Tables of Instructions

Table 1. Instructions for Completion of the Healthcare Personnel Safety Monthly Reporting Plan Form (CDC 57.203)

This form collects data on which options and which months a facility intends to participate in NHSN Healthcare Personnel Safety (HPS) Component. This form should be completed for every month that the facility will participate in the HPS Component.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Month/Year	Required. Enter the month and year for the surveillance plan being recorded.
No NHSN Healthcare Personnel Safety Modules Followed this Month	Conditionally required. Check this box if you do not plan to follow any of the NHSN Healthcare Personnel Safety Modules during the month and year selected.
Healthcare Personnel Exposure Module	
Blood/Body Fluid Exposure Only	Conditionally required. Check this box if you plan to follow blood/body fluid exposures only, without following exposure management during the month and year selected.
Blood/Body Fluid Exposure with Exposure Management	Conditionally required. Check this box if you plan to follow blood/body fluid exposure with exposure management during the month and year selected.
Influenza Exposure Management	Conditionally required. Check this box if you plan to follow influenza exposure management (i.e., antiviral chemoprophylaxis and/or treatment)
Healthcare Personnel Vaccination Module	
Influenza Vaccination Summary	Conditionally required. Check this box if you plan to follow the influenza vaccination summary option. Once the influenza vaccination summary is selected on the reporting plan, it is automatically updated with this information for the entire NHSN-defined influenza season (July 1 to June 30).

Table 2. Instructions for Completion of the Healthcare Worker Demographic Data Form (CDC 57.204)

This form must be completed for all HCP who have information recorded in HPS component of NHSN (e.g., exposure to blood or body fluid or influenza vaccination.) Alternatively, data for all or selected personnel can be imported from the facility's personnel database at facility enrollment.

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
HCW ID #	Required. Enter the healthcare worker's (HCW) alphanumeric identification number. This identifier is unique to the healthcare facility.
Social Security #	Optional. Enter the HCW's Social Security Number.
Secondary ID #	Optional. Enter the HCW's secondary ID number. This could be the employee's medical record # or some other unique identifier.
HCW Name: Last, First, Middle	Optional. Enter demographic information for the HCW.
Street Address City State Zip Code	
Home Phone	
E-mail Address	
Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Born in the U.S.?	Optional. Select Yes, No, or Unknown.
Ethnicity	Optional. Select one ethnicity of the HCW.
Race	Optional. Select the race of the HCW. Check all that apply.
Work Phone	Optional. Enter the work phone number of the HCW.
Start Date	Required. Enter the date the HCW began employment or affiliation with the facility (use format: mm/dd/yyyy).
Work Status	Required. Select Active, Inactive, or No longer affiliated.
Type of Employment	Required. Select from Full-time, Part-time, Contract, Volunteer, Other (please specify).
Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. For example, a radiology technician who spends most of his/her time performing portable x-rays throughout the facility works at multiple locations. In general, most interns/residents are not considered to work at a single location because they rotate every month or every few months. For HCP who do not work at least 75% of the time at a single location, the work location code for 'float' should be entered. Location codes must be customized to the facility and set up prior to entering HCW records. The work location must be mapped to a CDC Location (http://www.cdc.gov/nhsn/PDFs/master-locations-descriptions.pdf).
Department	Optional. Enter the department in which the HCW works (facility defined).

Data Field	Instructions for Data Collection
Supervisor	Optional. Enter the name of the HCW's supervisor (facility defined).
Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. These must be customized to the facility and set up prior to entering HCW records. The occupation must be mapped to a CDC Occupation Code.
Title	Conditionally required. Required only for HCP designated as Influenza Vaccinators if the facility intends on using NHSN to fulfill federal recordkeeping requirements for administration of vaccine covered by the Vaccine Injury Compensation Program. Enter the HCW's job title.
Clinical specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, select the appropriate clinical specialty.
Performs direct patient care	Conditionally required. Required only when the HCW has influenza vaccination and/or influenza chemoprophylaxis/treatment records. Select Y (Yes) if the HCW provides direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select N (No).
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information about the HCW. This information cannot be analyzed.

