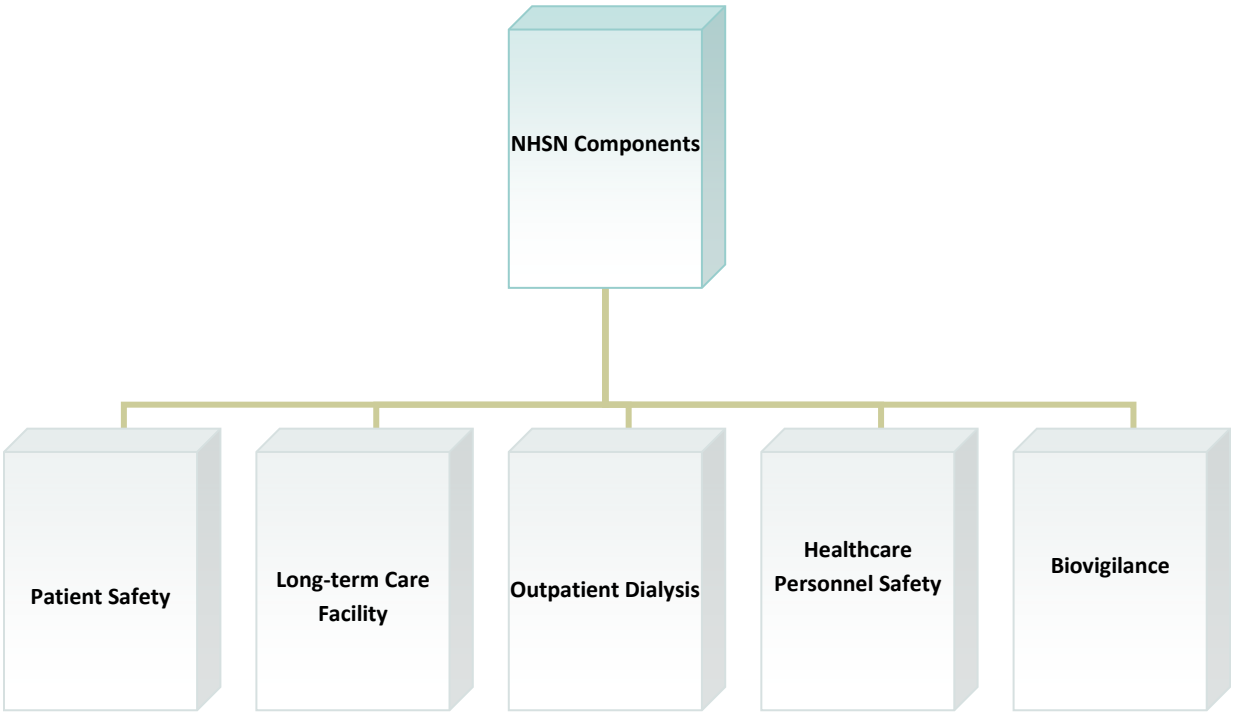
# National Healthcare Safety Network (NHSN) Overview

The NHSN is a secure, Internet-based surveillance system that expands and integrates patient, and healthcare personnel, safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at the Centers for Disease Control and Prevention. Facilities that participate in certain reporting programs operated by the Centers for Medicare and Medicaid Services (CMS) can do so through use of NHSN. Furthermore, some U.S. states use NHSN as a means for healthcare facilities to submit data on healthcare-associated infections (HAIs) mandated through their specific state legislation.

NHSN enables healthcare facilities to collect and use data about HAIs, adherence to clinical practices known to prevent HAIs, the incidence or prevalence of multidrug-resistant organisms within their organizations, trends and coverage of healthcare personnel safety and vaccination, and adverse events related to the transfusion of blood and blood products.

The NHSN includes five components: Patient Safety, Long-term Care Facility, Outpatient Dialysis, Healthcare Personnel Safety, and Biovigilance (Figure 1).

**Figure 1: NHSN Components**



The **Patient Safety Component** includes four modules that focus on events associated with devices, procedures, antimicrobial agents used during healthcare, or multidrug resistant organisms.

- Device-associated Module:
  - Bloodstream Infection (CLABSI – Central line-associated bloodstream infection)
  - Central Line Insertion Practices (CLIP) adherence
  - Urinary Tract Infection (CAUTI – Catheter-associated urinary tract infection)
  - Ventilator-associated Events (VAE ) (adult locations only)
  - Pneumonia (VAP – Ventilator-associated pneumonia) - in pediatric locations (in-plan* or off-plan*), or NICU and adult locations (off-plan* only)
- Procedure-associated Module:
  - Surgical site infection (SSI)
- Antimicrobial Use and Resistance Module (AUR)
- Multidrug-Resistant Organism and *Clostridium difficile* Infection (MDRO/CDI) Module

***Note:** "In-plan" surveillance means that the facility has committed to following the NHSN surveillance protocol, in its entirety, for that particular event, as shown in the facility's NHSN monthly reporting plan. "Off-plan" surveillance is surveillance that is done because a facility has decided to track a particular event for internal use. Data that are entered into NHSN "off-plan" are not included in NSHN annual reports or other NHSN publications. A facility makes no commitment to follow the NHSN protocol for "off-plan" events.

Instructions and standardized surveillance methods and definitions for each module of the Patient Safety Component are provided in this manual and on the NHSN website (www.cdc.gov/nhsn). Modules may be used singly or simultaneously.

The NHSN Long-term Care Component provides long-term care facilities (LTCFs) with standardized surveillance methods and definitions. The component is ideal for use by nursing homes, skilled nursing facilities, chronic care facilities, and assisted living and residential care facilities. The Component consists of three modules: 1) MDRO/*C. difficile* LabID Event; (2) Urinary Tract Infection; and (3) Prevention Process Measures. LTCF surveillance protocols, training materials, data collection forms, instructions, and other supporting materials are provided on the Long-term Care Component website: http://www.cdc.gov/nhsn/ltc/index.html

Outpatient hemodialysis centers have several surveillance options tailored to their patients and setting in the Dialysis Component. Facilities that treat hemodialysis

outpatients should refer to the Dialysis Component instructions and standardized surveillance methods and definitions at http://www.cdc.gov/nhsn/dialysis/index.html.

There are two modules in the Healthcare Personnel Safety (HPS) Component of NHSN: the Healthcare Personnel Exposure Module and the Healthcare Personnel Vaccination Module. These modules may be used singly or simultaneously. Instructions and standardized surveillance methods and definitions for each module are provided in the NHSN Manual: HPS Component Protocol http://www.cdc.gov/nhsn/PDFs/HPS-manual/HPS_Manual-exp-plus-flu-portfolio.pdf.

