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 2022, a facility would complete a 2021 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 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 years' 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 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.
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?	*Required.* Select 'Yes' if your facility has its own onsite laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'.
If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*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.
2. For the following organisms 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 (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, 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.

3. Does either the primary or secondary/supplemental antimicrobial susceptibility testing of *Pseudomonas* spp., include ceftolozane-tazobactam?	*Required.* Select 'Yes' if either the primary or secondary/supplemental antimicrobial susceptibility testing of *Pseudomonas* spp., includes ceftolozane-tazobactam; otherwise, select 'No'. If your lab does not perform AST for *Pseudomonas* spp., select 'Not Applicable.'
4. Has your laboratory implemented the revised breakpoints recommended by CLSI as of 2010?	
a. Cephalosporin and monobactam breakpoints for *Enterobacterales* in 2010	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae 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 Enterobacteriaceae 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'.
5. Does your laboratory test bacterial isolatesfor carbapenemase?	*Required.* Select 'Yes' if your laboratory tests bacterial isolates for carbapenemase production; otherwise, select 'No'.
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) are tested for the presence of carbapenemase. It is not required that the lab test all species within the pathogen group (for example, select "*Pseudomonas* spp." even if the only carbapenem-resistant *Pseudomonas aeruginosa* are tested for the presence of a carbapenemase). It is not required that labs test all isolates in each group (for example, select "*Enterobacterales*" even if the lab tests only a subset of *Enterobacterales* isolates that are carbapenem-resistant).

6. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli* and/or *Klebsiella spp.* either routinely or using a testing algorithm?	*Required.* Select 'Yes' if your facility routinely performs extended-spectrum beta-lactamase (ESBL) testing for E. coli or Klebsiella spp. or through an algorithm.
6a. If Yes, indicate what is done if ESBL is detected: (check one).	*Conditionally Required.* If 'Yes', indicate how laboratory results are managed if ESBL is detected
7. 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 8–13 for the laboratory that *performs yeast identification for your facility*:	
8. Which of the following methods are used for yeast identification? (check all that apply)	*Required.* Select from the choices listed, one or more methods used for yeast identification. If 'Other' is selected, specify.
9. Does the laboratory routinely use Chromagar for the identification or differentiation of *Candida* isolates?	*Required.* Select 'Yes' if the laboratory routinely uses Chromagar for the identification or differentiation of *Candida* isolates.
10. *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.
11. Does the laboratory employ any culture-independent diagnostic tests (CIDTs) to identify *Candida* from blood specimens?	*Required.* Select 'Yes' if the laboratory employs any culture-independent diagnostic tests (CIDT) to identify *Candida* from blood specimens.
11a. If yes, which culture-independent diagnostic tests (CIDTs) are used to identify *Candida* from blood specimens? (check all that apply)	*Conditionally Required.* If Yes, select the culture-independent diagnostic tests (CIDTs) used to identify *Candida* from blood specimens.
12. Are any culture-independent diagnostic tests (CIDTs) used to specifically identify *Candida auris* from clinical specimens?	*Required.* Select 'Yes' if there are any culture-independent diagnostic tests (CIDTs) used to specifically identify *Candida auris* from clinical specimens.
12a. If yes, which culture-independent diagnostic tests (CIDTs) are used to identify *Candida auris* from clinical specimens? (check all that apply)	*Conditionally Required.* If Yes, select the culture-independent diagnostic tests (CIDT) used to identify *Candida auris* from clinical specimens.

13. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check one)	*Required.* Select where is antifungal susceptibility testing (AFST) is performed for specimens collected at your facility.
Answer questions 14–18 for the laboratory that *performs AST for your facility*:	
14. What method is 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.
15. What method is 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.
16. If Vitek is used for AFST, which *Candida* species do you test with it? (check all that apply)	*Conditionally Required.* If Vitek is used for AFST, select the *Candida* species tested with it.
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.
18. AFST is performed on fungal isolates in which of the following situations:	*Required.* For each of the body sites listed select the most appropriate response for when antifungals susceptibility testing is performed. Choose "Performed automatically/ reflexively" 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. 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.
20. Indicate the primary and definitive method used to identify microbes from blood specimens collected in your facility. (check one)	*Required.* Select 'One Answer' indicating your facility's primary and definitive method used to identify microbes from blood specimens collected.

