



Patient Safety Component—Annual Hospital Survey

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

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| | |
|--|---------------|
| *required for saving | Tracking #: |
| Facility ID: | *Survey Year: |
| Facility Characteristics (completed by Infection Preventionist) | |
| <p>*Ownership (check one):</p> <p> <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit, including church <input type="checkbox"/> Government <input type="checkbox"/> Military <input type="checkbox"/> Veterans Affairs <input type="checkbox"/> Physician owned </p> | |
| <p>If facility is a Hospital:</p> <p>*Number of patient days: _____</p> <p>*Number of admissions: _____</p> <p><u>For any Hospital:</u></p> <p>*Is your hospital a teaching hospital for physicians and/or physicians-in-training? Yes No If Yes, what type: _____ Major _____ Graduate _____ Undergraduate</p> <p>*Number of beds set up and staffed in the following location types (as defined by NHSN):</p> <p style="margin-left: 20px;">a. ICU (including adult, pediatric, and neonatal levels II/III and III): _____</p> <p style="margin-left: 20px;">b. All other inpatient locations: _____</p> | |
| Facility Microbiology Laboratory Practices (completed with input from Microbiology Laboratory Lead) | |
| <p>*1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? (check one)</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>If No, where is your facility's antimicrobial susceptibility testing performed? (check one)</p> <p> <input type="checkbox"/> Affiliated medical center <input type="checkbox"/> Commercial referral laboratory <input type="checkbox"/> Other local/regional, non-affiliated reference laboratory </p> | |
| <i>Continued >></i> | |
| <p><small>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)).</small></p> <p><small>Public reporting burden of this collection of information is estimated to average 60 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, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).</small></p> | |
| <p><small>CDC 57.103 (Front) Rev. 10, v8.8</small></p> | |

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Facility Microbiology Laboratory Practices (continued)

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

(1) primary susceptibility testing and

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

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

Please use the testing codes listed below the table.

| Pathogen | (1) Primary | (2) Secondary | Comments |
|--------------------------------|---------------------------------------|--|----------|
| <i>Staphylococcus aureus</i> | _____ | _____ | _____ |
| Enterobacteriaceae | _____ | _____ | _____ |
| 1 = Kirby-Bauer disk diffusion | 5.1 = MicroScan walkaway rapid | 10 = E test | |
| 2 = Vitek (Legacy) | 5.2 = MicroScan walkaway conventional | 12 = Vancomycin agar screen (BHI + vancomycin) | |
| 2.1 = Vitek 2 | 5.3 = MicroScan auto or touchscan | 13 = Other (describe in Comments section) | |
| 3.1 = BD Phoenix | 6 = Other micro-broth dilution method | | |
| 4 = Sensititre | 7 = Agar dilution method | | |

*3. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? Yes No

*4. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? Yes No

*5. Does the laboratory perform a special test for presence of carbapenemase? Yes No

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

- Change susceptible carbapenem results to resistant
- Report carbapenem MIC results without an interpretation
- No changes are made in the interpretation of carbapenems, the test is used for epidemiological or infection control purposes

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

- PCR MBL screen
- Modified Hodge Test Carba NP
- E test Other (specify): _____

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Facility Microbiology Laboratory Practices (continued)

*6. Does the laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? Yes No

If Yes, please indicate methods: (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Vitek (Legacy) | <input type="checkbox"/> MicroScan walkaway rapid | <input type="checkbox"/> Agar dilution method |
| <input type="checkbox"/> Vitek 2 | <input type="checkbox"/> MicroScan walkaway conventional | <input type="checkbox"/> E test |
| <input type="checkbox"/> BD Phoenix | <input type="checkbox"/> MicroScan auto or touchscan | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Sensititre | <input type="checkbox"/> Other micro-broth dilution method | |

*7. Does your facility have its own laboratory that performs antifungal susceptibility testing for *Candida* species?

