



Patient Safety Component—Annual Facility Survey for LTAC

Instructions for this form are available at: <http://www.cdc.gov/nhsn/forms/instr/TOI-57.150-LTAC.pdf>

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*required for saving	Tracking #:
*Facility ID:	*Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

<input type="checkbox"/> For profit	<input type="checkbox"/> Not for profit, including church	<input type="checkbox"/> Government	<input type="checkbox"/> Veterans Affairs
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*Affiliation (check one):

<input type="checkbox"/> Independent	<input type="checkbox"/> Multi-facility organization (specialty hospital network)
<input type="checkbox"/> Hospital system	

*Setting/classification: ___ Free-standing ___ Within a hospital

If classified as "Free-standing," does your LTAC hospital share physical housing with one or more of the following on-site facilities or units (check all that apply)?

- No
- Skilled nursing facility (SNF)/nursing home
- Residential facility (assisted living)
- Inpatient rehabilitation facility
- Neuro-behavioral unit or facility
- Other (please specify: _____)

If classified as "Within a hospital," is your LTAC hospital located:

- | | | |
|---|------------------------------|-----------------------------|
| In a building that does not provide acute care services (e.g., psychiatric hospital)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Near (but not within) an acute care hospital? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

In the previous calendar year, indicate:

*Number of patient days: _____

*Number of admissions: _____

*Average daily census: _____

*Numbers of LTAC beds in the following categories (categories should equal total):

a. Intensive care unit (ICU) or critical care beds:	_____
b. High observation/special care/high acuity beds (not ICU):	_____
c. General LTAC beds:	
*Total number of LTAC beds (licensed capacity):	_____
*Number of single occupancy rooms:	_____

*Total number of admissions with one of the following conditions identified on admission (present on admission, not developing during LTAC stay): (Note: These categories are not mutually exclusive.)

If helpful for your facility in identifying these conditions on admission, please review a list of ICD-10 and DRG codes commonly associated with these conditions found here:

<http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx>

a. Ventilator dependence:	_____
b. Hemodialysis:	_____

Assurance of Confidentiality: The voluntarily provided 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 70 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). CDC 57.150 (Front) Rev. 5 , v9.2

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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; answers listed are generic antimicrobial susceptibility testing methods and do not imply they are recommended for use in polymyxin susceptibility testing)

- | | | |
|---|---|---|
| <input type="checkbox"/> Vitek 2 | <input type="checkbox"/> MicroScan autoSCAN | <input type="checkbox"/> Kirby-Bauer disk diffusion |
| <input type="checkbox"/> BD Phoenix | <input type="checkbox"/> Other broth microdilution method | <input type="checkbox"/> Accelerate Pheno |
| <input type="checkbox"/> Sensititre | <input type="checkbox"/> Agar dilution method | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> MicroScan-WalkAway | <input type="checkbox"/> E test | |

*7. Which of the following methods are used for yeast identification at your facility's laboratory or at the outside laboratory serving your facility? (check all that apply)

- MALDI-TOF MS System (Vitek MS)
- MALDI-TOF MS System (Bruker Biotyper)
- Vitek-2
- BD Phoenix
- MicroScan
- Non-automated Manual Kit (e.g., API 20C, RapID, Germ Tube, PNA-FISH, etc.)
- DNA sequencing
- Other (specify) _____

*8. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)

- Blood
- Other normally sterile body site (e.g.: CSF)
- Urine
- Respiratory
- Other (specify) _____
- None are fully identified to the species level

*9. What method is used for antifungal susceptibility testing (AFST) at your facility's laboratory or the outside laboratory serving your facility? (check all that apply)

- | | | | |
|--|--|---------------------------------|---------------------------------------|
| <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): _____ | | |

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Facility Microbiology Laboratory Practices (continued)

*10. Antifungal susceptibility testing is performed on fungal isolates in which of the following situations:

Candida albicans:

- Always
 Only when isolated from sterile sites (eg: blood, CSF, etc)
 Only when ordered by a clinician;
 Other (specify): _____

Candida glabrata:

- Always
 Only when isolated from sterile sites (eg: blood, CSF, etc)
 Only when ordered by a clinician;
 Other (specify): _____

All other *Candida* species:

- Always
 Only when isolated from sterile sites (eg: blood, CSF, etc)
 Only when ordered by a clinician;
 Other (specify)): _____

*11. 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)

Infection Control Practices

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

*12. 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: _____

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

*14. 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
 No
 Not applicable: my facility never admits these patients

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Infection Control Practices (continued)

If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

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

*15. 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
- No
- Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

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

*16. 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
- No
- Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

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

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Infection Control Practices (continued)

*17. 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
- No
- Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

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

*18. 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)

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

If yes, in which situations does the facility routinely perform screening testing for MRSA for non-NICU settings? (check all that apply)

- Surveillance testing at admission for all patients
- Surveillance testing at admission of high-risk patients (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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Infection Control Practices (continued)

*20. 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

*21. 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

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

*22. Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board). Yes No

*23. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)

- Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues.
- Providing opportunities for staff training and development on antibiotic stewardship.
- Allocating information technology resources to support antibiotic stewardship efforts.
- None of the above

*24. Our facility has a committee responsible for antibiotic stewardship. Yes No

If Yes, membership in our facility's antibiotic stewardship committee includes: (Check all that apply.)

