Patient Safety Component—Annual Facility Survey for IRF

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/TOI-57.151-IRF.pdf

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Tracking #: *Survey Year:

Facility ID:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):
  □ For profit  □ Not for profit, including church  □ Government  □ Veterans Affairs

*Affiliation (check one):
  □ Independent  □ Multi-facility organization (specialty network)
  □ Hospital system

*How would you describe your licensed inpatient rehabilitation facility? (check one)
  □ Free-standing  □ Healthcare facility based

In the previous calendar year, indicate the following counts for the Rehabilitation Facility:

*Total number of rehab beds:

*Average daily census:

*Number of patient days:

*Average length of stay:

*Indicate the number of admissions with the primary diagnosis for each of the following rehabilitation categories (must sum to the total number of admissions listed below)

  a. Traumatic spinal cord dysfunction:
  b. Non-traumatic spinal cord dysfunction:
  c. Stroke:
  d. Brain dysfunction (non-traumatic or traumatic):
  e. Other neurologic conditions (e.g., multiple sclerosis, Parkinson's disease, etc.):
  f. Orthopedic conditions (incl. fracture, joint replacement, other):
  g. All other admissions:

*Total number of admissions:

  *Number of admissions on a ventilator:

  *Number of pediatric (≤ 18 years old) admissions:

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).

Continued >>

CDC 57.151 (Front) Rev. 7, v10.1
**Patient Safety Component—Annual Facility Survey for IRF**

**Facility Microbiology Laboratory Practices (completed with input from Microbiology Laboratory Lead)**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>(1) Primary</th>
<th>(2) Secondary</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Staphylococcus aureus</em></td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Entrobacterales</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

1. Does your facility have its own on-site laboratory that performs antimicrobial bacterial susceptibility testing? □ Yes □ No

1a. If No, where is your facility’s antimicrobial susceptibility testing performed? (check one)

- □ Affiliated medical center
- □ Commercial referral laboratory
- □ Other local/regional, non-affiliated reference laboratory

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.*

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>(1) Primary</th>
<th>(2) Secondary</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Staphylococcus aureus</em></td>
<td>1 = Kirby-Bauer disk diffusion</td>
<td>5.1 = MicroScan WalkAway</td>
<td>10 = E test</td>
</tr>
<tr>
<td></td>
<td>2 = Vitek (Legacy)</td>
<td>5.2 = MicroScan autoSCAN</td>
<td>12 = Vancomycin agar screen (BHI + vancomycin)</td>
</tr>
<tr>
<td></td>
<td>2.1 = Vitek 2</td>
<td>6 = Other broth microdilution method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1 = BD Phoenix</td>
<td>7 = Agar dilution method</td>
<td>13 = Other (describe in Comments section)</td>
</tr>
<tr>
<td></td>
<td>4 = Sensititre</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

3. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Entrobacteriaceae recommended by CLSI as of 2010? (As of 2020, this includes organisms in the order Entrobacterales.) □ Yes □ No

4. Has the laboratory implemented the revised carbapenem breakpoints for Entrobacteriaceae recommended by CLSI as of 2010? (As of 2020, this includes organisms in the order Entrobacterales.) □ Yes □ No

5. Does the laboratory perform a test for presence of carbapenemase? (this does not include automated testing instrument expert rules) □ Yes □ No

5a. 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 practices

5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

- □ PCR
- □ Modified Hodge Test
- □ mCIM/CIM
- □ E test
- □ Cepheid, BioFire array, Verigene®
- □ MBL Screen
- □ Carba NP
- □ Rapid CARB Blue

Continued >>
Facility Microbiology Laboratory Practices (continued)

5c. If Yes, which of the following are routinely tested for the presence of carbapenemases: (check all that apply)
□ Enterobacterales spp. □ *Pseudomonas aeruginosa* □ *Acinetobacter baumannii*

*6. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli* or *Klebsiella* spp. either routinely or using a testing algorithm? □ Yes □ No

6a. If Yes, please 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

*7. Where is yeast identification performed for specimens collected at your facility? (check one)
□ On-site laboratory
□ Affiliated medical center
□ Commercial referral laboratory
□ Other local/regional, non-affiliated reference laboratory
□ Yeast identification not available (i.e., yeast identification is not performed onsite or at any affiliate/commercial/other laboratory) [If checked, skip questions 8-13]

*Answer questions 8–12 for the laboratory that performs yeast identification for your facility:*

*8. Which of the following methods are used for yeast identification? (check all that apply)
□ MALDI-TOF MS System (Vitek MS) □ MicroScan
□ MALDI-TOF MS System (Bruker Biotyper) □ Non-automated Manual Kit (e.g., API 20C, RapID, Germ Tube, PNA-FISH, etc.)
□ Vitek-2 □ DNA sequencing
□ BD Phoenix □ Other (specify) ______________________

*9. Does the laboratory routinely use Chromagar for the identification or differentiation of *Candida* isolates? □ Yes □ No □ Unknown

*10. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)
□ Blood □ Respiratory
□ Other normally sterile body site (e.g., CSF) □ Other (specify): ______________________
□ Urine □ None are fully identified to the species level

*11. Does the laboratory employ any culture-independent diagnostic tests (CIDT) to identify *Candida* from blood specimens? □ Yes □ No □ Unknown

Continued >>
Facility Microbiology Laboratory Practices (continued)

11a. If yes, which culture-independent diagnostic tests (CIDT) are used to identify Candida from blood specimens? (check all that apply)

- □ T2Candida Panel
- □ BioFire
- □ Other, specify: ______________________
- □ Unknown

*12. Are any culture-independent diagnostic tests (CIDT) used to specifically identify Candida auris from clinical specimens?

- □ Yes
- □ No
- □ Unknown

12a. If yes, which culture-independent diagnostic tests (CIDT) are used to identify Candida auris from clinical specimens? (check all that apply)

- □ T2Cauris Panel
- □ PCR
- □ Other, specify: ______________________
- □ Unknown

*13. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check one)

- □ On-site laboratory
- □ Other local/regional, non-affiliated reference laboratory
- □ Affiliated medical center
- □ AFST not available (i.e., AFST is not performed onsite or at any affiliate/commercial/other laboratory) [if selected, skip questions 14-16]
- □ Commercial referral laboratory

**Answer questions 14–16 for the laboratory that performs AFST for your facility:**

*14. What method is used for antifungal susceptibility testing (AFST)? (check all that apply)

- □ Broth microdilution
- □ YeastOne colorimetric microdilution
- □ Disk diffusion
- □ Other (specify): ______________________
- □ E test
- □ Unknown
- □ Vitek 2 card

14a. If Vitek is used for AFST, which Candida species do you test with it? (check all that apply)

- □ C. albicans
- □ C. parapsilosis
- □ C. glabrata
- □ Other Candida spp.
### Facility Microbiology Laboratory Practices (continued)

**15. AFST is performed for which of the following antifungal drugs? (check all that apply)**

- [ ] Fluconazole  
- [ ] Caspofungin  
- [ ] Voriconazole  
- [ ] Amphotericin B  
- [ ] Itraconazole  
- [ ] Flucytosine  
- [ ] Posaconazole  
- [ ] Other, specify: __________________  
- [ ] Micafungin  
- [ ] Unknown  
- [ ] Anidulafungin

**16. AFST is performed on fungal isolates in which of the following situations? (check only one box per row)**

<table>
<thead>
<tr>
<th>Isolate Type</th>
<th>Performed automatically/reflexively</th>
<th>Performed with a clinician’s order</th>
<th>Not performed</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other normally sterile body site</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>(e.g., CSF)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Urine</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Respiratory</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>____________________________________</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**17. 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): _________________________________
**Patient Safety Component—Annual Facility Survey for IRF**

**Facility Microbiology Laboratory Practices (continued)**

*18. Please 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 (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
- [ ] Other (specify): ____________________
- [ ] None

*19. Please indicate any additional secondary methods used for microbe identification from blood cultures 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). (check 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
- [ ] Other (specify): ____________________
- [ ] None

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

*20. 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: ____________________

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

Continued >>
### Infection Control Practices (continued)

*22. 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
- □ No
- □ Not applicable: my facility never admits these patients

22a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- □ All infected and all 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

*23. 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
- □ No
- □ Not applicable: my facility never admits these patients

23a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- □ All infected and all 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

*24. 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
- □ No
- □ Not applicable: my facility never admits these patients

Continued >>
### Patient Safety Component—Annual Facility Survey for IRF

#### Infection Control Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>24a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):</td>
<td>□ All infected and all colonized patients</td>
</tr>
<tr>
<td></td>
<td>□ Only all infected patients</td>
</tr>
<tr>
<td></td>
<td>□ Only infected or colonized patients with certain characteristics (check all that apply):</td>
</tr>
<tr>
<td></td>
<td>□ Patients admitted to high risk settings</td>
</tr>
<tr>
<td></td>
<td>□ Patients at high risk for transmission</td>
</tr>
</tbody>
</table>

*25. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacterales are routinely placed in contact precautions while these patients are in your facility? (check one)

□ Yes  □ No
□ Not applicable: my facility never admits these patients

25a. If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):

□ All infected and all 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

*26. Does the facility routinely perform screening testing (culture or non-culture) for CRE? This includes screening for patients at your facility performed by public health laboratories and commercial laboratories

□ Yes  □ No

26a. 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 (specify): ____________________

*27. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted?

□ Yes  □ No

Continued >>
## Infection Control Practices (continued)

27a. 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 long-term acute care [LTAC] or long-term care facility [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 (specify): _________________

*28. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients? □ Yes □ No

*29. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal antistaphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens? □ Yes □ No

## Antibiotic Stewardship Practices

(completed with input from Physician and Pharmacist Stewardship Leaders)

*30. 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

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

- □ Providing stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions.
- □ Allocating resources (e.g., IT support, training for stewardship team) to support antibiotic stewardship efforts.
- □ Having a senior executive that serves as a point of contact or “champion” to help ensure the program has resources and support to accomplish its mission.
- □ Presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually.

Continued >>
### Antibiotic Stewardship Practices (continued)

- □ Ensuring the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually.
- □ Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues.
- □ Providing opportunities for hospital staff training and development on antibiotic stewardship.
- □ Providing a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board).
- □ Ensuring that staff from key support departments and groups (e.g., IT and hospital medicine) are contributing to stewardship activities.
- □ None of the above

*32. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes.  
   □ Yes  □ No

32a. If Yes, what is the position of this leader? (Check one.)

- □ Physician
- □ Pharmacist
- □ Co-led by both Pharmacist and Physician
- □ Other (e.g., RN, PA, NP, etc.; please specify): ________________

32b. 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 on antibiotic stewardship
- □ Completed training courses (e.g., conferences or online modules) on antibiotic stewardship
- □ None of the above

32c. If ‘Has antibiotic stewardship responsibilities in their contract or job description’ is selected (for physician (co) leader): 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%
- □ Not specified

32d. If Physician or Co-led is selected: In an average week, what percent time does the physician (co) leader spend on antibiotic stewardship activities in your facility? (Check one.)

- □ 1-25%
- □ 26-50%
- □ Not specified

*Continued >>*
### Antibiotic Stewardship Practices (continued)

32e. 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 on antibiotic stewardship
- □ Completed training courses (e.g., conferences or online modules) on antibiotic stewardship
- □ None of the above

32f. If ‘Has antibiotic stewardship responsibilities in their contract or job description’ is selected (for pharmacist (co) leader): What percent time for antibiotic stewardship activities is specified in the pharmacist (co) leader’s contract or job description? (Check one)
- □ 1-25%
- □ 26-50%
- □ 51-75%
- □ Not specified

32g. If ‘Pharmacist’ or ‘Co-led’ is selected: In an average week, what percent time does the pharmacist (co) leader spend on antibiotic stewardship activities in your facility? (Check one)
- □ 1-25%
- □ 26-50%
- □ 51-75%

32h. If Pharmacist or Other is selected: Does your facility have a designated physician who can serve as a point of contact and support for the non-physician leader?
- □ Yes
- □ No

32i. If a pharmacist is not the leader or co-leader for the program, is there at least one pharmacist responsible for improving antibiotic use at your facility?
- □ Yes
- □ No

*33. Our facility has the following priority antibiotic stewardship interventions: (Check all that apply)
- □ Prospective audit and feedback for specific antibiotic agents

33a. If Prospective audit and feedback is selected: For which categories of antimicrobials? Please 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)
- □ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, imipenem-cilastatin/relebactam, or cefiderocol
- □ Fluoroquinolones
- □ Daptomycin, linezolid, or other newer anti-MRSA agents
- □ Ertapenem, imipenem/cilastatin, or meropenem

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Continued >>
### Antibiotic Stewardship Practices (continued)

- □ 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

33b. If Prospective audit and feedback is selected: Our antibiotic stewardship program monitors prospective audit and feedback interventions (e.g., by tracking antibiotic use, types of interventions, acceptance of recommendations).

- □ Yes
- □ No

□ Preauthorization for specific antibiotic agents.

33c. If Preauthorization is selected: For which categories of antimicrobials? Please 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

Continued >>
Antibiotic Stewardship Practices (continued)

33d. If Preauthorization is selected: Our antibiotic stewardship program monitors preauthorization interventions (e.g., by tracking which agents are requested for which conditions).

☐ Yes  ☐ No

☐ Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions (e.g., community acquired pneumonia, urinary tract infection, skin and soft tissue infection).

33e. If Facility-specific treatment recommendations is selected: Our stewardship program monitors adherence to our facility’s treatment recommendations for antibiotic selection for common clinical conditions (e.g., community acquired pneumonia, urinary tract infection, skin and soft tissue infection).

☐ Yes  ☐ No

☐ None of the above

*34. Our facility has a policy or formal procedure for other interventions to ensure optimal use of antibiotics: (Check all that apply.)

☐ Early administration of effective antibiotics to optimize the treatment of sepsis

☐ Treatment protocols for Staphylococcus aureus bloodstream infection

☐ Stopping unnecessary antibiotic(s) in new cases of Clostridioides difficile infection (CDI)

☐ Review of culture-proven invasive (e.g., bloodstream) infections

☐ Review of planned outpatient parenteral antibiotic therapy (OPAT)

☐ The treating team to review antibiotics 48-72 hours after initial order (i.e., antibiotic time-out).

☐ Assess and clarify documented penicillin allergy

☐ Using the shortest effective duration of antibiotics at discharge for common clinical conditions (e.g., community-acquired pneumonia, urinary tract infections, skin and soft tissue infections)

☐ None of the above

34a. If ‘Using the shortest effective duration of antibiotics at discharge for common clinical conditions’ is selected: Our stewardship program monitors adherence to use of shortest effective duration of antibiotics at discharge for common clinical conditions (e.g., community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.

☐ Yes  ☐ No
## Antibiotic Stewardship Practices (continued)

### *35. Our facility has in place the following specific 'pharmacy-based' interventions: (Check all that apply)*

- [ ] Pharmacy-driven changes from intravenous to oral antibiotics without a physician’s order (e.g., hospital-approved protocol)
- [ ] Alerts to providers about potentially duplicative antibiotic spectra (e.g., multiple antibiotics to treat anaerobes)
- [ ] Automatic antibiotic stop orders in specific situations (e.g., surgical prophylaxis)
- [ ] None of the above

### *36. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use.*

- [ ] Yes  
- [ ] No

36a. If Yes is selected: Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)

- [ ] Nurses receive training on appropriate criteria for sending urine and/or respiratory cultures.
- [ ] Nurses initiate discussions with the treating team on switching from intravenous to oral antibiotics.
- [ ] Nurses initiate antibiotic time-out discussions with the treating team.
- [ ] Nurses track antibiotic duration of therapy

36b. If ‘Nurses track antibiotic duration of therapy’ is selected: Is that information available at the bedside (e.g., on a whiteboard in the room)?

- [ ] Yes  
- [ ] No

### *37. Our stewardship program monitors:* (Check all that apply.)

- [ ] Antibiotic resistance patterns (either facility- or region-specific), at least annually
- [ ] *Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually
- [ ] 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, at least annually (please specify): _____________________

- [ ] None of the above

### *38. Our stewardship team provides the following reports on antibiotic use to prescribers, at least annually:* (Check all that apply.)

- [ ] Individual, prescriber-level reports
- [ ] Unit- or service-specific reports
- [ ] None of the above

38a. If ‘Individual, prescriber-level reports’ or ‘Unit- or service-specific reports’ is selected: Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.

- [ ] Yes  
- [ ] No

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*Continued >>*
Antibiotic Stewardship Practices (continued)

**39.** Our facility distributes an antibiogram to prescribers, at least annually

☐ Yes  ☐ No

**40.** Information on antibiotic use, antibiotic resistance, and stewardship efforts is reported to hospital staff, at least annually.

☐ Yes  ☐ No

**41.** Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually? (Check all that apply.)

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

**42.** Are patients provided education on important side effects of prescribed antibiotics?

☐ Yes  ☐ No

42a. If ‘Yes’ is selected: How is education to patients on side effects shared? (Check all that apply.)

☐ Discharge paperwork  ☐ Verbally by physician
☐ Verbally by nurse  ☐ None of the above
☐ Verbally by pharmacist

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.

43. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.

☐ Yes  ☐ No

44. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship to obtain facility-specific support for our antibiotic stewardship efforts

☐ Yes  ☐ No

45. 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

46. Which committees or leadership entities provide oversight of your facility’s antibiotic stewardship efforts? (Check all that apply.)

☐ Pharmacy director  ☐ Executive leadership (e.g., CEO, CMO)
☐ Pharmacy & therapeutics  ☐ Hospital board
☐ Patient safety  ☐ Other (please specify): ________________
☐ Quality improvement  ☐ None

Continued >>
**Facility Water Management Program (WMP) (Completed with input from WMP team members.)**

*47. Has your facility ever conducted an environmental 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)? This may include a basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points.

☐ Yes  ☐ No

47a. If Yes, when was the most recent assessment conducted? (Check one)

☐ Within the most recent year (≤ 1 year ago)
☐ Between 1 and 3 years ago (≥ 1 year and ≤ 3 years)
☐ More than 3 years ago (> 3 years)

*48. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness?

☐ Yes  ☐ No

48a. If Yes, when was the most recent assessment conducted? (Check one)

☐ Within the most recent year (≤ 1 year ago)
☐ Between 1 and 3 years ago (≥ 1 year and ≤ 3 years)
☐ More than 3 years ago (> 3 years)

*49. Does your facility have a water management program (WMP) to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens? An example WICRA tool can be accessed at [https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf](https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf)

☐ Yes  ☐ No

49a. If Yes, who is represented on your facility WMP team? (Check all that apply)

- Hospital Epidemiologist/ Infection Preventionist
- Compliance/ Safety Officer
- Hospital Administrator/Leadership
- Risk/Quality Management Staff
- Facilities Manager/ Engineer
- Infectious Disease Clinician
- Maintenance Staff
- Consultant
- Equipment/Chemical Acquisition/Supplier
- Laboratory Staff
- Environmental Services
- Other (please specify): ____________________

*Continued >>*
<table>
<thead>
<tr>
<th><strong>Facility Water Management Program (WMP) (continued)</strong></th>
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<tbody>
<tr>
<td><em>50. Does your facility regularly monitor the following parameters in the building water system(s)? (Check all that apply)</em></td>
</tr>
<tr>
<td><strong>Disinfectant (such as residual chlorine):</strong></td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>50a. If Yes, does your facility have a plan for corrective actions when disinfectant(s) are not within acceptable limits as determined by the water management program?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
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<tr>
<td><strong>Temperature:</strong></td>
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<tr>
<td>□ Yes □ No</td>
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<tr>
<td>50b. If Yes, does your facility have a plan for corrective actions when temperatures are not within acceptable limits as determined by the water management program?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
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<tr>
<td><strong>Heterotrophic plate counts:</strong></td>
</tr>
<tr>
<td>□ Yes □ No</td>
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<tr>
<td>50c. If Yes, does your facility have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by the water management program?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td><strong>Specific environmental testing for <strong>Legionella</strong>:</strong></td>
</tr>
<tr>
<td>□ Yes □ No</td>
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<tr>
<td>50d. If Yes, does your facility have a plan for corrective actions when environmental testing for <strong>Legionella</strong> are not within acceptable limits as determined by the water management program?</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>