Table 3. Instructions for Completion of the Exposure to Blood/Body Fluids Form (CDC 57.205)

Information for all blood/body fluid exposures should be recorded using this form. The variables to be entered depend upon whether the facility selects the exposure event only reporting or exposure reporting and management.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the application.	Required	Required
Exposure Event #	The exposure event number will be auto-generated by the application.	Required	Required
HCW ID	Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.	Required	Required
♦HCW Name: Last, First, Middle	Enter the HCW's name.	Optional	Optional
♦Gender	Indicate the gender of the HCW by checking F (Female) or M (Male).	Required	Required
♦Date of Birth	Enter the date of birth of the HCW using the format: mm/dd/yyyy.	Required	Required
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
Clinical Specialty	If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.	Conditionally required	Conditionally required
Exposure Type	The default setting is auto-entered by the application as Blood/Body Fluids.	Required	Required
Section I – General Exposure Information			
1. Did the exposure occur at this facility	Choose Y (Yes) or N (No).	Required	Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
1a. If No, specify the name of facility in which exposure occurred	If the exposure did not occur at the reporting facility, enter the name of the facility where the event occurred.	Conditionally required	Conditionally required
2. Date of exposure	Enter date of exposure in mm/dd/yyyy format.	Required	Required
3. Time of exposure	Enter the time the exposure occurred and whether it was AM or PM.	Required	Required
4. Number of hours on duty	Enter the number of hours the HCW had been on duty when the exposure occurred.	Optional	Optional
5. Is exposed person a temp/agency employee?	Choose Y (Yes) or N (No).	Optional	Optional
6. Location where exposure occurred	Choose the appropriate code for the physical location where the event took place. (This is customized to the facility).	Required	Required
7. Type of Exposure	Check the appropriate exposure type. Check all that apply.	Required	Required
7a. Percutaneous: Did the exposure involve a clean, unused needle or sharp object?	If Type of Exposure was Percutaneous, then check this item. If percutaneous is checked, then select Yes or No to indicate whether the exposure involved a clean, unused needle or sharp object. If the incident involved a clean, unused needle or sharp object you may not need to report this as an exposure (see your protocol for more information). If not, check No and complete Q8, Q9 and Section II. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required Conditionally required	Conditionally required Conditionally required
7b. Mucous membrane	If Type of Exposure was Mucous Membrane, then check this item and complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
7c. Skin: Was skin intact?	If Type of Exposure was Skin, then check this item. If Skin is checked, then indicate Y (Yes), N (No) or (U) Unknown for whether the skin remained intact during the exposure. If the answer is No, complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required Conditionally required	Conditionally required Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
7d. Bite	If Type of Exposure was Bite, then check this item and complete Q9 and Section IV. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
8. Type of fluid/tissue involved in exposure	Select the Type of fluid/tissue from the list.	Required	Required
	If Solutions or Body fluids are checked, indicate whether visibly bloody or not visibly bloody. For Body Fluids, indicate the primary body fluid type implicated in the exposure from the list.	Conditionally required	Conditionally required
	If Other is selected for either the Type of Fluid/Tissue involved in the exposure or the Body Fluid Type, please specify the type. (Make sure it is not a body fluid that is already listed in the box on the right side of the form).	Conditionally required	Conditionally required
9. Body site of exposure	Check body site of exposure from the list. Check all sites that were exposed.	Required	Required
	If the Body site of exposure was (Other), please specify the site.	Conditionally required	Conditionally required
Section II – Percutaneous Injury			
1. Was the needle or sharp object visibly contaminated with blood prior to exposure?	Choose Y (Yes) or N (No).	Required	Required
2. Depth of the injury (check one)	Indicate the depth of the injury from the needle or sharp object using the list provided. Exposures that are not obviously superficial (e.g., scratch) or deep (e.g., "muscle contracted" or "touched bone"), should be classified as moderate.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
