilities respond only 1 time (not per organism). Updated the response options to reflect currently used lab tests	0.5 minute decrease
revision	*3. Does either primary or secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply): **Drug** / ***Organism tested:*** *Enterobacterales* / *Pseudomonas aeruginosa* / *Acinetobacter baumanni* Cefiderocol ☐ ☐ ☐ Ceftazidime-Avibactam ☐ ☐ ☐ Ceftolozane-Tazobactam ☐ ☐ ☐ Colistin ☐ ☐ ☐ Delafloxacin ☐ ☐ ☐ Eravacycline ☐ ☐ ☐ Imipenem-Relebactam ☐ ☐ ☐ Meropenem-Vaborbactam ☐ ☐ ☐	*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 ☐ ☐	Simplified the question to have facilities respond only 1 time per drug (not per organism). Updated the response options to reflect drugs of interest.	No change
revision	*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	*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 ☐	to monitor the uptake of up-to-date CLSI breakpoints among clinical laboratories and interpret antimicrobial surveillance data which reuse	0.5 minute increase

	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 f. Fluroquinolone breakpoints for *Enterobacterales* in 2019 ◻ Yes ◻ No	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 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	hospital interpretations of antimicrobial susceptibility testing results. The additional organism-drug combos are the those that CLSI recently updated the breakpoints on.	
revision	*5. Does the laboratory test bacterial isolates for presence of carbapenemase? (this does not include automated testing instrument expert rules) ◻ 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	Grammar update	No change
revision	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ NAAT (for example, PCR) ◻ MLB Screen ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM ◻ Rapid CARB Blue ◻ E test ◻ CARBA 5 ◻ Cepheid, BioFire, Verigene, Genmark, etc ◻ Other _____	5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply) ◻ Nucleic Acid Amplification Test (for example, PCR, Cepheid) ◻ NG-Test Carba-5 (or other lateral flow assay) ◻ Modified Hodge Test ◻ Carba NP ◻ mCIM/CIM ◻ Other _____	Update of tests to more accurately reflect tests in use.	No change
Deletion of question	*9. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli Klebsiella pneumoniae*, *Klebsiella oxytoca*, or *Proteus mirabilis* routinely or using a testing	N/A	Not needed anymore	0.5 minute decrease

	algorithm? ◻ Yes ◻ No			
Deletion of question	9a. If Yes, 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	N/A	not needed anymore	0.5 minute decrease
Revision	*14. Does the laboratory employ any molecular tests to identify *Candida* from blood specimens? ◻ Yes ◻ No ◻ Unknown	*13. Does the laboratory employ any PCR molecular tests to identify *Candida* from blood specimens? ◻ Yes ◻ No ◻ Unknown	Revised question wording to increase clarity.	No change
Revision	14a. If yes, which molecular tests are used to identify *Candida* from blood specimens? (check all that apply) ◻ T2Candida Panel ◻ BioFire BCID ◻ GenMark ePlex BCID ◻ Other, specify: _____ ◻ 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	Revised question wording to increase clarity.	No change
Revision	*16. What method is 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	*15. What methods are used for antifungal susceptibility testing (AFST), excluding Amphotericin B? (check all that apply)	Grammar update	No change
Revision	*17. What method is 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	*16. What methods are used for antifungal susceptibility testing (AFST) of Amphotericin B? (check all that apply)	Grammar update	No change
Revision	*22. 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)	*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)	Updated question to more accurately reflect what we'd like facilities to answer.	No change

	□ MALDI-TOF MS System (Bruker Biotyper) □ Automated Instrument (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.) □ 16S rRNA Sequencing □ Other (specify): _____ □ None	□ 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		
revision	*23. Indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (for example, 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 (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.) □ Non-automated Manual Kit (for example, API, Crystal, RapID, etc.) □ Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, 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	Updated question to more accurately reflect what we'd like facilities to answer.	No change
Deletion of question	*25. Number of fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility: _____	N/A	Not needed anymore	0.5 minutes decrease
Deletion of question	*35. 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	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	38a. If Prospective audit and feedback is selected: For which categories of antimicrobials? 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,	N/A	Not needed anymore	0.5 minute decrease

	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			
Deletion of question	38c. If Preauthorization is selected: For which categories of antimicrobials? 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 □ Colistin or polymyxin B □ Anidulafungin, caspofungin, or micafungin □ Isavuconazole, posaconazole, or voriconazole □ Amphotericin B and/or lipid-based amphotericin B □ None of the above	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	41b. If 'Nurses track antibiotic duration of therapy' is selected: Is that information available at the bedside (for example, on a whiteboard in the room)? □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of question	48. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. □ Yes □ No	N/A	Not needed anymore	0.5 minute decrease
Deletion of	49. Our facility accesses targeted remote stewardship expertise (for example, tele-	N/A	Not needed anymore	0.5 minute

<table>
<tr><td>question</td><td>stewardship to obtain facility-specific support for our antibiotic stewardship efforts).
□ Yes □ No</td><td></td><td></td><td>decrease</td></tr>
<tr><td>Deletion of question</td><td>50. 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</td><td>N/A</td><td>Not needed anymore</td><td>0.5 minute decrease</td></tr>
<tr><td>Deletion of question</td><td>51. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply)
□ Pharmacy director
□ Executive leadership (for example, CEO, CMO)
□ Pharmacy & therapeutics
□ Hospital board
□ Patient safety
□ Other (specify): _____
□ Quality improvement
□ None</td><td>N/A</td><td>Not needed anymore</td><td>0.5 minute decrease</td></tr>
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D2. Explanation for Program Changes or Adjustments 2024