21. Indicate any additional secondary methods used for microbe identification from blood specimens collected in your facility (for example, a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). (check all that apply)	*Required.* Select 'All that Apply' indicating your facility's secondary methods used for microbe identification from blood specimens collected 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.*	
22. 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.
a. 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.
b. 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.
23. 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 .	
24. 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)	*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'.
24a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility	*Conditionally Required.* If Yes, indicate which type of patients the policy requires are routinely placed in Contact Crecautions 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.

25. 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? 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 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.
26. 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) 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 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.
27. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant *Enterobacteralesare* 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 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.
28. Does the facility routinely perform screening testing (culture or non-culture) for CRE? 28a. 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. Note: 'Epidemiologically-linked' patients refer to healthcare contacts of the patient with newly identified CRE. This might include current or prior roommates, patients who shared the same healthcare personnel, or patients who are located on the same unit or ward.
29. 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.	*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.

29a. If Yes, in which situations does the facility routinely perform screening testing for Candida auris? (check all that apply) 29b. If Yes, what method is routinely used by the lab conducting *Candida auris* testing of screening swabs from your facility?	*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.
30. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings? 30a. If yes, in which situation does the facility routinely perform screening testing for MRSA? (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 for MRSA. 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 MRSA screening is performed.
31. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings? 31a. If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (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 for MRSA; 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 MRSA screening is performed.
32. 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? 32a. If yes, indicate which patients: (select all that apply)	*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. Select 'No' if your facility does not have this policy. If 'Yes', indicate which patients are subject to this policy.

33. 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.
33a. 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 7 questions. Facilities that do not provide neonatal care at any level will answer N/A for question 31 and skip questions 32-36.

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.

34. Was this section completed in collaboration with your facility's neonatal or newborn patient care team? For example, was input sought from a neonatal or newborn patient care team member, such as a NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner)?	*Required.* Select 'Yes' if input was sought from one or more of the listed neonatal or newborn patient care team members. Select 'No' if input was not sought from any of the listed neonatal or newborn patient care team members. Select 'N/A' if your facility does **not** provide neonatal or newborn patient care at any level, such as your facility does not have any of the following NHSN location types: - Well newborn nursery/mother-baby unit (Level I) - 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

If N/A was selected in question 34 above, questions 35–39 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*	
35. 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.
36. 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 32 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.
37. Does your facility provide Level III (or higher) neonatal 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)?	*Required.* Select 'Yes' if your facility has one or more Level II/III, Level III or Level IV NICU; otherwise, select 'No.' <u>American Academy of Pediatrics Neonatal Levels of Care:</u> **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.
38. 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.'
39. 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 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.	**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. 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.
39a. If answer choice c. or d. was selected in question 36 above, to which neonatal unit would a baby be transferred in order to receive oral or parenteral antimicrobials (select all that apply)	*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 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 36). Select 'Level II special care nursery' if newborns requiring antimicrobials (via route(s) specified in question 36) 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 36) 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 newly 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.	
40. Did the antibiotic stewardship leader(s) participate in completing these questions? (Check one.)	*Required.* indicate which antibiotic stewardship leader(s), if any, participated in completing the 'Antibiotic Stewardship Practices' portion of the survey. If no antibiotic stewardship leader participated, either because your facility does not have an appointed leader or the appointed leader(s) did not participate, select 'No.'
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 33b, 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. For which categories of antimicrobials? answer for the following categories of antimicrobials, *whether or not* they are on formulary. (Check all that apply.)	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected, specify for which categories of antimicrobials the stewardship team reviews courses of therapy for specified agents and provides feedback and recommendations to the treating team (such as, prospective audit and feedback). select all categories containing at least one relevant antimicrobial that undergoes prospective audit and feedback regardless of whether or not it is on formulary in your facility.
43b. 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'.
43c. For which categories of antimicrobials? *only* answer for categories of antimicrobials that are *on formulary*. (Check all that apply.)	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. only select categories containing at least one relevant antimicrobial requiring preauthorization that is on formulary.
43d. 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'.
41e. 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, specify which common clinical conditions listed this applies to. If your facility does not have such recommendations for those listed, select 'None of the above.'
43f. 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).	*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'.
43g. For which common clinical conditions?	*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.	*Required*. Select 'Yes' if your facility engaged bedside nurses in actions to optimize antibiotic use over the past calendar year; otherwise, select 'No'.
46a. Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)	*Conditionally Required*. If 'Yes', select from the choices listed, the interventions that your facility had in place to engage nurses in antibiotic stewardship efforts.
46b. Is that information available at the bedside (for example, on a whiteboard in the room)?	*Conditionally Required*. If selected "Nurses track antibiotic duration of therapy" was selected, select 'Yes' if the information about antibiotic duration of therapy was available at the patient's bedside (for example, on a whiteboard in the room, on a clipboard, etc.); otherwise, select 'No.'

