



# Patient Safety Monthly Reporting Plan

OMB No. 0920-0666  
Exp. Date: 03-31-2011

\* required for saving

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

No NHSN Patient Safety Modules Followed this Month

## Device-Associated Module

Locations	CLA BSI	DE	VAP	CAUTI	CLIP
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Procedure-Associated Module

Procedures	SSI (Circle one setting)			Post-procedure PNEU (Circle)
	In	Out	Both	In
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				

## Medication-Associated Module: Antimicrobial Use and Resistance

Locations	Microbiology	Pharmacy
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

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

Public reporting burden of this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).



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## MDRO and CDAD Module

Locations	Setting (Circle one)	Specific Organism Type	±LabID Event
ALL	In Out Both	_____	<input type="checkbox"/>
ALL	In Out Both	_____	<input type="checkbox"/>
ALL	In Out Both	_____	<input type="checkbox"/>
ALL	In Out Both	_____	<input type="checkbox"/>

## Process and Outcome Measures

Locations	Specific Organism Type	Infection Surveillance	§AST Timing	§AST Eligible	Inci- dence	Preva- lence	Lab ID Event	HH	GG
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	Adm Both	All NHx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## High Risk Inpatient Influenza Vaccination Module

Check one:

Method A

Method B

§For AST, circle one to indicate timing of testing and one to indicate type of patients tested.

Timing: Adm = Admission    Both = Both Admission and Discharge/Transfer

Patients: All = All patients tested    NHx = Only patients tested are those who have no documentation at the admitting facility in the previous 12 months of MDRO-colonization or infection at the time of admission.

±LabID Event – Laboratory-identified Event