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<td>Added new question</td>
<td>N/A</td>
<td>50. Our facility uses the following venous thromboembolism (VTE) prevention practices (select all that apply, and select at least one)</td>
<td>provide data (baseline and annually) on VTE prevention</td>
<td>1.0 minute increase</td>
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		□ 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. □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.	practices in hospitals/facilities and help identify gaps between evidence-based guidelines for VTE prevention and implementation of those guidelines in practice. The baseline data would also be helpful in the evaluation of future VTE prevention initiatives.	
Added new question	N/A	*51. 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		2.0 minute increase

		□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 □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		
Added new question	N/A	52. 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		3.0 minute increase

		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): _____ □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 □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): _____		
Added new question	N/A	*53. 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		1.0 minute increase

		□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 □Quarterly □Yearly □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		

57.500 Outpatient Dialysis Center Practices Survey **Dialysis center survey questions help in understanding practices followed in the dialysis facilities as well as provide data for future analysis of infection control initiatives.**				
Q3 - Removal of Joint Commission option	Is your facility accredited by an organization other than CMS? ☐ Yes ☐ No a. If yes, specify (choose one) ☐ Joint Commission ☐ National Dialysis Accreditation Commission (NDAC) ☐ Accreditation Commission for Health Care (ACHC) ☐ Other (specify) _____	Is your facility accredited by an organization other than CMS? ☐ Yes ☐ No b. If yes, specify (choose one) ☐ National Dialysis Accreditation Commission (NDAC) ☐ Accreditation Commission for Health Care (ACHC) ☐ Other (specify) _____	Joint Commission no longer used	Zero impact

D2. Explanation for Program Changes or Adjustments 2024

Q4 - Deletion of verbiage	What types of dialysis services does your center offer (certified and non-certified)? (select all that apply): ☐ In-center daytime hemodialysis ☐ Home Peritoneal Dialysis ☐ Home Hemodialysis ☐ In-center nocturnal hemodialysis ☐ In Center Peritoneal Dialysis	a. What types of dialysis services does your center offer? (select all that apply): ☐ In-center daytime hemodialysis ☐ Home Peritoneal Dialysis ☐ Home Hemodialysis ☐ In-center nocturnal hemodialysis ☐ In Center Peritoneal Dialysis	The certified and non-certified verbiage was removed from the question to provide clarification.	Zero impact
Q8 - language updated	Is there someone at your dialysis center in charge of infection control? ☐ Yes ☐ No	Is there someone at your dialysis center in charge of infection control training or oversight? ☐ Yes ☐ No	Language updated for clarity.	Zero impact
Q9 - NEW Question added	In the past year, has your clinic been cited for infection control breaches in a state/certification/recertification survey? ☐ Yes ☐ No		To ascertain any infection control breaches citations.	3 additional minutes
Q10 – Acronyms spelled out	Does your center provide dialysis services within long-term care facilities (e.g., staff-assisted dialysis in nursing homes or skilled nursing facilities; not long-term acute care hospitals)? ☐ Yes ☐ No a. If yes, which dialysis services are provided within LTC facilities? (check all that apply): ☐ HD in LTC ☐ PD in LTC	Does your center provide dialysis services within long-term care facilities (e.g., staff-assisted dialysis in nursing homes or skilled nursing facilities; not long-term acute care hospitals)? ☐ Yes ☐ No b. If yes, which dialysis services are provided within long-term care facilities? (check all that apply): ☐ Hemodialysis in LTC ☐ Peritoneal Dialysis in LTC	Acronyms spelled out for clarity.	Zero impact
Q11 – verbiage updated	Is there a dedicated vascular access nurse/coordinator (either full or part-time) at your center? Yes No	Which staff are responsible for ensuring permanent vascular access placement and maintenance? (to decrease CVC use in hemodialysis patients)? ☐ Dedicated vascular access coordinator ☐ Nephrologist who oversees patient education and coordinates patient care related to vascular access ☐ Relationship with or access to a surgeon skilled in access placement (or a process to refer patients to a surgeon that is skilled in access placement) ☐ Cannulation expert ☐ Relationship with or access to interventional nephrologists or interventional radiologist	Question was updated to capture additional data on staff whom ensure vascular access placement and maintenance.	Zero impact

		☐ Other, specify: _____		
Q14 reworded and additional options	Are patients routinely isolated or cohorted for treatment within your center for any of the following conditions? (if yes, select all that apply) ☐ No, none ☐ Hepatitis C Active tuberculosis (TB disease) ☐ Vancomycin-resistant *Enterococcus* (VRE) ☐ Methicillin-resistant *Staphylococcus aureus (MRSA)* ☐ *Clostridioides difficile* (C. diff.) ☐ Other, specify: _____	Are patients routinely isolated or cohorted for treatment within your center for any of the following pathogens? (if yes, select all that apply) ☐ No, none ☐ Hepatitis C ☐ Vancomycin-resistant *Enterococcus* (VRE) ☐ Methicillin-resistant *Staphylococcus aureus* ☐ *Clostridioides difficile* (C. diff.) ☐ Any carbapenem- resistant organism [(i.e., carbapenem-resistant *Enterobacterales* (CRE), carbapenem-resistant *Acinetobacter* (CRAB), carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)] ☐ *Candida auris* ☐ Other, specify: _____	Question reworded and options added for clarity and better surveillance of isolated or cohorted patients.	Zero impact
Q15 – Question being removed	In the past year, where have you dialyzed patients with SARS-COV-2 infections? (Select all that apply) ☐ Isolation room ☐ Covid shift ☐ Covid Unit ☐ Separate area on treatment floor while other non-COVID patients are dialyzed ☐ Not Applicable		Question removed upon expiration of public health emergency	2 minute savings
Q17 added		Does your facility have an airborne infection isolation room (AIIR) to isolate patients infected with pathogens that are transmitted through the airborne route (for example, active tuberculosis)? ☐ Yes ☐ No	Question added to obtain additional data on isolated patients.	1 minute additional
Q23 – Additional subcategories added	How many MAINTENANCE, NON-TRANSIENT ESRD and AKI PATIENTS were assigned to your center during the first week of February (2/1 through 2/7)? _____ Of these, indicate the number who received: a. In-Center Hemodialysis: _____ b. Home Hemodialysis: _____ c. Peritoneal Dialysis: _____	How many MAINTENANCE, NON-TRANSIENT ESRD and AKI PATIENTS were assigned to your center during the first week of February (2/1 through 2/7)? _____ Of these, indicate the number who received: a. In-Center Hemodialysis: _____ a1. No. of pediatric patients: _____ b. Home Hemodialysis: _____ b1. No. of pediatric patients: _____ c. Peritoneal Dialysis: _____	The addition to this question allows us to capture data on the pediatric patients served in the dialysis facilities.	2 additional minutes