3. What needle or sharp object caused the injury?	Select one of the following categories: Device, Non-Device Sharp Object, or Unknown Sharp Object. If you select Device in the application you will be provided with a **Device** button that will take you to a screen to enter manufacturer, model, etc. Once a device has been entered you will be able to select it from the drop down list.	Conditionally required	Conditionally required
	If a Non-Device Sharp is selected, please describe the item or object.	Conditionally required	Conditionally required
	Within Devices, there are six categories: *Hollow-bore needles, Suture needles, Other solid sharps, Glass, Plastic, Non-sharp safety devices, and Other devices.*		
	If Other known device is selected, please specify.	Conditionally required	Conditionally required
4. Manufacturer and model	Enter the brand name and model of the device used. If the brand and model are unknown, generic device descriptors can be entered.	Conditionally required	Conditionally required
5. Did the needle or other sharp object involved in the injury have a safety feature?	Choose Y (Yes) or N (No). If Yes, answer 5a and 5b. If No, skip to Q6.	Conditionally required	Conditionally required
5a. If Yes, indicate the type of safety feature	If above is Y (Yes), choose one item from the list of safety devices.	Conditionally required	Conditionally required
5b. If the device had a safety feature, when did the injury occur?	Choose the timing of the injury event with relation to the use of the safety device. Check one item from the list provided.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
6. When did the injury occur? (check one) Before use of the item During use of the item After use of item, before disposal During or after disposal Unknown	Choose the timing of the injury event from the list provided. Injuries that occurred prior to intended use and usually involve clean needles or sharp objects. It may also include injuries that occurred with a clean device that passed through bloody gloves. Injuries that occurred during the use of the needle or sharp object. It also includes surgical or other invasive procedures with many steps. Injuries that occurred while in transit to disposal, cleaning instrument or recapping. Injuries that occurred during or after the process of disposal or because of improper disposal of a needle or other sharp object. Time of injury relative to the use of the device or object is unknown.	Conditionally required	Conditionally required
7. For what purpose or activity was the sharp device being used?	Choose from the lists provided. If Other specify the purpose in the space provided. Select Unknown if injury was a result of contact with discarded or uncontrolled sharps, or in circumstances where the intent of device or object use is unknown or cannot be ascertained.	Conditionally required	Conditionally required
8. What was the activity at the time of injury?	Choose the activity being performed at the time of injury involving the sharp object or needle. If the activity being performed at the time of the injury was different than the purpose indicated in Q7, select the activity at the time the actual injury event took place.	Conditionally required	Conditionally required
9. Who was holding the device at the time the injury occurred?	Select one answer.	Conditionally required	Conditionally required
10. What happened when the injury occurred?	Choose one item from the list. If Other, please record details in the space provided.	Conditionally required	Conditionally required
Section III – Mucous Membrane and/or Skin Exposure			
1. Estimate the amount of blood/body fluid exposure	Select the estimated amount of blood or body fluid involved in the mucous membrane or skin exposure. Indicate Unknown if unable to estimate the amount.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
2. Activity/event when exposure occurred	Select the activity or event at the time mucous membrane or skin exposure occurred. If Other is selected record details of the activity or event in the space provided.	Conditionally required Conditionally required	Conditionally required Conditionally required
3. Barriers used by the worker at the time of exposure	Check all that apply. If Other is selected, list other barriers in the space provided.	Conditionally required Conditionally required	Conditionally required Conditionally required
Section IV – Bite			
1. Wound description	Select the description of the bite wound from the list provided.	Conditionally required	Conditionally required
2. Activity/event when exposure occurred	Choose the activity or event when the bite occurred. If Other, specify the event in the space provided.	Conditionally required Conditionally required	Conditionally required Conditionally required