Yes No

If No, where is your facility's antifungal susceptibility testing performed? (check one)

- | | |
|--|---|
| <input type="checkbox"/> Affiliated medical center | <input type="checkbox"/> Commercial referral laboratory |
| <input type="checkbox"/> Other local/regional, non-affiliated reference laboratory | <input type="checkbox"/> Not offered by my facility |

8. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Broth macrodilution | <input type="checkbox"/> Broth microdilution | <input type="checkbox"/> YeastOne colorimetric microdilution | <input type="checkbox"/> E test |
| <input type="checkbox"/> Vitek 2 card | <input type="checkbox"/> Disk diffusion | <input type="checkbox"/> Other (specify): _____ | |

*9. Is antifungal susceptibility testing performed automatically/reflexively without needing a specific order or request for susceptibility testing from the clinician for the below *Candida* species when cultured from normally sterile body sites (such as blood)?

Candida albicans: Yes No

If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)

- Fluconazole Voriconazole Anidulafungin/Caspofungin/Micafungin

Candida glabrata: Yes No

If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)

- Fluconazole Voriconazole Anidulafungin/Caspofungin/Micafungin

Candida parapsilosis: Yes No

If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)

- Fluconazole Voriconazole Anidulafungin/Caspofungin/Micafungin

Other *Candida* species: Yes No

If Yes, what antifungal drugs are tested automatically/reflexively? (check all that apply)

- Fluconazole Voriconazole Anidulafungin/Caspofungin/Micafungin

Automatic testing is not performed for any *Candida* species

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Facility Microbiology Laboratory Practices (continued)

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

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

("Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.)

*11. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)?

- Yes No

If Yes, is the antibiogram produced at least annually?

- Yes No

If Yes, are data stratified by hospital location?

- Yes No

If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)

- The laboratory data are difficult to access
- Limited or no information technology tool for data analysis
- Limited personnel time for data analysis
- Limited personnel skills for data analysis
- Limited interest in an antibiogram from staff who prescribe antibiotics
- Our institution does not have enough isolates of any or most species (i.e., < 30 isolates per species) to produce an antibiogram
- Other (please specify): _____

12. Please indicate the primary and definitive method used to identify microbes from blood specimens collected in your facility. (**SELECT ONE ANSWER**)

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

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13. Please indicate any additional secondary methods used for microbe identification from blood specimens collected in your facility (e.g., a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). **(SELECT ALL THAT APPLY)**

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

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

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

a. Total hours per week performing surveillance: _____

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

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

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

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

- Yes, all infected or colonized patients
- Yes, only all infected patients
- Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- Yes, only those admitted to high-risk settings (e.g., ICU)
- No
- Not applicable: my facility never admits these patients

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

- Yes, all infected or colonized patients
- Yes, only all infected patients
- Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- Yes, only those admitted to high-risk settings (e.g., ICU)
- No
- Not applicable: my facility never admits these patients

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- *18. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)
- Yes, all infected or colonized patients
 - Yes, only all infected patients
 - Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
 - Yes, only those admitted to high-risk settings (e.g., ICU)
 - No
 - Not applicable: my facility never admits these patients
- *19. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)
- Yes, all infected or colonized patients
 - Yes, only all infected patients
 - Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
 - Yes, only those admitted to high-risk settings (e.g., ICU)
 - No
 - Not applicable: my facility never admits these patients

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

- *20. Does the facility routinely perform screening testing (culture or non-culture) for CRE?
- Yes No
- If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)
- Surveillance testing at admission for all patients
 - Surveillance testing of epidemiologically-linked patients of newly identified CRE patients (e.g., roommates)
 - Surveillance testing at admission of high-risk patients (e.g., admitted from LTAC or LTCF)
 - Surveillance testing at admission of patients admitted to high-risk settings (e.g. ICU)
 - Other (please specify): _____
- *21. Does the facility routinely perform screening testing (culture or non-culture) for MRSA?
- Yes No
- If yes, in which situations does the facility routinely perform screening testing for MRSA? (check all that apply)
- Surveillance testing at admission for all patients
 - Surveillance testing at admission of high-risk patients (e.g., admitted from LTAC or LTCF)
 - Surveillance testing at admission of patients admitted to high-risk settings (e.g. ICU)
 - Surveillance testing of pre-operative patients to prevent surgical site infections
 - Other (please specify): _____

