

A cluster of MDRO involving COVID-19 unit(s)

Please complete the survey for each healthcare facility cluster of novel or targeted antimicrobial resistant organisms where suspected or confirmed transmission occurred involving a unit caring for patients or residents with SARS-CoV-2 infection or under observation for SARS-CoV-2 infection and the index case specimen collection date was on or before October 31, 2020.

Please also report:

two or more eligible clusters at the same facility at the same period. For example, a CRAB outbreak and a C auris outbreak in the same unit would be considered two separate clusters (but an outbreak of one organism with different mechanisms in the same unit would be considered the same cluster). Or, eligible clusters in two or more facilities belonging to the same outbreak investigation. They should be treated as separate clusters. You will need to fill out one survey for each eligible cluster in your jurisdiction.

Facility details

Does this cluster belong to a bigger outbreak involving multiple facilities?

- ☐ Yes
☐ No
(Clusters involving two or more facilities should be treated as separate clusters)

The following questions are about the facility where the cluster occurred, organisms involved, and the size and timing of the outbreak. There will be an opportunity to provide unit specific information later in the survey.

- 1 Facility type
- ☐ Acute care hospital, not critical access
 - ☐ Critical access hospital
 - ☐ Freestanding inpatient rehabilitation facility
 - ☐ Long-term acute care hospital
 - ☐ Ventilator/tracheostomy-capable nursing home/skilled nursing facility (vSNF)
 - ☐ Nursing home/skilled nursing facility without ventilator/tracheostomy capability (SNF)
 - ☐ Intermediate care facility, such as for individuals with intellectual disabilities (ICF/IID)
 - ☐ Assisted living facilities (ALFs)
 - ☐ Other (please specify)
 - ☐ Don't know

Facility type: other, please specify

- 2 Number of licensed beds in the facility
- ☐ 50 or under
 - ☐ 51-200
 - ☐ 201-500
 - ☐ 500 or over
 - ☐ Don't know

3	Organism(s) associated with the cluster (For carbapenemase producing organism outbreaks in which multiple organisms have the same mechanism, check all that apply.)	☐ Acinetobacter baumannii ☐ Citrobacter spp. ☐ Enterobacter aerogenes (Klebsiella aerogenes) ☐ Enterobacter cloacae complex ☐ Escherichia coli ☐ Klebsiella oxytoca ☐ Klebsiella pneumoniae ☐ Morganella morganii ☐ Proteus mirabilis ☐ Providencia spp. ☐ Pseudomonas aeruginosa ☐ Raoultella spp. ☐ Serratia marcescens ☐ Candida auris ☐ Other(s) (please specify) ☐ No organism identified (e.g. mechanism identified through molecular screening test) ☐ Don't know (For carbapenemase producing organism outbreaks in which multiple organisms have the same mechanism, check all that apply)
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Organism(s): other, please specify

4	If Carbapenem-resistant Enterobacterales, Acinetobacter baumannii or Pseudomonas aeruginosa, please indicate mechanism	☐ Not tested for carbapenemase (no phenotypic or genotypic testing) ☐ Not carbapenemase producing ☐ KPC ☐ NDM ☐ IMP ☐ VIM ☐ OXA 48-like ☐ OXA 23 ☐ OXA 24/40 ☐ OXA 58 ☐ OXA 235-like ☐ mCIM or other phenotypic test positive for carbapenemase production but PCR negative ☐ Other(s) (please specify) ☐ Don't know
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Mechanism(s): other, please specify

5	Number of patients with target mechanism or organism identified as of today	(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)
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Number of patients with any clinical culture

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients with positive blood cultures

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients with positive urine cultures

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients with positive respiratory cultures (e.g. sputum, bronchoalveolar lavage)

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients identified by surveillance culture or test but not clinical culture

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients died within 30 days of specimen culture

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

Number of patients coinfectd with SARS-CoV-2

(Please enter 0 if zero patient, and enter 9999 if you do not know the number.)

6 Earliest date of specimen collection associated with the cluster

7 Most recent date of specimen collection associated with the cluster

Is outbreak ongoing in this facility?

- ☐ Yes
☐ No
☐ Don't know
-

8 Has contact screening been performed as part of the public health response to the MDRO cluster?

- ☐ Yes, contact screening performed
☐ No, no contact screening performed
☐ Don't know
-

9 Which of the following best describes the epidemiology of the cluster organism or mechanism in the jurisdiction (e.g., county) prior to identification of the cluster/index case?

- ☐ No cases ever reported
☐ Most cases occur sporadically (i.e., mostly single cases not epidemiologically related)
☐ Multiple single facility outbreaks, without evidence of regional spread
☐ Regional spread where clusters have been identified in multiple facilities within one referral network/region
☐ Interregional spread where multiple clusters have been identified across different referral networks
☐ Endemic, where most facilities are repeatedly seeing cases admitted from unrelated sources
☐ Don't know

- If community transmission changed substantially over the cluster period, please describe the change:

(e.g., changing from minimal transmission to moderate transmission)

MDRO affected unit

The following questions collect data about the unit/ward in which MDRO transmission was initially identified (whether or not the unit cared or observed patients/residents for SARS-CoV-2 infection) during the cluster period (i.e., the two-week period prior to detection of the cluster through the period of suspected transmission).

There will be an opportunity to enter information about other units involved in this cluster, including those units that cared for or observed individuals for SARS-CoV-2 infection (if not the initially identified unit) later in the survey.