		c1. No. of pediatric patients: _____		
Q24 - updated from optional to required	Optional: Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Race: a. American Indian/Alaska Native: ____ b. Black or African American: _____ c. Asian: _____ d. Native Hawaiian/Other Pacific Islander: _____ e. White: _____ f. More than one Race: _____ g. Unknown: _____ h. Declined to response: _____	Required: Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Race: a. American Indian/Alaska Native: _____ b. Black or African American: _____ c. Asian: _____ d. Native Hawaiian/Other Pacific Islander: _____ e. White: _____ f. More than one Race: _____ g. Unknown: _____ Declined to response: _____	Optional question added to obtain data on patient race	5 additional minutes
Q25 - updated from optional to required	Optional: Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Ethnicity a. Hispanic or Latino: _____ b. Not Hispanic or Latino: _____ c. Unknown: _____ Declined to respond: _____	Required: Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Ethnicity d. Hispanic or Latino: _____ e. Not Hispanic or Latino: _____ f. Unknown: _____ Declined to respond: _____	Optional question added to obtain data on patient ethnicity	5 additional minutes
Q27 - options updated	Of the patient care staff members counted in question 26, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____	Of the patient care staff members counted in question 26, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. Annual COVID-19 vaccine?	Addition of common vaccines will be beneficial for infection surveillance.	5 minutes additional
Q29 – question reworded	Does your center have a respiratory program for annual fit testing on your healthcare personnel? ≤ Yes ≤ No If yes: a. Which staff do you fit test?? (select all that apply) ≤ Nurse/Nurse Assistant ≤ Dietitian ≤ Dialysis Patient-Care Technician ≤ Physicians/Physician Assistant	Does your center have a respiratory protection program for annual respirator use/training of your healthcare personnel? ≤ Yes ≤ No If yes: a. Which staff are trained to use respirators? (select all that apply) ≤ Nurse/Nurse Assistant ≤ Dietitian ≤ Dialysis Patient-Care Technician ≤ Physicians/Physician Assistant	The questions were reworded because not all respirators require annual fit testing.	Zero impact

	≤ Dialysis Biomedical Technician ≤ Nurse Practitioner ≤ Social Worker ≤ Other: _____	≤ Dialysis Biomedical Technician ≤ Nurse Practitioner ≤ Social Worker ≤ Other: _____		
Q34 - options updated	Of the **In-Center Hemodialysis** patients in question #31, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____	Of the **In-Center Hemodialysis** patients in question #31, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____ d. Annual COVID-19 vaccine? _____	Question options updated to include annual COVID-19 vaccine.	5 additional minutes
Q42 – options updated	Of the **Peritoneal Dialysis** patients in question #41, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____	Of the **Peritoneal Dialysis** patients in question #41, how many received: a. A completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____ d. Annual COVID-19 vaccine?	Question updated to include the Annual COVID-19 vaccine.	5 additional minutes.
Q49 - options updated	Of the **Home Hemodialysis** patients from question #46, how many received: a. At completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____	Of the **Home Hemodialysis** patients from question #46, how many received: a. At completed series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____ d. Annual COVID-19 vaccine?	Question updated to include the Annual COVID-19 vaccine.	5 additional minutes
Q60b – options updated	b. If yes, is your center actively participating in any of the following prevention initiatives (select all that apply): ≤ CDC Making Dialysis Safer for Patients Coalition – facility-level participation ≤ CDC Making Dialysis Safer for Patients Coalition – corporate or other organization-level participation ≤ The Standardizing Care to improve Outcomes in Pediatric End Stage Renal Disease (SCOPE) Collaborative Peritoneal Dialysis Catheter-related Infection Project ≤ SCOPE Collaborative Hemodialysis Access-related Infection Project ≤ None of the above ___	c. If yes, is your center actively participating in any of the following prevention initiatives (select all that apply): ≤ CDC Making Dialysis Safer for Patients Coalition – facility-level participation ≤ CDC Making Dialysis Safer for Patients Coalition – corporate or other organization-level participation ≤ The Standardizing Care to improve Outcomes in Pediatric End Stage Renal Disease (SCOPE) Collaborative Peritoneal Dialysis Catheter-related Infection Project ≤ SCOPE Collaborative Hemodialysis Access-related Infection	'Other' added to the options to allow for learning if there are other initiatives we may not be aware of.	Zero impact

