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 2019, a facility would complete a 2018 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

Facility Characteristics (continued)	
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 year's worth of data from which to obtain the maximum number, indicate the maximum number from the number of months available. For definitions of CDC location types, see 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? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
2. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*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, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.

Facility Microbiology Laboratory Practices (continued)	
3. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 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'.
4. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply).	*Required.* Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
6. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.
7. Which of the following methods are used for yeast identification at your facility's laboratory or at the outside laboratory serving your facility? (check all that apply)	*Required.* Select from the choices listed one or more the method(s) used for yeast identification at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
8. *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, please specify.

Facility Microbiology Laboratory Practices (continued)	
9. What method is used for antifungal susceptibility testing (AFST) at your facility's laboratory or the outside laboratory serving your facility? (check all that apply)	*Required.* Select from the choices listed, one or more method (s) used for antifungal susceptibility testing at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
10. AFST is performed on fungal isolates in which of the following situations:	*Required.* For each of the *Candida* species listed (Candida albicans, Candida glabrata, and all other Candida species), select the most appropriate response for when antifungals susceptibility testing is performed. Chose "Always" if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient, regardless of the source of clinical specimen. Chose "Only when isolated from a sterile site" if susceptibility testing is performed routinely without a clinician order. Chose "only when ordered by a clinician" if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing. On that particular species of *Candida* when isolated from a sterile site. If 'Other' is selected, please specify.
11. 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, please 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. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
12. Please indicate the primary and definitive method used to identify microbes from blood specimens collected in your facility. (SELECT ONE ANSWER)	*Required.* Select 'One Answer' indicating your facility's primary and definitive method used to identify microbes from blood specimens collected.
13. Please indicate any additional secondary methods used for microbe identification from blood specimens collected in your facility (e.g., a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary	*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

method). (SELECT ALL THAT APPLY)	

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.*	
14. Number of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
15. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf).	
16. 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 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.

17. 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?	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.

Infection Control Practices (continued)	
18. 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)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.
19. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select 'Not applicable'.
20. Does the facility routinely perform screening testing (culture or non-culture) for CRE? 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 (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *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 CRE screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
21. Does the facility routinely perform screening testing (culture or non-culture) for MRSAfor any patients admitted to non-NICU settings?	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.

If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.

Infection Control Practices (continued)	
22. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings?	*Required.* Select 'Yes' if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.
If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.
23. Does the facility routinely use chlorhexidine bathing on any patient to prevent infection or transmission of MDROs at your facility? (Note: this does not include the use of such bathing in pre-operative patients to prevent SSIs)	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.
24. Does the facility routinely use a combination of topical chlorhexidine AND intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)	*Required.* Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used **routinely** (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients.

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 25 and skip questions 26-30.

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.

25. 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, i.e. 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 25 above, questions 26-30 below do not apply to your facility and should be skipped. If your facility does care for neonates or newborns (at any level), please 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.

26. 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 a 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; primary admissions only.
27. 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 26 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; primary admissions only.
28. Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (e.g. 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.
29. 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.'
30. 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? Please 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 '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. Select 'N/A 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 (please 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 'N/A my facility requires that babies receiving oral **and/or** parenteral (including IV) 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, intramuscularly, or intravenously. 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 D. 2. In my facility, newborns are not administered antimicrobials orally or parenterally while they are roomed with their mother. a. Select answer choice E. 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.
If answer choice d. or e. was selected in question 30 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 30). Select 'Level II special care nursery' if newborns requiring antimicrobials (via route(s) specified in question 30) 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 30) are ever transferred to a neonatal intensive unit in order for those antimicrobials to be administered.

Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*

31. Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board).	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.