Sections V – IX are required when following the protocols for Exposure Management			
Section V – Source Information			
1. Was the source patient known?	Choose Y (Yes) if the source of the exposure (patient) is known. Otherwise, select N (No).	Optional	Required
2. Was HIV status known at time of exposure?	Indicate Y (Yes) if the source patient's serostatus was known at the time of exposure.	Optional	Required
3. Check the test results for the source patient: **Hepatitis B** HbsAg HBeAg Total anti-HBc anti-HBs **Hepatitis C** anti-HCV EIA anti-HCV suppl PCR-HCV RNA **HIV** HIV EIA, ELISA Rapid HIV Confirmatory HIV	Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused and NT=Not tested. Indicate the results of any tests performed prior to the exposure (as found in the medical record) or performed immediately after the exposure. If the source is not known, check U. If the source refuses to be tested, check R. Not all tests listed on the form need to be offered after all exposures.	Optional	Required
Section VI – For HIV Infected Source			
1. Stage of Disease	Indicate the stage of HIV disease of the source patient. Use CDC surveillance definitions. For end stage AIDS and acute HIV illness, use definitions as defined in the protocol.	Optional	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
2. Is the source patient taking anti-retroviral drugs?	Indicate if the source patient is was taking anti-retroviral drugs at the time of the exposure, Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
2a. If Yes, indicate drug(s)	If the source patient was taking anti-retroviral drugs at the time of the exposure, list them here. Drug codes are listed in Chapter 7 and will be in a drop down list in the application.	Optional	Conditionally required
3. Most recent CD4 count Date	If available, indicate the most recent CD4 count in mm^3 for the source patient. Enter the month and year of the test for the source patient.	Optional	Conditionally required
4. Viral Load Date	If available, indicate the most recent HIV viral load (# of copies per ml) or Undetectable for the source patient. Enter the month and year of the test.	Optional	Conditionally required
Section VII: Initial Care Given to Healthcare Worker			
1. HIV postexposure prophylaxis Offered? Taken?	 Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were offered to the HCW following this exposure. Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were taken by the HCW. If Yes is selected, complete Post-Exposure Prophylaxis/Treatment form (CDC form 57.206).	 Optional Optional	 Required Required
2. HBIG given? Date administered	Choose Y (Yes), N (No), or U Unknown) for whether Hepatitis B immunoglobulin was given. Enter date HBIG prophylaxis pertaining to this exposure was administered. Use mm/dd/yyyy format.	Optional Optional	Required Conditionally Required
3. Hepatitis B vaccine given? Date first dose administered	Choose Y (Yes), N (No), or U. (Unknown) for whether Hepatitis B vaccine was given after exposure. Enter date of first dose of Hepatitis B vaccine (mm/dd/yyyy format). This and subsequent doses to complete the HBV series should be recorded in the HCW's file.	Optional Optional	Required Conditionally Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
4. Is the HCW pregnant?	Indicate the pregnancy status of HCW. Choose Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
4a. If yes, which trimester?	Check 1 (1st trimester), 2 (2nd trimester), or 3 (3rd trimester) at the time of exposure. If stage of pregnancy is unknown, check U.	Optional	Conditionally required
Section VIII – Baseline Lab Testing			
Was baseline testing performed on the HCW?	Choose Y (Yes) or N (No) or U (Unknown). Baseline lab tests should be performed within hours of the exposure .	Optional	Required
HIV EIA HIV confirmatory HepC anti-HCV EIA HepC anti-HCV-supp HepC PCR HCV RNA HepB HBsAg HepB IgM anti-Hbc HepB Total anti-Hbc HepB Anti-HBs	Enter the dates for each test performed and the result (Use codes: P= Positive, N= Negative, I=Indeterminate, U=Unknown, R=Refused).	Optional	Conditionally required
ALT Amylase Blood glucose Hematocrit Hemoglobin Platelets Blood cells in urine WBC Creatinine Other	Additional baseline laboratory tests may be completed to document potential physiologic changes associated with a blood/body fluid exposure. Enter the date (in mm/dd/yyyy format) and result, using the specified units.	Optional	Optional
Section IX – Follow-up			
1. Is it recommended that the HCW return for follow-up of this exposure?	Choose Y (Yes) or N (No).	Optional	Required
1a. If Yes, will follow-up be performed at this facility?	Choose Y (Yes) or N (No).	Optional	Conditionally Required
Section X – Narrative			
In the worker's words, how did the injury occur?	Enter the narrative of the HCW's description of how the injury occurred.	Optional	Optional
Section XI – Prevention			