		Project ≤ None of the above ≤ Other (please specify) _____		
Q62 - options updated	Which of the following CDC Core Interventions does your center apply for prevention of blood stream infections? (Check all that apply) ≤ Surveillance and feedback using NHSN ≤ Hand hygiene observations ≤ Catheter/vascular access care observations ≤ Staff education and competency ≤ Patient education/engagement ≤ Catheter reduction ≤ Chlorhexidine for skin antisepsis ≤ Catheter hub disinfection ≤ Antimicrobial ointment or chlorhexidine-impregnated dressing ≤ None	Which of the following CDC Core Interventions does your center apply for prevention of blood stream infections? (Check all that apply) ≤ Surveillance and feedback using NHSN ≤ Hand hygiene observations ≤ Catheter/vascular access care observations ≤ Staff education and competency ≤ Patient education/engagement ≤ Catheter reduction ≤ Chlorhexidine with alcohol ≤ Catheter hub disinfection ≤ Antimicrobial ointment ≤ Chlorhexidine-impregnated dressing ≤ None	Options revised as chlorhexidine w alcohol is recommended.	Zero impact
Q76 - options updated	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections in your center? ≤ Yes, for all catheter patients ≤ Yes, for some catheter patients ≤ No a. If yes, which lock solution is most commonly used? (select one) ≤ Sodium citrate ≤ Gentamycin ≤ Vancomycin ≤ Taurolidine ≤ Ethanol ≤ Multi-component lock solution or other, specify: _____	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections in your center? ≤ Yes, for all catheter patients ≤ Yes, for some catheter patients ≤ No a. If yes, which lock solution is most commonly used? (select one) ≤ Sodium citrate ≤ Gentamycin ≤ Vancomycin ≤ Taurolidine ≤ Ethanol ≤ Taurolidine and heparin (Defencath™) ≤ Multi-component lock solution or other, specify: _____	Defencath was recently approved by the FDA.	Zero impact.
Q79 - verbiage updated	Does your center provide hemodialysis catheter patients with supplies to allow for changing catheter dressings outside the dialysis center? ≤ Yes, routinely for all or most patients with a catheter ≤ Yes, only for select patients with a catheter ≤ No	Does your center provide in-center hemodialysis catheter patients with supplies to allow for changing catheter dressings outside the dialysis center? ≤ Yes, routinely for all or most patients with a catheter ≤ Yes, only for select patients with a catheter	Updated question to ensure clarity that question is asking about in-center only patients	Zero impact

		≤ No		

57.507 Home Dialysis Center Practices Survey

In the effort to review all data collection forms in the NHSN OMB package to ensure compliance, we are submitting updates to form 57.507 Home Dialysis Center Practices Survey, as the data collection form on the OMB webpage does not match what is currently collected by NHSN.

The crosswalk below lists all the updates that are being made to the form.

Type of Change	Changed From	Changed To	Justification	Impact to Burden
Q3 – Revision of options Joint commission removed	Is your facility accredited by an organization other than CMS? ☐ Yes ☐ No c. If yes, specify (choose one) ☐ Joint Commission ☐ National Dialysis Accreditation Commission (NDAC) ☐ Accreditation Commission for Health Care (ACHC) ☐ Other (specify) _____	Is your facility accredited by an organization other than CMS? ☐ Yes ☐ No d. If yes, specify (choose one) ☐ National Dialysis Accreditation Commission (NDAC) ☐ Accreditation Commission for Health Care (ACHC) ☐ Other (specify) _____	Joint Commission no longer used	Zero impact

D2. Explanation for Program Changes or Adjustments 2024

Q4 – deletion of verbiage	a. What types of dialysis services does your center offer (certified and non-certified)? (select all that apply):	What types of dialysis services does your center offer? (select all that apply): □ Home Peritoneal Dialysis □ Home Hemodialysis	the certified and non-certified verbiage was removed from the question to provide clarification".	Zero impact
Q4 – additional verbiage for clarity	□ Peritoneal Dialysis □ Home Hemodialysis	□ Home Peritoneal Dialysis □ Home Hemodialysis	Added “home” before peritoneal dialysis for clarity	Zero impact
Q7 - NEW Question added		Within the last 3 years, has your facility/organization been surveyed by CMS or a CMS approved accrediting organization (i.e., state survey agency, Accreditation Commission for Health Care [ACHC], National Dialysis Accreditation Commission [NDAC])? □ Yes □ No	To ascertain any infection control breaches citations.	3 additional minutes
Q8 - Sub-question 8a added	Does your center provide dialysis services within long-term care facilities (e.g., staff-assisted dialysis in nursing homes or skilled nursing facilities; not long-term acute care hospitals)? □ Yes □ No	8a. Does your center provide dialysis services within long-term care facilities (e.g., staff-assisted dialysis in nursing homes or skilled nursing facilities; not long-term acute care hospitals)? □ Yes □ No 8b. If yes, what types of dialysis services are provided within long-term care facilities? (check all that apply): □ HD in LTC □ PD in LTC	Sub-Question was added for clarity	1 additional minute
Revised Patient Section	Combined Patient/Staff Census	Patient Census	To keep all patient questions combined and separate from staff questions	Zero impact
Q12 - Language modified	How many MAINTENANCE, NON-TRANSIENT PATIENTS were assigned to your center during the first week of February (2/1 through 2/7)?	How many ADULT MAINTENANCE, NON-TRANSIENT ESRD and AKI PATIENTS were assigned to your center during the first week of February (2/1 through 2/7)?	Provides clarity to the question	Zero impact
Q13 – New question		If MIXED Population or PEDIATRIC Population was selected in question 4, how many Maintenance, Non-Transient ESRD and AKI **PEDIATRIC PATIENTS** were assigned to your center the first week of February (2/1 through 2/7) _____ a. Home Hemodialysis _____ Peritoneal Dialysis: _____	To allow for capture of pediatric patient data	5 minutes additional
Q14 added		Based on the number of patients that treated in the first week of	Optional question added to	5 additional