The NHSN Biovigilance Component, Hemovigilance Module facilitates national surveillance of transfusion-related recipient adverse events. The Hemovigilance Module is designed for transfusion service staff to collect data on annual facility and transfusion service characteristics, individual reports on adverse transfusion reactions, errors or accidents associated with adverse reactions, and monthly counts of transfused or discarded components. The Hemovigilance Module surveillance protocol, training materials, data collection forms, instructions, and other supporting materials are provided on the Hemovigilance Module website: http://www.cdc.gov/nhsn/acute-care-hospital/bio-hemo/index.html

**Surveillance Techniques**

Some of the options in the following modules require active, patient-based, prospective surveillance of events and their corresponding denominator data by a trained Infection Preventionist (IP). This means that the IP shall seek out infections during a patient's stay by screening a variety of data sources, such as laboratory, pharmacy, admission/discharge/transfer, radiology/imaging, and pathology databases, as well as patient charts, including history and physical exam notes, nurses/physicians notes, temperature charts, etc. Others may be trained to screen data sources for these infections, but the IP must make the final determination. Laboratory-based surveillance should not be used alone, unless all possible criteria for identifying an infection are solely determined by laboratory evidence (e.g., LabID event detection in the MDRO/CDI Module). Retrospective chart reviews should be used only when patients are discharged before all information can be gathered. NHSN forms should be used to collect all required data, using the NHSN definitions of each data field. To minimize the IP's data collection burden, others may be trained to collect the denominator data and process of care data (e.g., central line insertion practices).

## Procedure-Associated Module

Surgical site infection (SSI) monitoring is offered through a protocol in this module. This protocol requires active, patient-based, prospective surveillance (see Surveillance Techniques above). To minimize IPs' workload of collecting denominator data, operating room data may be downloaded (see file specifications at: http://www.cdc.gov/nhsn/PDFs/ImportingProcedureData_current.pdf).

Both pre-discharge and post-discharge surveillance methods should be used to detect SSIs. Surveillance may include both inpatient and outpatient operative procedures. These methods include 1) direct examination of patients' wounds during hospitalization, or follow-up visits to either surgery clinics or physicians' offices, 2) review of medical records or surgery-clinic patient records, 3) surgeon surveys by mail or telephone, and 4) patient surveys by mail or telephone (though patients may have a difficult time assessing their own infections). Any combination of these methods is acceptable for use; however, CDC criteria for SSI must be applied.

## Device-Associated Module

Medical instrumentation increases the risk of development of an HAI and most patients admitted for health care are exposed to some kind of medical device in the course of their treatment. Such devices include, but are not limited to, venous and urinary catheters, and ventilators. NHSN enables facilities to monitor infectious complications associated with the use of these devices and also to monitor processes related to their use which might increase infection risk. Specifically, surveillance of central line-associated bloodstream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), ventilator-associated events (VAE), and/or ventilator-associated pneumonia (VAP) is possible using the NHSN. See Dialysis Component for detailed instructions for Dialysis Event (DE) surveillance of hemodialysis outpatients (http://www.cdc.gov/nhsn/dialysis/index.html). In addition, central line insertion practices (CLIP) can be monitored to inform facilities of the appropriateness of their processes and how they may relate to CLABSI development.

Device-associated denominator data should be collected at the same time each day, or by weekly sampling methods for CLABSI and CAUTI surveillance (see the CLABSI and CAUTI protocols for guidance). When denominator data are available from electronic databases (e.g., ventilator days from respiratory therapy), these sources may be used as long as the counts are not substantially different (+/- 5%) from manually-collected counts that have been validated for a minimum of three months. See the respective device-associated event protocols for detailed surveillance instructions.

## Antimicrobial Use and Resistance (AUR) Module

The use of antimicrobial agents has a direct effect on antimicrobial resistance patterns of pathogens. The observed increase in multidrug resistance is in part due to inappropriate prescription of, as well as incomplete completion of, courses of antibiotics.

The AUR Module allows facilities to collect information on the amount of antimicrobials that are used for patient care within their systems, as well as to collect data on the prevalence of drug-resistant organisms in their inpatient and outpatient areas. Electronic capture and reporting of microbiology and pharmacy data are the only available options for reporting data into this module.

See the Antimicrobial Use and Resistance protocol for detailed surveillance instructions.

**Multidrug-resistant Organism and *Clostridium difficile* Infection *(MDRO/CDI)* Module**

The NHSN MDRO/CDI Module offers a means for facilities to meet criteria and metrics that are outlined in several organizational guidelines to control and measure the spread of MDROs and CDI within their healthcare system. The module has both required and optional surveillance activities that can be tailored to meet the needs of the facility. Laboratory-identified (LabID) Event and Infection Surveillance are available choices for participating NHSN facilities.

In addition, the following process measures are available: (1) adherence to hand hygiene; (2) adherence to contact precautions when caring for patients infected or colonized with an MDRO or *C. difficile;* and (3) adherence to active surveillance testing (AST) of MRSA and/or VRE. Measurement of active surveillance testing outcomes is also available in locations where AST adherence is being performed, and enables facilities to use the results of AST to monitor the incidence and prevalence of positive MRSA and/or VRE cultures. See the MDRO/CDI protocol for detailed surveillance instructions.

# Identifying Healthcare-associated Infections (HAI) for NHSN Surveillance

To standardize the classification of an infection as present on admission (POA) or a healthcare-associated infection (HAI), the following objective surveillance definitions and guidance are used for NHSN surveillance:

- 7-day Infection Window Period
- Date of Event
- POA
- HAI
- 14-day Repeat Infection Timeframe (RIT)
- Secondary Bloodstream Infection Attribution Period
- Pathogen Assignment Guidance

The intention of this approach is to align criteria and definitions and decrease subjectivity while maintaining epidemiologic standardization and clinical relevance. A variety of scenarios to include repeat infections of the same type, concurrent infections of differing types, and pathogen assignment in multi-pathogen infections are addressed.

**Notes:**

- Infection window period, POA, HAI, and RIT definitions **do not** apply to SSI, VAE, or LabID Events.
- Date of Event, as defined in this chapter, **does not** apply to VAE or LabID Events;
- Secondary BSI attribution period, as defined in this chapter, does not apply to SSI, VAE, LabID or primary BSI events.
    - SSI surveillance utilizes a 30 or 90 day surveillance period. Since the Infection Window Period and RIT do not apply, the secondary BSI attribution period, by name, also cannot apply. However, a 17-day period that includes the date of SSI event, 3 days prior and 13 days after, is still used to attribute a BSI as secondary to an SSI.
    - Specific guidance can be found in the VAE protocol for secondary BSI attribution.
    - A primary BSI/CLABSI by definition can never have a secondary BSI.
- Organisms belonging to the following genera are typically causes of community-associated infections and are rarely or are not known to be causes of healthcare-associated infections, they are excluded, and cannot be used to meet any NHSN definition: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.*

- If the date of culture collection is on or after the date the patient is declared brain dead AND the patient is being supported for organ donation purposes, the event should not be reported as an HAI. For VAE surveillance, if the date of event (date of onset of

worsening oxygenation) is on or after the date the patient is declared brain dead AND the patient is being supported for organ donation purposes, the event should not be reported as a VAE.