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
In the worker's words, what could have prevented the injury?	Enter the narrative of the HCW's assessment of how the injury might have been prevented.	Optional	Optional
Custom Fields	Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.	Optional	Optional
Comments	Enter any additional information about the HCW. CDC will not analyze this information.	Optional	Optional

Table 4. Instructions for Completion of the Healthcare Worker Prophylaxis/Treatment – BBF Postexposure Prophylaxis (PEP) Form (CDC 57.206)

Use this form if HIV postexposure prophylaxis (PEP) was administered to a healthcare worker following a blood or body fluid exposure.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
MedAdmin ID#	Required. Medical administration number. Data will be auto-entered by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of Birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Infectious Agent	Required. Enter HIV on form. Select HIV in the application.
Exposure Event #	Required. The Exposure event number will be auto-entered by the system. Use the Link/Unlink button to find any exposures for the entered HCW, select, and link the exposure for which PEP is being administered. PEP records cannot be saved unless they are linked to an exposure. PEP records entered from the Blood and Body Fluid Exposure Form will automatically be linked to that exposure.
Initial PEP	**Indication: Prophylaxis**
Time between exposure and 1st dose	Required. Enter the number of hours between the exposure and when the 1st dose of PEP was administered.
Drug	Required. Enter any drugs prescribed for prophylaxis. See Chapter 7 in the protocol for a list of individual drug codes.
Drug	Conditionally required. Enter any additional drugs prescribed for initial prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Required. Enter the date the initial PEP regimen commenced (mm/dd/yyyy format). The start date will apply to all drugs selected as the initial PEP regimen. The date started must be on or after the exposure date.
Date Stopped	Required. Enter the date the initial PEP regimen was stopped (mm/dd/yyyy format). Note: If any drug(s) of a drug regimen are discontinued, the entire regimen is considered 'stopped.' If select drugs in the regimen continue to be used as prophylaxis (and if other drugs are added) enter them as drugs under a PEP change with a new start date.

Data Field	Instructions for Data Collection
Reason for Stopping	Required. Indicate the primary reason for stopping the initial PEP regimen by selecting the appropriate choice.
PEP Change 1	**Indication: Prophylaxis**
Drug	Required. Enter drugs prescribed for a second prophylaxis regimen. Note that the second PEP regimen may contain drugs that were included in the first regimen.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Conditionally required. Enter the date the second PEP regimen was started using mm/dd/yyyy format.
Date Stopped	Conditionally required. Enter the date the second PEP regimen was stopped using mm/dd/yyyy format. Note: If any drug(s) of a drug regimen are discontinued, the regimen is considered 'stopped.' Whatever drugs in the regimen are continued (and if other drugs are added) will constitute a new regimen and should be recorded as part of a new PEP regimen(s) with dates that resume from the last stop date. .
Reason for Stopping	Conditionally required. Indicate the primary reason for stopping this PEP regimen by selecting the appropriate choice.
PEP Change 2	**Indication: Prophylaxis**
Drug	Conditionally required. Enter drugs prescribed for a third prophylaxis regimen. Note that the third PEP regimen may contain drugs that were included in previous regimens.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Drug	Conditionally required. Enter any additional drugs prescribed for prophylaxis.
Date Started	Conditionally required. Enter the date the new PEP regimen was started using mm/dd/yyyy format.
Date Stopped	Conditionally required. Enter the date the new PEP regimen was stopped using mm/dd/yyyy format. Note: If any drug(s) of a drug regimen are discontinued, the regimen is considered 'stopped.' Whatever drugs in the regimen are continued (and if other drugs are added) will constitute a new regimen and should be entered as such.
Reason for Stopping	Conditionally required. Indicate the primary reason for stopping this PEP regimen by selecting the appropriate choice.
Adverse Reactions	
Signs or symptoms of adverse reactions to post-exposure prophylaxis	Optional. Indicate any adverse signs/symptoms the HCW experienced while receiving postexposure prophylaxis. You may select up to six. If Other is selected, briefly specify details of adverse reaction.

