



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

Data Field	Instructions for Form Completion
Facility ID #	<i>Required.</i> The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	<i>Required.</i> Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2017, a facility would complete a 2016 survey.
<b>Facility Characteristics</b>	
Ownership (check one)	<i>Required.</i> Select the appropriate ownership of this facility: <ul style="list-style-type: none"> <li>• P - For profit</li> <li>• NP - Not for profit, including church</li> <li>• GOV - Government</li> <li>• MIL - Military</li> <li>• VA- Veterans Affairs</li> <li>• PHY - Physician owned</li> </ul>
Number of patient days	<i>Required.</i> 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	<i>Required.</i> 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?	<i>Required.</i> If a teaching hospital, select 'Yes'. Otherwise, select 'No'.
If Yes, what type?	<i>Conditionally Required.</i> 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.) <ul style="list-style-type: none"> <li>• <b>Major:</b> Facility has a program for medical students and post-graduate medical training.</li> <li>• <b>Graduate:</b> Facility has a program for post-graduate medical training (i.e., residency and/or fellowships).</li> <li>• <b>Undergraduate:</b> Facility has a program for medical/nursing students only.</li> </ul>



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Number of beds set up and staffed in the following location types (as defined by NHSN)	<i>Required.</i> Record the maximum 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 year's worth of data from which to obtain the maximum number, indicate the maximum number from the number of months available. For definitions of CDC location types, see <a href="#">CDC Locations and Descriptions</a> 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.
<b>Facility Microbiology Laboratory Practices.</b> <i>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.</i>	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	<i>Required.</i> Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'.  <i>Conditionally Required.</i> 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.
2. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	<i>Required.</i> Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism.  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, please 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.



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3. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	<i>Required.</i> Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
4. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	<i>Required.</i> Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Does your laboratory perform a special test for the presence of carbapenemase? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply).	<p><i>Required.</i> Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'.</p> <p><i>Conditionally Required.</i> If 'Yes', specify what is done if carbapenemase production is detected.</p> <p><i>Conditionally Required.</i> If 'Yes', specify which test is performed to detect carbapenemase.</p>
6. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	<p><i>Required.</i> Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'.</p> <p><i>Conditionally Required.</i> If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.</p>



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7. Does your facility have its own laboratory that performs antifungal susceptibility testing for <i>Candida</i> species? If No, where your facility's antifungal susceptibility testing is performed? (check one).	<i>Required.</i> Select 'Yes' if your laboratory performs antifungal susceptibility testing for <i>Candida</i> species; otherwise, select 'No'.  <i>Conditionally Required.</i> If 'No', select one of the choices provided.
8. If antifungal susceptibility testing is performed at your facility or an outside laboratory, what methods are used? (check all that apply)	<i>Required.</i> Select from the choices listed the method(s) of antifungal susceptibility testing performed at your facility or an outside laboratory. If 'Other' is selected, please specify.
9. Is antifungal susceptibility testing performed automatically/reflexively without needing a specific order or request for susceptibility testing from the clinician for the below <i>Candida</i> species when cultured from normally sterile body sites (such as blood)? Check all species and corresponding drugs for which automatic testing is done.	<i>Required.</i> Select the appropriate <i>Candida</i> species and drugs for which your laboratory or outside laboratory automatically/reflexively performs antifungal susceptibility testing from normally sterile body sites (such as blood), without needing a specific order or request for susceptibility testing from the clinician. If antifungal susceptibility testing is not performed automatically on <i>Candida</i> species, select "Automatic testing is not performed for any <i>Candida</i> species".
10. What is the primary testing method for <i>C. difficile</i> used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	<i>Required.</i> Select from the choices listed the testing methods used to perform <i>C. difficile</i> testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify.  <b>Note:</b> "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of <i>C. difficile</i> tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.



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<p>11. Does your facility produce an antibiogram (i.e., cumulative antimicrobial susceptibility report)?</p> <p>If Yes, is the antibiogram produced at least annually?</p> <p>If Yes, are data stratified by hospital location?</p> <p>If No, please identify any obstacle(s) to producing an antibiogram. (Check all that apply)</p>	<p><i>Required.</i> Select 'Yes' if your facility produces an antibiogram; otherwise select 'No'.</p> <p><i>Conditionally Required.</i> If 'Yes', indicate whether the antibiogram is produced at least annually.</p> <p><i>Conditionally Required.</i> If 'Yes', indicate whether antibiogram data are stratified by hospital location.</p> <p><i>Conditionally Required.</i> If 'No', indicate the obstacle(s) to producing an antibiogram at your facility. If 'Other' is selected, please specify.</p>
<p><b>Infection Control Practices.</b> <i>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.</i></p>	
12. Number or fraction of infection preventionists (IPs) in facility	<p><i>Required.</i> Enter the number or fraction of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.</p>
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	<p><i>Required.</i> Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. 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.</p>
<p><i>For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (<a href="http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf">http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf</a>).</i></p>	
14. Is it a policy in your facility that patients infected or	<p><i>Required.</i> Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best</p>



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colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)	choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.
15. Is it a policy in your facility that patients infected or colonized with VRE are routinely placed in contact precautions while these patients are in your facility? (check one)	<i>Required.</i> Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.
16. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)	<i>Required.</i> Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.
17. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)	<i>Required.</i> Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select 'Not applicable'.