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.

53. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.	*Optional*. Select 'Yes' if your facility's antibiotic stewardship activities are developed or implemented in conjunction with quality improvement and/or patient safety initiatives in the facility (for example, the stewardship team works with the quality improvement or patient safety team to implement stewardship interventions, the stewardship team participates in quality improvement meetings regarding sepsis core measures); otherwise, select 'No.'
54. Our facility accesses remote stewardship expertise (for example tele-stewardship) to obtain support for our antibiotic stewardship efforts.	*Optional.* Select 'Yes' if, over the past calendar year, your facility ever accessed remote stewardship expertise that was specifically targeted for your facility's antibiotic stewardship efforts. This typically occurs when antibiotic stewardship expertise is not otherwise available at the facility to provide specific feedback or recommendations needed. This does *not* include generic stewardship resources (for example, webinars) or using remote methods (for example, telephone) to contact an antibiotic steward who otherwise works onsite at the facility; otherwise, select 'No.'
55. Our stewardship program works with the microbiology laboratory to implement the following interventions: (Check all that apply.)	*Optional*. Select, from the choices listed, the ways in which your stewardship program worked with your facility's microbiology laboratory to implement antibiotic stewardship interventions over the past calendar year. Select 'Selective reporting of antimicrobial susceptibility testing results' if your facility tailors facility susceptibility reports to show antibiotics that are consistent with facility treatment guidelines or recommendations by the stewardship program. Select 'Placing comments in microbiology reports to improve prescribing' if, for example, information is included to help providers know which pathogens might represent colonization or contamination.
56. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship program? (Check all that apply.)	*Optional*. Select, from the choices listed, the group(s) that provide(s) oversight of your facility's antibiotic stewardship efforts and to whom the antibiotic stewardship leader is accountable. If 'Other' is selected, specify the committee or job title. Select 'None' if no further oversight is provided to the antibiotic stewardship leader(s).
Sepsis management and practices	
57. Our facility has a committee charged with monitoring and reviewing sepsis care and/or outcomes.	*Required*. Select 'Yes' if your facility has a committee charged with monitoring and reviewing sepsis care and/or outcomes; otherwise, select 'No'.
57a. If Yes, the responsibilities of this committee include the following: (Check all that apply)	*Conditionally Required*. If 'Yes', select from the choices below the responsibilities listed for this committee.
57b. If Yes, this committee includes representatives with the following backgrounds (Check all that apply)	*Conditionally Required*. If 'Yes', select from the choices the backgrounds of persons in the committee. Select 'Other' if there are members of the sepsis committee from backgrounds not mentioned in the options above. Please describe this background in the free text section.
57c. If Yes, this committee includes representatives from the following hospital locations or services (Check all that apply)	*Conditionally Required.* If 'Yes', select from the choices the hospital locations or services of persons in the committee.