Table 1: Definition Application

| | SSI | LabID | VAE | BSI |
|---|---|---|---|---|
| Infection Window Period | N/A | **Not Applicable** | **Not Applicable** | Yes |
| Date of Event | Yes | | | Yes |
| POA | N/A | | | Yes |
| HAI | N/A | | | Yes |
| Repeat Infection Timeframe (RIT) | N/A | | | Yes |
| Secondary BSI Attribution Period | * | | | N/A |

*See SSI specific guidance
N/A=Not Applicable

**Observation Patients in Inpatient Locations:**

For purposes of NHSN surveillance, if an observation patient is sent to an inpatient location, the patient must be included in infection surveillance, patient day, and device day counts. The facility assignment of the patient as an observation patient or an inpatient has no bearing in this instance for counting purposes. The patient is being housed, monitored, and cared for in an inpatient location and therefore is at risk for acquisition of an HAI.

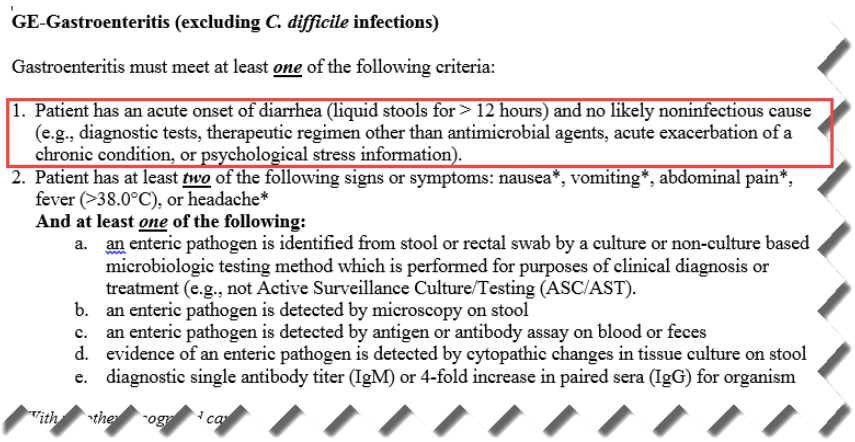
**NHSN Infection Window Period:**

The NHSN Infection Window Period is defined as the 7-days during which all site-specific infection criteria must be met. It includes the day the first positive diagnostic test that is used as an element of the site-specific infection criterion, was obtained, the 3 calendar days before and the 3 calendar days after. For purposes of defining the Infection Window Period the following are considered diagnostic tests:

- laboratory specimen collection
- imaging test
- procedure or exam
- physician diagnosis
- initiation of treatment

For site-specific infection criteria that do not include a diagnostic test, the first documented localized sign or symptom that is used as an element of NHSN infection criterion should be used to define the window (e.g., diarrhea, site specific pain, purulent exudate).

For example, when meeting GE using criterion 1, there is no diagnostic test as a part of this site-specific infection criterion. A sign or symptom (diarrhea) must be used to set the infection window period.



**GE-Gastroenteritis (excluding *C. difficile* infections)**

Gastroenteritis must meet at least ***one*** of the following criteria:

1. Patient has an acute onset of diarrhea (liquid stools for > 12 hours) and no likely noninfectious cause (e.g., diagnostic tests, therapeutic regimen other than antimicrobial agents, acute exacerbation of a chronic condition, or psychological stress information).
2. Patient has at least ***two*** of the following signs or symptoms: nausea*, vomiting*, abdominal pain*, fever (>38.0°C), or headache*
   **And at least *one* of the following:**
   a. an enteric pathogen is identified from stool or rectal swab by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. an enteric pathogen is detected by microscopy on stool
   c. an enteric pathogen is detected by antigen or antibody assay on blood or feces
   d. evidence of an enteric pathogen is detected by cytopathic changes in tissue culture on stool
   e. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

Table 2: Infection Window Period

| | | |
|---|---|---|
| **Infection Window Period** | | **3 days before** |
| | **First positive diagnostic test OR First documented localized sign and/or symptom in the absence of a diagnostic test** | |
| | | **3 days after** |

**Date of Event (Event Date):**

The Date of Event is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period.

An infection is considered **Present on Admission (POA)** if the date of event of the NHSN site-specific infection criterion occurs during the POA time period, which is defined as the day of admission to an inpatient location (calendar day 1), the 2 days before admission, and the calendar day after admission. For purposes of NHSN surveillance and determination of the Repeat Infection Timeframe (as defined below) if the date of event is determined to be either of the two days prior to inpatient admission, then the date of event will be hospital day 1.

An infection is considered a **Healthcare-associated Infection (HAI)** if the date of event of the NHSN site-specific infection criterion occurs on or after the 3rd calendar day of admission to an inpatient location where day of admission is calendar day 1.

Table 3: Date of Event and Classification Determination

| Hospital Day | Date of Event Assignment for RIT | Classification |
|---|---|---|
| 2 days before admit | Hospital Day 1 | **POA** |
| 1 day before admit | Hospital Day 1 | |
| 1 | Hospital Day 1 | |
| 2 | Hospital Day 2 | |
| 3 | Hospital Day 3 | **HAI** |
| 4 | Hospital Day 4 | |
| 5 | Hospital Day 5 | |

Table 4: Infection Window Period and Date of Event

(Patient age < 65)

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Date of event**
(date the first element occurs for the first time within the infection window period)

| HOSPITAL DAY | INFECTION WINDOW PERIOD |
|---|---|
| 1 | |
| **2** | Fever > 38.0 C |
| 3 | Fever > 38.0 C |
| 4 | **Urine culture:** >100,000 cfu/ml *E. coli* |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |
| 11 | |
| 12 | |
| 13 | |
| 14 | |
| 15 | |
| 16 | |
| 17 | |
| 18 | |
| | **SUTI-POA**<br>**Date of Event = 2**<br>**Pathogen = *E. coli*** |

| HOSPITAL DAY | INFECTION WINDOW PERIOD |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| **4** | **Urine culture**: >100,000 cfu/ml *E. coli* |
| 5 | Fever > 38.0 C |
| 6 | Fever > 38.0 C |
| 7 | |
| 8 | |
| 9 | |
| 10 | |
| 11 | |
| 12 | |
| 13 | |
| 14 | |
| 15 | |
| 16 | |
| 17 | |
| 18 | |
| | **SUTI-HAI**<br>**Date of Event = 4**<br>**Pathogen = *E. coli*** |

**Notes:**

- Acceptable documentation includes patient-reported signs or symptoms documented in the chart by a healthcare professional (e.g., patients states measured fever > 38.0° C or 100.4° F, nursing home documents fever prior to arrival to the hospital, patient complains of dysuria).
- Physician diagnosis can be accepted as evidence of an infection only when physician diagnosis is an element of the specific infection definition. For example, physician diagnosis is not an element of any UTI criteria; therefore, physician diagnosis of a UTI may not be used to satisfy POA status of a UTI.
- Infections occurring in newborns with date of event on hospital day 1 or day 2 are considered POA. Those with date of event on day 3 or later are HAI. This would include infections acquired transplacentally (e.g., herpes simplex, toxoplasmosis, rubella, cytomegalovirus, or syphilis) or as a result from passage through the birth canal (e.g., Group B Streptococcus).
- Reactivation of a latent infection (e.g., herpes zoster [shingles], herpes simplex, syphilis, or tuberculosis) is not considered to be HAI.

