# Instructions for Completion of the Patient Safety Annual Facility Survey for IRF (CDC 57.151)

| Data Field | Instructions for Form Completion |
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| 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:<br>• For profit<br>• Not for profit, including church<br>• Government<br>• Veterans Affairs |
| Affiliation (check one) | *Required.* Select the appropriate affiliation for this facility:<br>• Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution.<br>• Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system.<br>• Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure. |
| How would you describe your licensed inpatient rehabilitation facility? (check one) | *Required.* Select the appropriate classification of your inpatient rehabilitation facility:<br>• Free-standing - The rehabilitation facility functions as a stand-alone facility. Patients receive all required care within the constructs of this facility. The facility may share a building with another healthcare facility, but does not share staff, patients, or policies (such as infection control) with the other healthcare facility.<br>• Healthcare facility based - The rehabilitation facility functions as part of a larger healthcare facility. Patients can be transported from the rehabilitation area to the healthcare facility area on a regular/daily basis for procedures or therapy. The facility may share staff and policies (such as infection control) with the affiliated healthcare facility. |
| Total number of rehab beds | *Required.* Enter the total number of beds in your inpatient rehabilitation facility during the last full calendar year. |
| Average daily census | *Required.* Enter the average number of patients housed each day in your inpatient rehabilitation facility during the last full calendar year. Round to the nearest whole number. |

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| Number of patient days | *Required.* Enter the total number of patient days for your inpatient rehabilitation facility during the last full calendar year. |
| Average length of stay | *Required.* Enter the average number of days that patients stay in your inpatient rehabilitation facility during the last full calendar year. Round to the nearest whole number. |
| Number of airborne infection isolation room (AIIR) beds | *Required.* Record the number of staffed airborne infection isolation room (AIIR) beds for the last full calendar year.<br><br>An Airborne Infection Isolation Room (AIIR) is a private patient room designed with specialized ventilation and air-handling systems that comply with the standards set by the American Institute of Architects and the Facility Guidelines Institute (AIA/FGI). |
| Indicate the number of admissions with the primary diagnosis for each of the following rehabilitation categories (*must sum to the total number of admissions listed below*) | *Required.* For your inpatient rehabilitation facility during the last full calendar year, enter the number of admissions with the primary diagnosis for each of the categories listed.<br>• Traumatic spinal cord dysfunction<br>• Non-traumatic spinal cord dysfunction<br>• Stroke<br>• Brain dysfunction (non-traumatic or traumatic)<br>• Other neurologic conditions (for example, multiple sclerosis, Parkinson's disease, etc.)<br>• Orthopedic conditions (incl. fracture, joint replacement, other)<br>• All other admissions |
| Total number of admissions | *Required.* The total number of admissions will be automatically summed from the categories above.<br>Additionally, enter the total number of admissions that were patients on a ventilator as well as the number that were pediatric (≤ 18 years old) admissions. |
| **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 on-site laboratory that performs antimicrobial susceptibility testing?<br><br>1a. If No, where is your facility's antimicrobial susceptibility testing performed? (check one)<br><br>1b. If Yes, do you also send out any antimicrobial susceptibility testing? (check one) | *Required.* Select 'Yes' if your facility has its own onsite laboratory that performs antimicrobial susceptibility testing; otherwise, select 'No'.<br><br>*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.<br><br>*Conditionally Required*. If your facility has its own laboratory that performs antimicrobial susceptibility testing, select 'Yes' to indicate if additional antimicrobial susceptibility testing is also sent out, or 'No' if all routine susceptibility testing is performed onsite. |
| 2. For *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex, indicate which methods are used for (1) primary susceptibility testing | *Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental or confirmatory testing method(s) (if performed) for *Enterobacterales, Pseudomonas aeruginosa* and/or *Acinetobacter baumannii* complex. |