	Select 'Other' if there are sepsis committee representatives from hospital locations or services not mentioned in the options above. Please describe this background in the free text section.
58. Facility leadership has demonstrated commitment to improving sepsis care by: (Check all that apply.)	*Required*. Select from the choices the ways in which facility leadership demonstrated their commitment to improving sepsis care in your facility during the past calendar year. Clarification on some of the response options can be found below. Select 'Providing sepsis program leader(s) dedicated time to manage a sepsis program and conduct daily activities' if any leaders of the committee supervising sepsis care activities have been either required to lead these activities as part of their job description or have been granted or assigned protected time from their other clinical or other job responsibilities to dedicate to sepsis activities. Select 'Allocating resources (for example, IT support, training for stewardship team) to support sepsis efforts.' if facility leadership have dedicated resources such as information technology or data analyst support for the committee supervising sepsis care activities. 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 'Presenting information on sepsis activities and outcomes to facility leadership and/or board at least annually.' if your program reports sepsis activities and outcomes to senior leadership and/or the facility board at least once per year This presentation may be during a meeting, or otherwise sharing reports or information up the chain to leadership. Select 'Ensuring the sepsis program has an opportunity to discuss resource needs with facility leadership and/or board at least annually.' if your program has the opportunity to discuss resource needs with senior leadership and/or the facility board at least once per year. Select 'Communicating to staff about sepsis activities, via email, newsletters, events, or other avenues' if there is evidence of broad-reaching communication from senior-level management to facility staff about sepsis activities within the past calendar year. Examples include written communication to facility staff that encourages early recognition of sepsis, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility's sepsis efforts. Select 'Providing opportunities for hospital staff training on sepsis protocols' if facility leadership or management has provided staff sepsis education in-house (for example, workshops, lectures) or access to sepsis educational materials (for example, links to professional society guidelines, online resources) within the past calendar year.

	Select 'Providing a formal statement of support for a sepsis program (for example, a written policy or statement approved by the board)' if there is evidence of senior-level management support focused on efforts to improve sepsis care (for example, formal letter of support for sepsis care improvement 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 sepsis activities' if your facility ensures other groups and departments in the facility are aware of sepsis efforts and collaborate with the sepsis program.
59. Our facility uses the following approaches to assist in the rapid identification of patients with sepsis: (Check all that apply.)	*Required*. Select from the choices below all of the methods used within your facility to assist in the rapid identification of patients with sepsis. Select 'Electronic Health Record (EHR)-generated alert based on Systemic Inflammatory Response Syndrome (SIRS) criteria' if your hospital has an EHR-generated alert based that is generated when a patient meet parts of the SIRS criteria, which was originally defined as at least 2 of the following criteria: 1) Temperature >38°C (100.4°F) or less than 36°C (96.8°F), 2) Heart Rate >90, 3) Respiratory rate >20 or PaCO2 <32mm Hg, and 4) White Blood Cell Count >12,000/mm^3, <4,000/mm^3, or >10% bands. Select this option even if your facility uses a modified version of the SIRS criteria. Select 'EHR-generated alert based on qSOFA (Quick SOFA) criteria' if your hospital has an EHR-generated alert based that is generated when a patient meet qSOFA or Quick SOFA criteria (at least two of the following: 1) Glasgow coma scale score <15, 2) Respiratory rate ≥22, 3) Systolic blood pressure ≤100). Select this option even if your facility uses a modified version of qSOFA. Select 'EHR-generated alert based on a predictive model' if your hospital has an EHR-generated alert based that is generated when a predictive model identifies a patient as high risk for sepsis. Select 'EHR-generated alert using other criteria not already specified' if your hospital has an EHR-generated alert that uses another criterion not including SIRS criteria, qSOFA, or a predictive model. Select 'Manual screening (for example, use of a checklist) using Systemic Inflammatory Response Syndrome (SIRS) or similar criteria' if your hospital has a manual screening system based on the SIRS criteria, which was originally defined as at least 2 of the following criteria: 1) Temperature >38°C (100.4°F) or less than 36°C (96.8°F), 2) Heart Rate >90, 3) Respiratory rate >20 or PaCO2 <32mm Hg, and 4) White Blood Cell Count >12,000/mm^3, <4,000/mm^3, or >10% bands. Select this option even if your facility uses a modified version of the SIRS criteria. Select 'Manual screening (for example, use of a checklist) using qSOFA (Quick SOFA) or similar criteria' if your hospital has a manual screening system that is based on qSOFA or Quick SOFA criteria (at least two of the following: 1) Glasgow coma scale score <15, 2) Respiratory rate ≥22, 3) Systolic blood pressure ≤100). Select this option even if your facility uses a modified version of qSOFA.