11a Indicate the unit/ward type where suspected or confirmed MDRO transmission was identified

- ☐ Short stay acute care hospital: intensive care unit
- ☐ Short stay acute care hospital: post-critical care/step down
- ☐ Short stay acute care hospital: surgical and/or medical
- ☐ Short stay acute care hospital: rehabilitation ward
- ☐ Short stay acute care hospital: long-term care ward
- ☐ Short stay acute care hospital: other (please specify)
- ☐ Long-term acute care hospital: intensive care unit
- ☐ Long-term acute care hospital: non-intensive care unit
- ☐ Skilled nursing facility: ventilated unit
- ☐ Skilled nursing facility: non-ventilated unit
- ☐ Other nursing facility
- ☐ Other (please specify)
- ☐ Don't know

Unit/ward type: Short stay acute care hospital: other, please specify

Unit/ward type: other, please specify

12a Indicate the COVID-19 status for patients/residents on the unit/ward where MDRO transmission was first identified.

(The unit may have a mix of patients/residents with and without COVID. Please select all that apply.)

- ☐ Patients or residents with confirmed SARS-CoV-2 infection
 - ☐ Patients or residents with suspected SARS-CoV-2 infection
 - ☐ Patients or residents under observation for SARS-CoV-2 infection (e.g., patients in observation units, or newly admitted or readmitted residents in long term care facilities)
 - ☐ Patients or residents not known or suspected to have SARS-CoV-2 infection nor under observation for SARS-CoV-2
 - ☐ Don't know
- (Select all that apply.)

13a Estimated number of licensed beds in the unit

(Please enter 9999 if you do not know the number.)

14a Room types in the unit: number of beds per room

- ☐ Private (1 bed per room)
 - ☐ Semiprivate (2 beds per room)
 - ☐ 3 beds per room
 - ☐ 4 beds per room
 - ☐ >4 beds per room
 - ☐ Don't know
- (Select all that apply.)

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- 15a Which of the following best describes the frequency of hand hygiene audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit hand hygiene in the unit prior to COVID-19
 - ☐ Facility audited hand hygiene in the unit pre-COVID but stopped audits of hand hygiene prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued hand hygiene audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
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- 16a Which of the following best describes the frequency of PPE audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit PPE in the unit prior to COVID-19
 - ☐ Facility audited PPE in the unit pre-COVID but stopped audits of PPE prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued PPE audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
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- 17a Which of the following best describes the frequency of audits of environmental cleaning and disinfection of patient (or resident) rooms on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit environmental cleaning and disinfection of patient (or resident) rooms in the unit prior to COVID-19
 - ☐ Facility audited environmental cleaning and disinfection of patient (or resident) rooms in the unit pre-COVID but stopped audits prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued audit with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 18a Did the facility report changes in the frequency of routine chlorhexidine (CHG) bathing on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely bathe patients on this unit prior to COVID
 - ☐ Yes, compliance with CHG bathing decreased relative to pre-COVID
 - ☐ No, compliance with CHG bathing same as pre-COVID
 - ☐ Yes, compliance with CHG bathing increased relative to pre-COVID
 - ☐ Don't know
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- 19a Did the facility report changes in the frequency of indwelling device rounds (e.g., foley rounds, central line rounds) on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely do indwelling device rounds on this unit prior to COVID
 - ☐ Yes, frequency of indwelling device rounds decreased relative to pre-COVID
 - ☐ No, frequency of indwelling device rounds same as pre-COVID
 - ☐ Yes, frequency of indwelling device rounds increased relative to pre-COVID
 - ☐ Don't know

20a Was suspected or confirmed MDRO transmission identified on additional unit(s)?

☐ Yes

☐ No

(Please report information on ALL unit(s) involved in this cluster in the facility, including unit(s) without patients/residents with COVID-19 or were under observation.)

MDRO affected unit (second)

The following questions collect data about the second unit/ward in which MDRO transmission was identified (whether or not the unit cared or observed patients/residents for SARS-CoV-2 infection) during the cluster period (i.e., the two-week period prior to detection of the cluster through the period of suspected transmission).

There will be an opportunity to enter information about other units involved in this cluster to include those units that cared for or observed individuals for SARS-CoV-2 infection (if not the first two identified units) later in the survey.

Please keep a note of the order of units you're entering data for. You will need this order when answering some of the subsequent questions.

- 11b Indicate the type of the second unit/ward where suspected or confirmed MDRO transmission was identified

- ☐ Short stay acute care hospital: intensive care unit
☐ Short stay acute care hospital: post-critical care/step down
☐ Short stay acute care hospital: surgical and/or medical
☐ Short stay acute care hospital: rehabilitation ward
☐ Short stay acute care hospital: long-term care ward
☐ Short stay acute care hospital: other (please specify)
☐ Long-term acute care hospital: intensive care unit
☐ Long-term acute care hospital: non-intensive care unit
☐ Skilled nursing facility: ventilated unit
☐ Skilled nursing facility: non-ventilated unit
☐ Other nursing facility
☐ Other (please specify)
☐ Don't know

Unit/ward type: Short stay acute care hospital: other, please specify _____

Unit/ward type: other, please specify _____

- 12b Indicate the COVID-19 status for patients/residents on the second unit/ward where MDRO transmission was identified.

(The unit may have a mix of patients/residents with and without COVID. Please select all that apply.)