NEW		February (2/1 through 2/7), please indicate the number of patients per Race: h. American Indian/Alaska Native: _____ i. Black or African American: _____ j. Asian: _____ k. Native Hawaiian/Other Pacific Islander: _____ l. White: _____ m. More than one Race: _____ n. Unknown: _____ Declined to response: _____	obtain data on patient race	minutes
Q15 added NEW		Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Ethnicity g. Hispanic or Latino: _____ h. Not Hispanic or Latino: _____ i. Unknown: _____ Declined to respond: _____	Optional question added to obtain data on patient ethnicity	5 additional minutes
NEW Staff Section	Combined Patient/Staff Census	Staff Census	To keep all staff questions combined	Zero impact
Q16 new to staff section	Added to new Staff Section from Patient/Staff Census section	How many patient care STAFF (full time, part time, or affiliated with) worked in your center during the first week of February (2/1 through 2/7)? *Include only staff who had direct contact with dialysis patients or equipment*: _____ Of these, how many were in each of the following categories? a. Nurse/nurse assistant: _____ b. Dialysis patient-care technician: _____ c. Dialysis biomedical technician: _____ d. Social worker: _____ e. Dietitian: _____ f. Physicians/physician assistant: _____ g. Nurse practitioner: _____ h. Other: _____	Moved from Patient/Staff Census section to keep all staff questions in one section	Zero impact
Directions clarified	Please respond to the following questions based on information from your center in the first week of February (2/1 through 2/7). This applies to current or most recent February relative to current date.	Please respond to the following questions based on your peritoneal dialysis patients in the first week of February (2/1 through 2/7). This applies to current or most recent February relative to current date.	Provides clarity in the directions for the section	Zero impact
New	New Peritoneal Dialysis Patient Section added		Created new section to keep	Zero impact

Peritoneal Dialysis Patient Section Added			all Peritoneal Dialysis Patient-related questions together	
Q18 - New question under Peritoneal Dialysis Patient Section		Number of maintenance, non-transient ESRD and AKI **Peritoneal Dialysis** patients that were assigned to your center during the first week of February (2/1 through 2/7	To obtain additional information on peritoneal dialysis patients	Zero impact – question auto-populates from a prior question in the survey
Directions clarified	Please respond to the following questions based on information from your center in the first week of February (2/1 through 2/7). This applies to current or most recent February relative to current date.	Please respond to the following questions based on your home dialysis patients in the first week of February (2/1 through 2/7). This applies to current or most recent February relative to current date.	Provides clarity in the directions for the section	Zero impact
New Home Hemodialysis Patients Section Added			To keep all home hemodialysis patient-related questions together	Zero impact
Q22 - New Question added to Home Hemodialysis Patient section		Number of maintenance, non-transient ESRD and AKI **Home Hemodialysis** patients that were assigned to your center during the first week of February (2/1 through 2/7):	To obtain additional data on home hemodialysis patients.	Zero impact – question auto-populates from a prior question in the survey
Q24 - Modified language	Does your home hemodialysis facility perform buttonhole cannulation	Does your dialysis facility utilize buttonhole cannulation techniques for **Home Hemodialysis** patients? ☐ Yes ☐ No a. Of the AV fistula patients from question #22a, how many had buttonhole cannulation? _____ b. When buttonhole cannulation is performed for home hemodialysis patients: i. Who most often performs it?	To clarify question	Zero impact

D2. Explanation for Program Changes or Adjustments 2024

Q25 – Moved from Vaccine Section to Home Hemodialysis Patients section	Of the **Home Hemodialysis** patients counted in question #21, how many received: a. A complete series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____	Of the **Home Hemodialysis** patients counted in question #21, how many received: a. A complete series of hepatitis B vaccine (ever)? _____ b. The influenza (flu) vaccine for the current/most recent flu season? _____ c. At least one dose of pneumococcal vaccine (ever)? _____ d. The annual COVID-19 vaccine	Placement of question within the survey moved as well as the addition of the Annual COVID-19 vaccine as a new option.	Zero impact
Q26 Moved from Surveillance section to Home Hemodialysis Patients section	Which of the following events in your **Home Hemodialysis** patients does your center routinely track?	Which of the following events in your **Home Hemodialysis** patients does your center routinely track? □ Bloodstream infection □ Needle/access dislodgement □ Vascular access site □ Air embolism infection □ Catheter breakage or bloodline separation □ Other (specify): _____	Wording did not change, just placement within the survey.	Zero impact
Q27 – Options Updated	Which type of pneumococcal vaccine does your center offer to **patients**? (choose one) Polysaccharide (i.e., PPSV23) only Conjugate (e.g., PCV13) only Both polysaccharide & conjugate Neither offered	Which type of pneumococcal vaccine does your center offer to patients? (choose one) □ New Conjugate (PCV20) only □ New Conjugate (PCV15) and Polysaccharide (PPSV23) □ Both New Conjugate (Either PCV20 or PCV15) and Polysaccharide (PPSV23) □ Other (please specify) □ Neither offered	Updated pneumococcal vaccine options added.	3 additional minutes
Q32 – verbiage modified	Is your center actively participating in any of the following prevention initiatives (select all that apply): □ CDC Making Dialysis Safer for Patients Coalition – facility-level participation □ CDC Making Dialysis Safer for Patients Coalition – corporate- or other organization-level participation □ The Standardizing Care to improve Outcomes in Pediatric End Stage Renal Disease (SCOPE) Collaborative Peritoneal Dialysis Catheter-related Infection Project □ SCOPE Collaborative Hemodialysis Access-related Infection Project None of the above	Has your center participated in any national or regional infection prevention-related initiatives in the past year? □ Yes □ No a. If yes, what is the primary focus of the initiative(s)? (if >1 initiative, select all that apply) □ Catheter reduction □ Hand hygiene □ Bloodstream infection prevention □ Patient education/engagement for infection prevention □ Increase vaccination rates □ Decrease/improve use of antibiotics □ Improve general infection control practices □ Improve culture of safety	Revised question to obtain better, more complete data.	5 additional minutes