**Repeat Infection Timeframe (RIT):**

The RIT is a 14-day timeframe during which no new infections of the same type are reported. **The RIT applies to both POA and HAI determinations.** The date of event is Day 1 of the 14-day RIT. If criteria for the same type of infection are met within the 14 day RIT, a new event is not identified or reported. Additional pathogens recovered during the RIT from the same type of infection are added to the event.

The RIT will apply at the level of specific type of infection with the exception of BSI, UTI, and PNEU where the RIT will apply at the major type of infection.

Specific Type Example:

- Patients will have no more than one BONE infection in an RIT, but may have a BONE and DISC in two overlapping RITs (specific type)

Major Type Examples:

- Patients will have no more than one LCBI in an RIT (e.g., LCBI 1, LCBI 2, MBI-LCBI 1, etc.)
- Patients will have no more than one PNEU in an RIT (e.g., PNU1, PNU2, PNU3)
- Patients will have no more than one UTI in an RIT (e.g., SUTI, ABUTI)

The RIT applies during a patient's single admission, including the day of discharge and the day after, in keeping with the Transfer Rule. **An RIT does not carry over from one admission to another even if readmission is to the same facility.**

In the example below (**Table 5**), the Date of Event is hospital day 4. The 14-day RIT is hospital day 4 through day 17. On hospital day 12, within the RIT, a urine culture with > 100,000 CFU/ml *S. aureus* is identified. The urine pathogen identified from the hospital day 12 culture is added to the originally identified infection on hospital day 4. Determination of a new infection or continuation of ongoing infection is not required.

Table 5: Repeat Infection Timeframe

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| HOSPITAL DAY | RIT | INFECTION WINDOW PERIOD |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | 1 | **Urine culture:** >100,000 cfu/ml *E. coli* |
| 5 | 2 | Fever > 38.0 C |
| 6 | 3 | Fever > 38.0 C |
| 7 | 4 | |
| 8 | 5 | |
| 9 | 6 | Urine culture: No growth |
| 10 | 7 | |
| 11 | 8 | |
| 12 | 9 | Urine culture: > 100,000 cfu/ml *S. aureus* |
| 13 | 10 | |
| 14 | 11 | |
| 15 | 12 | |
| 16 | 13 | |
| 17 | 14 | |
| 18 | | |
| 19 | | |
| | | **SUTI-HAI**<br>**Date of Event = 4**<br>**Pathogens = *E. coli, S. aureus*** |

**Notes:**

- A patient may have negative cultures during the RIT without impact on the RIT.
- Do not change the device-association determination during the RIT.
    - Example: A non-catheterized UTI is identified and initiates an RIT. During the RIT, a Foley catheter is placed and more than 2 days later, still in the RIT, another urine culture is collected and resulted as positive for > 100,000 CFU/ml with a different bacteria. Add this pathogen to the original UTI but do not change the non-catheter associated UTI to CAUTI.

**Secondary BSI Attribution Period (*Refer to Appendix 1, Secondary BSI Guide of the BSI Event Protocol*):**

The Secondary BSI Attribution Period* is the period in which a positive blood culture must be collected to be considered as a secondary bloodstream infection to a primary site infection. This period includes the Infection Window Period combined with the Repeat Infection Timeframe (RIT). It is 14-17 days in length depending upon the date of event.

For a bloodstream infection to be determined secondary to another site of infection, the blood culture must be collected during the site-specific infection Secondary BSI Attribution Period and satisfy one of the following‡ (See Appendix 1: Secondary BSI Guide):

1. An organism identified from the site specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site specific specimen
   ***OR***
2. The positive blood specimen is an element used to meet the site-specific infection criterion

***Note:** SSI surveillance utilizes a 30 or 90 day surveillance period. Since the Infection Window Period and RIT do not apply, the secondary BSI attribution period, by name, also cannot apply. However, a 17-day period that includes the date of SSI event, 3 days prior and 13 days after, is still used to attribute a BSI as secondary to an SSI.

‡**Exception:**

Necrotizing enterocolitis (NEC) criteria include neither a site-specific specimen nor organism identified from blood specimen, however an exception for assigning a BSI secondary to NEC is provided.

A BSI is considered secondary to NEC if the patient meets one of the two NEC criteria AND an organism identified from blood specimen collected during the secondary BSI attribution period is an LCBI pathogen, or the same common commensal which is identified from two or more blood specimens drawn on separate occasions collected on the same or consecutive days.

In the example below (**Table 6**), the Date of Event is hospital day 4. The 14-day RIT is hospital day 4 through day 17. The Secondary BSI Attribution Period is the Infection Window Period combined with the Repeat Infection Timeframe (RIT), 17 days in this example. The blood culture collected on hospital day 10 has a matching pathogen to the site specific culture used to meet SUTI definition, and therefore, a secondary BSI is identified.

Table 6: Secondary BSI Attribution Period

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| HOSPITAL DAY | BSI | RIT | INFECTION WINDOW PERIOD |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | 1 | **Urine culture:** >100,000 cfu /ml *E. coli* |
| 5 | | 2 | Fever > 38.0 C |
| 6 | | 3 | Fever > 38.0 C |
| 7 | | 4 | |
| 8 | | 5 | |
| 9 | | 6 | |
| 10 | | 7 | Blood culture : *E.coli* |
| 11 | | 8 | |
| 12 | | 9 | Urine culture: > 100,000 cfu/ml *S. aureus* |
| 13 | | 10 | |
| 14 | | 11 | |
| 15 | | 12 | |
| 16 | | 13 | |
| 17 | | 14 | |
| 18 | | | |
| 19 | | | |
| | | | **SUTI & Secondary BSI**<br>**Date of Event = 4**<br>**Pathogens = *E. coli, S. aureus*** |

In the example below (**Table 7**), the Date of Event is hospital day 4. The 14-day RIT is hospital day 4 through day 17. The secondary BSI Attribution Period is 17 days in length. The blood culture collected on hospital day 5 is used as an element to meet the PNU2 infection definition and therefore a secondary BSI is identified.