- ☐ Patients or residents with confirmed SARS-CoV-2 infection
☐ Patients or residents with suspected SARS-CoV-2 infection
☐ Patients or residents under observation for SARS-CoV-2 infection (e.g., patients in observation units, or newly admitted or readmitted residents in long term care facilities)
☐ Patients or residents not known or suspected to have SARS-CoV-2 infection nor under observation for SARS-CoV-2
☐ Don't know
 (Select all that apply.)

- 13b Estimated number of licensed beds in the unit

(Please enter 9999 if you do not know the number.)

- 14b Room types in the unit: number of beds per room

- ☐ Private (1 bed per room)
☐ Semiprivate (2 beds per room)
☐ 3 beds per room
☐ 4 beds per room
☐ >4 beds per room
☐ Don't know
 (Select all that apply.)

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- 15b Which of the following best describes the frequency of hand hygiene audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit hand hygiene in the unit prior to COVID-19
 - ☐ Facility audited hand hygiene in the unit pre-COVID but stopped audits of hand hygiene prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued hand hygiene audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 16b Which of the following best describes the frequency of PPE audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit PPE in the unit prior to COVID-19
 - ☐ Facility audited PPE in the unit pre-COVID but stopped audits of PPE prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued PPE audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 17b Which of the following best describes the frequency of audits of environmental cleaning and disinfection of patient (or resident) rooms on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit environmental cleaning and disinfection of patient (or resident) rooms in the unit prior to COVID-19
 - ☐ Facility audited environmental cleaning and disinfection of patient (or resident) rooms in the unit pre-COVID but stopped audits prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued audit with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 18b Did the facility report changes in the frequency of routine chlorhexidine (CHG) bathing on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely bathe patients on this unit prior to COVID
 - ☐ Yes, compliance with CHG bathing decreased relative to pre-COVID
 - ☐ No, compliance with CHG bathing same as pre-COVID
 - ☐ Yes, compliance with CHG bathing increased relative to pre-COVID
 - ☐ Don't know
-
- 19b Did the facility report changes in the frequency of indwelling device rounds (e.g., foley rounds, central line rounds) on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely do indwelling device rounds on this unit prior to COVID
 - ☐ Yes, frequency of indwelling device rounds decreased relative to pre-COVID
 - ☐ No, frequency of indwelling device rounds same as pre-COVID
 - ☐ Yes, frequency of indwelling device rounds increased relative to pre-COVID
 - ☐ Don't know

20b Was suspected or confirmed MDRO transmission identified on additional unit(s)?

☐ Yes

☐ No

(Please report information on ALL unit(s) involved in this cluster in the facility, including unit(s) without patients/residents with COVID-19 or were under observation.)

MDRO affected unit (third)

The following questions collect data about the third unit/ward in which MDRO transmission was identified (whether or not the unit cared or observed patients/residents for SARS-CoV-2 infection) during the cluster period (i.e., the two-week period prior to detection of the cluster through the period of suspected transmission).

There will be an opportunity to enter information about other units involved in this cluster to include those units that cared for or observed individuals for SARS-CoV-2 infection (if not the first three identified units) later in the survey.

Please keep a note of the order of units you're entering data for. You will need this order when answering some of the subsequent questions.

11c Indicate the type of the third unit/ward where suspected or confirmed MDRO transmission was identified

- ☐ Short stay acute care hospital: intensive care unit
- ☐ Short stay acute care hospital: post-critical care/step down
- ☐ Short stay acute care hospital: surgical and/or medical
- ☐ Short stay acute care hospital: rehabilitation ward
- ☐ Short stay acute care hospital: long-term care ward
- ☐ Short stay acute care hospital: other (please specify)
- ☐ Long-term acute care hospital: intensive care unit
- ☐ Long-term acute care hospital: non-intensive care unit
- ☐ Skilled nursing facility: ventilated unit
- ☐ Skilled nursing facility: non-ventilated unit
- ☐ Other nursing facility
- ☐ Other (please specify)
- ☐ Don't know

Unit/ward type: Short stay acute care hospital: other, please specify

Unit/ward type: other, please specify

12c Indicate the COVID-19 status for patients/residents on the third unit/ward where MDRO transmission was identified.

(The unit may have a mix of patients/residents with and without COVID. Please select all that apply.)

- ☐ Patients or residents with confirmed SARS-CoV-2 infection
 - ☐ Patients or residents with suspected SARS-CoV-2 infection
 - ☐ Patients or residents under observation for SARS-CoV-2 infection (e.g., patients in observation units, or newly admitted or readmitted residents in long term care facilities)
 - ☐ Patients or residents not known or suspected to have SARS-CoV-2 infection nor under observation for SARS-CoV-2
 - ☐ Don't know
- (Select all that apply.)

13c Estimated number of licensed beds in the unit

(Please enter 9999 if you do not know the number.)

14c Room types in the unit: number of beds per room

- ☐ Private (1 bed per room)
 - ☐ Semiprivate (2 beds per room)
 - ☐ 3 beds per room
 - ☐ 4 beds per room
 - ☐ >4 beds per room
 - ☐ Don't know
- (Select all that apply.)