		☐ Other, specify: _____ b. If yes, is your center actively participating in any of the following prevention initiatives (select all that apply): ☐ CDC Making Dialysis Safer for Patients Coalition – facility-level participation ☐ CDC Making Dialysis Safer for Patients Coalition – corporate or other organization-level participation ☐ The Standardizing Care to improve Outcomes in Pediatric End Stage Renal Disease (SCOPE) Collaborative Peritoneal Dialysis Catheter-related Infection Project ☐ SCOPE Collaborative Hemodialysis Access-related Infection Project ☐ None of the above ☐ Other, specify		
Q33 – Added as new		a. What education do you provide to patients in your center when they start dialysis? (check all that apply): ☐ Vascular access care ☐ Hand hygiene ☐ Risks related to catheter use ☐ Recognizing signs of infection ☐ Instructions for access management when away from the dialysis unit ☐ Different dialysis modalities (i.e., home dialysis or peritoneal dialysis) ☐ Other, specify: _____ ☐ None b. What education do you provide to your patients regularly (at least annually) (check all that apply): ☐ Vascular access care ☐ Hand hygiene ☐ Risks related to catheter use ☐ Recognizing signs of infection ☐ Instructions for access management when away from the dialysis unit ☐ Different dialysis modalities (i.e., home dialysis or peritoneal dialysis) ☐ Other, specify: _____ ☐ None	To obtain data on the types of education provided to patients	10 additional minutes

D2. Explanation for Program Changes or Adjustments 2024

Q34 - Added as New		Does your center provide training for staff on infection prevention and control at least once annually? □ Yes □ No	To obtain data on staff training on infection control measures	5 additional minutes
Q35 - Added as New		Does your center perform staff knowledge assessments for infection prevention and control (select all that apply) □ At least annually □ One or more times each year □ At least once a year □ When new equipment or procedures are introduced	To obtain data on staff training on infection control measures	5 additional minutes
Section Title Updated	**Vascular Access**	**Arteriovenous (AV) Fistulas or Grafts**	For clarity of the questions under the section	Zero impact
Q36 - verbiage updated	Before prepping the fistula or graft site for rope-ladder cannulation, what is the site most often cleansed	Before prepping the fistula or graft site for cannulation, what is the access site most often cleansed with (either by patients or staff upon entry to the clinic)? □ Soap and water □ Alcohol-based hand rub □ Antiseptic wipes □ Other, specify: _____ □ Nothing	For clarity of the data requested under the question	Zero impact
Q37 - verbiage updated	Before rope-ladder cannulation of a fistula or graft, what is the site most often prepped with? (select the one most commonly used)	Before cannulation of a fistula or graft, what is the skin most often prepped with? (select one) □ Alcohol □ Chlorhexidine without alcohol □ Chlorhexidine with alcohol (e.g., Chloraprep™, PDI Prevantics®) □ Povidone-iodine (or tincture of iodine) □ Sodium hypochlorite solution (e.g., ExSept®, Alcavis) without alcohol □ Sodium hypochlorite solution (e.g., ExSept®, Alcavis) followed by alcohol □ Other, specify: _____ □ Nothing	For clarity of the data requested under the question	Zero impact
Q43 – Added new option	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections? □ Yes, for all catheter patients □ Yes, for some catheter patients □ No a. If yes, which lock solution is most commonly used? (select one) □ Sodium citrate □ Taurolidine □ Gentamicin □ Ethanol	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections? □ Yes, for all catheter patients □ Yes, for some catheter patients □ No a. If yes, which lock solution is most commonly used? (select one) □ Sodium citrate □ Taurolidine	Added new antimicrobial lock approved by FDA	Zero impact

	☐ Vancomycin ☐ Multi-component lock solution or other, specify: _____	☐ Gentamicin ☐ Ethanol ☐ Vancomycin ☐ Multi-component lock solution or other, specify: _____ ☐ Taurolidine and heparin (Defencath™)		
Q45 – Old Q45 Removed	Does your center provide hemodialysis catheter patients with supplies to allow for changing catheter dressings outside the dialysis center? Yes, routinely for all or most patients with a catheter Yes, only for select patients with a catheter No		Question removed to avoid confusion as to where home patients would obtain their supplies (would be sent directly to patient home, not provided by center)	Zero impact

57.701 Glycemic Control Module-HYPO Annual Survey

The Medication Safety Annual Hospital Survey collects facility-level data from the previous calendar year and is completed by all facilities enrolled in the Medication Safety Component. The data will be used in analysis of data collected within the modules included in the Medication Safety Component, as well as used to support decision making, program planning, and research across CDC. Annual survey data will be collected electronically once annually via the NHSN application. The crosswalk below lists all the updates that are being made to the form.

Changed From	Changed To	Justification	Impact to Burden
Glycemic Control Module Annual Hospital Survey	Medication Safety Component – Annual Hospital Survey	A revision to the title reflects additional opioid-related topics added to the facility survey such that the survey encompasses topics related to all NHSN Medication Safety Component modules.	None