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<p>18. Does the facility routinely perform screening testing (culture or non-culture) for CRE?</p> <p>If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)</p>	<p><i>Required.</i> Select 'Yes' if the facility routinely (i.e., 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 CRE; select no if either testing is not routinely performed or not performed at all.</p> <p><i>Conditionally Required.</i> If 'Yes', select <b><u>all</u></b> the situations for which screening testing is done <b><u>routinely</u></b>. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed.</p> <p>Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. 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.</p>
<p>19. Does the facility routinely perform screening testing (culture or non-culture) for MRSA?</p> <p>If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)</p>	<p><i>Required.</i> Select 'Yes' if the facility routinely (i.e., 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.</p> <p><i>Conditionally required.</i> If 'Yes', select <b><u>all</u></b> the situations for which screening testing is done <b><u>routinely</u></b>. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.</p>
<p>20. Does the facility routinely use chlorhexidine bathing on any patients to prevent infection or transmission of MDROs at your facility? Note: this does not include the use of such bathing in pre-operative patients to prevent surgical site infections (SSIs)</p>	<p><i>Required.</i> Select 'Yes' if your facility <b><u>routinely</u></b> uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent SSIs.</p> <p>Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.</p>





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21. Does the facility routinely use a combination of topical chlorhexidine <u>and</u> intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)	<i>Required.</i> Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used <b>routinely</b> (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in dialysis patients or patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients or to prevent infection in dialysis patients.
22. Among patients with an MDRO admitted to your facility from another healthcare facility, please estimate how often your facility receives information from the transferring facility about the patient's MDRO status?	<i>Required.</i> Please select the most appropriate response that indicates approximately how often your facility receives information from a transferring facility about the MDRO status of a patient known to be colonized or infected with an MDRO. If your facility does not receive transferred patients, or does not receive transferred patients with a known MDRO, select 'Not applicable'.
<b>Antibiotic Stewardship Practices.</b> <i>Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (<a href="http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html">http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html</a>). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.</i>	
23. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?	<i>Required.</i> Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.
24. Is there a leader responsible for stewardship activities at your facility?	<i>Required.</i> Select 'Yes' if any individual has been identified as a lead to antibiotic stewardship activities as evidenced by responsibility for improving antibiotic use in the job description or performance review, authority to coordinate activities of staff from multiple departments (e.g. laboratory, pharmacy, information





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If Yes, what is the position of this leader? (check one)	technology), and/or responsibility to report to senior level management on program planning and outcomes.  <i>Conditionally Required.</i> If 'Yes', specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position.
25. Is there at least one pharmacist responsible for improving antibiotic use at your facility?	<i>Required.</i> 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'.
26. Does your facility provide any salary support for dedicated time for antibiotic stewardship leadership activities?	<i>Required.</i> Select 'Yes' if any individual was given salary support (any amount) to serve as a leader of the stewardship program; otherwise, select 'No'.
27. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?  If Yes, has adherence to the policy to document an indication been monitored?	<i>Required.</i> Select 'Yes' if your facility has a policy requiring documentation of dose, duration and indication for all antibiotics in the medical record or during order entry; otherwise, select 'No'.  <i>Conditionally Required.</i> If 'Yes' to question 27, select 'Yes' if charts have been audited to confirm documentation of dose, duration, and indication in patient medical records; otherwise, select 'No'.
28. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?  If Yes, has adherence to facility-specific treatment recommendations been monitored?	<i>Required.</i> Select 'Yes' if there are facility-specific recommendations for antibiotic treatment selection based on national guidelines <u>and local susceptibility</u> reports for ANY common clinical conditions (e.g., community acquired pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'.  <i>Conditionally Required.</i> If 'Yes' to question 28, select 'Yes' if charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above; otherwise, select 'No'.



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29. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g. antibiotic time out)?	<i>Required.</i> Select 'Yes' if your facility has developed a standardized way for clinicians on the treating team (or attending physician? or physician of record?) to reassess the continuing need and choice of antibiotics at or after 48 hours after the initial orders (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration); otherwise, select 'No'.
30. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?	<i>Required.</i> Select 'Yes' if your facility has at least one antibiotic agent that requires a physician or pharmacist to review and approve administration of the drug due to its spectrum of activity, cost, or associated toxicities; otherwise, select 'No'.
31. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers at your facility?  If yes, what type of feedback is provided to prescribers? Check all that apply.	<i>Required.</i> Select 'Yes' if your facility had physicians or pharmacists knowledgeable in antibiotic use, and not part of the treating team, review courses of therapy for specified antibiotic agents <u>and</u> communicate the results to prescribers (such as audit with feedback); otherwise, select 'No'.  <i>Conditionally required.</i> Select the type(s) of feedback that is provided to prescribers.
32. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide?  If Yes, by which metrics (Check all that apply)	<i>Required.</i> Select 'Yes' if your facility monitors antibiotic use or consumption at the unit, service, and/or facility wide level at least quarterly; otherwise, select 'No'.  <i>Conditionally Required.</i> If 'Yes', select from the choices of listed antibiotic use metrics. Days of Therapy (also known as Antimicrobial Days) is defined by any amount of a specific antimicrobial agent administered in a calendar day to a particular patient (i.e., each antimicrobial agent administered to a patient counted as one day of therapy). The Defined Daily Dose is the assumed average maintenance dose per day for a drug used for its main indication in adults and is derived from the total number of grams of each antibiotic purchased, dispensed, or administered. If 'Other' is selected, please specify the method(s) or metric(s) used.



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If Yes, are facility- and/or unit-specific reports on antibiotic use shared with prescribers?	<i>Conditionally Required.</i> Select 'Yes' if facility and/or unit-specific reports on antibiotic use are shared with prescribers (individually, by service line, by medical group, etc.); otherwise, select 'No'.
33. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use?	<i>Required.</i> Select 'Yes' if your facility has provided education on how to improve antibiotic use to clinicians and other relevant staff (e.g. Grand Rounds, in-service training, or direct instruction); otherwise, select 'No'.