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- 15c Which of the following best describes the frequency of hand hygiene audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit hand hygiene in the unit prior to COVID-19
 - ☐ Facility audited hand hygiene in the unit pre-COVID but stopped audits of hand hygiene prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued hand hygiene audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 16c Which of the following best describes the frequency of PPE audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit PPE in the unit prior to COVID-19
 - ☐ Facility audited PPE in the unit pre-COVID but stopped audits of PPE prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued PPE audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 17c Which of the following best describes the frequency of audits of environmental cleaning and disinfection of patient (or resident) rooms on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit environmental cleaning and disinfection of patient (or resident) rooms in the unit prior to COVID-19
 - ☐ Facility audited environmental cleaning and disinfection of patient (or resident) rooms in the unit pre-COVID but stopped audits prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued audit with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 18c Did the facility report changes in the frequency of routine chlorhexidine (CHG) bathing on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely bathe patients on this unit prior to COVID
 - ☐ Yes, compliance with CHG bathing decreased relative to pre-COVID
 - ☐ No, compliance with CHG bathing same as pre-COVID
 - ☐ Yes, compliance with CHG bathing increased relative to pre-COVID
 - ☐ Don't know
-
- 19c Did the facility report changes in the frequency of indwelling device rounds (e.g., foley rounds, central line rounds) on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely do indwelling device rounds on this unit prior to COVID
 - ☐ Yes, frequency of indwelling device rounds decreased relative to pre-COVID
 - ☐ No, frequency of indwelling device rounds same as pre-COVID
 - ☐ Yes, frequency of indwelling device rounds increased relative to pre-COVID
 - ☐ Don't know

20c Was suspected or confirmed MDRO transmission identified on additional unit(s)?

☐ Yes

☐ No

(Please report information on ALL unit(s) involved in this cluster in the facility, including unit(s) without patients/residents with COVID-19 or were under observation.)

MDRO affected unit (fourth)

The following questions collect data about the fourth unit/ward in which MDRO transmission was identified (whether or not the unit cared or observed patients/residents for SARS-CoV-2 infection) during the cluster period (i.e., the two-week period prior to detection of the cluster through the period of suspected transmission).

Please keep a note of the order of units you're entering data for. You will need this order when answering some of the subsequent questions.

11d Indicate the type of the fourth unit/ward where suspected or confirmed MDRO transmission was identified	☐ Short stay acute care hospital: intensive care unit ☐ Short stay acute care hospital: post-critical care/step down ☐ Short stay acute care hospital: surgical and/or medical ☐ Short stay acute care hospital: rehabilitation ward ☐ Short stay acute care hospital: long-term care ward ☐ Short stay acute care hospital: other (please specify) ☐ Long-term acute care hospital: intensive care unit ☐ Long-term acute care hospital: non-intensive care unit ☐ Skilled nursing facility: ventilated unit ☐ Skilled nursing facility: non-ventilated unit ☐ Other nursing facility ☐ Other (please specify) ☐ Don't know
Unit/ward type: Short stay acute care hospital: other, please specify _____	
Unit/ward type: other, please specify _____	
12d Indicate the COVID-19 status for patients/residents on the fourth unit/ward where MDRO transmission was identified. (The unit may have a mix of patients/residents with and without COVID. Please select all that apply.)	☐ Patients or residents with confirmed SARS-CoV-2 infection ☐ Patients or residents with suspected SARS-CoV-2 infection ☐ Patients or residents under observation for SARS-CoV-2 infection (e.g., patients in observation units, or newly admitted or readmitted residents in long term care facilities) ☐ Patients or residents not known or suspected to have SARS-CoV-2 infection nor under observation for SARS-CoV-2 ☐ Don't know (Select all that apply.)
13d Estimated number of licensed beds in the unit (Please enter 9999 if you do not know the number.)	
14d Room types in the unit: number of beds per room	☐ Private (1 bed per room) ☐ Semiprivate (2 beds per room) ☐ 3 beds per room ☐ 4 beds per room ☐ >4 beds per room ☐ Don't know (Select all that apply.)

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- 15d Which of the following best describes the frequency of hand hygiene audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit hand hygiene in the unit prior to COVID-19
 - ☐ Facility audited hand hygiene in the unit pre-COVID but stopped audits of hand hygiene prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued hand hygiene audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 16d Which of the following best describes the frequency of PPE audits on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit PPE in the unit prior to COVID-19
 - ☐ Facility audited PPE in the unit pre-COVID but stopped audits of PPE prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued PPE audits with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 17d Which of the following best describes the frequency of audits of environmental cleaning and disinfection of patient (or resident) rooms on the unit compared to the same unit before COVID-19?
- (If the unit did not exist prior to COVID-19, how did it compare to audits on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ Facility did not audit environmental cleaning and disinfection of patient (or resident) rooms in the unit prior to COVID-19
 - ☐ Facility audited environmental cleaning and disinfection of patient (or resident) rooms in the unit pre-COVID but stopped audits prior to the cluster
 - ☐ Audit frequency decreased relative to pre-COVID but continued some audits
 - ☐ Facility continued audit with the same audit frequency as pre-COVID
 - ☐ Audit frequency increased relative to pre-COVID
 - ☐ Don't know
-
- 18d Did the facility report changes in the frequency of routine chlorhexidine (CHG) bathing on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely bathe patients on this unit prior to COVID
 - ☐ Yes, compliance with CHG bathing decreased relative to pre-COVID
 - ☐ No, compliance with CHG bathing same as pre-COVID
 - ☐ Yes, compliance with CHG bathing increased relative to pre-COVID
 - ☐ Don't know
-
- 19d Did the facility report changes in the frequency of indwelling device rounds (e.g., foley rounds, central line rounds) on this unit during the cluster period?
- (If the unit did not exist prior to COVID-19, how did it compare to the frequency on an equivalent unit before COVID-19 (e.g., comparing a COVID ICU unit to an ICU unit prior to COVID-19)?)
- ☐ N/A - facility did not routinely do indwelling device rounds on this unit prior to COVID
 - ☐ Yes, frequency of indwelling device rounds decreased relative to pre-COVID
 - ☐ No, frequency of indwelling device rounds same as pre-COVID
 - ☐ Yes, frequency of indwelling device rounds increased relative to pre-COVID
 - ☐ Don't know

20d Was suspected or confirmed MDRO transmission identified on additional unit(s)?