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

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| 4e. 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'. |
| 4f. 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'. |
| 4g. Aminoglycoside breakpoints for *Enterobacterales* in 2023 | *Required.* Select 'Yes' if your laboratory has implemented the revised Aminoglycoside breakpoints for *Enterobacterales* recommended by CLSI as of 2023; otherwise, select 'No'. |
| 4h. Aminoglycoside breakpoints for *Pseudomonas aeruginosa* in 2023 | *Required.* Select 'Yes' if your laboratory has implemented the revised Aminoglycoside breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2023; otherwise, select 'No'. |
| 4i. Piperacillin-tazobactam breakpoints for *Pseudomonas aeruginosa* in 2023 | *Required.* Select 'Yes' if your laboratory has implemented the revised Piperacillin-tazobactam breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2023; otherwise, select 'No'. |
| 4j. Piperacillin-tazobactam breakpoints for *Enterobacterales* in 2022 | *Required.* Select 'Yes' if your laboratory has implemented the revised Piperacillin-tazobactam breakpoints for *Enterobacterales* recommended by CLSI as of 2022; otherwise, select 'No'. |
| 5. Does the laboratory test bacterial isolates for the presence of a carbapenemase? | *Required.* Select 'Yes' if your laboratory tests bacterial isolates for carbapenemase production; otherwise, select 'No'.<br>Note: Only tests performed on bacterial isolates should be included. If the laboratory is only able to test for presence of carbapenemases in specimens (e.g., positive blood cultures), select 'No'.<br><br>Note: Only tests that evaluate for the presence/absence of carbapenemase, or who identify specific carbapenemase mechanisms should be included. 'No' should be selected if the laboratory only performs tests that screen for elevated carbapenem minimum inhibitory concentrations (MICs) or assign a result of 'carbapenemase positive' based on automated testing instrument expert rules. |
| 5a. If Yes, indicate what is done if carbapenemase production is detected (check one). | *Conditionally Required.* If 'Yes', specify how laboratory results are managed if carbapenemase production is detected. |
| 5b. If Yes, which test is routinely performed to detect carbapenemase (check all that apply)? | *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase. |
| 5c. If Yes, which of the following are routinely tested for the presence of carbapenemases. | *Conditionally Required.* If 'Yes', specify which pathogen(s) routinely undergo a testing algorithm that requires testing for the presence of a carbapenemase. For example, select '*Pseudomonas aeruginosa*' if it is a routine for your laboratory to test for the presence of a carbapenemase for *Pseudomonas aeruginosa* when the isolate tests resistant for a carbapenem(s). |
| 6. Does your facility use commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections? Examples of commercially available systems include BioFire FilmArray, Luminex Verigene, etc. | *Required.* Select 'Yes' if your laboratory uses commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections; otherwise, select 'No'. |

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| 6a. If Yes, which test panel(s) does your facility use? (check all that apply) | *Conditionally Required.* If 'Yes', select the test panel(s) that your facility uses. If the test panel(s) your facility uses are not listed:<br>select 'Other Commercial Test(s)' if the other test(s) used is/are commercially available then indicate which test is used by entering in the test name in the blank field<br>or<br>select 'Other Laboratory Developed Test(s)' if the other test used is laboratory developed, then indicate which test is used by entering in the test name in the blank field. |
| 7. In a scenario where the *mecA* resistance marker and *Staphylococcus aureus* are detected by rapid molecular testing, select the procedure(s) your facility conducts. (check one) | *Required.* Select your facility's procedure(s) after detecting the *mecA* resistance marker and *Staphylococcus aureus* using rapid molecular testing. If the *mecA* resistance marker is not tested for *Staphylococcus aureus* in your facility, select the first answer choice and skip to question 8. |
| 7a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus*, and discordance is found between their results, how are results reported? (check one) | *Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 8. |
| 8. In a scenario where the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* aredetected by rapid molecular testing, select the procedure(s) your facility conducts. (check one) | *Required.* Select your facility's procedure(s) after detecting the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* using rapid molecular testing. If the *bla*$_{CTX-M}$ (CTX-M) resistance marker is not tested for *Escherichia coli* in your facility, select the first answer choice and skip to question 9. |
| 8a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli* and discordance is found between their results, how are results reported? (check one) | *Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 9. |
| 9. Where is yeast identification performed for specimens collected at your facility? (check the most applicable) | *Required.* Select where yeast identification is performed for specimens collected at your facility. |
| 10. Which of the following methods are used for yeast identification? (check all that apply) | *Required.* Select from the choices listed one or more the method(s) used for yeast identification. If 'Other' is selected, specify the method. |
| 11. Does the laboratory routinely use chromogenic agar for the identification or differentiation of *Candida* isolates? | *Required.* Select 'Yes' if the laboratory routinely uses chromogenic agar for the identification or differentiation of *Candida* isolates; otherwise, select 'No'. If not known, select 'Unknown'. |