	Select 'Manual screening (for example, use of a checklist) using other criteria not already specified' if your hospital has a manual sepsis screening process that uses another criterion not including SIRS criteria or qSOFA. Select 'No standardized process' if your facility does not have a standardized alert system or screening process for sepsis. Select 'Other' and complete the free text section if your hospital uses an approach to the rapid identification of sepsis that was not mentioned above.
60. Our facility uses the following approaches to assist in the management of patients with sepsis: (Check all that apply.)	*Required*. Select from the choices below all of the methods used within your facility to assist in the management of patients with sepsis. Select 'Protocols that help identify and tailor care for patients with septic shock (for example, vasopressor orders)' if your facility provides specific protocols that help identify and tailor care for patients with septic shock. For example, those may include order sets with vasopressor orders. Select 'Protocols that prompt the ordering of sepsis diagnostic tests such as blood cultures, lactate, urinalysis, chest radiography, etc.' if your facility provides specific protocols that include prompts or lists of recommended or common diagnostic tests such as blood cultures, lactate, urinalysis, chest radiography, or other tests. Select 'Protocols that prompt the ordering of preferred antimicrobial treatment regimens for sepsis and/or underlying infection types.' if your facility provides specific protocols that include prompts or lists of recommended antimicrobial treatments for sepsis or specific infection types, such as pneumonia, urinary tract infections, abdominal infections, skin and soft tissue infections, sepsis without a clear source, sepsis with neutropenia, or other scenarios. Select 'Protocols that prompt the ordering of intravenous fluids.' if your facility provides specific protocols that include prompts or lists of recommended intravenous fluids to administer in patients with sepsis. Select 'Protocols that prompt the reassessment of resuscitative efforts.' if your facility provides specific protocols that include prompts orders that direct a reassessment of resuscitative efforts in patients with sepsis or septic shock. Select 'Protocols that are tailored to specific populations (for example, neonates, pregnant, oncology, or neutropenic patients, etc.)' if your facility provides sepsis protocols that are tailored to specific populations, such as neonates, pregnancy, oncology, neutropenic patients, etc. These customized order sets may contain, for example, additional diagnostic studies and/or preferred antimicrobial order sets. Select 'Automated systems (for example, EHR timers, prompts, or dashboards) that facilitate compliance with time-sensitive aspects of sepsis care.' if your facility provides automated systems that help prompt time-sensitive aspects of sepsis care, such as timely antibiotic use, and timely assessments of resuscitation. These automated systems could take the form of EHR timers or running clocks, timed provider prompts, or dashboards for monitoring broader compliance.

	Select 'No standardized sepsis protocols or automated systems for sepsis care prompting or monitoring' if your facility has no standardized sepsis protocols, time-sensitive prompts for sepsis care such as timely blood culture collection and antimicrobial administration, or automated systems for monitoring sepsis care compliance, such as dashboards. Select 'Other systemic approach' if your facility uses a systemic approach to assist with sepsis management that was not mentioned in the above choices. Describe that approach in the free text section.
Facility Water Management Program (WMP) (Required section. Complete with input from facility water management team.)	
61. 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)?	*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' .
61a. If Yes, who is represented on your WMP team? (Check all that apply)	*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.
62. 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 systems using text or basic diagrams that map all water supply sources, treatment systems, processing steps, control measures, and end-use points.	*Required*. Select 'Yes' if your facility has conducted a facility risk 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'
62a. If Yes, when was the most recent assessment conducted? (Check one)	*Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted.
63. 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? An example WICRA tool can be accessed at https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf	*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
63a If Yes, when was the most recent assessment conducted? (Check one)	*Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted.

64. Do you regularly monitor the following parameters in your building's water system? (Check all that apply) If Yes, do you have a plan for corrective actions when disinfectant levels are not within acceptable limits as determined by your water management program?	*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 *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?