☐ Yes

☐ No

(We will not collect unit-specific information from more units in this survey. If this cluster involves more unit(s), we will contact you directly to gather information on additional unit(s).)

Information source

All following questions are intended to capture staffing and infection control practices in the MDRO affected unit(s). Specifically of interest are practices implemented or paused in response to or because of the COVID-19 pandemic. Please complete these questions using information gathered during the public health investigation.

When answering these questions, focus on the timeframe immediately prior to (i.e., in the 2 weeks prior) and during the period of transmission on the unit(s) where transmission was suspected or confirmed (the cluster period). Some questions will qualitatively assess practices during this period relative to practices before COVID-19.

Please do not include practices implemented in response to the MDRO cluster. For example, if MDRO surveillance culture collection was paused due to COVID, and reimplemented after the cluster was identified in order to control transmission, please indicate that surveillance cultures were stopped/paused.

- 21 Please indicate which of the following information sources were used to understand IPC practices implemented in the affected units?

- ☐ Onsite visit by health department (nonregulatory)
- ☐ Onsite visit by regulatory partners
- ☐ Video assessment by health department
- ☐ Telephone assessment with structured evaluation of practices, such as tele-ICAR by health department
- ☐ Telephone conversation without structured evaluation of practices by health department
- ☐ Facility self-reports or surveys by health department
- ☐ Supply monitoring/request by health department
- ☐ Other (please specify)
(Select all that apply.)

Information source: other, please specify _____

Facility staffing

The following questions will ask about shortages of frontline personnel during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

- | | | |
|----|---|--|
| 22 | Did the facility identify additional healthcare personnel beyond those used pre-pandemic to work in the facility, such as auxiliary or supplemental staffing? | ☐ Yes
☐ No
☐ Don't know
(Examples include but are not limited to contracted or registry staff, temp agency personnel, volunteer providers, and national guard care providers.) |
| | If yes, did the additional healthcare personnel receive infection prevention and control training upon arrival? | ☐ Yes
☐ No
☐ Don't know |
| 23 | Did the facility reassign healthcare personnel to units they had not typically worked in pre-pandemic? | ☐ Yes
☐ No
☐ Don't know
(Example includes but is not limited to floor nurse reassigned to ICU; this would not include ICU nurse assigned to COVID ICU or a floor nurse assigned to a non-ICU COVID unit.) |
| | If yes, did the reassigned personnel receive infection prevention and control training specific to activities for the new unit? | ☐ Yes
☐ No
☐ Don't know |
| 24 | Is there additional information about staffing changes in response to COVID-19 you wish to share?
If yes, please share: | <div><div></div><div>(e.g., institute longer shifts or other practices that may affect MDRO transmission.)</div></div> |

Hand hygiene

The following questions will ask about changes to hand hygiene practices during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

-
- 25 Did the facility have shortages of commercially manufactured alcohol-based hand sanitizers (ABHS) or soap on MDRO affected unit(s) during the cluster period?
- ☐ Yes, had shortage of ABHS
☐ Yes, had shortage of soap
☐ Yes, had shortage of ABHS and soap
☐ No, did not have shortage
☐ Don't know
-
- 26 Did the facility encourage staff to use soap and water for hand hygiene over alcohol-based hand sanitizers (ABHS) to conserve ABHS during the cluster period?
- ☐ Yes
☐ No
☐ Don't know
(Note this question is specifically about measures to preserve ABHS supplies. Facilities that routinely prefer soap and water to ABHS would not be considered a "yes" unless they changed practices to further encourage soap and water.)
-
- 27 Is there additional information about hand hygiene changes in response to COVID-19 you wish to share? If yes, please share:
-

PPE supplies

The following questions will ask about changes to PPE supplies during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

-
- 28 Did the facility calculate their PPE utilization rate (e.g., using the CDC/NIOSH burn rate calculator or some other method)?
- ☐ Yes
☐ No
☐ Don't know
-
- 29 Did the facility have an anticipated shortage of any of the following PPE components during the cluster period?
- ☐ No shortage
☐ Gowns
☐ Gloves
☐ N95 or higher level respiratory protection
☐ Facemask
☐ Eye protection
☐ Don't know
(Check all that apply.)
-
- 30 Did the facility have an actual shortage of any of the following PPE components during the cluster period?
- ☐ No shortage
☐ Gowns
☐ Gloves
☐ N95 or higher level respiratory protection
☐ Facemask
☐ Eye protection
☐ Don't know
(Check all that apply.)
-
- 31 Please provide details of the anticipated and/or actual shortages of the components listed above:
- _____
-
- 32 Is there additional information about PPE supplies you wish to share? If yes, please share:
- _____

Changes to PPE practices and use of PPE optimization strategies during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

- 33 Please indicate if the facility reported any of the following practices for isolation gowns on any of the MDRO-affected unit(s) during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period)?

If practices differed by unit(s), there will be an opportunity to specify which unit(s) these practices were practiced on.