Antibiotic Stewardship Practices (continued)	
32. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)	*Required*. 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 hospital staff about antibiotic stewardship efforts (e.g., written communication to hospital 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 staff training and development on antibiotic stewardship' if facility leadership and/or management has provided staff antibiotic stewardship education in-house (e.g., workshops, lectures) or access to antibiotic stewardship trainings (e.g., by approving time and/or providing funds to attend stewardship conferences, webinars) within the past year. Select 'allocating information technology resources to support antibiotic stewardship efforts' if your facility has prioritized information technology (IT)-related antibiotic stewardship efforts within the most recent budgeted year (e.g., by providing clinical decision support software, IT staff). If none of these statements apply to your facility, select 'None of the above.'
33. Our facility has a committee responsible for antibiotic stewardship.	*Required*. Select 'Yes' if your facility has convened a formalized antibiotic stewardship committee or if your facility has expanded the roles and responsibilities of an existing committee to assess and improve antibiotic use and stewardship; otherwise, select 'No.'
If Yes, membership in our facility's antibiotic stewardship committee includes: (Check all that apply.)	*Conditionally Required*. If 'Yes' to question 33, specify the qualification or job title of the committee members. If none of the response options provided apply to your facility, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
34. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship 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 (e.g., laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on antibiotic stewardship planning and outcomes; otherwise, select 'No.'
34a. If Yes, what is the position of this leader? (Check one.)	*Conditionally Required*. If 'Yes' to question 34, specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position. *Conditionally Required*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected in question 34a, specify qualities of your facility's **physician** leader from the choices listed. Select 'Has antibiotic stewardship responsibilities in their contract or job description' 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.
34b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)	Select 'Is physically on-site in your facility (either part-time or full-time)' if the **physician** stewardship leader works onsite at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed an ID fellowship' if the **physician** stewardship leader completed an ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program or other coursework' if the **physician** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s). If none of these statements apply to your facility's antibiotic stewardship **physician** leader, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
34c. 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 in question 34a, specify from the choices listed qualities of your facility's **pharmacist** leader. Select 'Has antibiotic stewardship responsibilities in their contract or job description' 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 onsite 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, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program or other coursework' if the **pharmacist** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s). If none of these statements apply to your facility's antibiotic stewardship **pharmacist** leader, select 'None of the above
34d. If Physician or Other is selected, is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Conditionally Required*. If 'Physician' or 'Other' was selected in question 34a, 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'.

Antibiotic Stewardship Practices (continued)	
35. Our facility has a policy or formal procedure for: (Check all that apply.)	*Required*. Specify the policies or formal procedures that your facility has in place from the choices listed. Antibiotic time-out refers to a standardized process or protocol for clinicians on the treating team to reassess the continuing need and choice of antibiotics between 48 and 72 hours after the initial order (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration). Prospective audit with feedback refers to 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) conducting a prospective review of the appropriateness of antibiotic use and then providing 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. Prior authorization refers to if 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 (on the formulary) due to its spectrum of activity, cost, or associated toxicities before the agent can be dispensed. It is assumed that non-formulary drugs already require prior authorization. If your facility does not have any of the listed policies or formal procedures, select 'None of the above.'
35a. Our stewardship team audits antibiotic orders to review appropriateness of indications.	*Conditionally Required*. If 'required documentation of indication for antibiotic orders' was selected in question 35, select 'Yes' if antibiotic orders have been reviewed to ensure appropriateness of indication; otherwise, select 'No'.
35b. For which categories of antimicrobials? (Check all that apply.)	*Conditionally Required*. If 'prospective audit with feedback' was selected for question 35, 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 (i.e., prospective audit and feedback). If none of the listed categories of antimicrobials apply, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
35c. For which categories of antimicrobials? (Check all that apply.)	*Conditionally Required*. If 'prior authorization' was selected for question 35, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. If none of the listed categories of antimicrobials apply, select 'None of the above.'
36. Providers have access to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections.	*Required*. Select 'Yes' if your facility has, or accesses, and uses facility- or region-specific guidelines or recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'. *Conditionally Required*. If 'Yes' to question 36, select 'Yes' if charts have been audited to confirm adherence to facility- or region-specific treatment guidelines or recommendations for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'.
37. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response).	*Required*. Select 'Yes' if your facility targets any diagnoses for active interventions specifically to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response); otherwise, select 'No.'
38. Our stewardship team monitors: (Check all that apply.)	*Required*. Select, from the choices listed, the measures that your facility's stewardship team monitors. Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (e.g., receiving local data from a neighboring hospital). Monitoring *Clostridium difficile* includes infection rates or events in your facility. If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at least quarterly at the unit-, service-, and/or facility-wide level, select 'antibiotic use in some other way' and specify the metric. If your facility does not monitor any of the items listed, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
38a. If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually.	*Conditionally Required*. If 'DOT,' 'DDD,' or 'Other' antibiotic use measure is selected for question 38, select 'Yes' if individual-, unit-, or service-specific reports are developed and provided to prescribers, at least annually, on their antibiotic use; otherwise, select 'No.'
38b. If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.	Conditionally Required. If 'Yes' to question 38a, select 'Yes' if your facility's stewardship team provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (e.g., academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select 'No.'
39. Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.)	*Required*. Select, from the choices listed, the ways in which your stewardship team reports out your facility's antibiotic stewardship activities. Select 'updates to facility leadership on antibiotic use and stewardship efforts' if your facility's stewardship team shares updates with facility-level leadership (e.g., executive leadership, or other leadership committees or entities that are responsible for the facility) on antibiotic use and stewardship efforts or outcomes, at least annually. Select 'outcomes for antibiotic stewardship interventions to staff' if your facility's antibiotic stewardship team communicates outcomes of antibiotic stewardship interventions (e.g., antibiotic use or patient outcome measures) with hospital staff, at least annually. If your facility does not provide the updates or reports included in this question, at least annually, select 'None of the above.'
40. Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.)	*Required*. Select, from the choices listed, the groups in your facility that receive education specifically about appropriate antibiotic use (e.g., Grand Rounds, in-service training, and direct instruction) at least annually. 'Prescribers' includes both prescribers employed by the facility and licensed independent practitioners. If none of the listed groups at your facility receive education on appropriate antibiotic use at least annually, select 'None of the above.'