Table 7: Secondary BSI Attribution Period

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| HOSPITAL DAY | BSI | RIT | INFECTION WINDOW PERIOD |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | 1 | **Chest Imaging:** infiltrate |
| 5 | | 2 | Blood Culture: *S. aureus*, Fever > 38.0 C, new onset cough |
| 6 | | 3 | Fever > 38.0 C, rales |
| 7 | | 4 | |
| 8 | | 5 | |
| 9 | | 6 | |
| 10 | | 7 | |
| 11 | | 8 | |
| 12 | | 9 | |
| 13 | | 10 | |
| 14 | | 11 | |
| 15 | | 12 | |
| 16 | | 13 | |
| 17 | | 14 | |
| 18 | | | |
| 19 | | | |
| | | | **PNEU (PNU2) & Secondary BSI**<br>**Date of Event = 4**<br>**Pathogens = *S. aureus***|

**Pathogen Assignment Guidance:**

The following provides guidance for reporting pathogens associated with site-specific infections that are identified during the RIT or during the secondary BSI attribution period.

- Additional pathogens recovered during the RIT from the same type of infection are added to the event.
- Report all site-specific pathogens before secondary BSI pathogens.
    - SUTIs can only have two organisms entered according to NHSN application rules. However, if yes is selected for the secondary BSI field, the third pathogen field will become available for data entry.
- BSI pathogens may be assigned to more than one infection source at the same time in the following scenarios.
    1) Secondary BSI pathogen assigned to two different site-specific infections (see example 1) OR
    2) Secondary BSI pathogen assigned to a site-specific infection and assigned as pathogen to a primary BSI event (see example 2).

**Example 1:**

*K. pneumoniae* is identified in a blood culture during the RIT of a SUTI with *K. pneumoniae*. The patient is also recovering from COLO surgery performed at your facility in the past week and now has:

- Fever > 38.0° C
- Abdominal pain, and
- CT showing abdominal abscess

These three elements, when combined with a positive blood culture, meet IAB criterion 3b. **If a facility includes both UTI and SSI (for COLO) in their monthly reporting plan, an UTI and SSI would be reported, both with a secondary BSI and with pathogen *K. pneumoniae.***

**Note:** SSI-IAB does not have an Infection Window Period or RIT. The secondary BSI attribution period is 17 days in duration including the date of event, 3 days prior and 13 days after the date of event.

## *Cont.* Example 1

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Secondary BSI Attribution Period for SSI**

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| Hospital Day | BSI | RIT | Infection Window Period | Infection Window Period | BSI -SSI |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| **4** | | 1 | **Urine culture**: >100,000 cfu/ml *K. pneumoniae* | | |
| 5 | | 2 | Fever > 38.0 C | | |
| 6 | | 3 | | | |
| 7 | | 4 | | | |
| **8** | | 5 | | Fever >38.0 C, Abdominal pain | |
| 9 | | 6 | | CT Scan : Abdominal abscess | |
| 10 | | 7 | Blood culture: *K. pneumonia*e | Blood culture: *K. pneumoniae* | |
| 11 | | 8 | | | |
| 12 | | 9 | | | |
| 13 | | 10 | | | |
| 14 | | 11 | | | |
| 15 | | 12 | | | |
| 16 | | 13 | | | |
| 17 | | 14 | | | |
| 18 | | | | | |
| 19 | | | | | |
| 20 | | | | | |
| 21 | | | | | |
| 22 | | | | | |
| 23 | | | | | |
| | | | **SUTI & Secondary BSI Date of Event = 4 Pathogen: *K. pneumoniae*** | **SSI-IAB & Secondary BSI Date of Event = 8 Pathogen: *K. pneumoniae*** | |

**Example 2:**
On day 4 of hospital admission, *S. aureus* is identified in a blood culture meeting the HAI, LCBI 1 criterion. On day 8 the patient has a fever > 38.0° C and *E. coli* is identified in a urine culture meeting the SUTI definition. On hospital day 13, a blood culture positive for *E.coli* is identified. **Because the blood culture occurs within both the LCBI RIT and the SUTI secondary BSI attribution period, the pathogen, *E.coli* is assigned to both events.**

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| Hospital Day | RIT | Infection Window Period | Infection Window Period | RIT | BSI |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | 1 | **Blood culture**: *S. aureus* | | | |
| 5 | 2 | | | | |
| 6 | 3 | | | | |
| 7 | 4 | | | | |
| 8 | 5 | | Fever >38.0 C, | 1 | |
| 9 | 6 | | **Urine culture**: >100,000 cfu / ml *E.coli* | 2 | |
| 10 | 7 | | | 3 | |
| 11 | 8 | | | 4 | |
| 12 | 9 | | | 5 | |
| 13 | 10 | | | 6 | |
| 14 | 11 | | | 7 | |
| 15 | 12 | | | 8 | |
| 16 | 13 | Blood Culture: *E.coli* | Blood Culture: *E.coli* | 9 | |
| 17 | 14 | | | 10 | |
| 18 | | | | 11 | |
| 19 | | | | 12 | |
| 20 | | | | 13 | |
| 21 | | | | 14 | |
| 22 | | | | | |
| | | **LCBI Date of Event = 4 Pathogen: S. aureus and E.coli** | **SUTI & Secondary BSI Date of Event = 8 Pathogen: E.coli** | | |

- Pathogens excluded from specific infection definitions (e.g., yeast in UTI, *Enterococcus* spp. in PNEU) are also excluded as pathogens for BSIs secondary to that type of infection (i.e., they cannot be added to one of these infections as a pathogen). The excluded organism must be accounted for as either:
    1) A primary bloodstream infection (BSI/CLABSI) (see example 3)

       **OR**

    2) A secondary BSI attributed to another primary infection (e.g., IAB, SINU, etc.), in accordance with Appendix 1, Secondary BSI Guide of the BSI Event protocol (see example 4)

**Example 3:**

A SUTI with *Enterococcus faecalis* is identified and a subsequent blood culture with yeast and *E. faecalis* is collected during the SUTI secondary BSI attribution period. A BSI secondary to SUTI is identified. ***E. faecalis* is already documented as a pathogen, but the yeast will not be reported as a secondary BSI pathogen, because yeasts are excluded as organisms in the UTI definition.** In this example, no other primary source of infection for which the yeast BSI can be assigned as secondary is identified. Therefore a primary BSI with yeast only is identified.

**Note:** The *Enterococcus faecalis* is not assigned as a pathogen for the primary BSI because if an excluded organism had not been identified, a primary BSI would not have been reported.