- 33a Shifted from disposable to reusable (launderable) cloth gowns
- ☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

- 33b Shifted from reusable (launderable) cloth gowns to disposable gowns
- ☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

33c Used coveralls instead of isolation gowns	☐ Yes ☐ No ☐ Don't know
If yes, was it practiced on all MDRO affected units?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the unit MDRO transmission was initially identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the second unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the third unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the fourth unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
33d Prioritize gown use for certain activities?	☐ Yes ☐ No ☐ Don't know
If yes, was it practiced on all MDRO affected units?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the unit MDRO transmission was initially identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the second unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the third unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
Was it practiced on the fourth unit MDRO transmission was identified?	☐ Yes ☐ No ☐ Don't know
If yes to gown prioritization, which activities?	☐ High touch activities ☐ Activities involving splash and sprays ☐ Other (please specify) ☐ Don't know (Select all that apply.)
Please specify gown use was prioritized for which other activities?	

33e Extended the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient/resident without removing between multiple patients/residents

- ☐ Yes
☐ No
☐ Don't know

Extended gown use was practiced for which patients/residents?

- ☐ Patients/residents with confirmed or suspected SARS-CoV-2 infection not known to have other organisms transmitted by contact, such as novel or targeted multi-drug resistant organisms or C. difficile
☐ Patients/residents with confirmed or suspected SARS-CoV-2 infection regardless of infection or colonization by other organisms such as MDROs
☐ Patients/residents under observation for SARS-CoV-2 infection not known to have other organisms transmitted by contact, such as novel or targeted multi-drug resistant organisms or C. difficile
☐ Patients/residents under observation for SARS-CoV-2 infection regardless of infection or colonization by other organisms such as MDROs
☐ Patients/residents without confirmed or suspected SARS-CoV-2 infection, not under observation for SARS-CoV-2, and not known to have other organisms transmitted by contact, such as MDROs or novel or targeted multi-drug resistant organisms or C. difficile
☐ Patients/residents without confirmed or suspected SARS-CoV-2 infection, not under observation for SARS-CoV-2, regardless of infection or colonization by other organisms transmitted by contact, such as MDROs or C. difficile
☐ Other (please specify)
☐ Don't know
(Select all that apply.)

Please specify which other patients/residents were extended gown use practiced for?

Was extended use of gowns practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

33f	Reused gowns such that the same gown was donned, doffed, stored, and then re-donned for more patient encounters (note, CDC does not recommend strategy). This would not include cloth isolation gowns doffed and laundered between uses.	☐ Yes ☐ No ☐ Don't know
Were reused gowns:		☐ Disposable isolation gowns ☐ Cloth isolation gowns without laundering between use ☐ Other (please specify) ☐ Don't know (Select all that apply.)
Specify the other type(s) of gowns reused		
Did multiple HCP reuse the same gown?		☐ Yes ☐ No ☐ Don't know
Was the reused gown dedicated to one patient?		☐ Yes ☐ No, reused gown was used on multiple patients ☐ Don't know
Was gown reuse practiced on all MDRO affected units?		☐ Yes ☐ No ☐ Don't know
Was it practiced on the unit MDRO transmission was initially identified?		☐ Yes ☐ No ☐ Don't know
Was it practiced on the second unit MDRO transmission was identified?		☐ Yes ☐ No ☐ Don't know
Was it practiced on the third unit MDRO transmission was identified?		☐ Yes ☐ No ☐ Don't know
Was it practiced on the fourth unit MDRO transmission was identified?		☐ Yes ☐ No ☐ Don't know
33g	Used gown alternatives (e.g., laboratory coats or patient gowns)	☐ Yes ☐ No ☐ Don't know
Specify which gown alternatives were used?		
If yes, was it practiced on all MDRO affected units?		☐ Yes ☐ No ☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

33h HCP wore multiple layers of protective gowns or clothing (e.g., two isolation gowns, a patient gown and an isolation gown)? (Note: CDC does not recommend this strategy)

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

33i HCP wore gowns for non-COVID-19 patients who were not in contact precautions

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

33j HCP wore gowns also used for patient/resident care in common areas (e.g., hallways and other non-patient care areas)

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

33k Is there additional information about the use of gowns in response to COVID-19 you wish to share? If yes, please share below:

34 Please indicate if the facility reported any of the following practices for gloves on any of the MDRO-affected unit(s) during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period)?

If practices differed by unit(s), please select "yes" if the practice was practiced on any of the MDRO-affected unit(s), and there will be an opportunity to specify which unit(s) these practices were practiced on.

34a Extended use of disposable medical gloves by HCP, i.e., the practice of wearing gloves without changing them between multiple patients or tasks

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was hand hygiene performed over the gloves at intervals where gloves would normally be changed?

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

34b HCP wore multiple layers of gloves (Note: CDC does not recommend this strategy)

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

34c HCP wore gloves in common areas (e.g., hallways)?

☐ Yes
☐ No
☐ Don't know

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

34d Is there additional information about the use of gloves in response to COVID-19 you wish to share? If yes, please share:

(Example includes but not limited to reuse of gloves.)

35 Please indicate if the facility reported any of the following practices for NIOSH approved N95 or higher level respirators for HCPs on any of the MDRO-affected unit(s) during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period)?

If practices differed by unit(s), please select "yes" if the practice was practiced on any of the MDRO-affected unit(s), and there will be an opportunity to specify which unit(s) these practices were practiced on.

35a Extended the use of respirators such that HCP wore the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters, and then disposed of the N95 after encounters are complete.