Optional Antibiotic Stewardship Practices Questions **Responses to the following questions are not required to complete the annual survey.** **Please provide additional information about your facility's antibiotic stewardship activities and leadership.**	
41. 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 (e.g., 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.'
42. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific 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 does *not* include generic stewardship resources (e.g., webinars). Otherwise, select 'No.'
43. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities.	*Optional*. Select 'Yes' if your facility uses cascade and/or selective reporting, and stewardship representation participates in the development of cascade and/or selective reporting protocols. Select 'No' if your facility uses cascade and/or selective reporting, but protocols are developed <u>without</u> input from stewardship representation. Select 'Not applicable' if your facility does not use cascade and/or selective reporting.
44. Our stewardship team monitors compliance with appropriate surgical prophylaxis.	*Optional*. Select 'Yes' if your facility's stewardship team monitors compliance with appropriate surgical antibiotic prophylaxis guidelines intended to optimize antibiotic selection and duration; otherwise, select 'No.'
45. If you selected 'Yes' to question 34 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)	*Conditional to Q34; optional*. If 'Yes' to question 34, specify 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, please specify the committee or job title. Select 'None' if no further oversight is provided to the antibiotic stewardship leader(s).

Optional Antibiotic Stewardship Practices Questions	
46. If you selected 'Physician' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the **physician** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)	*Conditional to Q34; optional*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected for question 4a, specify the best estimate for the percentage of time the **physician** stewardship leader dedicates to antibiotic stewardship activities in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship, on average, in your facility.
47. If you selected 'Pharmacist' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the **pharmacist** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)	*Conditional to Q34; optional.* If 'Pharmacist or 'Co-led by both Pharmacist and Physician' was selected for question 34 specify the best estimate for the percentage of time the pharmacist stewardship leader dedicates to antibiotic stewardship efforts in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship activities, on average, in your facility.
48. If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's contract or job description? (Check one.)	*Conditional to Q34; optional*. If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 34, 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. This may be the same, more, or less than the time specified in question 47.
49. If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's contract or job description? (Check one.)	*Conditional to Q34; optional*. If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 34, specify the percent time (or equivalent) stipulated in the **pharmacist** 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. This may be the same, more, or less than the time specified in question 48.

Water Management Program (prevent legionella) **(*Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)**	
50. Have you ever conducted a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)?	*Optional*. Select 'Yes' if your facility has conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No'
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.
51. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens??	*Optional.* Select 'Yes' if your has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No'
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, please specify the role of the team member.
52. Do you regularly monitor the following parameters in your building's water system? (Check all that apply)	*Optional.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No' • Disinfectant (such as residual chlorine) • Temperature • Heterotrophic plate counts • Specific tests for *Legionella*
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?	*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?