Data Field	Instructions for Data Collection
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. CDC will not analyze this information.

Table 5: Instructions for Completion of Follow-Up Laboratory Testing Form (CDC 57.207)

This form should be completed for HCP who have additional laboratory testing done as a result of blood or body fluid exposures. These tests would occur after baseline laboratory testing had been completed.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Lab #	Required. The lab testing ID number will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
Exposure Event #	Required. The user is required to link the laboratory follow-up record to a blood and body fluid exposure record using the Link feature within the application. Once the exposure is selected and submitted, the form will display the message "Lab is Linked." Laboratory records must be linked to an exposure.
Lab Results	
Lab Test	Required (At least one laboratory test and date are required). Multiple test results may be recorded on this form. Select lab test from dropdown menu: HIV EIA HIV confirmatory HepC anti-HCV EIA HepC anti-HCV-supp HepC PCR HCV RNA HepB HBsAg HepB IgM anti-Hbc HepB Total anti-Hbc HepB Anti-HBs ALT Amylase Blood glucose Hematocrit Hemoglobin Platelets Blood cells in urine WBC Creatinine Other
Date	Required. Indicate date of test using mm/dd/yyyy format.
Result	Conditionally required. Select one of the result codes: Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused)
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. CDC will not analyze this information.

Table 6. Instructions for Completion of the Healthcare Worker Prophylaxis/Treatment – Influenza Form (CDC 57.210)

This form should be completed when an HCW receives antiviral medications as influenza treatment or as chemoprophylaxis against influenza infection. It is used to collect information on which antiviral medications were administered, when, and what (if any) adverse reactions were experienced by the HCW.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Med Admin ID #	Required. The medication administration ID number will be auto-generated by the application.
HCW ID #	Required. Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.
♦HCW Name: Last, First, Middle	Optional. Enter the HCW's name.
♦Gender	Required. Indicate the gender of the HCW by checking F (Female) or M (Male).
♦Date of Birth	Required. Enter the date of birth of the HCW using the format: mm/dd/yyyy.
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.
♦Clinical Specialty	Conditionally required. If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.
♦Performs direct patient care	Required. Select Yes if the HCW provides direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring); otherwise select No.
Infectious agent	Required. Auto-filled on hard copy form. Select Influenza in application.
For season	Required. Select the vaccination season. Specify the year(s) during which this chemoprophylaxis or treatment date falls. For NHSN purposes, the vaccination "season" is 7/1 of the first year to 6/30 of the next calendar year.
#	Required. Indicate up to 10 antiviral medications given using sequential numbers starting with 1.
Indication	Required. Select Prophylaxis or Treatment as appropriate.
Influenza subtype	Required. Select the influenza subtype for which the HCW is receiving antiviral medications (for post-exposure chemoprophylaxis or for treatment). Select Unknown, if you do not know the specific subtype necessitating antiviral medication use.
Antiviral medication	Required. Enter the code of the antiviral medication that was administered to the HCW using the codes listed at the bottom of the form.
Start date	Required. Enter the start date of the antiviral using mm/dd/yyyy format.
Stop date	Conditionally required. Enter the stop date of the antiviral using mm/dd/yyyy format.