	6. *Select the module(s) for which your facility currently reports or intends to report data: ☐ Glycemic Control Module ☐ Opioid-Related Adverse Events (ORAE) Module	Addition of question to allow facility to indicate which NHSN Medication Safety Component modules they will participate in. This will allow facilities to be prompted only to complete survey questions that correspond to the modules they will participate in.	None
3. *Does your facility have an inpatient glycemic control quality improvement or safety program in place as demonstrated by: (Check all that apply.) Special team(s) dedicated to consulting on patients with diabetes that actively assist in the management of inpatients with diabetes Senior executive who serves as a point of contact or "champion" to help ensure the glycemic control program has resources and support to accomplish its mission Clinician (physician, nurse, or pharmacist) leader with dedicated time to manage the program and conduct daily interventions Allocation of dedicated resources to support glycemic control activities Staff from key support departments and groups who contribute to glycemic control activities At least annual presentation of information on glycemic control activities and outcomes to facility leadership and/or board At least annual opportunity to address glycemic control resource needs with facility leadership and/or board Facility communication mechanisms about glycemic control activities, via email, newsletters, events, or other avenues Provision of facility staff training and development on glycemic control activities Documented statement of facility support for glycemic control activities (e.g., a	7. *Does your facility provide leadership support and clinical resources specifically for inpatient glycemic control quality improvement or safety program activities as demonstrated by: (Check all that apply.) ☐ Special team(s) dedicated to assisting in the management of inpatients with diabetes ☐ Senior executive who serves as a point of contact or "champion" to help ensure the glycemic control program has resources and support to accomplish its mission ☐ Clinician (physician, nurse, or pharmacist) leader with dedicated time to oversee development and implementation of glycemic control improvement interventions ☐ Allocation of dedicated resources to support glycemic control activities ☐ Our facility has other leadership support or clinical resources to address inpatient glycemic control practices, describe: _____ Currently, our facility does not have leadership support or clinical resources specifically to address inpatient glycemic control as part of our patient safety and quality improvement activities	Provides clarity to the data collection and streamlines facility response options	None

written policy or statement approved by the board) Our facility does not have a glycemic control quality improvement or safety program in place Our facility has other glycemic control programmatic components, please describe briefly: _____			
4.Does your facility have inpatient glycemic control quality improvement or safety practices as demonstrated by: (Check all that apply.) Provider education Patient education Provider reminder systems Active surveillance for glucose control metrics, such as hypoglycemia/hyperglycemia events or other facilitated relay of clinical data to providers Audit and feedback on performance to providers Incentives, regulation, or policy that are provider- or health system-directed Insulin orders/protocols that are standardized across units or the facility Our facility does not have practices specific to glycemic control quality improvement or patient safety Our facility has other glycemic control practices, please describe briefly: _____	8. *Does your facility promote inpatient glycemic control practices as part of your patient safety and quality improvement activities as demonstrated by: (Check all that apply.) Offering provider education on glycemic control and best-practices for managing diabetic patients at least annually Offering prescriber (e.g., physician, nurse practitioner) education and/or training on glycemic control and best-practices for managing patients with diabetes at least annually Offering nurse education and/or training on glycemic control and best-practices for managing patients with diabetes at least annually Offering pharmacy education and/or training on glycemic control and best-practices for managing patients with diabetes at least annually Using facility communication to raise awareness about inpatient glycemic control activities via email, newsletters, events, or other avenues (e.g., grand rounds) Offering patient education Active surveillance for glucose control metrics, such as hypoglycemia/hyperglycemia events or other facilitated relay of clinical data to providers Insulin orders/protocols that are standardized across units or the facility		

	Our facility uses other approaches to promote inpatient glycemic control practices, please describe : _____ Currently, our facility does not have specific activities to promote inpatient glycemic control practices		
5. Describe the current state of hypoglycemia management / prevention protocols at your facility: (Check one.) Nurse driven protocols for hypoglycemia management / prevention are not available at our facility Standardized nurse driven protocols for hypoglycemia management / prevention are available, but use of the protocols are not monitored Standardized nurse driven protocols for hypoglycemia management / prevention are available and use of the protocols are monitored 6. Describe the level of coordination between point of care glucose testing, insulin delivery, and nutrition delivery on the non-critical care wards at your facility. (Check one.) • There is not a systematic mechanism or protocol to coordinate glucose testing, insulin administration, and meal/nutrition scheduling • There is a systematic mechanism or protocol to coordinate glucose testing, insulin administration, and meal/nutrition scheduling in some units but not all units • There is a systematic mechanism or protocol to coordinate glucose testing, insulin administration, and meal/nutrition scheduling in all units of the facility 7. Select the description that most accurately reflects the approach to glycemic control and insulin management in the non-critical care units at your facility: (Check one.)	N/A (DELETION)	These questions are no longer required; data collection is consolidated and streamlined.	None

No protocol is available in the non-critical care units at our facility Our facility has a protocol for insulin and hyperglycemia management (including subcutaneous insulin orders) that outlines preferred insulin choices for different situations; however, the protocol guidance is not embedded in order sets			
	9. *Does your facility use the following strategies to implement inpatient glycemic control and insulin management practices? (Check all that apply.) Our facility has a standardized protocol for insulin use and hyperglycemia management (including subcutaneous insulin orders) that outlines preferred insulin choices for different situations 9a. If this response is selected, please indicate how this protocol is implemented. (Check one.) • The insulin use protocol is available for use, but not embedded into any standardized (e.g., admission) order sets • The insulin use protocol is integrated into standardized (e.g., admission) order sets; however, providers must “opt in” • The insulin use protocol is integrated into standardized (e.g., admission) order sets that requires providers to “opt out” Our facility has standardized nurse-driven protocols for monitoring for and responding to hypoglycemia events 9b. If this response is selected, please indicate where these protocols are used. (Check one.) • Nurse-driven glycemic control monitoring protocols are used only in critical care units • Nurse-driven glycemic control monitoring protocols are used in select medical or surgical units • Nurse-driven glycemic control monitoring protocols are used in	These questions consolidate previous data collection questions and more accurately collect data of interest.	None