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| Hospital Day | BSI | RIT | Infection Window Period | Infection Window Period | RIT |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | 1 | Dysuria | | |
| 4 | | 2 | **Urine culture**: > 100,000 cfu/ml *E. faecalis* | | |
| 5 | | 3 | | | |
| 6 | | 4 | | | |
| 7 | | 5 | | | |
| 8 | | 6 | | | |
| 9 | | 7 | | | |
| 10 | | 8 | | | |
| 11 | | 9 | Blood culture: *E.faecalis* / Yeast | **Blood culture:** *E. faecalis* / Yeast | 1 |
| 12 | | 10 | | | 2 |
| 13 | | 11 | | | 3 |
| 14 | | 12 | | | 4 |
| 15 | | 13 | | | 5 |
| 16 | | 14 | | | 6 |
| 17 | | | | | 7 |
| 18 | | | | | 8 |
| 19 | | | | | 9 |
| 20 | | | | | 10 |
| 21 | | | | | 11 |
| 22 | | | | | 12 |
| 23 | | | | | 13 |
| 24 | | | | | 14 |
| 25 | | | | | |
| | | | **UTI & Secondary BSI Date of Event = 3 Pathogen: *E. faecalis*** | **Primary BSI Date of Event = 11 Pathogen: Yeast** | |

**Example 4:**

A PNU2 with *Acinetobacter baumannii* cultured from blood is identified. **Note:** the positive chest imaging result is the diagnostic test that is used to define the infection window period. A subsequent blood culture with *Enterococcus faecalis* and *A. baumannii* is collected during the secondary BSI attribution period of this PNU2 event. ***Enterococcus faecalis* will not be reported as a pathogen for the PNU2, because *Enterococcus* spp. are excluded as organisms in the PNEU definition.** Another primary source of infection, SUTI, is found and *Enterococcus faecalis* is assigned as a secondary BSI pathogen.

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| Hospital Day | BSI | RIT | Infection Window Period | Infection Window Period | RIT | BSI |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | 1 | New onset cough | | | |
| 8 | | 2 | **Imaging test: Infiltrate** | | | |
| 9 | | 3 | Fever > 38.0 C | Fever > 38.0 C | 1 | |
| 10 | | 4 | Fever > 38.0 C | Fever > 38.0 C | 2 | |
| 11 | | 5 | Blood culture: *A. baumannii* | **Urine culture:** > 100,000 cfu/ml *E. faecalis* | 3 | |
| 12 | | 6 | Blood culture: *A.baumannii, E.faecalis* | Blood culture: *A.baumannii, E.faecalis* | 4 | |
| 13 | | 7 | | | 5 | |
| 14 | | 8 | | | 6 | |
| 15 | | 9 | | | 7 | |
| 16 | | 10 | | | 8 | |
| 17 | | 11 | | | 9 | |
| 18 | | 12 | | | 10 | |
| 19 | | 13 | | | 11 | |
| 20 | | 14 | | | 12 | |
| 21 | | | | | 13 | |
| 22 | | | | | 14 | |
| 23 | | | | | | |
| 24 | | | | | | |
| 25 | | | | | | |
| 26 | | | | | | |
| | | | **PNU2 & Secondary BSI Date of Event = 7 Pathogen: *A.baumannii*** | **SUTI & Secondary BSI Date of Event = 9 Pathogens: *E. faecalis, A.baumannii*** | | |

- Determination of a secondary BSI to a primary site of infection does not set an RIT for all subsequent BSIs. If a blood culture occurs during a site specific infection's secondary BSI attribution period and it cannot be used as an element to meet the infection definition or does not have at least one matching pathogen to the site-specific infection culture used to meet the site-specific infection criterion the BSI must be evaluated as a new BSI event (see example 5)

  **Example 5:**

  A SUTI with *Enterococcus faecalis* is identified and a blood culture with *E. faecalis* collected on hospital day 11 within the SUTI secondary BSI attribution period is also identified. On hospital day 15 (also within the SUTI RIT and secondary BSI attribution period), a blood culture growing *Staphylococcus aureus* is identified. **Because the blood growing *S. aureus* does not have at least one pathogen that matches the urine culture used to meet the SUTI criterion the BSI cannot be attributed as secondary to the SUTI. The BSI will need to be investigated as a new BSI event** and either assigned as a secondary BSI to another primary site of infection or determined to be a primary BSI.

  **Note: The secondary BSI attribution period for a primary site of infection does not establish a repeat infection timeframe for all subsequent BSIs.**

***Cont*. Example 5**

**Infection Window Period**
(first positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

**Date of Event**
(date the first element occurs for the first time within the infection window period)

| Hospital Day | BSI | RIT | Infection Window Period |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | 1 | Dysuria |
| 4 | | 2 | **Urine culture**: > 100,000 cfu/ml *E. faecalis* |
| 5 | | 3 | |
| 6 | | 4 | |
| 7 | | 5 | |
| 8 | | 6 | |
| 9 | | 7 | |
| 10 | | 8 | |
| 11 | | 9 | Blood culture: *E.faecalis* |
| 12 | | 10 | |
| 13 | | 11 | |
| 14 | | 12 | |
| 15 | | 13 | Blood cu… *S.aureus* |
| 16 | | 14 | |
| 17 | | | |
| 18 | | | |
| 19 | | | |
| 20 | | | |
| 21 | | | |
| | | | **UTI & Secondary BSI Date of Event = 3 Pathogen: *E. faecalis*** |

**Location of Attribution:**

The inpatient location where the patient was assigned on the date of event is the location of attribution (see Date of Event definition).

**Exception to Location of Attribution:**

*Transfer Rule*: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location. This is called the Transfer Rule and examples are found in UTI, BSI and PNEU modules. Receiving facilities should share information about such HAIs with the transferring location or facility to enable reporting.

**Multiple Transfers:**

In instances where a patient has been transferred to more than one location on the date of an infection, or the day before, attribute the infection to the **first** location in which the patient was housed the **day before** the infection's date of event.

Example of multiple transfers within the transfer rule time-frame:

| | 3/22 | 3/23 | 3/24 |
|---|---|---|---|
| Locations in which patient was housed | Unit A | Unit A<br>Unit B<br>Unit C | Unit C<br>Unit D<br>This is also the date of event for a CAUTI. CAUTI is attributed to Unit A since Unit A was the first location in which the patient was housed the day before the date of event. |

**Note:** The complete set of CDC/NHSN HAI site-specific infection criteria, and the comments and reporting instructions integral to the correct application of the criteria, can be found in Chapter 17, CDC/NHSN Surveillance Definitions for Specific Types of Infections.

# Patient Safety Monthly Reporting Plan and Annual Surveys

The *Patient Safety Monthly Reporting Plan* form (CDC 57.106) is used by NHSN institutions to inform CDC which Patient Safety modules are used during a given month. This allows CDC to select the data that should be included in the aggregate data pool for analysis. Each participating institution must identify and enter a monthly plan to indicate the module(s) used, if any, and the events, locations and/or procedures that will be monitored. There must be a plan completed for every month that data are entered into NHSN although a facility may choose "No NHSN Patient Safety Modules Followed this Month" as an option. The reporting plan should take into account reporting requirements (e.g., local, state, or CMS mandates) when applicable to the facility. The monthly reporting plan is the first step in indicating the data that should be submitted to CMS as part of the CMS Quality Reporting Programs.

Upon enrollment into NHSN, activation of an NHSN component, and/or identification of select CMS-certified units, one or more annual facility surveys must be completed. Thereafter, at the beginning of each year, the facility survey(s) must be updated to reflect data from the prior calendar year. For example, at the beginning of 2015, an acute care hospital completes a 2014 Annual Hospital Survey containing data for 2014.