Data Field	Instructions for Data Collection
Adverse reactions?	Required. Check Yes if the HCW had a severe adverse reaction attributable to the influenza antiviral medication; otherwise check No. If it is unknown whether or not the HCW experienced any adverse reactions, check Don't Know.
Adverse reactions to antiviral medication #1…#10	Conditionally required. If the HCW had a severe adverse reaction, check all reactions that apply for each medication administered. Please correlate the antiviral medication # with the antiviral medication on page 1. If an adverse reaction is not listed, check Other and specify the adverse reaction in the space provided. All Other adverse reactions should be included if the reactions were severe enough to affect daily activities and/or resulted in the discontinuation of the antiviral medication.
Custom Fields	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information about the HCW. CDC will not analyze this information.

Table 7. Instructions for Completion of Healthcare Personnel Safety Component – Annual Facility Survey (CDC 57.200)

This form must be completed once a year by any facility using the Healthcare Personnel Safety Component.

Data Field	Instructions for Data Collection/Entry
Tracking #	Required. The NHSN-assigned Tracking # will be auto-entered by the application.
Facility ID #	Required. The NHSN-assigned facility ID will be auto-entered by the application.
Survey year	Required. Enter the year of the survey using the format: yyyy.
Total beds set up and staffed	Required. Enter the number of all active beds across specialties and intensive care units.
Patient admissions	Required. Enter the number of patients, excluding newborns, admitted for inpatient service.
Inpatient days	Required. Enter the number of adult and pediatric days of care, excluding newborn days of care, rendered during a specified reporting period.
Outpatient encounters	Required. Enter the number of visits by patients who are not admitted as inpatients to the hospital while receiving medical, dental, or other services.
Number of hours worked by all employees	Optional. Number of hours worked is available from OSHA300 reporting logs. The value can also be calculated by identifying the number of full time employees working in your facility within a year, multiply by the number of work hours for one full time employee in a year (typically ranges from 2000-2100 hours per year). Add in overtime hours and total hours worked by part-time, temporary, and contracted staff.
Number of HCWs	Required. HCWs are all persons who work in the hospital. Calculate the number of attending physicians by including only those who are active or associate staff (e.g. similar methodology to the American Hospital Association annual survey, if applicable). Do not include courtesy, consulting, honorary, provisional, or other attending physicians in this number. If you cannot determine the exact number for a particular category, please estimate it. If the facility does not have any HCP in a specific occupation, the user may enter 0. This is the denominator when used to calculate rates of particular exposure events per HCW.
Number of FTEs	Required. A subset of total number of HCP. FTEs are all HCP whose regularly scheduled workweek is 35 hours or more. To calculate the number of FTE's add the number of FTEs to ½ the number of part-time HCP (e.g., 2 part-time HCP = 1 FTE). If you cannot determine the exact number for a particular category, please estimate it. If the facility does not have any FTEs in a specific occupation, the user may enter 0. This is the denominator used to calculate rates of particular exposure events per FTE.

REFERENCES

The following CDC/PHS publications provide recommendations for management and follow-up of blood and body fluid exposures to HBV, HCV, and HIV:

- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. (MMWR, June 29, 2001 / 50(RR11); 1-42)*
- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis (PEP regimens have been changed). (MMWR, September 30, 2005 / 54(RR09); 1-17)*

The following CDC/PHS publication provides recommendations for the immunization of HCP:

- *A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. (MMWR, December 8, 2006 / 55(RR16); 1-25)*
- *Influenza Vaccination of Health-care Personnel. (MMWR, February 24, 2006 / 55(RR02); 1-16)*
- *Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP). (MMWR, July 29, 2009 / 58(Early Release); 1-52)*