- Non-infectious diseases trained prescriber(s)
- Infectious disease physician(s)
- Pharmacist(s)
- Nurse(s)
- Infection preventionist(s)
- Microbiologist(s)
- Information technologist(s)
- A patient representative
- None of the Above

*25. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes. Yes No

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

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

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Antibiotic Stewardship Practices (continued)

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

- Has antibiotic stewardship responsibilities in their contract or job description
- Is physically on-site in your facility (either part-time or full-time)
- Completed an ID fellowship
- Completed a certificate program or other coursework
- None of the above

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

- Has antibiotic stewardship responsibilities in their contract or job description
- Is physically on-site in your facility (either part-time or full-time)
- Completed a PGY2 ID residency and/or ID fellowship
- Completed a certificate program or other coursework
- None of the above

If Physician or Other, is there at least one pharmacist responsible for improving antibiotic use at your facility?

Yes No

*26. Our facility has a policy or formal procedure for: (Check all that apply.)

- Required documentation of indication for antibiotic orders.

If selected: Our stewardship team monitors adherence to the policy or formal procedure for required documentation of indication for all antibiotic orders.

Yes No

- Required documentation of duration for antibiotic orders.
- The treating team to review antibiotics 48-72 hours after initial order (i.e., antibiotic time-out).
- The stewardship team to review courses of therapy for specific antibiotic agents and provide real-time feedback and recommendations to the treating team (i.e., prospective audit and feedback).

If selected: For which categories of antimicrobials? (Check all that apply.)

- Cefepime, ceftizidime, or piperacillin/tazobactam
- Ertapenem, imipenem/cilastatin, or meropenem
- Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors
- Colistin or polymyxin B
- Quinolones
- Vancomycin
- Daptomycin, linezolid, or other anti-MRSA agents
- Anidulafungin, caspofungin, or micafungin
- Isavuconazole, posaconazole, or voriconazole
- Amphotericin B and/or lipid-based amphotericin B
- None of the above

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Antibiotic Stewardship Practices (continued)

Required authorization by the stewardship team before restricted antibiotics on the formulary can be dispensed (i.e., prior authorization).

If selected: For which categories of antimicrobials? (Check all that apply.)

- Cefepime, ceftizidime, or piperacillin/tazobactam
- Ertapenem, imipenem/cilastatin, or meropenem
- Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors
- Colistin or polymyxin B
- Quinolones
- Vancomycin
- Daptomycin, linezolid, or other anti-MRSA agents
- Anidulafungin, caspofungin, or micafungin
- Isavuconazole, posaconazole, or voriconazole
- Amphotericin B and/or lipid-based amphotericin B
- None of the above

None of the above

*27. Providers have access to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. Yes No

If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. Yes No

*28. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response). Yes No

*29. Our stewardship team monitors: (Check all that apply.)

- Antibiotic resistance patterns (either facility- or region-specific)
- Clostridioides difficile*
- Antibiotic use in days of therapy (DOT) per 1000 patient days or days present, at least quarterly
- Antibiotic use in defined daily doses (DDD) per 1000 patient days, at least quarterly
- Antibiotic expenditures (i.e., purchasing costs), at least quarterly
- Antibiotic use in some other way (please specify): _____
- None of the above

If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually. Yes No

If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually. Yes No

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Antibiotic Stewardship Practices (continued)

*30. Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.)

- Updates to facility leadership on antibiotic use and stewardship efforts.
- Outcomes for antibiotic stewardship interventions to staff.
- None of the above

*31. Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.)

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

Optional Antibiotic Stewardship Practices Questions

Responses to the following questions are not required to complete the annual survey.

Please provide additional information about your facility's antibiotic stewardship activities and leadership.

32. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. Yes No

33. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific support for our antibiotic stewardship efforts. Yes No

34. Our facility has a clinical decision support tool embedded in the electronic health record for antibiotic use or stewardship interventions available to prescribers. Yes No

35. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities. Yes No Not applicable, our facility does not use cascade and/or selective reporting

36. Our stewardship team monitors compliance with appropriate surgical prophylaxis. Yes No

37. If you selected 'Yes' to question 25 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)

- Pharmacy director
- Pharmacy & therapeutics
- Patient safety
- Quality improvement
- Executive leadership (e.g., CEO, CMO)
- Board of directors
- Other (please specify): _____
- None

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Optional Antibiotic Stewardship Practices (continued)

38. If you selected 'Physician' or 'Co-led...' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the **physician** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- 1-25%
- 26-50%
- 51-75%
- 76-100%

39. If you selected 'Pharmacist' or 'Co-led...' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the **pharmacist** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- 1-25%
- 26-50%
- 51-75%
- 76-100%

40. If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's contract or job description? (Check one.)

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

41. If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's contract or job description? (Check one.)

- 26-50%
- 51-75%
- 76-100%
- Not specified

Water Management Program (prevent legionella)

(Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)

42. Have you performed an assessment of the water systems in your facility to identify areas of risk for growth and transmission of Legionella and other opportunistic waterborne pathogens? (e.g. pseudomonas, acinetobacter, burkholderia, and nontuberculous mycobacteria) Yes No

If Yes, when? (Check one)

- ≤ 1 year ago
- ≥ 1-3 years ago
- ≥ 3 years ago
- Other (please specify): _____

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Water Management Program (continued)

43. Has your hospital established a team specifically for the purpose of developing and implementing a water management program to prevent the growth and transmission of *Legionella* and other waterborne pathogens? Yes No

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

- | | |
|---|--|
| <input type="checkbox"/> Hospital Epidemiologist/ Infection Preventionist | <input type="checkbox"/> Compliance Officer |
| <input type="checkbox"/> Hospital Administrator | <input type="checkbox"/> Risk/Quality Management Staff |
| <input type="checkbox"/> Facilities Manager/ Engineer | <input type="checkbox"/> Infectious Disease Clinician |

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

Disinfectant (such as residual chlorine): Yes No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? Yes No

Temperature: Yes No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? Yes No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? Yes No

Specific tests for *Legionella*: Yes No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? Yes No