In the Patient Safety Component there are separate surveys for the following types of facilities:

- Hospital (includes general, acute care hospitals; critical access hospitals; surgical; oncology; orthopedic; pediatric; women's; women's and children's; military; psychiatric; and Veterans Affairs): *Patient Safety Component – Annual Hospital Survey* (57.103)
- Long-term Acute Care (LTAC) Hospital: *Patient Safety Component – Annual Facility Survey for LTAC* (57.150)
- Inpatient Rehabilitation Facility: *Patient Safety Component – Annual Facility Survey for IRF* (57.151)
- Ambulatory Surgery Center (ASC): *Patient Safety Component – Annual Facility Survey for ASC* (form number 57.400 is accessible at this location: http://www.cdc.gov/nhsn/ambulatory-surgery/index.html)

Instructions for completing the *Patient Safety Monthly Reporting Plan* form and the applicable Annual Survey forms can be found in the applicable Table of Instruction, which provide brief instructions for collection and entry of each data element on each of the forms.

# Bloodstream Infection Event (Central Line-Associated Bloodstream Infection and Non-central line-associated Bloodstream Infection)

**Introduction:** Although a 46% decrease in CLABSIs has occurred in hospitals across the U.S. from 2008-2013, an estimated 30,100 central line-associated bloodstream infections (CLABSI) still occur in intensive care units and wards of U.S. acute care facilities each year.[1] CLABSIs are serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality.

CLABSI can be prevented through proper insertion techniques and management of the central line. These techniques are addressed in the CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HIPAC) *Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011*.[2]

**Settings:** Surveillance may occur in any inpatient location where denominator data can be collected, which can include critical/intensive care units (ICU), specialty care areas (SCA), neonatal units including neonatal intensive care units (NICUs), step down units, wards, and long term care units. A complete listing of inpatient locations and instructions for mapping can be found in the CDC Locations and Descriptions chapter.

**Note:** Surveillance for CLABSIs after the patient is discharged from the facility is not required. However, if discovered, any CLABSIs with a date of event on the day of discharge or the next day is attributable to the discharging location and should be included in any CLABSIs reported to NHSN for that location (see Transfer Rule). No additional associated central line days are reported.

**Definitions:**

Present on Admission (POA): Infections that are POA, as defined in Chapter 2, are not considered HAIs and therefore are never reported to NHSN.

Healthcare-associated infections (HAI): All NHSN site specific infections must first meet the HAI definition as defined in Chapter 2 before a site specific infection (e.g., CLABSI) can be reported to NHSN.

Primary bloodstream infections (BSI): Laboratory-confirmed bloodstream infections (LCBI) that are not secondary to an infection at another body site (see Appendix 1. Secondary Bloodstream Infection (BSI) Guide and Surveillance Definitions chapter).

Date of event (DOE): The BSI date of event is the date when the FIRST element used to meet the laboratory-confirmed bloodstream infection (LCBI) criterion occurs for the first time within the 7-day infection window period. (See definition of Infection Window Period in Chapter 2). Synonym: infection date.

Central line: An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line BSI and counting central-line days in the NHSN system:

- Aorta
- Pulmonary artery
- Superior vena cava
- Inferior vena cava
- Brachiocephalic veins
- Internal jugular veins
- Subclavian veins
- External iliac veins
- Common iliac veins
- Femoral veins
- In neonates, the umbilical artery/vein.

**Notes:**

1. Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart, and be used for one of the purposes outlined above, to qualify as a central line.
2. At times an intravascular line may migrate from its original great vessel location. Subsequent to the original confirmation, NHSN does not require ongoing confirmation that a line resides in a great vessel. Therefore, once a line is identified to be a central line for NHSN purposes, it is considered a central line until discontinuation, regardless of migration, and associated central line days are included in any CLABSI surveillance being performed in that location.
3. An introducer is considered an intravascular catheter, and depending on the location of its tip and use, may be a central line.
4. Pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart are not considered central lines, because fluids are not infused, pushed, nor withdrawn through such devices.
5. The following devices are not considered central lines:
    - Extracorporeal membrane oxygenation (ECMO)
    - Femoral arterial catheters
    - Intra-aortic balloon pump (IABP) devices.
    - Hemodialysis reliable outflow (HeRO) dialysis catheters
    - Impella heart devices

Infusion: The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes, IV antimicrobial administration, or blood transfusion or hemodialysis.

Umbilical catheter: A central vascular device inserted through the umbilical artery or vein in a neonate.

Temporary central line: A non-tunneled, non- implanted catheter.

Permanent central line: Includes

- Tunneled catheters, including certain dialysis catheters
- Implanted catheters (including ports)

Central line-associated BSI (CLABSI): A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

**AND**

the line was also in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule). Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

**Examples of Determining a CLABSI versus BSI that is not central-line associated**

- Patient has a central line inserted on June 1. On June 3, the central line is still in place and the patient's blood is collected for culture. The culture is positive for *S. aureus*. This is a CLABSI because the central line was in place for >2 calendar days (June 1, 2, and 3), and still in place, on the date of event (June 3).
- Patient has a central line inserted on June 1. On June 3, the central line is removed and on June **4** the patient's blood is collected for culture. The culture is positive for *S. aureus*. This is a CLABSI because the central line was in place for >2 calendar days (June 1, 2, and 3), and was in place the day before the date of event (June 4).
- Patient has a central line inserted on June 1. On June 3, the central line is removed. On June **5** patient spikes a fever of 38.3°C and the patient's blood is collected for culture. The culture is positive for *S. aureus*. This meets LCBI Criterion 1 but it is not a CLABSI because the Date of Event (June 5) did not occur on the day the central line was discontinued (June 3) nor the next day (June 4).

**Notes:**

1. **Central lines that are removed and reinserted**: If, after central line removal, the patient is without a central line for at least one full calendar day (NOT to be read as 24 hours), then the central line day count to determine eligibility for a CLABSI, will start anew. If instead, a new central line is inserted before a full calendar day without a central line has passed, the central line day count, to determine eligibility for a CLABSI, will continue uninterrupted. See Figure 1 below.
2. Bloodstream infections will not be reported if they occur within the Repeat Infection Timeframe (RIT) of a previously identified BSI. See Repeat Infection Timeframe guidance in Chapter 2, Identifying HAIs.
3. **Note that only primary BSIs create a BSI RIT. Secondary BSIs do not create a BSI RIT.**
4. A positive blood specimen meeting LCBI criteria, that is accompanied by **documentation** of observed or suspected patient accession into vascular access lines, within the BSI infection window period, will be considered an LCBI, but not CLABSI for NHSN reporting purposes. A BSI RIT will be created. If reporting the BSI to NHSN, answer "No" to the risk factor event field "Central line?" If a facility is reporting CLABSIs electronically to NHSN via Clinical Document Architecture (CDA), no CLABSI should be reported for this event, since this BSI is not considered associated to the central line. If blood specimens meeting LCBI criteria with a date of event outside of the BSI RIT occur, they must be investigated as a part of any BSI surveillance. Documentation of observed or suspected patient accession into vascular access lines, within the BSI infection window period, will again be necessary in order to determine that the LCBI is not central-line associated for this reason.