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

35b Reused respirators such that the same N95 respirator was used by one HCP for multiple encounters with different patients but doffed after each encounter and stored prior to redonning.

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

35c Both extended and reused the same N95 respirator (i.e., doffed after multiple encounters, stored, and then redonned for future encounters).

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know
-

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit
-

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit
-

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit
-

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit
-

35d How many times were disposable respirators reused before disposal?

(Please enter your best estimate, or 9999 if unknown.)

35e Were respirators decontaminated?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit(s)
-

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know
-

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit
-

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear respirators in the MDRO-affected unit

If respirators were decontaminated, specify the type of respirator that were decontaminated (filtering facepiece respirators (FFRs, e.g., N95s), elastomeric half mask, or PAPR) and method of decontamination if known

35f Is there additional information about the use of respirators in response to COVID-19 you wish to share? If yes, please share:

36 Please indicate if the facility reported any of the following practices for facemasks for HCPs on any of the MDRO-affected unit(s) during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period)?

If practices differed by unit(s), please select "yes" if the practice was practiced on any of the MDRO-affected unit(s), and there will be an opportunity to specify which unit(s) these practices were practiced on.

36a Extended the use of facemasks such that HCP wore the same facemask during encounters with several different patients, without removing the facemask between encounters, and then disposed of the facemask after encounters are complete.

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit(s) (e.g., if only respirators were worn in the affected unit(s))

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

36b Reused facemasks such that the same facemask was used by one HCP for multiple encounters with different patients but doffed after each encounter and stored prior to redonning.

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit(s) (e.g., if only respirators were worn in the affected unit(s))

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

36c Both extended and reused the same facemask (i.e., doffed after multiple encounters, stored, and then redonned for future encounters).

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit(s) (e.g., if only respirators were worn in the affected unit(s))

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear facemasks in the MDRO-affected unit (e.g., if only respirators were worn in the affected unit)

36d Is there additional information about the use of facemasks in response to COVID-19 you wish to share? If yes, please share: _____

37 Please indicate if the facility reported any of the following practices for eye protection for HCP on any of the MDRO-affected unit(s) during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period)?

If practices differed by unit(s), please select "yes" if the practice was practiced on any of the MDRO-affected unit(s), and there will be an opportunity to specify which unit(s) these practices were practiced on.

37a Extended the use of eye protection such that the same equipment is worn by the same HCP when interacting with more than one patient without doffing between patients and then disposing it after each encounter with patients.

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

37b Reused eye protection such that the same eye protection was used by one HCP for multiple encounters with different patients but doffed after each encounter and stored prior to redonning.

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

37c Both extended and reused the same eye protection (i.e., doffed after multiple encounters, stored, and then redonned for future encounters)

☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit(s)

If yes, was it practiced on all MDRO affected units?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know
☐ Not applicable: HCP did not wear eye protection in the MDRO-affected unit

37d Was eye protection reprocessed (cleaned and disinfected) between uses?

- ☐ Yes
☐ No
☐ Don't know

What was the method for reprocessing?

- ☐ Manufacturer instructions
☐ CDC recommendations, for when manufacturer instructions are unavailable
☐ Used method that is not recommended, e.g. cleaned with soap and water, and wiped with alcohol-based hand sanitizers
☐ Other
☐ Don't know

What was the method for reprocessing? Please specify other method

37e Is there additional information about the use of eye protection in response to COVID-19 you wish to share? If yes, please share:

38 Did the facility routinely use any of the following additional PPE items when caring for patients on the MDRO affected unit?

- ☐ Bouffant caps
☐ Shoe covers
☐ None of the above answer choice
☐ Don't know if additional PPE was used (Select all that apply.)

38 Did the facility routinely use any of the following additional PPE items when caring for patients on the unit MDRO transmission was initially identified?

- ☐ Bouffant caps
☐ Shoe covers
☐ None of the above answer choice
☐ Don't know if additional PPE was used (Select all that apply.)

Did the facility routinely use any of the following additional PPE items when caring for patients on the second unit MDRO transmission was identified?

- ☐ Bouffant caps
 - ☐ Shoe covers
 - ☐ None of the above answer choice
 - ☐ Don't know if additional PPE was used
- (Select all that apply.)

Did the facility routinely use any of the following additional PPE items when caring for patients on the third unit MDRO transmission was identified?

- ☐ Bouffant caps
 - ☐ Shoe covers
 - ☐ None of the above answer choice
 - ☐ Don't know if additional PPE was used
- (Select all that apply.)

Did the facility routinely use any of the following additional PPE items when caring for patients on the fourth unit MDRO transmission was identified?

- ☐ Bouffant caps
 - ☐ Shoe covers
 - ☐ None of the above answer choice
 - ☐ Don't know if additional PPE was used
- (Select all that apply.)