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

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| 20. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one) | *Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, specify.<br><br>**Note**: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Ask your laboratory or conduct a search for further guidance on selecting the correct option to report. |
| 21. Which of the following methods serve as the primary method used for bacterial identification at your facility? (check one) | *Required.* Select 'One Answer' indicating your facility's primary and definitive method used for bacterial identification. |
| 22. Which of the following methods serve as the secondary or backup method used for bacterial identification at your facility? (for example, a secondary method if the primary method fails to give an identification, or if the primary method is unavailable). (check one) | *Required.* Select 'One Answer' indicating your facility's secondary methods used for microbe identification from bacterial identification in your facility. For example, if a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method |
| **Infection Control Practices.** *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.* | |
| 23. Number or fraction of infection preventionists (IPs) in facility | *Required.* Enter the number of individuals who work full-time in the infection prevention department of the hospital as infection prevention professionals. If an individual works part-time, indicate what proportion of full-time hours they work (for example, if full time is considered 40 hours and an individual works 16 hours per week, their work is counted as 16/40 = 0.4). Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey. |
| 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 infection prevention measures are implemented, attending meetings, etc. |

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| *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)<br><br>24a. If Yes, check the type of patients that are routinely placed in Contact Precautions while 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'.<br><br>*Conditionally Required.* If Yes, indicate which type of patients the policy requires are routinely placed in Contact Precautions for MRSA 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? (check one)<br><br>25a. If Yes, check the type of patients that are routinely placed in Contact Precautions while 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 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'.<br><br>*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)<br><br>26a. If Yes, check the type of patients that are routinely placed in Contact Precautions while 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 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'.<br><br>*Conditionally Required.* If 'Yes', check the type of patients that are routinely placed in Contact Precautions 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 *Enterobacterales* are routinely placed in Contact Precautions while these patients are in your facility? (check one)<br><br>27a. If Yes, check the type of patients that are routinely placed in Contact Precautions while 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 extended spectrum beta-lactamase (ESBL) producing *Enterobacterales* or extended spectrum cephalosporin-resistant *Enterobacterales*. Select 'No' if your facility does have this policy. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant *Enterobacterales*, select 'Not applicable'.<br><br>*Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions for CRE while in your facility. |

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| 28. Does the facility routinely perform screening testing (culture or non-culture) for CRE? | *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 to detect CRE. Select 'No' if either testing is not routinely performed or not performed at all. |
| 28a. If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply) | *Conditionally Required*. If 'Yes', select **all** the situations for which CRE screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which CRE screening is performed. |
| 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) | *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 *Candida auris* screening is performed. |
| 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 the method that's routinely used by the lab conducting screening. If 'Other' is selected, specify the methods(s) in which *Candida auris* screening is performed.<br><br>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 adult patients admitted? | *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 of adult patients using either culture or non-culture based methods for MRSA; select 'No' if either testing is not routinely performed or not performed at all. |
| 30a. If yes, in which situations does the facility routinely perform screening testing for MRSA (check all that apply) | *Conditionally required.* If 'Yes', select **all** the situations for which MRSA screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which MRSA screening is performed. |
| 31. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients? | *Required.* Select 'Yes' if your facility has a policy to routinely use chlorhexidine bathing for any adult patients.<br><br>Select 'No' if your facility does not have a policy to routinely use chlorhexidine bathing for any adult patients. |
| 32. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal anti-staphylococcal agent (mupirocin iodophor, or an alcohol based intranasal agent) on any adult patients to prevent healthcare-associated infection 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 patient to prevent healthcare-associated infection or reduce transmission of resistant pathogens.<br><br>Select 'No' if the facility does not have this policy. |

| ***Facility Water Management Program and Practices (WMP)***<br>*(Required section. Complete with input from facility water management team.)* | |
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| 33. 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' |
| 33a. 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. |
| 34. 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 environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No' |
| 35. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness? An example WICRA tool can be accessed at https://www.cdc.gov/healthcare-associated-infections/media/pdfs/water-assessment-tool-508.pdf?CDC_AAref_Val=https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf | *Required*. Select 'Yes' your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness; Otherwise, select 'No' |