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*22. Does the facility routinely use chlorhexidine bathing on any patient to prevent infection or transmission of MDROs at your facility? (Note: this does not include the use of such bathing in pre-operative patients to prevent SSIs)

Yes No

*23. Does the facility routinely use a combination of topical chlorhexidine AND intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)

Yes No

*24. Among patients with an MDRO admitted to your facility from another healthcare facility, please estimate how often your facility receives information from the transferring facility about the patient's MDRO status?

- All the time
 More than half of the time
 About half of the time
 Less than half of the time
 None of the time
 Not applicable: my facility does not receive transferred patients with a known MDRO

Antibiotic Stewardship Practices (completed with input from Physician and Pharmacist Stewardship Champions)

*25. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?

Yes No

*26. Is there a leader responsible for stewardship activities at your facility?

Yes No

If Yes, what is the position of this leader: (check one)

- Physician Co-led by both Pharmacist and Physician
 Pharmacist Other (please specify): _____

*27. Is there at least one pharmacist responsible for improving antibiotic use at your facility?

Yes No

*28. Does your facility provide any salary support for dedicated time for antibiotic stewardship leadership activities?

Yes No

*29. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?

Yes No

If Yes, has adherence to the policy to document an indication been monitored?

Yes No

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*30. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?

Yes No

If Yes, has adherence to facility-specific treatment recommendations been monitored?

Yes No

*31. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?

Yes No

*32. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?

Yes No

*33. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers at your facility?

Yes No

If Yes, what type of feedback is provided to prescribers? (check all that apply)

Feedback on antimicrobial route and/or dosage

Feedback on the selection of antimicrobial therapy and/or duration of therapy

Other (please specify) : _____

*34. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide?

Yes No

If Yes, by which metrics? (Check all that apply)

Days of Therapy (DOT)

Purchasing Data

Defined Daily Dose (DDD)

Other (please specify): _____

If Yes, are facility- and/or unit- or service-specific reports on antibiotic use shared with prescribers?

Yes No

*35. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use?

Yes No

Facility Water Management and Monitoring Program

36. Have you ever conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (e.g. *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)?

Yes

No

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

≤ 1 year ago

≥ 1-3 years ago

≥ 3 years ago

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

Yes

No

If Yes, who is represented on the team? (Check all that apply)

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- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Hospital Administrator | <input type="checkbox"/> Hospital Epidemiologist/ Infection Preventionist | <input type="checkbox"/> Consultant | <input type="checkbox"/> Facilities Manager/ Engineer |
| <input type="checkbox"/> Maintenance Staff | <input type="checkbox"/> Infectious Disease Clinician | <input type="checkbox"/> Risk/Quality Management Staff | <input type="checkbox"/> Compliance Officer |
| <input type="checkbox"/> Equipment/ Chemical Supplier | <input type="checkbox"/> Other (specify): _____ | | |

38. Do you regularly monitor the following parameters in your building's water system? (Check all that apply)

- | | | | | |
|--|------------------------------|-----------------------------|------------------------------|-----------------------------|
| Disinfectant (such as residual chlorine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| If Yes, do you have a plan for corrective actions when disinfectant (s) are not within acceptable limits as determined by your water management program? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Temperature | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| If Yes, do you have a plan for corrective actions when temperatures are not within acceptable limits as determined by your water management program? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heterotrophic plate counts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| If Yes, do you have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by your water management program? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Specific tests for <i>Legionella</i> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| If Yes, do you have a plan for corrective actions when Specific tests for <i>Legionella</i> are not within acceptable limits as determined by your water management program? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |