Instructions for Completion of the Patient Safety Component-Annual Hospital Survey (CDC 57.103)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2026, a facility would complete a 2025 survey.
Facility Characteristics	
Ownership (check one)	*Required.* Select the appropriate ownership of this facility: • P - For profit • NP - Not for profit, including church • GOV - Government • MIL - Military • VA- Veterans Affairs • PHY - Physician owned
Number of patient days	*Required.* Enter the total number of patient days from inpatient locations in your hospital during the last full calendar year. Newborns should be included in this count.
Number of admissions	*Required.* Enter the total number of inpatient admissions, including newborns, for your hospital during the last full calendar year.
Is your hospital a teaching hospital for physicians and/or physicians in training? If Yes, what type?	*Required.* If a teaching hospital, select 'Yes'. Otherwise, select 'No'. *Conditionally Required.* If a teaching hospital, select the type from the options listed: (**Note**: There is no minimum requirement for the number of students in training to meet these definitions.) • **Major:** Facility trains medical students and/or nursing students, and post-graduate residents. • **Graduate:** Facility trains only post-graduate medical (MD/DO only) residents/fellows • **Undergraduate:** Facility trains current (undergraduate) medical students and/or nursing students. Select the highest level that your facility meets

Number of beds set up and staffed in the following location types (as defined by NHSN)	*Required*. Record the number of beds set up and staffed for the last full calendar year for the bed types listed below. If any bed type is new or has not been available long enough to have a full calendar years' worth of data record the number of beds used for the majority (six months or greater) of the survey year. For definitions of CDC location types, see CDC Locations and Descriptions chapter.
a. ICU	Enter the number of beds in locations designated as intensive care units (ICUs) in the facility. This includes all adult, pediatric, and neonatal levels II/III and III.
b. All other inpatient locations	Enter the number of beds set up and staffed in all other inpatient locations used for overnight stay patients in this hospital. This includes all inpatient beds in the facility, and not just those that are subject to NHSN surveillance.
Number of airborne infection isolation room (AIIR) beds in the following location types (as defined by NHSN)	*Required*. Record the number of staffed airborne infection isolation room (AIIR) beds for the last full calendar year for the bed types listed below. If any bed type is new or has not been available long enough to have a full calendar years' worth of data record the number of beds used for the majority (six months or greater) of the survey year. For definitions of CDC location types, see CDC Locations and Descriptions chapter. An Airborne Infection Isolation Room (AIIR) is a private patient room designed with specialized ventilation and air-handling systems that comply with the standards set by the American Institute of Architects and the Facility Guidelines Institute (AIA/FGI).
a. ICU	Enter the number of staffed beds in locations designated as intensive care units (ICUs) in the facility. This includes all adult, pediatric, and neonatal levels II/III and III.
b. All other inpatient locations	Enter the number of staffed beds in in all other inpatient locations used for overnight stay patients in this hospital. This includes all inpatient beds in the facility, and not just those that are subject to NHSN surveillance.
Number of protective environment beds	*Required*. Record the number of staffed protective environment beds for the last full calendar year. If this bed type is new or has not been available long enough to have a full calendar years' worth of data record the number of beds used for the majority (six months or greater) of the survey year. A protective environment bed is a bed in a specialized patient care area designed to protect allogenic hematopoietic stem cell transplant (HSCT) patients from environmental pathogens using positive air pressure, HEPA filtration, and other infection-control measures.
Number of biocontainment patient care beds	*Required*. Record the number of biocontainment patient care beds for the last full calendar year. If this bed type is new or has not been available long enough to have a full calendar years' worth of data record the number of beds used for the majority (six months or greater) of the survey year.

	A biocontainment patient care bed is a bed located in a specialized unit designated and equipped to provide care for patients with highly infectious or hazardous pathogens, utilizing enhanced infection control and isolation practices.
Number of licensed beds	*Required*. Record the number of licensed beds for the last full calendar year. If a bed is new or has not been available long enough to have a full calendar years' worth of data record the number of beds used for the majority (six months or greater) of the survey year. "Licensed beds" is the number of beds a hospital is licensed to operate under state licensing regulations, regardless of whether all are staffed or in use.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? 1a. If No, where is the facility's antimicrobial susceptibility testing performed? (check one) 1b. If Yes, do you also send out any antimicrobial susceptibility testing? (check one)	*Required.* Select 'Yes' if your facility has its own onsite laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory. *Conditionally Required*. If your facility has its own laboratory that performs antimicrobial susceptibility testing, select 'Yes' to indicate if additional antimicrobial susceptibility testing is also sent out, or 'No' if all routine susceptibility testing is performed onsite.
2. For *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex, indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method(s) (if performed) for *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex. **Note**: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used. Primary susceptibility testing: the antimicrobial susceptibility testing routinely utilized by the testing laboratory. Secondary, Supplemental, or Confirmatory susceptibility testing: the antimicrobial susceptibility testing utilized by the testing laboratory either upon clinician request or tested reflexively based on the primary susceptibility testing results.

3. Does either the primary or secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply):	*Required.* For *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex, select 'Tested' if the given drug is included as part of the primary or secondary/supplemental susceptibility testing described in 2. Select 'Not Tested' if the given drug is not included in any part of the primary or secondary/supplemental susceptibility testing for Enterobacterales, *Pseudomonas aeruginosa* or *Acinetobacter baumannii* complex. Primary antimicrobial susceptibility testing: The bacterial antimicrobial agents or panels routinely utilized by the testing laboratory, regardless of whether the result is reported. Select 'Tested' if the antimicrobial agent is included on the routine testing panel, even if results are conditionally suppressed due to selective or cascade reporting rules. Secondary/Supplemental antimicrobial susceptibility testing: The bacterial antimicrobial agents and/or AST panels utilized by the testing laboratory either upon clinician request or tested reflexively based on the primary antimicrobial susceptibility results.
4. Has your laboratory implemented the revised breakpoints recommended by CLSI as of 2010?	
a. Third Generation Cephalosporin and monobactam (i.e., aztreonam) breakpoints for *Enterobacterales* in 2010	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for *Enterobacterales* recommended by CLSI as of 2010; otherwise, select 'No'.
b. Carbapenem breakpoints for *Enterobacterales* in 2010	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for *Enterobacterales* recommended by CLSI as of 2010; otherwise, select 'No'.
c. Ertapenem breakpoints for *Enterobacterales* in 2012	*Required*. Select 'Yes' if your laboratory has implemented the revised ertapenem breakpoints for *Enterobacterales* recommended by CLSI as of 2012; otherwise, select 'No'.
d. Carbapenem breakpoints for *Pseudomonas aeruginosa* in 2012	*Required*. Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2012; otherwise, select 'No'.
e. Fluroquinolone breakpoints for *Pseudomonas aeruginosa* in 2019	*Required*. Select 'Yes' if your laboratory has implemented the revised fluroquinolone breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2019; otherwise, select 'No'.
f. Fluroquinolone breakpoints for *Enterobacterales* in 2019	*Required*. Select 'Yes' if your laboratory has implemented the revised fluroquinolone breakpoints for *Enterobacterales* recommended by CLSI as of 2019; otherwise, select 'No'.

g. Aminoglycoside breakpoints for *Enterobacterales* in 2023	*Required.* Select 'Yes' if your laboratory has implemented the revised Aminoglycoside breakpoints for *Enterobacterales* recommended by CLSI as of 2023; otherwise, select 'No'.
h. Aminoglycoside breakpoints for *Pseudomonas aeruginosa* in 2023	*Required.* Select 'Yes' if your laboratory has implemented the revised Aminoglycoside breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2023; otherwise, select 'No'.
i. Piperacillin-tazobactam breakpoints for *Pseudomonas aeruginosa* in 2023	*Required.* Select 'Yes' if your laboratory has implemented the revised Piperacillin-tazobactam breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2023; otherwise, select 'No'.
j. Piperacillin-tazobactam breakpoints for *Enterobacterales* in 2022	*Required.* Select 'Yes' if your laboratory has implemented the revised Piperacillin-tazobactam breakpoints for *Enterobacterales* recommended by CLSI as of 2022; otherwise, select 'No'.
5. Does the laboratory test bacterial isolates for presence of a carbapenemase?	*Required.* Select 'Yes' if your laboratory tests bacterial isolates for carbapenemase production; otherwise, select 'No'. **Note**: Only tests performed on bacterial isolates should be included. If the laboratory is only able to test for presence of carbapenemases in specimens (e.g., positive blood cultures), select 'No'. **Note**: Only tests that evaluate for the presence/absence of carbapenemase, or who identify specific carbapenemase mechanisms should be included. 'No' should be selected if the laboratory only performs tests that screen for elevated carbapenem minimum inhibitory concentrations (MICs) or assign a result of 'carbapenemase positive' based on automated testing instrument expert rules.
5a. If Yes, indicate what is done if carbapenemase production is detected: (check one)	*Conditionally Required.* If 'Yes', specify how laboratory results are managed if carbapenemase production is detected.
5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)	*Conditionally Required.* If 'Yes', specify which test(s) are routinely used to detect carbapenemase.
5c. If Yes, which of the following are routinely tested for the presence of carbapenemases: (check all that apply)	*Conditionally Required.* If 'Yes', specify which pathogen(s) routinely undergo a testing algorithm that requires testing for the presence of a carbapenemase. For example, select '*Pseudomonas aeruginosa*' if it is a routine for your laboratory to test for the presence of a carbapenemase for *Pseudomonas aeruginosa* when the isolate tests resistant for a carbapenem(s).
6. Does your facility use commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections? Examples of commercially available systems include BioFire FilmArray, Luminex Verigene, etc.	*Required.* Select 'Yes' if your laboratory uses commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections; otherwise, select 'No'.

6a. If Yes, which test panel(s) does your facility use? (check all that apply)	*Conditionally Required.* If 'Yes', select the test panel(s) that your facility uses. If the test panel(s) your facility uses are not listed: select 'Other Commercial Test(s)' if the other test(s) used is/are commercially available then indicate which test is used by entering in the test name in the blank field, or select 'Other Laboratory Developed Test(s)' if the other test used is laboratory developed, then indicate which test is used by entering in the test name in the blank field.
7. In a scenario where the *mecA* resistance marker and *Staphylococcus aureus* are detected by rapid molecular testing, select the procedure(s) your facility conducts. (check one)	*Required.* Select your facility's procedure(s) after detecting the *mecA* resistance marker and *Staphylococcus aureus* using rapid molecular testing. If the *mecA* resistance marker is not tested for *Staphylococcus aureus* in your facility, select the first answer choice and skip to question 8.
7a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus*, and discordance is found between their results, how are results reported? (check one)	*Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 8.
8. In a scenario where the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* are detected by rapid molecular testing, select the procedure(s) your facility conducts. (check one)	*Required.* Select your facility's procedure(s) after detecting the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* using rapid molecular testing. If the *bla*$_{CTX-M}$ (CTX-M) resistance marker is not tested for *Escherichia coli* in your facility, select the first answer choice and skip to question 9.
8a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli* and discordance is found between their results, how are results reported? (check one)	*Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 9.
9. Where is yeast identification performed for specimens collected at your facility? (check one)	*Required.* Select where is yeast identification performed for specimens collected at your facility.
Answer questions 10-14 for the laboratory that *performs yeast identification for your facility*:	

10. Which of the following methods are used for yeast identification? (check all that apply)	*Required.* Select from the choices listed, one or more methods used for yeast identification. If 'Other' is selected, specify the method.
11. Does the laboratory routinely use chromogenic agar for the identification or differentiation of *Candida* isolates?	*Required.* Select 'Yes' if the laboratory routinely uses chromogenic agar for the identification or differentiation of *Candida* isolates; otherwise, select 'No'. Select 'Unknown' if not known.
12. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)	*Required.* Select from the choices listed, one or more body sites from which *Candida* is routinely identified to the species level without a specific request from a clinician. If 'Other' is selected, specify the body site.
13. Does the laboratory employ any PCR molecular tests to identify *Candida* from blood specimens? 13a. If yes, which PCR molecular tests are used to identify *Candida* from blood specimens? (check all that apply) 13b. If yes and you get a positive result, does this lab culture the blood to obtain an isolate?	*Required.* Select 'Yes' if the laboratory employs any PCR molecular tests to identify *Candida* from blood specimens; otherwise, select 'No'. Select 'Unknown' if not known. *Conditionally Required.* If 'Yes', select the PCR molecular test(s) used to identify *Candida* from blood specimens. If 'Other' is selected, specify. Select 'Unknown' if not known. *Conditionally Required.* If 'Yes' and you get a positive result on the PCR molecular test, indicate whether this lab cultures the blood to obtain an isolate.
14. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check one)	*Required.* Select where antifungal susceptibility testing (AFST) is performed for specimens collected at your facility.
Answer questions 15-19 for the laboratory that *performs AST for your facility*:	
15. What methods are used for antifungal susceptibility testing (AFST), excluding Amphotericin B? (check all that apply)	*Required.* Select from the choices listed, one or more method(s) used for antifungal susceptibility testing of antifungals except for Amphotericin B. If 'Other' is selected, specify the method.
16. What methods are used for antifungal susceptibility testing (AFST) of Amphotericin B? (check all that apply)	*Required.* Select from the choices listed, one or more method(s) used for antifungal susceptibility testing of Amphotericin B. If 'Other' is selected, specify the method.
17. AFST is performed for which of the following antifungal drugs? (check all that apply)	*Required.* Select the antifungal drugs for which AFST is performed. If 'Other' is selected, specify the antifungal.
18. AFST is performed on fungal isolates in which of the following situations? (check only one box per row)	*Required.* For each of the body sites listed, select the most appropriate response for when antifungals susceptibility testing is performed. Choose "Performed automatically" if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient. Choose "Performed with a clinician's order" if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing.

	If 'Other' body site is selected, specify.
19. Is this laboratory developing antibiograms or other reports to track susceptibility trends for *Candida* spp. isolates tested in this laboratory?	*Required.* Select from the choices listed to indicate if this laboratory develops reports (for example, antibiograms) to track antifungal susceptibility trends for *Candida* spp. isolates tested in this laboratory.
20. 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)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, specify. **Note:** "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. Ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
21. Which of the following methods serve as the primary method used for bacterial identification at your facility? (check one)	*Required.* Select 'One Answer' indicating your facility's primary and definitive method used for bacterial identification.
22. Which of the following methods serve as the secondary or backup method used for bacterial identification at your facility? (for example, a secondary method if the primary method fails to give an identification, or if the primary method is unavailable). (check one)	*Required.* Select 'One Answer' indicating your facility's secondary methods used for microbe identification from bacterial identification in your facility. For example, if 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
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
23. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals who work full-time in the infection prevention department of the hospital as infection prevention professionals. If an individual works part-time, indicate what proportion of full-time hours they work (for example, if full time is considered 40 hours and an individual works 16 hours per week, their work is counted as 16/40 = 0.4). Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
23a. Total hours per week performing surveillance	Enter the combined total number of hours per week performed by all employees engaged in activities designed to find and report healthcare-associated infections (in the hospital). The total should include time to analyze data and disseminate results.
23b. Total hours per week for infection control activities other than surveillance	Enter the combined total number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, providing education, ensuring prevention measures are implemented, attending meetings, etc.

24. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the total number or fraction of individuals who full-time performing the functions of a hospital epidemiologist in the facility. If an individual works part-time, include the proportion of full-time hours they work (for example, if they work 20 hours of a standard 40-hour workweek, include them as 0.5). An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
For detailed description about the use of Contact Precautions, refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html .	
25. 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) 25a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with methicillin-resistant *Staphylococcus aureus* (MRSA). Select 'No' if your facility does not have this policy If your facility never admits patients with MRSA, select 'Not applicable'. *Conditionally Required.* If Yes, indicate which type of patients the policy requires are routinely placed in Contact Precautions while in your facility: all patients with MRSA, regardless of whether the MRSA is associated with infection or colonization; only those patients with MRSA infections (specifically, patients with only MRSA colonization are not subject to this policy); or a subset of patients with either MRSA infection or colonization with certain characteristics.
26. 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? 26a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with vancomycin-resistant Enterococci (VRE). Select 'No' if your facility does not have this policy If your facility never admits patients with VRE, select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions for VRE while in your facility.
27. 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) 27a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with carbapenem-resistant *Enterobacterales* (CRE). Select 'No' if your facility does not have this policy. If your facility never admits patients with CRE, select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions for CRE while in your facility.

28. 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) 28a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with extended spectrum beta-lactamase (ESBL) producing *Enterobacterales* or extended spectrum cephalosporin-resistant *Enterobacterales*. Select 'No' if your facility does not have this policy. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant *Enterobacterales* select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in contact precautions while in your facility.
29. Does the facility routinely perform screening testing (culture or non-culture) for CRE? 29a. If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if the facility routinely (such as, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture-based methods to detect CRE. Select No if either testing is not routinely performed or not performed at all. *Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which CRE screening is performed.
30. Does the facility routinely perform screening testing (culture or non-culture) for *Candida auris*? This includes screening for patients at your facility performed by public health laboratories and commercial laboratories. 30a. If Yes, in which situations does the facility routinely perform screening testing for *Candida auris*? (check all that apply) 30b. If Yes, what method is routinely used by the lab conducting *Candida auris* testing of screening swabs from your facility?	*Required.* Select 'Yes' if the facility routinely (specifically, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture-based methods for *Candida auris*; select 'No' if either testing is not routinely performed or not performed at all. *Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which *Candida auris* screening is performed. *Conditionally Required*. If 'Yes', select the method that's routinely used by the lab conducting screening. If 'Other' is selected, please specify the methods(s) in which *Candida auris* screening is performed. **Note**: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified *Candida auris*. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
31. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings?	*Required.* Select 'Yes' if the facility routinely (such as, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture-based methods for MRSA. Select No if either testing is not routinely performed or not performed at all.

31a. If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which MRSA screening is performed.
32. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings?	*Required.* Select 'Yes' if the facility routinely (such as, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture-based methods for MRSA; select no if either testing is not routinely performed or not performed at all.
32a. If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which MRSA screening is performed.
33. Does the facility have a policy to routinely use chlorhexidine bathing on any adult patient to prevent infection or transmission of MDROs at your facility?	*Required.* Select 'Yes' if your facility has a policy to **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO.
33a. If yes, indicate which patients: (select all that apply)	Select 'No' if your facility does not have this policy. If 'Yes', indicate which patients are subject to this policy.
34. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens?	*Required.* Select 'Yes' if the facility has a policy to routinely use a combination of topical chlorhexidine AND an intranasal anti-staphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens. Select 'No' if the facility does not have this policy.
34a. If yes, indicate which patients: (select all that apply)	*Conditionally Required*. If Yes, select the patients for which a combination of topical chlorhexidine AND an intranasal agent are used.

Facility Neonatal or Newborn Patient Care Practices and Admissions Information

Facilities that provide any level of neonatal care (including well newborn care) will answer the following 6 questions. Facilities that do not provide neonatal care at any level will answer No for question 35 and skip questions 36-40.

To ensure data accuracy and quality, it is recommended that this section be completed in collaboration with your facility's neonatal patient care team. Input should be sought from at least one of the following neonatal patient care team members: NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner.

Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

35. Does your facility provide neonatal or newborn patient care services at any level	*Required.* Select 'Yes' if your facility provides any neonatal or newborn patient care. This includes care provided in any of the following NHSN location types: - Well newborn nursery/mother-baby unit (Level I)

(specifically, does your facility provide delivery services, Level 1 well newborn care, Level II special care, or neonatal intensive care)?	- Special care nursery/stepdown neonatal nursery (Level II) - Neonatal critical care unit (Level II/III, Level III, Level IV) - Labor and delivery unit - Postpartum unit - Labor, delivery, recovery, postpartum suite Select 'No' if your facility does not provide any form of neonatal/newborn patient care.
If 'No" was selected in question 35 above, questions 36-40 below do not apply to your facility and should be skipped. If your facility does care for neonates or newborns (at any level), complete questions below. *Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
36. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions to Special Care Nurseries (Level II) and Intensive Care Units (Level II/III, Level III, Level IV): a. Inborn admissions b. Outborn admissions	*Required.* Excluding admissions to Level I units (well newborn nurseries), record the total number of admissions for the last full calendar year to Special Care Nurseries (Level II) and Intensive Care Units (Level II/III, Level III, Level IV), where inborn and outborn admissions are defined as follows: a. Inborn admission: admission of an infant delivered in your facility. b. Outborn admission: admission of an infant delivered outside of your facility. Facilities with one or more Level I well newborn nursery but no neonatal special care nursery or critical care unit will enter 0 for both and b. This question asks for ALL neonatal admissions to your facility, including infants >28 days or infants who went home before admission. Don't count readmissions or unit transfers; primary facility-level admissions only. However, if an infant was admitted to a Level I well newborn nursery and later moved to a Level II or higher unit, then please DO count that infant.
37. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions (both inborn and outborn) to Special Care (Level II) and Intensive Care (Level II/III, Level III, Level IV) in each of following birth weight categories: a. ≤750 grams b. 751-1000 grams c. 1001-1500 grams d. 1501-2500 grams e. >2500 grams	*Required.* Excluding admissions to Level I units (well newborn nurseries), enter the total number of admissions (both inborn and outborn) to Special Care Nurseries (Level II) or Neonatal Intensive Care Units (Level II/III, Level III, Level IV) for the past full calendar year for each of the five specified birth-weight categories. Summing the number of admissions across the five categories (a-e) should equal the summation of inborn and outborn admissions (a-b) designated in question 36 above. Facilities with one or more Level I well newborn nursery but no neonatal special care nursery or critical care unit will enter 0 for parts a - e. This question asks for ALL neonatal admissions to your facility, including infants >28 days or infants who went home before admission. Don't count readmissions or unit transfers; primary facility-level admissions only. However, if an infant was admitted to a Level I well newborn nursery and later moved to a Level II or higher unit, then please DO count that infant.
38. Does your facility provide Level III (or higher) neonatal	*Required.* Select 'Yes' if your facility has one or more Level II/III, Level III or Level IV NICU; otherwise, select 'No.'

intensive care as defined by the American Academy of Pediatrics (for example capable of providing sustained life support, comprehensive care for infants born <32 weeks gestation and weighing <1500 grams, a full range of respiratory support that may include conventional and/or high-frequency ventilation)?	American Academy of Pediatrics Neonatal Levels of Care: **Level III (NICU):** Level II capabilities plus: • Provide sustained life support • Provide comprehensive care for infants born <32 wks. gestation and weighing <1500 g and infants born at all gestational ages and birth weights with critical illness • Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists • Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide • Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography **Level IV (Regional NICU):** Level III capabilities plus: • Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions • Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists, and pediatric anesthesiologists at the site • Facilitate transport and provide outreach education http://pediatrics.aappublications.org/content/pediatrics/130/3/587.full.pdf NHSN-defined Level II/III Neonatal Critical Care Units are combined nurseries housing both Level II and Level III newborns and infants. They are analogous to mixed acuity units specifically for Neonatal Critical Care patients. Facilities with one or more Level II/III NICU should select 'Yes' to indicate Level III neonatal care is provided.
39. Does your facility accept neonates as transfers for any of the following procedures: Omphalocele repair; ventriculoperitoneal shunt; tracheoesophageal fistula (TEF)/esophageal atresia repair; bowel resection/reanastomosis; meningomyelocele repair; cardiac catheterization?	*Required.* Select 'Yes' if your facility accepts neonates as transfers for at least one of the procedures listed; otherwise, select 'No.'
40. If babies are roomed with their mother in a labor and delivery or postpartum ward and are administered oral or parenteral antimicrobials, such as ampicillin, what location is the medication administration attributed to in the electronic medication administration record (eMAR) system and/or	**Background and purpose of question**: hospitals have different practices and protocols for administering antimicrobials to newborns. Data reported here allow us to better understand these practices and provide insight into how antimicrobial days of therapy are captured in newborn and neonatal units reporting to NHSN. *Required.* Select 'Level I Well Newborn Nursery' if a newborn in his/her mother's room has oral or parenteral antimicrobial administration attributed in the electronic medication administration record system to a well newborn nursery, often called a mother-baby unit or family-centered care unit.

bar code medication administration (BCMA) system? Ask your clinical pharmacist to review the eMAR and/or BCMA system to determine this and select all that apply.	Select 'Labor and Delivery Ward, Postpartum Ward, or Labor, Delivery, Recovery, Postpartum Suite' if a newborn in his/her mother's room has oral or parenteral antimicrobial administration attributed in the electronic medication administration record system to one of the following NHSN location types: - Labor and Delivery Ward - Labor, Delivery, Recovery, Postpartum Suite - Postpartum Ward Select 'My facility requires that babies receiving antimicrobials **intravenously** (IV) are transferred out of their mother's room in order for IV antimicrobials to be administered (babies receiving oral or intramuscular antimicrobials may remain in their mother's room for antimicrobial administration)' if your hospital has the following practice in place: • Newborns are often administered oral or intramuscular antimicrobials while in their mother's room (also select response choice a. and/or b. to indicate the location for which this antimicrobial administration is attributed) but newborns must be transferred out of their mother's room in order for antimicrobials to be administered intravenously. Select 'My facility requires that babies receiving oral and/or intramuscular antimicrobials are transferred out of their mother's room in order for antimicrobials to be administered' if your facility has the following practice in place: • Newborns must be transferred out of their mother's room in order for antimicrobials to be administered orally or intramuscularly. Select 'N/A my facility does not provide delivery services' if your facility provides Level II special care and/or neonatal intensive care but does **not** care for well newborns and does **not** provide delivery services. Examples: 1. In my facility, newborns often receive antimicrobials intramuscularly while residing with their mother in a labor and delivery or postpartum ward, however, my hospital requires that newborns be transferred to a higher level of care in order for antimicrobials to be administered intravenously. My clinical pharmacist confirmed that newborns in a labor and delivery or postpartum ward have intramuscular antimicrobial administration attributed to a Level I well newborn nursery in the eMAR system. a. Select answer choices A. and C. 2. In my facility, newborns are not administered antimicrobials orally or intramuscularly while they are roomed with their mother. a. Select answer choice D. 3. In my facility, when a baby is born in a labor and delivery (LD) ward and started on ampicillin intramuscularly in that ward, antimicrobial administration is attributed to the LD ward in the eMAR system. Other times, a baby born via c-section may receive ampicillin intramuscularly while with their mother in a recovery room and my clinical pharmacist reports that this administration is captured in the eMAR system in a Level I well newborn nursery. a. Select answer choices A. and B.
40a. If answer choice c. or d. was selected in question above, to which neonatal	*Required.* Select 'Level I well newborn nursery separate from the mother's room' if a baby receiving antimicrobials is transferred to a newborn nursery location in a

unit would a baby be transferred in order to receive oral or parenteral antimicrobials (select all that apply)	separate physical room from mom's labor and delivery or postpartum ward in order for antimicrobials to be administered (via route(s) specified in question 40). Select 'Level II special care nursery' if newborns requiring antimicrobials (via route(s) specified in question 40) are ever transferred to a Level II special care nursery in order for those antimicrobials to be administered. Select 'Level II/III or higher neonatal intensive care unit' if newborns requiring antimicrobials (via route(s) specified in question 40) are ever transferred to a neonatal intensive unit in order for those antimicrobials to be administered.
Antibiotic Stewardship Practices. Completion of this section should involve the leader(s) of the Antibiotic Stewardship Program (ASP), such as a pharmacist and/or physician; if your facility does not have an ASP program leader, completion should involve other leaders of the work, such as a pharmacist or physician who focuses on antibiotic stewardship or infectious diseases and/or members of the Pharmacy and Therapeutics Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to the 2019 Core Elements of Hospital Antibiotic Stewardship Programs https://www.cdc.gov/antibiotic-use/core-elements/hospital.html). For additional implementation guidance for small and critical access hospitals, see https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements-small-critical.html.	
41. Facility leadership has demonstrated commitment to antibiotic stewardship efforts by: (Check all that apply.)	*Required*. Select, from the choices listed, the ways in which facility leadership demonstrated their commitment to antibiotic stewardship efforts in your facility during the past calendar year. Clarification on some of the response options can be found below. Select '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' if a senior executive, such as a clinical administrator, Chief Medical Officer, or other senior-level management, at your facility supports your program and is responsible for ensuring availability of necessary resources. Select 'Information on stewardship activities and outcomes is presented to facility leadership and/or board at least annually' if your program reports stewardship activities and outcomes to senior leadership and/or the facility board at least once per year (for example, including stewardship measures in facility quality dashboard reports). This presentation may be during a meeting or otherwise sharing reports or information up the chain to leadership. Select 'Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues' if there is evidence of broad-reaching communication from senior-level management to facility staff about antibiotic stewardship efforts within the past calendar year. Examples include written communication to facility staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility's stewardship efforts. Select 'Providing opportunities for facility staff training and development on antibiotic stewardship' if facility leadership or management has provided staff antibiotic stewardship education in-house (for example, workshops, lectures) or access to antibiotic stewardship trainings (for example, by approving time and/or

	providing funds to attend stewardship conferences, webinars) within the past calendar year. Select 'Providing a formal statement of support for antibiotic stewardship (for example, a written policy or statement approved by the board)' if there is evidence of senior-level management support focused on antibiotic use, prescribing, and/or stewardship (for example, formal letter of support for antibiotic stewardship efforts, written support in an annual report, communication of support in executive-level meetings notes). Select 'Ensuring that staff from key support departments and groups (for example, IT) are contributing to stewardship activities' if your facility ensures other groups and departments in the facility are aware of stewardship efforts and collaborate with the stewardship program.
42. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes.	*Required*. Select 'Yes' if at least one individual has been identified to lead antibiotic stewardship activities, as evidenced by responsibility for improving antibiotic use in their job description or performance review, authority to coordinate activities of staff from multiple departments (for example, laboratory, pharmacy, information technology), and/or responsibility to report to senior-level management on antibiotic stewardship planning and outcomes; otherwise, select 'No.'
42a. If Yes, what is the position of this leader? (Check one.)	*Conditionally Required*. If, specify the qualification or job title of the leader(s). If 'Other' is selected, specify the position.

42b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)	*Conditionally Required*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected, specify, from the choices listed, the qualities of your facility's **physician** leader. Clarification on some of the response options can be found below. Select 'Has antibiotic stewardship responsibilities in their contract. job description or performance review' if the **physician** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the **physician** stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **physician** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging remotely in your facility's stewardship activities. Select 'Completed an ID fellowship' if the **physician** stewardship leader completed an ID fellowship, such as, a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program on antibiotic stewardship' if the **physician** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or commensurate level of continuing education credit(s). Select 'Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship' if the **physician** stewardship leader completed other antibiotic stewardship trainings, exclusive of other response options, such as CDC's online training course on antibiotic stewardship that offers participants over 10 hours of free continuing education: https://www.cdc.gov/antibiotic-use/training/continuing-education.html.
42c. What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 42b, specify the percent time (or equivalent) stipulated in the **physician** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select 'Not specified.' This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked.
42d. **In an average week**, what percentage of time does the **physician** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected, specify the percentage of time (or equivalent) that the **physician** stewardship leader, on average, actually spends on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in their contract or job. An estimate is fine.

42e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected, specify, from the choices listed, the qualities of your facility's **pharmacist** leader. Clarification on some of the response options can be found below. Select 'Has antibiotic stewardship responsibilities in their contract, job description or performance review' if the **pharmacist** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the pharmacist stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **pharmacist** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed a PGY2 ID residency and/or ID fellowship' if the **pharmacist** stewardship leader completed a PGY2 ID residency and/or ID fellowship, such as, a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program on antibiotic stewardship' if the **pharmacist** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or commensurate level of continuing education credit(s). Select 'Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship' if the **pharmacist** stewardship leader completed other antibiotic stewardship trainings, exclusive of other response options, such as CDC's online training course on antibiotic stewardship that offers participants over 10 hours of free continuing education: https://www.cdc.gov/antibiotic-use/training/continuing-education.html.
42f. What percentage of time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for the pharmacist lead, specify the percentage of time (or equivalent) stipulated in the **pharmacist** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percentage of time or equivalent is stipulated, select "Not specified." This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked.
42g. **In an average week**, what percentage of time does the **pharmacist** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected, specify the percent time (or equivalent) that the **pharmacist** stewardship leader, on average, actually spends on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in their contract or job description. An estimate is fine.
42h. 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?	*Conditionally Required*. If 'Pharmacist' or 'Other' was selected, select 'Yes' if your facility has at least one **physician** who dedicates time distinct from general physician duties to provide antibiotic stewardship support to the non-physician leader and serve as a point of contact for antibiotic stewardship efforts; otherwise, select 'No'.

42i. 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?	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was not selected, select 'Yes' if your facility has at least one **pharmacist** who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
43. Our facility has the following priority antibiotic stewardship interventions: (Check all that apply.)	*Required*. select the intervention(s), from the choices listed, that your facility has implemented over the past calendar year. Clarification on some of the response options can be found below. Select 'Prospective audit and feedback for specific antibiotic agents' if the stewardship team (or physicians or pharmacists knowledgeable in antibiotic use and who are overseen by the stewardship team and are not part of the treating team) conducts a prospective review of the appropriateness of antibiotic use for any antibiotic (whether or not it is on formulary) and then provides feedback in real-time to the front-line clinicians with recommendations based on the culture results, clinical status of the patient, and other important factors. Facilities may implement prospective audit and feedback in different ways, depending on the level of expertise available (for example, on a limited number of floors/units, for a limited number of agents, on limited days, or across the entire facility). Select 'Preauthorization for specific antibiotic agents' if an approval is required prior to using certain antibiotics that are on formulary. Facilities may implement preauthorization in different ways. Examples include: - your facility has at least one antibiotic agent that requires the stewardship team, or a physician or pharmacist overseen by the stewardship team, to review and approve administration of the drug due to its spectrum of activity or associated toxicities before the agent can be dispensed; - preauthorization is required immediately, or within a specified short timeframe such a 24 hours; - there are specific indications or restrictive criteria in the computer entry process. **Note***:* It is assumed that non-formulary drugs already require preauthorization. Select 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions' if your facility has or accesses (for example, via your health system or a neighboring facility), and uses guidelines or recommendations for antibiotic treatment selection that are based on national guidelines and take into account facility-specific factors such as formulary, resistance patterns, etc. for ANY common clinical conditions.
43a. Our antibiotic stewardship program monitors prospective audit and feedback interventions (for example, by tracking antibiotic use, types of interventions, acceptance of recommendations).	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected, select 'Yes' if your antibiotic stewardship program monitors prospective audit and feedback interventions through means such as tracking antibiotic use, the types of interventions implemented, and/or the acceptance of recommendations; otherwise, select 'No'.

43b. Our antibiotic stewardship program monitors preauthorization interventions (for example, by tracking which agents are requested for which conditions).	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected, select 'Yes' if your antibiotic stewardship program monitors preauthorization interventions through means such as tracking which agents are being requested for which conditions; otherwise, select 'No'.
43c. Our stewardship program monitors adherence to our facility's treatment recommendations for antibiotic selection for common clinical conditions (for example, community-acquired pneumonia, urinary tract infection, skin and soft tissue infection). 43d. For which common clinical conditions?	*Conditionally Required*. If 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilites, to assist with antibiotic selection for common clinical conditions' was selected, select 'Yes' if audits have been conducted to confirm adherence to facility-specific treatment guidelines or recommendations for ANY common clinical conditions; otherwise, select 'No'. *Conditionally Required*. If 'Yes,' specify which common clinical conditions the stewardship program monitors adherence to the facility's treatment recommendations for antibiotic selection. If your facility does not monitor for the conditions listed, select 'None of the above.'
44. Our facility has a policy or formal procedure for other interventions to ensure optimal use of antibiotics: (Check all that apply.)	*Required*. Select, from the choices listed, the policies or formal procedures that your facility had in place during the past calendar year. Clarification on some of the response options can be found below. Select 'Early administration of effective antibiotics to optimize the treatment of sepsis' if your antibiotic stewardship program works with sepsis experts in the facility, as well as pharmacy and microbiology lab, to optimize the treatment of sepsis. Select 'Stopping unnecessary antibiotic(s) in new cases of *Clostridioides difficile* infection (CDI)' if your facility reviews antibiotics in patients with new diagnoses of CDI infection to identify opportunities to stop unnecessary antibiotics Select 'Review of culture-proven invasive (for example, bloodstream) infections' if your facility conducts prospective audit and feedback of new culture or rapid diagnostic results to reduce the time needed to discontinue, narrow, or broaden antibiotic therapy as appropriate. Select 'Review of planned outpatient parenteral antibiotic therapy (OPAT)' if OPAT is reviewed by your antibiotic stewardship program to determine if it is necessary and optimize therapy. Select 'The treating team reviews antibiotics 48-72 hours after initial order (such as, antibiotic time-out)' if providers at your facility reassess the continuing need and choice of antibiotics after more data (including clinical results) become available.
44a. Our stewardship program monitors adherence in using the shortest effective duration of antibiotics at discharge for common clinical conditions (for example community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.	*Conditionally Required.* If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' was selected, select 'Yes' if your facility's antibiotic stewardship program reviews how often patients are discharged on antibiotics for the shortest effective duration; these are retrospective reviews of patterns within the facility. Otherwise, select 'No'.

45. Our facility has in place the following specific 'pharmacy-based' interventions: (Check all that apply.)	*Required*. Select, from the choices listed, the interventions that your facility had in place, over the past calendar year, that are initiated by pharmacists and/or embedded into pharmacy sections of electronic health records.
46. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use. 46a. Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)	*Required*. Select 'Yes' if your facility engaged bedside nurses in actions to optimize antibiotic use over the past calendar year; otherwise, select 'No'. *Conditionally Required*. If 'Yes', select from the choices listed, the interventions that your facility had in place to engage nurses in antibiotic stewardship efforts.
47. Our stewardship program monitors: (Check all that apply.)	*Required*. Select, from the choices listed, the measures that your facility's stewardship team monitored over the past calendar year. Clarification on some of the response options can be found below. For 'Antibiotic resistance patterns (either facility- or region-specific), at least annually': Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (for example, receiving local data from a neighboring facility); or use of the NHSN AR Option. For '*Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually': Monitoring *Clostridioides difficile* includes infection rates or LabID events in your facility. If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at the unit-, service-, and/or facility-wide level, select 'antibiotic use in some other way' and specify the metric.
48. Our stewardship program provides the following antibiotic use reports to prescribers, at least annually: (Check all that apply.) 48a. Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.	*Required*. Specify the reports on antibiotic use that the program shared with prescribers over the past calendar year, from the choices listed. These reports are intended to be targeted towards specific prescribers, units, or services rather than generic facility-wide reports. *Conditionally Required*. If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' was selected, select 'Yes' if your facility's stewardship program provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (for example, academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select 'No.'
49. Our facility distributes an antibiogram to prescribers, at least annually.	*Required*. Select 'Yes' if your facility distributed an antibiogram (a facility cumulative antibiotic resistance report that presents data from lab reports in a way that supports optimal antibiotic use and is consistent with facility guidelines) to prescribers at least once in the past calendar year; otherwise, select 'No.'
50. Information on antibiotic use, antibiotic resistance, and stewardship efforts is presented to facility staff, at least annually.	*Required*. Select 'Yes' if your facility's stewardship program shared updates with facility staff on antibiotic use, antibiotic resistance, and stewardship efforts either via in-person presentations or distribution of written materials, at once in the past calendar year; otherwise, select 'No.'

51. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) at least annually? (Check all that apply.)	*Required*. Select, from the choices listed, the groups in your facility that received education specifically about appropriate antibiotic use, adverse reactions, and antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) within the past calendar year. 'Prescribers' includes both prescribers employed by the facility and licensed independent practitioners.
52. Are patients provided education on important side effects of prescribed antibiotics? 52a. How is education to patients on side effects shared? (Check all that apply.)	*Required*. Select 'Yes' if patients received education on important side effects of prescribed antibiotics; otherwise, select 'No.' *Conditionally Required*. If 'Yes', specify, from the choices listed, how education on side effects of prescribed antibiotics is regularly provided to patients.
Sepsis management and practices. Completion of this section should involve the leader(s) of the Sepsis program, such as a physician or nurse; if your facility does not have a Sepsis program leader, completion should involve other leaders of the work, such as another physician or nurse who focuses on sepsis stewardship or a Sepsis Coordinator.	

53. Our facility has a program or committee charged with monitoring and improving sepsis care and/or outcomes.	*Required*. Select 'Yes' if your hospital or healthcare system has a program or committee charged with monitoring and improving sepsis care and/or outcomes. If there is no sepsis program or committee charged with monitoring and improving sepsis care and/or outcomes, select "no".
53a. If Yes, the responsibilities of this committee include the following: (Check all that apply)	*Conditionally Required*. If 'Yes', please identify which of the below items are responsibilities of the program or committee. If your program or committee does not have any of these responsibilities, select "none of the above". Select 'developing and updating hospital sepsis guidelines' if your hospital's sepsis program or committee has the role of developing and/or updating hospital sepsis guidelines Select 'developing and updating hospital sepsis order sets' if your hospital's sepsis program or committee has the role of working with the information technology team to develop and/or update order sets for use in the electronic health record Select 'monitoring and reviewing compliance with Centers for Medicare & Medicaid SEP-1 measure' if your hospital's sepsis program or committee has the role of monitoring and reviewing compliance with the CMS SEP-1 measure Select 'monitoring and reviewing effectiveness of sepsis identification strategies' if your hospital's sepsis program or committee has the role of monitoring and reviewing the effectiveness of sepsis identification strategies at your hospital Select 'monitoring and reviewing management of patients with sepsis' if your hospital's sepsis program or committee has the role of monitoring and reviewing management of patients with sepsis Select 'monitoring and reviewing outcomes of patients with sepsis' if your hospital's sepsis program or committee has the role of monitoring and reviewing the outcomes of patients with sepsis Select 'monitoring and reviewing antimicrobial use in sepsis in conjunction with antimicrobial stewardship or infectious disease staff' if your hospital's sepsis program or committee is charged with working with the antimicrobial stewardship team or infectious diseases staff to monitor and review antimicrobial use Select 'providing education to hospital staff on sepsis' if your hospital's sepsis program or committee is responsible for overseeing the provision of education to hospital staff on sepsis Select 'setting annual goals for sepsis management and/or outcomes' if your hospital's sepsis program or committee sets the annual goals for sepsis management and/or outcomes
53b. If Yes, this committee includes representatives with the following backgrounds (Check all that apply)	*Conditionally Required*. If 'Yes', please identify the types of healthcare personnel that sit on the hospital's sepsis program or committee. If none of the below groups sits on this program or

	committee, select “none of the above” Select ‘physician’ if at least one physician sits on your hospital’s sepsis program or committee Select ‘nurse’ if at least one nurse sits on your hospital’s sepsis program or committee Select ‘pharmacist’ if at least one pharmacist sits on your hospital’s sepsis program or committee Select ‘advanced practice provider’ if at least one APP sits on your hospital’s sepsis program or committee Select ‘case manager’ if at least one case manager sits on your hospital’s sepsis program or committee Select ‘discharge planner’ if at least one discharge planner sits on your hospital’s sepsis program or committee Select ‘microbiology staff member or laboratory staff member’ if at least one member of the microbiology or lab team sits on your hospital’s sepsis program or committee Select ‘Hospital Epidemiologist or member of the Infection Prevention Team’ if at least one member of the Infection prevention team or a hospital epidemiologist sits on your hospital’s sepsis program or committee Select ‘phlebotomist’ if at least one phlebotomist sits on your hospital’s sepsis program or committee Select ‘Outpatient clinician’ if at least one outpatient clinician sits on your hospital’s sepsis program or committee Select ‘Patients/families/caregivers’ if at least one patient/family/caregiver sits on your hospital’s sepsis program or committee
53c. If Yes, this committee includes representatives from the following hospital locations or services (Check all that apply)	*Conditionally Required.* If ‘Yes’, please identify whether your sepsis program or committee includes representatives from the following locations or services. If the sepsis program or committee does not have representation from any of the groups/departments identified below, select “none of the above”. Select ‘antimicrobial stewardship’ if at least one member of your hospital’s antimicrobial stewardship program sits on your hospital’s sepsis program or committee (e.g., pharmacist, physician) Select ‘critical care/intensive care (excluding neonatal intensive care’ if your hospital’s sepsis program or committee has at least one representative from the critical care department (excluding neonatal intensive care) (e.g., physician, advanced practice provider, nurse) Select ‘data analytics’ if your hospital’s sepsis program or committee has at least one representative from the hospital’s data analytics team

	Select 'emergency medicine' if your hospital's sepsis program or committee has at least one representative from the emergency department (e.g., physician, advanced practice provider, nurse) Select 'hospital medicine' if your hospital's sepsis program or committee has at least one representative from the department of hospital medicine (e.g., hospitalist, advanced practice provider) Select 'infectious diseases' if your hospital's sepsis program or committee has at least one representative from the infectious diseases department (e.g., physician, advanced practice provider) Select 'information technology' if your hospital's sepsis program or committee has at least one representative from the information technology department (e.g., Chief Information Officer, other staff member) Select 'laboratory' if your hospital's sepsis program or committee has at least one representative from the laboratory department Select 'neonatal intensive care' if your hospital's sepsis program or committee has at least one representative from your hospitals' neonatal intensive care unit (e.g., physician, advanced practice provider, nurse) Select 'obstetrics/labor and delivery' if your hospital's sepsis program or committee has at least one representative from the obstetrics department (e.g., physician, advanced practice provider, nurse) Select 'pediatrics' if your hospital's sepsis program or committee has at least one representative from your hospitals' pediatrics department (e.g., pediatrician, advanced practice provider, nurse) Select 'pharmacy' if your hospital's sepsis program or committee has at least one representative from your hospitals' pharmacy department
54. Our facility has one leader or two co-leaders responsible for sepsis program or committee management and outcomes. (Check one) 54a. If yes selected in 54: What is the professional background of the sepsis program or committee leader(s)? (Check all that apply; check at least one response) 54b. If yes selected in 54: Did the sepsis program leader(s) participate in responding to these questions? (Check one)	*Required.* Select 'yes' if at least one individual has been identified to lead the sepsis activities, as evidenced by responsibility for coordinating activities of staff from multiple departments, responsibility for reporting to senior-level management on sepsis activities and outcomes, or having sepsis leadership as part of their job description and/or performance review. Select 'no' if your hospital has no designated leaders or if you have more than two leaders. *Conditionally required.* If yes in question 54, specify the professional background of the leader(s). If none of these apply, select 'none of the above' *Conditionally required.* If yes was answered in question 54, select 'yes' if the leader(s) of the sepsis program or committee assisted in the response to these questions. If the leader(s) did not participate, select 'no'.

54c. If yes selected in 54a: What percentage of the **APP** leader's effort is specified for sepsis activities? If there are two APP leaders, please indicate the sum of their combined effort if it were applied towards a single APP. (Check one)	*Conditionally required.* If '**Advanced practice professional (APP)**' was selected in question 54a, specify the percentage of the APP leaders effort that is specified for sepsis activities. If there are two **APP** leaders, indicate the sum of their combined effort as though it were applied toward a single **APP**. If no percent effort or equivalent is specified, select 'not specified'. This effort should reflect the stated expectation for sepsis efforts, not necessarily the actual effort put forward. Categories for effort include: • 0% (sepsis activities are voluntary with no specified effort) • 1 to 10% • 11 to 25% • 26 to 50% • More than 50% Not specified
54d. If nurse selected in 54a: What percentage of the nurse leader's effort is specified for sepsis activities? If there are two nurse leaders, please indicate the sum of their combined effort if it were applied towards a single nurse.	*Conditionally required.* If '**Nurse**' was selected in question 54a, specify the percentage of the **nurse** leaders effort that is specified for sepsis activities. If there are two **nurse** leaders, indicate the sum of their combined effort as though it were applied toward a single **nurse**. If no percent effort or equivalent is specified, select 'not specified'. This effort should reflect the stated expectation for sepsis efforts, not necessarily the actual effort put forward. Categories for effort include: • 0% (sepsis activities are voluntary with no specified effort) • 1 to 10% • 11 to 25% • 26 to 50% • More than 50% Not specified
54e. If physician selected in 54a: What percentage of the physician leader's effort is specified for sepsis activities? If there are two physician leaders, please indicate the sum of their combined effort if it were applied towards a single physician.	*Conditionally required.* If '**Physician**' was selected in question 54a, specify the percentage of the **Physician** leaders effort that is specified for sepsis activities. If there are two **Physician** leaders, indicate the sum of their combined effort as though it were applied toward a single **Physician**. If no percent effort or equivalent is specified, select 'not specified'. This effort should reflect the stated expectation for sepsis efforts, not necessarily the actual effort put forward. Categories for effort include: • 0% (sepsis activities are voluntary with no specified effort) • 1 to 10% • 11 to 25% • 26 to 50% • More than 50% Not specified

55. Facility leadership has demonstrated commitment to improving sepsis care by: (Check all that apply; check at least one response)	*Required.* Select from the choices below all of the ways in which your hospital leadership has demonstrated commitment to improving sepsis care; if none of these items apply, select "none of the above". Select 'providing sepsis program leader(s) with sufficient time to manage the hospital sepsis program' if your hospital provides sepsis program leadership with sufficient time to manage the hospital's sepsis program. Select 'providing sufficient resources, including data analytics and information technology support, to operate the program effectively' if your hospital provides sufficient resources, such as data analytics and information technology support, to enable the operation of the sepsis program efficiently. Select 'ensuring that relevant staff from key clinical groups and support departments have sufficient time to contribute to sepsis activities' if your hospital ensures that relevant staff from key clinical groups and support departments have sufficient time to contribute to sepsis activities. (e.g., pharmacy, hospital medicine, laboratory, antimicrobial stewardship, etc.). Select 'appointing a senior leader to serve as an executive sponsor for the sepsis program' if your hospital has appointed a senior leader to serve as an executive sponsor for the sepsis program. Select 'identifying sepsis as a hospital priority and communicating this priority to hospital staff' if your hospital has identified sepsis as a hospital and communities this priority through the hospital staff. (e.g., staff email, or other forum for staff announcements). Select 'Having a sepsis coordinator who oversees day-to-day implementation of sepsis activities' if your facility has a designated staff member who performs this role.
56. Our facility uses the following approaches to assist in identification of sepsis upon presentation to the hospital: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches to assist in identification of sepsis upon presentation to the hospital are used by your hospital; if none of these items apply, select "none of the above". Select 'manual screening for clinical instability' if clinicians at your hospital manually screen for clinical instability in patients at the time patients arrive at the hospital using a MEWS (modified early warning score) or NEWS (national early warning score) score (e.g., upon arrival at the emergency department; direct admission to the hospital). Select 'electronic health record (EHR)-based screening for clinical instability' if clinicians at your hospital use an EHR-based screening tool to identify clinical instability at the time patients present to the hospital (e.g., upon arrival at the emergency department; direct admission to the hospital). Select 'manual screening for sepsis criteria' if clinicians at your hospital use a manual process to screen for sepsis criteria at the

	time patients present to the hospital (e.g., upon arrival at the emergency department; direct admission to the hospital). Select 'electronic health record (EHR)-based screening for sepsis criteria if clinicians at your hospital use an EHR-based tool to screen for sepsis criteria at the time that patients present to the hospital (e.g., upon arrival at the emergency department; direct admission to the hospital).
57. Our facility uses the following approaches to assist in the identification of sepsis throughout hospitalization: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches to assist in identification of sepsis throughout hospitalization to the hospital are used by your hospital; if none of these items apply, select "none of the above". Select 'manual screening for clinical instability' if clinicians at your hospital manually screen for clinical instability in patients during the course of their hospitalization using a MEWS (modified early warning score) or NEWS (national early warning score) score (e.g., during stay on a hospital ward or intensive care unit). Select 'electronic health record (EHR)-based screening for clinical instability' if clinicians at your hospital use an EHR-based screening tool to identify clinical instability throughout patients' hospitalization (e.g., during stay on a hospital ward or intensive care unit). Select 'manual screening for sepsis criteria' if clinicians at your hospital use a manual process to screen for sepsis criteria throughout patients' hospitalization (e.g., during stay on a hospital ward or intensive care unit). Select 'electronic health record (EHR)-based screening for sepsis criteria if clinicians at your hospital use an EHR-based tool to screen for sepsis criteria throughout patients' hospitalization (e.g., during stay on a hospital ward or intensive care unit).
58. Our facility uses the following approaches to promote evidence-based management of patients with sepsis: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches your hospital uses to promote evidence-based management of patients with sepsis; if none of these items apply, select "none of the above". Select 'hospital guideline or care pathway for management of sepsis' if your hospital has developed and/or implemented a hospital guideline or care pathway providing standards for how to provide care to sepsis patients. Select 'hospital order set for management of sepsis' if your hospital has developed and/or implemented a hospital order set providing standards for how to provide care to sepsis patients. Select 'structured template for documentation of sepsis treatment' if your hospital has developed and/or implemented a structured template to provide guidance on how to document the treatment of sepsis patients. Select 'Standardized process for verbal hand-off of sepsis treatment' if your hospital has developed and/or implemented a standardized process for verbal hand-off of sepsis treatment, such as at times of transition from one care location to another (e.g., from

	hospital ward to intensive care unit, from emergency department to the hospital ward). Select 'sepsis response team' if your hospital had created a sepsis response team. Select 'rapid response team with training in sepsis management' if your hospital has created a rapid response team with training in sepsis management. Select 'Use of "Code Sepsis" protocol for facilitating prompt recognition and team-based care of sepsis ' if your hospital utilizes a code specific for Sepsis. "Code Sepsis" is typically activated by clinical staff based on suspicion of sepsis, often in response to vital signs and chief complaint upon presentation to the ED. Code sepsis activation triggers a multi-disciplinary team huddle (e.g., physician or physician assistant, primary nurse, ED pharmacist, and ED charge nurse) at the patient's bedside for evaluation of the clinical scenario and initiation of expedited early sepsis treatment (e.g., cultures, lactate measurement, imaging, antimicrobials, fluid) if indicated. .
59. Our facility uses the following approaches to promote rapid antimicrobial delivery to patients with sepsis: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches your hospital uses to promote rapid antimicrobial delivery to patients with sepsis; if none of these items apply, select "none of the above". Select 'stocking of common antimicrobials in locations outside of the pharmacy' if your hospital stocks common antimicrobials in locations outside of the hospital pharmacy, such as in the emergency department, intensive care unit, or hospital wards. Select 'immediate processing of new antimicrobial orders in patients with sepsis' if your hospital processes new antimicrobial orders in patients with sepsis immediately. Select 'orders that default to ordering immediate administration of new antimicrobials' if your hospital has an order-set that defaults to ordering immediate administration of new antimicrobials. Select 'pharmacists on-site in key locations outside the pharmacy' if your hospital has pharmacists that are present in key locations outside the pharmacy, such as the emergency department, intensive care unit, or hospital wards.
60. Our facility uses the following approaches to facilitate recovery after sepsis hospitalization: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches your hospital uses to facilitate recovery for sepsis patients after sepsis hospitalization, if none of these items apply select "none of the above". Select 'communicating a patient's sepsis diagnosis and care plan to the patient's primary care physician' if your hospital provides primary care physicians with patients discharge and care plan (e.g. sending a message to the primary care physician through the electronic health record).

	Select 'providing contact information for a clinical staff at the hospital to addresses post-discharge questions and/or troubleshoot post-discharge issues' if your hospital provides contact information to patients that they can use to address post-discharge questions and/or troubleshoot post-discharge issues (e.g., on call physician or nurse care coordinator; this would not include telling patients to call 911 with questions). Select 'contacting patients within 2 days of discharge by clinical staff to follow-up on discharge instructions, symptoms, and/or issues' if your hospital contacts patients within 2 days of discharge by clinical staff to follow-up on discharge instructions, symptoms, and/or issues (e.g., nurse care coordinator reaches out to patient in 2 days to speak with patient, family, or caregiver). Select 'screening patients for new functional and/or cognitive impairment after sepsis and referring patients to relevant evaluation or support services' if your hospital screens patients for new functional and/or cognitive impairment after sepsis. This includes referring patients to relevant evaluation or support services as appropriate. Select 'reconciling and optimizing medications prior to hospital discharge' if your hospital reconciles and optimizes medications prior to hospital discharge (e.g., physician or advanced practice provider conducts a medication reconciliation prior to discharge). Select 'screening patients for social vulnerability and referring to available support services as needed' if your hospital screens patients for social vulnerability and refer sepsis patients to available support services as necessary.
61. Our facility uses the following approaches to ensure that all patients hospitalized with sepsis (or their family or caregivers) are educated about sepsis. (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches your hospital routinely uses to ensure that all patients hospitalized with sepsis (or their families or caregivers) are educated about sepsis; if none of these items apply select "none of the above are used routinely". Select 'direct 1:1 education on sepsis from a healthcare personnel' if your hospital provides patients and/or their families or caregivers with directed one on one education related to their sepsis diagnosis (e.g., one on one conversation between clinician and patient/family/caregiver to follow-up steps necessary after hospital discharge). Select 'written educational material about sepsis' if your hospital provides patients and/or their families or caregivers with written education materials about their sepsis hospitalization (e.g., provision of written materials at hospital discharge). Select 'pre-recorded video material about sepsis' if your hospital provides patients and/or their families or caregivers with pre-recorded video materials about sepsis their sepsis hospitalization (e.g., provided with a video to watch prior to hospital discharge).

62. Our facility tracks the following hospital sepsis metrics: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the approaches your hospital uses to track the below hospital sepsis metrics; if none of these items apply select "none of the above". Select 'hospital sepsis epidemiology' if your hospital tracks the epidemiology related to sepsis patients (e.g., number of characteristics of sepsis hospitalizations). Select 'hospital sepsis treatment' if your hospital tracks treatment metrics related to sepsis patients (e.g., time-to-antibiotics, type, volume of fluid delivery). Select 'hospital sepsis outcomes' if your hospital tracks outcomes related to sepsis patients (e.g., mortality, length of hospitalization). Select 'progress towards achieving hospital goals for sepsis treatment and/or outcomes' if your hospital tracks progress towards achieving hospital goals for sepsis treatment and/or outcomes. Select 'use of hospital sepsis tools' if your hospital tracks use of tools used to manage patients with sepsis (e.g., how often sepsis order-set is used). Select 'usability or acceptability of hospital sepsis tools' if your hospital tracks the usability/acceptability of hospital sepsis tools (e.g., clinician acceptance). Select 'impact of hospital sepsis tools' if your hospital tracks the impact of hospital sepsis tools (e.g., impact on sepsis alert or order-set on treatment or outcomes).
63. Describe your facility's use of chart review for sepsis performance evaluation and improvement: (Check all that apply; check at least one response)	*Required.* Indicate which of the below best describes your hospital's use of chart review for sepsis performance evaluation and improvement; please select only one response. If your hospital does not use chart review for sepsis performance evaluation and improvement, select "we do not complete routine chart reviews of sepsis hospitalizations".
64. Sepsis treatment and/or outcome data are reported to unit-based or service-based leadership at following frequency. (Check one)	*Required.* Indicate the frequency with which hospital sepsis treatment and/or outcome data are reported to unit-based or service-based leadership. Select 'continuously' if your hospital provides data on sepsis treatment and/or outcomes to unit-based or service-based leadership continuously, such as through a sepsis dashboard that updates in real time. Select 'at least monthly' if your hospital provides data on sepsis treatment and/or outcomes to unit-based or service-based leadership at least once a month. Select 'at least quarterly' if your hospital provides data on sepsis treatment and/or outcomes to unit-based or service-based leadership at least quarterly.

	Select 'at least annually' if your hospital provides data on sepsis treatment and/or outcomes to unit-based or service-based leadership at least annually. Select 'not reported or reported less often than annually' if your hospital does provides data on sepsis treatment and/or outcomes to unit-based or service-based leadership OR provides this information infrequently (less than once per year).
64a. If question 64 has answered either "continuously", "at least monthly", "at least quarterly", or "at least annually": Feedback data provided to clinician and/or unit-based leadership on sepsis treatment and outcomes includes the following elements at least annually. (Check all that apply; check at least one response)	*Conditionally required.* Please select from one or more of the below options if 'continuously', 'at least monthly', 'at least quarterly', or 'at least annually' was selected with regard to feedback data provided to clinician and/or unit-based leadership on sepsis treatment and outcomes. If none of these items apply, select "none of the above". Select 'unit-specific or service-specific data' if your hospital provides feedback on sepsis treatment and/or outcomes to clinician and/or unit-based leadership based on unit or department, such as summary data for the emergency department, intensive care unit, or a particular specialty service. Select 'clinician-specific data' if your hospital if your hospital provides feedback on sepsis treatment and/or outcomes to clinician and/or unit-based leadership based on unit or department, such as data relating to the performance of a specific physician or nurse. Select 'benchmarking or comparative data' if your hospital provides feedback on sepsis treatment and/or outcomes to clinician and/or unit-based leadership using benchmarking or comparative data, such as comparisons to of one unit to another similar unit. Select 'temporal trends' if your hospital provides feedback on sepsis treatment and/or outcomes to clinician and/or unit-based leadership using temporal trends, such as how treatment and/or outcomes have changed over time.
65. Our facility provides education on sepsis to the following groups as part of their hiring or onboarding process: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the groups your hospital provides education to during the onboarding/hiring process, if none of these items apply select "none of the above". Select 'APPs' if your hospital provides education to advanced practice professionals at the time of their hiring/onboarding. Select 'certified nursing assistants' if your hospital provides education to certified nursing assistants at the time of their hiring/onboarding. Select 'nurses' if your hospital provides education to nurses (LPNs, RNs) at the time of their hiring/onboarding. Select 'patient care technicians' if your hospital provides education to patient care technicians at the time of their hiring/onboarding. Select 'physicians' if your hospital provides education to physicians at the time of their hiring/onboarding.

	Select 'trainees' if your hospital provides education to trainees at the time of their hiring/onboarding. This includes nursing students, medical students or residents.
66. Our facility provides sepsis education to the following groups at least annually, for example, through lectures, staff meetings, etc.: (Check all that apply; check at least one response)	*Required.* Select from the choices below all the groups to which your hospital provides education at least annually. If none of these items apply select "none of the above". Select 'APPs' if your hospital provides education to advanced practice professionals at least annually, such as through lectures, staff meetings, etc. Select 'certified nursing assistants' if your hospital provides education to certified nursing assistants at least annually, such as through lectures, staff meetings, etc. Select 'nurses' if your hospital provides education to nurses (LPNs, RNs) at least annually, such as through lectures, staff meetings, etc. Select 'patient care technicians' if your hospital provides education to patient care technicians at least annually, such as through lectures, staff meetings, etc. Select 'physicians' if your hospital provides education to physicians at least annually, such as through lectures, staff meetings, grand rounds, etc.

Facility Water Management Program and Practices (WMP) (Required section. Complete with input from facility water management team.)	
67. Does your facility have a water management program (WMP) to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas,* nontuberculous mycobacteria, and fungi)? 67a. If Yes, who is represented on your WMP team? (Check all that apply)	*Required.* Select 'Yes' if your facility has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify the roles of the team members represented on the water management program team. If 'Other' is selected, specify the role of the team member.
68. Has your facility ever conducted an environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure)? This may include a description of building water	*Required*. Select 'Yes' if your facility has conducted a facility environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No'.

systems using text or basic diagrams that map all water supply sources, treatment systems, processing steps, control measures, and end-use points.	
69. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and/or program preparedness?	*Required.* Select 'Yes' if your facility has ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness; Otherwise, select 'No'.
70. Does your facility regularly monitor the following parameters in the building water system(s)? (Check all that apply) If Yes, do you have a plan for corrective actions when the parameters are not within acceptable limits as determined by your water management program? If Yes, where and how frequently does your facility monitor the parameters?	*Required.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No'. • Disinfectant (such as residual chlorine) • Water temperature • Water pH • Heterotrophic plate counts (HPC) testing • Specific *Legionella* testing • Specific *Pseudomonas* testing *Conditionally Required*. For each parameter, if 'Yes', specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program. *Conditionally Required*. For each parameter, if 'Yes', specify the location of monitoring. If 'Other' is selected, specify the location. (Check all that apply) • Entry point(s) • Cold potable water storage tank(s) • Hot potable water storage tank(s) • Hot water supply • Hot water return • Representative locations throughout cold potable building water system(s) • Representative locations throughout hot potable building water system(s) • Other *Conditionally Required*. For each parameter location, if 'Yes', specify the frequency of monitoring. If 'Other' is selected, specify the frequency. (Check one) • Daily • Weekly • Monthly

	• Quarterly • Annually • Other • N/A
71. Does your facility water management program address measures to prevent transmission of pathogens from wastewater premise plumbing to patients?	*Required.* Select 'Yes' if your facility's water management program addresses measures to prevent transmission of bacterial pathogens from wastewater premise plumbing to patients.; select 'No' if it does not; select 'N/A, my facility does not have a water management program' if your facility does not have a water management program. This questions was intended to address measures to prevent transmission from wastewater premise plumbing such as regularly cleaning and disinfecting surfaces near sink drains, avoiding placement of patient care items or personal items on counters next to sinks, offsetting faucets so they don't discharge directly over sink drains, not discarding patient waste down sinks and minimizing discarding liquid nutritional supplements or other beverages down sinks or toilets, and installing toilet and hopper covers to prevent splashing as outlined in the "Sinks, Drains, Plumbing" section of this website: Reduce Risk from Water | HAI | CDC
Facility Venous Thromboembolism (VTE)	
72. Our facility uses the following venous thromboembolism (VTE) prevention practices ☐ Our facility has a VTE prevention policy. ☐ Our facility has a multidisciplinary team that addresses VTE prevention. ☐ Our facility has a facility-wide VTE prevention protocol that includes VTE and bleeding risk assessments linked to clinical decision support for appropriate VTE prophylaxis options. If [X or yes] above: ○ Our facility has embedded the VTE prevention protocol in admission order sets.	*Required.* Select all that apply and select at least one. Select if your facility has a VTE prevention policy. A VTE prevention policy is a formal written principle or plan of action adopted by facility leadership to prevent VTE in patients. Select if your facility has a multidisciplinary team that addresses VTE prevention. A multidisciplinary team includes representatives from two or more different disciplines or fields of study (e.g., physicians, nurses, pharmacists, quality improvement experts, health informatics experts, etc.). Select if your facility has a facility-wide VTE prevention protocol that includes VTE and bleeding risk assessments linked to clinical decision support for appropriate VTE prophylaxis options. A VTE prevention protocol defines best local practice for the prevention of VTE in patients based on best evidence and includes operational definitions. Clinical decision support tools provide risk-appropriate VTE prophylaxis options based on results of the VTE and bleeding risk assessments. If your facility has a facility-wide VTE prevention protocol selected: Select if your facility has embedded the VTE prevention protocol in admission order sets. Select if your facility provides VTE prevention education, including the importance of VTE prophylaxis, for clinicians at least annually.

☐ Our facility provides VTE prevention education for clinicians annually. ☐ Our facility provides VTE prevention education for patients during their stay at our facility. ☐ Our facility performs audits to determine whether patients are on risk-appropriate VTE prophylaxis and provides clinician feedback for quality improvement. ☐ Our facility tracks the incidence of VTE that develops during a patient's stay at our facility (VTE not present on admission). ☐ Our facility does not do any of the above.	Select if your facility provides VTE prevention education, including the importance of VTE prophylaxis, for patients at any time during their stay at your facility. Select if your facility performs audits to determine whether patients are on risk-appropriate VTE prophylaxis and provides clinician feedback for quality improvement. Select if your facility tracks the incidence of VTE that develops during a patient's stay at your facility (VTE not present on admission). Select if your facility does not do any of the above (no boxes above selected).
Prevention Practices	
73. Does your facility utilize a prevention checklist or bundle for any of the following HAIs? (Check all that apply) [HAIs] At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? [HAIs] Is checklist/bundle adherence shared routinely with the clinical team?	*Required*. Select HAI/s for which a prevention checklist or bundle is utilized. A checklist or bundle could be a grouping of protocols or steps taken to aid in the prevention of the HAI/s selected. *Conditionally required*. For each selected HAI, check the answer choice that best represents the minimum frequency at which adherence to the prevention checklist or bundle is monitored or measured. If the frequency at which adherence is monitored/measured at your facility is not listed as an answer choice, check "Other." If adherence is not monitored/measured, check "Not regularly monitored/measured." *Conditionally required*. For each of the selected HAIs, check "Yes" if checklist/bundle adherence is routinely shared with the clinical team; otherwise, check "No" or "Unknown." The clinical team may be made up of nursing and/or, but not limited to, physicians/providers that are key stakeholders for infection prevention for a facility or part of a facility.
74. Did your facility (or any part of your facility) implement a new HAI prevention strategy within the last calendar year? If yes, check all HAIs that apply. *The following prevention strategies are examples from HAI prevention guidance documents (for example, 2022 SHEA/IDSA/APIC Practice Recommendations – Compendium of Strategies) and are supported by varying levels of evidence. [HAI/s] prevention strategies	*Required*. If your facility implemented a new HAI prevention strategy in within the last calendar year, check "Yes"; otherwise, select "No" or "Unknown." If "Yes" was checked, proceed to select HAI/s for which a new prevention strategy was implemented in the last calendar year. Implementation of new HAI prevention strategies may be facility-wide, or in just part of a facility (for example, unit-wide or service line-wide). *Conditionally required*. For each of the selected HAIs, check all the new prevention strategies your facility implemented in the last calendar year. If your facility implemented a new strategy within the last calendar year that is not listed as an answer choice, check "Other (specify)" and briefly describe the prevention strategy implemented. If your facility has implemented any of the listed prevention strategies,

	but they are not a new strategy (implemented within the last calendar year), do not check those answer choice/s.
75. Does your facility provide training and/or education on HAI prevention to healthcare personnel as it relates to their role? If yes, check all HAIs that apply. [HAI/s] At what frequency is training or education provided? Check all that apply.	*Required*. Check "Yes" if your facility provides training and/or education on HAI prevention to healthcare personnel as it relates to their role; otherwise, check "No" or "Unknown." If "Yes" was checked, proceed to select HAI/s for which training/education is provided. Training or education could be, but is not limited to, orientation programs, simulation trainings, skills fairs, competency assessments, etc. *Conditionally required*. For HAI/s selected, check the answer choice/s that best describes the frequency at which training or education for that HAI is provided. If your facility conducts training at a frequency not listed, select the "Other" answer choice.