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| 36. Does your facility regularly monitor the following parameters in the building water system(s)? *(Check all that apply)*<br><br>If Yes, do you have a plan for corrective actions when the parameters are not within acceptable limits as determined by your water management program?<br><br>If Yes, where and how frequently does your facility monitor the parameters? | *Required.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No'<br>• Disinfectant (such as residual chlorine)<br>• Water temperature<br>• Water pH<br>• Heterotrophic plate counts (HPC) testing<br>• Specific *Legionella* testing<br>• Specific *Pseudomonas* testing<br><br>*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?<br><br>*Conditionally Required*. For each parameter, if 'Yes', specify the location of monitoring. If 'Other' is selected, specify the location. (Check all that apply)<br><br>• Entry point(s)<br>• Cold potable water storage tank(s)<br>• Hot potable water storage tank(s)<br>• Hot water supply<br>• Hot water return<br>• Representative locations throughout cold potable building water system(s)<br>• Representative locations throughout hot potable building water system(s)<br>• Other<br><br>*Conditionally Required*. For each parameter location, if 'Yes', specify the frequency of monitoring. If 'Other' is selected, specify the frequency. (Check one)<br><br>• Daily<br>• Weekly<br>• Monthly<br>• Quarterly<br>• Annually<br>• Other<br>• N/A |
| 37. Does your Water Management Program address measures to prevent transmission of bacterial pathogens from wastewater premise plumbing to patients? | *Required.* Select 'Yes' if your facility's Water Management Program addresses measures to prevent transmission of bacterial pathogens from wastewater premise plumbing to patients; select 'No' if it does not; select 'N/A, my facility does not have a Water Management Program' if your facility does not have a Water Management Program.<br><br>This questions was is intended to address measures to prevent transmission from wastewater premise plumbing such as regularly cleaning and disinfecting surfaces near sink drains, avoiding placement of patient care items or personal items on counters next to sinks, offsetting faucets so they don't discharge directly over sink drains, not discarding patient waste down sinks and minimizing discarding liquid nutritional supplements or other beverages down sinks or toilets, and installing toilet and hopper covers to prevent splashing as outlined in the "Sinks, Drains, Plumbing" section of this website: Reduce Risk from Water \| HAI \| CDC |

| **Facility Venous Thromboembolism (VTE) Prevention** | |
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| 38. Our facility uses the following venous thromboembolism (VTE) prevention practices | *Required.* Select all that apply and select at least one. |
| ☐ Our facility has a VTE prevention policy. | Select if your facility has a VTE prevention policy. A VTE prevention policy is a formal written principle or plan of action adopted by facility leadership to prevent VTE in patients. |
| ☐ Our facility has a multidisciplinary team that addresses VTE prevention. | Select if your facility has a multidisciplinary team that addresses VTE prevention. A multidisciplinary team includes representatives from two or more different disciplines or fields of study (e.g., physicians, nurses, pharmacists, quality improvement experts, health informatics experts, etc.). |
| ☐ Our facility has a facility-wide VTE prevention protocol that includes VTE and bleeding risk assessments linked to clinical decision support for appropriate VTE prophylaxis options. | Select if your facility has a facility-wide VTE prevention protocol that includes VTE and bleeding risk assessments linked to clinical decision support for appropriate VTE prophylaxis options. A VTE prevention protocol defines best local practice for the prevention of VTE in patients based on best evidence and includes operational definitions. Clinical decision support tools provide risk-appropriate VTE prophylaxis options based on results of the VTE and bleeding risk assessments. |
| If [X or yes] above:<br>○ Our facility has embedded the VTE prevention protocol in admission order sets. | If your facility has a facility-wide VTE prevention protocol selected:<br>Select if your facility has embedded the VTE prevention protocol in admission order sets. |
| ☐ Our facility provides VTE prevention education for clinicians annually. | Select if your facility provides VTE prevention education, including the importance of VTE prophylaxis, for clinicians at least annually. |
| ☐ Our facility provides VTE prevention education for patients during their stay at our facility. | Select if your facility provides VTE prevention education, including the importance of VTE prophylaxis, for patients at any time during their stay at your facility. |
| ☐ Our facility performs audits to determine whether patients are on risk-appropriate VTE prophylaxis and provides clinician feedback for quality improvement. | Select if your facility performs audits to determine whether patients are on risk-appropriate VTE prophylaxis and provides clinician feedback for quality improvement. |
| ☐ Our facility tracks the incidence of VTE that develops during a patient's stay at our facility (VTE not present on admission). | Select if your facility tracks the incidence of VTE that develops during a patient's stay at your facility (VTE not present on admission). |
| ☐ Our facility does not do any of the above. | Select if your facility does not do any of the above (no boxes above selected). |

| **Prevention Practices** | |
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| 39. Does your facility utilize a prevention checklist or bundle for any of the following HAIs? (Check all that apply) | *Required*. Select HAI/s for which a prevention checklist or bundle is utilized. A checklist or bundle could be a grouping of protocols or steps taken to aid in the prevention of the HAI/s selected. |
| [HAI/s] At what minimum, regular frequency is adherence to the checklist/bundle monitored/measured? | *Conditionally required*. For each selected HAI, check the answer choice that best represents the minimum frequency at which adherence to the prevention checklist or bundle is monitored or measured. If the frequency at which adherence is monitored/measured at your facility is not listed as an answer choice, check "Other." If adherence is not monitored/measured, check "Not regularly monitored/measured." |
| [HAI/s] Is checklist/bundle adherence shared routinely with the clinical team? | *Conditionally required*. For each of the selected HAIs, check "Yes" if checklist/bundle adherence is routinely shared with the clinical team; otherwise, check "No" or "Unknown." The clinical team may be made up of nursing and/or, but not limited to, physicians/providers that are key stakeholders for infection prevention for a facility or part of a facility. |
| 40. Did your facility (or any part of your facility) implement a new HAI prevention strategy within the last calendar year? If yes, check all HAIs that apply. *The following prevention strategies are examples from HAI prevention guidance documents (for example, 2022 SHEA/IDSA/APIC Practice Recommendations – Compendium of Strategies) and are supported by varying levels of evidence. | *Required*. If your facility implemented a new HAI prevention strategy in within the last calendar year, check "Yes"; otherwise, select "No" or "Unknown." If "Yes" was checked, proceed to select HAI/s for which a new prevention strategy was implemented in the last calendar year. Implementation of new HAI prevention strategies may be facility-wide, or in just part of a facility (for example, unit-wide or service line-wide). |
| [HAI/s] prevention strategies | *Conditionally required*. For each of the selected HAIs, check all the new prevention strategies your facility implemented in the last calendar year. If your facility implemented a new strategy within the last calendar year that is not listed as an answer choice, check "Other (specify)" and briefly describe the prevention strategy implemented. If your facility has implemented any of the listed prevention strategies, but they are not a new strategy (implemented within the last calendar year), do not check those answer choice/s. |

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| 41. Does your facility provide training and/or education on HAI prevention to healthcare personnel as it relates to their role? If yes, check all HAIs that apply.<br><br>[HAI/s] At what frequency is training or education provided? Check all that apply. | *Required*. Check “Yes” if your facility provides training and/or education on HAI prevention to healthcare personnel as it relates to their role; otherwise, check “No” or “Unknown.” If “Yes” was checked, proceed to select HAI/s for which training/education is provided. Training or education could be, but is not limited to, orientation programs, simulation trainings, skills fairs, competency assessments, etc.<br><br>*Conditionally required*. For HAI/s selected, check the answer choice/s that best describes the frequency at which training or education for that HAI is provided. If your facility conducts training at a frequency not listed, select the “Other“ answer choice. |