	all inpatient units • Nurse-driven glycemic control monitoring protocols are used elsewhere; please indicate:_____ Our facility has standardized nurse-driven protocols for monitoring for and responding to hyperglycemia events 9c. If this response is selected, please indicate where these protocols are used. (Check one.) • Nurse-driven glycemic control monitoring protocols are used only in critical care units • Nurse-driven glycemic control monitoring protocols are used in select medical or surgical units • Nurse-driven glycemic control monitoring protocols are used in all inpatient units • Nurse-driven glycemic control monitoring protocols are used elsewhere; please indicate:_____ Our facility has a standardized process/protocol to coordinate glycemic control monitoring (i.e. glucose testing, insulin administration) with meal/nutrition scheduling 9d. If this response is selected. Please indicate where these protocols are used. (Check one.) • Coordinating glycemic control with nutrition is done only in critical care units • Coordinating glycemic control with nutrition is done in select medical or surgical units • Coordinating glycemic control with nutrition is done in all		

	inpatient units • Coordinating glycemic control with nutrition is done elsewhere; please indicate:_____ Our facility uses a different strategy to implement inpatient glycemic control practices, please describe: _____ Currently, our facility does not have any standardized protocols to support implementation of inpatient glycemic control practices 10. *Does your facility use the following approaches to monitor and report inpatient glycemic control and insulin management practices? (Check all that apply.) Our facility monitors the use of standardized protocols for insulin use and hyperglycemia management for inpatients with diabetes Our facility performs active surveillance for hypoglycemia events on a daily basis to allow real-time correction of insulin use / diabetes management Our facility performs active surveillance for hyperglycemia events on a daily basis to allow real-time correction of insulin use / diabetes management Our facility performs retrospective review of hypoglycemia / hyperglycemia events on a regular (monthly or quarterly) basis to identify opportunities to improve insulin use / diabetes management Our facility reports unit-level results of glycemic control event monitoring Our facility shares feedback to providers on the glycemic control of their inpatients with diabetes		

	Our facility uses a different approach to monitor inpatient glycemic control and insulin management practices, please describe: _____ Currently, our facility does not monitor inpatient glycemic control and insulin management practices		
9. Approximately what percentage of your inpatient population with diabetes is utilizing continuous glucose monitoring (CGM): (Check one.) _____ % Unsure	12.*Approximately what percentage of your inpatient population with diabetes have a continuous glucose monitoring (CGM) device that is being used in the course of inpatient care: (Check one.) _____ % Unsure	Revision Clarifies Question	None
	Section 3a. Opioid Prescribing Safety Practices 13. *Does your facility have an inpatient opioid stewardship quality improvement program? (Check one.) Yes No Other; please describe: 14. *Does your facility have any of the following practices in place within or outside of an opioid stewardship program: (Check all that apply.) Leadership Commitment such as a senior executive who serves as a point of contact or “champion” to help ensure the opioid stewardship practices has resources and support to accomplish its mission. Maintain written policies and procedure that support opioid	Addition of questions to collect information about facility’s opioid prescribing safety practices, education, and quality measurement corresponding to facility data collected with the NHSN Opioid-Related Adverse Events (ORAE) Module.	Increase in burden due to addition of new questions.

	stewardship activities. Support clinical knowledge, expertise, and practice such as require ongoing clinician training, education, and engagement to support effective pain management and opioid stewardship for prescribers and care teams. Patient and Family Caregiver Education and Engagement, such as patient/family education related to pain management goals and modalities. Tracking, Monitoring, and Reporting of key quality metrics are used to identify opportunities for improvement and to assess the impact of opioid stewardship efforts. Accountability, such as set measurable goals for promoting, establishing, and maintaining a culture of opioid stewardship. Community Collaboration and coordination with community leaders and stakeholders Our facility does not have an opioid stewardship quality improvement or safety program in place. Our facility has other opioid safety practices, please describe briefly: _____ Section 4b. Education 15. *Does your facility have opioid prescribing education programs or practices in place? (Check one.) Yes No [If checked, skip questions 15a and 15b]		

	Other; please describe: _____ [If checked, skip questions 15a and 15b] 15a. If your facility has opioid prescribing education programs or practices in place, how frequently is education provided? (Check all that apply.) At time of hire/orientation At least annually At least quarterly Other; please describe: _____ 15b. If your facility has opioid prescribing education programs or practices in place, what groups of healthcare workers are included in your opioid education programs or practices? (Check all that apply.) Physicians and licensed independent practitioners authorized to prescribe in your state (e.g., physician assistants, nurse practitioners) Nursing staff Pharmacy staff Other staff; please describe: _____ Section 4c. Quality Measurement 16. *What quality metrics are tracked, monitored and/or reported related to opioid safety or quality improvement? (Check all that apply.) Opioid prescribing trends(e.g., provider, unit, patient-level		

	Use of multi-modal pain management tools Opioid-related adverse events Our facility does not track, monitor, or report opioid quality metrics. [If checked, skip 16a – 16c] Our facility monitors other opioid quality/safety metrics, please describe briefly: _____ 16a. If opioid quality/safety metrics are tracked, monitored, and/or reported, at what level is data trended and/or reported? (Check one.) Physician-level Specialty-level Unit-level Facility-Level Other level; please describe: _____ 16b. What type of opioid-related adverse events are tracked in your facility? (Check all that apply.) Allergic adverse events (e.g., anaphylaxis) Other adverse drug events (e.g., constipation) confusion, delirium, respiratory depression) Events requiring administration of an opioid antagonist Events that result in a transfer to a higher level of care Events that result in patient death Our facility does not track, monitor, or report opioid-related		

	adverse events Our facility monitors other opioid-related adverse events, please describe briefly: _____ 16c. If opioid-related events are tracked, what methods are used to identify potential opioid-related adverse events? (Check all that apply.) Voluntary reporting system Alerts for antagonist medication administration (e.g., naloxone administration) Code Blue/Medical Emergency Team activations Reports to quality/safety leadership Other methods, please describe briefly: _____		