39 Is there additional information about PPE changes in response to COVID-19 you wish to share? If yes, please share:

(e.g., the presence and quality of training on PPE supply optimization strategies)

EVS

The following questions will ask about changes to environmental cleaning and disinfection practices during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

40	Did the facility report shortages or difficulty obtaining their preferred disinfectant product during the cluster period?	☐ Yes ☐ No ☐ Don't know
41	Did the facility report using disinfectant product requiring onsite additional preparation prior to use (i.e., mixing with other chemicals, diluting with water) during the cluster period?	☐ Yes ☐ No ☐ Don't know
If yes, please describe and note any gaps observed 		
42	Did the facility use household disinfectants (e.g., Comet, Fantastik, Fabulosos or other products that are not EPA-registered hospital disinfectants) to clean surfaces in patient care areas?	☐ Yes ☐ No ☐ Don't know
43	What was the relative frequency of cleaning the patient environment on MDRO affected unit during the cluster period compared to the same units before COVID-19?	☐ Increased frequency relative to pre-COVID ☐ Decreased frequency relative to pre-COVID ☐ Same frequency as pre-COVID ☐ Don't know
43	What was the relative frequency of cleaning the patient environment on the unit MDRO transmission was initially identified during the cluster period compared to the same units before COVID-19?	☐ Increased frequency relative to pre-COVID ☐ Decreased frequency relative to pre-COVID ☐ Same frequency as pre-COVID ☐ Don't know
	What was the relative frequency of cleaning the patient environment on the second MDRO affected unit during the cluster period compared to the same units before COVID-19?	☐ Increased frequency relative to pre-COVID ☐ Decreased frequency relative to pre-COVID ☐ Same frequency as pre-COVID ☐ Don't know
	What was the relative frequency of cleaning the patient environment on the third MDRO affected unit during the cluster period compared to the same units before COVID-19?	☐ Increased frequency relative to pre-COVID ☐ Decreased frequency relative to pre-COVID ☐ Same frequency as pre-COVID ☐ Don't know
	What was the relative frequency of cleaning the patient environment on the fourth MDRO affected unit during the cluster period compared to the same units before COVID-19?	☐ Increased frequency relative to pre-COVID ☐ Decreased frequency relative to pre-COVID ☐ Same frequency as pre-COVID ☐ Don't know
44	Was responsibility for cleaning the patient environment on any MDRO affected unit(s) shifted from EVS staff to patient care staff in response to COVID-19 during the cluster period?	☐ Yes ☐ No ☐ Don't know
	If yes, was it practiced on all MDRO affected units?	☐ Yes ☐ No ☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

- ☐ Yes
☐ No
☐ Don't know

-
- 45 Is there additional information about environmental cleaning and disinfection in response to COVID-19 you wish to share? If yes, please share:

Other practices related to MDRO transmission

The following questions will ask about changes to device-associated infection prevention activities during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

46 Please indicate if the facility reported any of the following practices for medical equipment on any of the MDRO affected unit(s) during the cluster period

46a Reusable medical equipment that would typically be dedicated to a single patient's use was used for multiple patients with cleaning and disinfection between patients on the MDRO affected unit(s)

☐ Yes
☐ No
☐ Don't know

Reuse of medical equipment for multiple patients:
please describe

(e.g., which type of equipment?)

If yes, was it practiced on all MDRO affected units?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the unit MDRO transmission was initially identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the second unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the third unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

Was it practiced on the fourth unit MDRO transmission was identified?

☐ Yes
☐ No
☐ Don't know

46b Ventilator sharing, such as dual-patient ventilation with a single mechanical ventilator or "co-venting"

☐ Yes
☐ No
☐ Don't know
☐ Not applicable, affected unit(s) did not have patients on ventilators

46c Is there additional information about medical equipment in response to COVID-19 you wish to share?
If yes, please share:

The following questions will ask about changes to targeted MDRO prevention activities during the two-week period prior to detection of the cluster through the period of suspected transmission (cluster period).

-
- 47 Did the facility report changes in the frequency of obtaining active surveillance cultures (e.g., routine admission, discharge, or PPS) for MDROs (including and not limited to the MDRO of interest) on MDRO affected unit(s)?
- ☐ Facility did not routinely obtain active surveillance cultures
 - ☐ Facility obtained routine active surveillance cultures pre-COVID but stopped obtaining them
 - ☐ Frequency of obtaining active surveillance cultures decreased relative to pre-COVID but continue to obtain routine cultures
 - ☐ Frequency of obtaining active surveillance cultures the same as pre-COVID
 - ☐ Frequency of obtaining active surveillance cultures increased relative to pre-COVID
 - ☐ Don't know
-
- 48 Has the facility stopped transmission-based precautions (such as contact precaution or enhanced barrier precaution) for endemic MDROs (e.g., MRSA, ESBL-Enterobacterales)?
- ☐ Yes, stopped in response to or contemporaneous with COVID
 - ☐ Yes, facility stopped transmission-based precautions for some patients, but is continuing transmission-based precautions for other patients (e.g., facility stopped transmission-based precautions for those colonized with endemic MDROs but is continuing transmission-based precautions for those infected with endemic MDROs)
 - ☐ No, facility is continuing to use all transmission-based precaution used prior to COVID-19
 - ☐ Don't know
 - ☐ Not applicable - facility did not use transmission-based precautions prior to COVID-19
-
- 49 In the MDRO affect unit(s) that cared for patients/residents with SARS-CoV-2 infection, was proning practiced?
- ☐ Yes
 - ☐ No
 - ☐ Don't know
 - ☐ Not applicable: this cluster does not involve a unit caring for COVID-19 patients
-
- If yes to proning, did HCP change gowns and gloves between proning different patients?
- ☐ Yes for all patients
 - ☐ Yes, but not with patients with MDRO colonization or infection
 - ☐ No
 - ☐ Don't know

Thank you for providing information on this cluster! Lastly:

50 Is there anything additional you would like to share regarding this cluster and how changes in practices due to COVID-19 may have contributed to transmission?

51 What changes did the facility implement in response to this cluster?

52 What changes did you recommend to prevent the spread of this cluster?

53 In your opinion, what are some of the barriers to implementing these changes to prevent future MDRO transmission within this facility?