Figure 2: Associating Central Line (CL) Use to BSI

| | March 31 (Hospital day 3) | April 1 | April 2 | April 3 | April 4 | April 5 | April 6 |
|---|---|---|---|---|---|---|---|
| Patient A | Central Line **Day 3** | Central Line **Day 4** | Central Line removed **(CL Day 5)** | Central Line replaced **(CL Day 6)** | Central Line **Day 7** | Central Line removed **Day 8** | No Central Line |
| Patient B | Central Line **Day 3** | Central Line **Day 4** | Central Line removed **(CL Day 5)** | No Central Line | Central Line Replaced **(CL Day 1)** | Central Line **Day 2** | Central Line **Day 3** |

**Rationale:** NHSN surveillance for infection is not aimed at a specific device. Instead surveillance is aimed at identifying risk to the patient that is the result of device use in general.

1. In the examples above, Patient A is eligible for a CLABSI beginning on March 31, through April 6, since a CL was in place for some portion of each calendar day until April 6. A BSI with date of event on April 6 would be a CLABSI since the CL had been in > 2 days and was removed the day before the date of event.

2. Patient B is eligible for a CLABSI on March 31 (CL Day 3) through April 3. The catheter had been in place > 2 days and an HAI occurring on the day of device discontinuation or the following calendar day is considered a device-associated infection. The patient is not eligible again for a CLABSI until April 6, when the second central line had been in place for greater than 2 days. (Note: NHSN will not require the BSI to be attributed to a specific central line when reporting.)

Location of attribution: The inpatient location where the patient was assigned on the date of the LCBI event, which is further defined as the date when the first element used to meet the LCBI criterion occurred (see Exception to Location of Attribution below).

**Exception to Location of Attribution:**

*Transfer Rule*: If the date of event for a CLABSI is the day of transfer or discharge, or the next day, the infection is attributed to the transferring location. Receiving facilities should share information about such HAIs with the transferring facility to enable reporting. This is called the Transfer Rule and examples are shown below and in Figure 2:

- Patient with a central line in place in the SICU is transferred to the surgical ward. The day after transfer is the date of event for an LCBI. This is reported to NHSN as a CLABSI for the SICU.
- Patient with a central line in place is transferred from the medical ward to the coronary care ICU (CCU). An LCBI date of event is on day four in the CCU. The central line is still in place. This is reported to NHSN as a CLABSI for the CCU because the date of event was not the date of transfer from the medical ward, or the next day.
- After a two-week hospital stay, a patient in the urology ward of Hospital A has his only central line removed and is discharged home a few hours later. The IP from Hospital B calls the next day to report that this patient has been admitted to Hospital B and meets LCBI criteria. This CLABSI should be reported to NHSN for, and by, Hospital A and attributed to the urology ward because the date of event was the day after transfer.

Figure 2: Example of Multiple Transfers within the Transfer Rule Time-Frame

| | 3/22 | 3/23 | 3/24 |
|---|---|---|---|
| Locations in which patient was housed | Unit A | Unit A<br>Unit B<br>Unit C | Unit C<br>Unit D<br>This is also the date of event for a CLABSI. CLABSI is attributed to Unit A since Unit A was the first location in which the patient was housed the day before the date of event. |

**Inpatient Dialysis:**

Inpatients receiving dialysis are included in any CLABSI surveillance in the location in which they are housed, regardless of whether or not the central line is the only central line and only accessed for dialysis. This also applies to patients in Long-Term Acute Care (LTAC) facilities within Acute Care Facilities when dialysis is received from the Acute Care Facility staff.

**Examples:** *CLABSIs in the following examples will be attributed to Unit A*

- Patient on Unit A receives onsite dialysis by contracted dialysis staff
- Dialysis staff travels to Unit A to provide dialysis to Unit A patient
- Patient resides on Unit A for inpatient care, but is transported to dialysis unit within the facility for dialysis. Since CLABSIs cannot be attributed to non-bedded locations, such an event must be attributed to the inpatient location housing the patient.

Facilities may choose to capture information about the presence of a dialysis catheter in patients with LCBIs. The BSI collection form includes an optional data field "Any hemodialysis catheter present," which may be marked yes or no, and used internally by facility to identify association of dialysis to LCBI.

Table 1: Laboratory-Confirmed Bloodstream Infection Criteria

| **Criterion** | **Laboratory-Confirmed Bloodstream Infection (LCBI)**<br>*Comments and reporting instructions that follow the site-specific criteria provide further explanation and are integral to the correct application of the criteria.*<br><br>Must meet ***one*** of the following criteria: |
|---|---|
| **LCBI 1** | Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).<br>**AND**<br>Organism(s) identified in blood is not related to an infection at another site.(See Appendix 1 Secondary BSI Guide) |

<table>
<tr>
<td>LCBI 2</td>
<td>
Patient has at least one of the following signs or symptoms: fever (>38.0ºC), chills, or hypotension<br><br>
AND<br><br>
Organism(s) identified from blood is not related to an infection at another site (See Appendix 1 Secondary BSI Guide)<br><br>
AND<br><br>
the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions (see comment 5 below), by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period (see Chapter 2), the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after. (See complete list of common commensals by selecting the common commensal tab at the bottom of the Excel worksheet at http://www.cdc.gov/nhsn/XLS/master-organism-Com-Commensals-Lists.xlsx)<br><br>
Note: The matching common commensals represent a single element; therefore, the collection date of the <u>first</u> common commensal is the date of the element used to determine the Date of Event.
<table>
<tr><td>6/1/2014</td><td>6/2/2014</td><td>6/3/2014</td><td>6/4/2014</td><td rowspan="2">Date of LCBI Event = 6/1/2014</td></tr>
<tr><td>S. epidermidis (1 of 2)</td><td>S. epidermidis (2 of 2)</td><td>No LCBI elements</td><td>Fever > 38.0 °C</td></tr>
</table>
</td>
</tr>
</table>

| | |
|---|---|
| **LCBI 3** | Patient ≤ 1 year of age has at least ***one*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C), apnea, or bradycardia<br><br>**AND**<br><br>Organism(s) identified from blood is not related to an infection at another site (See Appendix 1 Secondary BSI Guide)<br><br>**AND**<br><br>the same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions (see comment 5 below), by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after. (See complete list of common commensals by selecting the common commensal tab at the bottom of the Excel worksheet at http://www.cdc.gov/nhsn/XLS/master-organism-Com-Commensals-Lists.xlsx)<br><br>**Note:** The matching common commensals represent a single element; therefore, the collection date of the ***first*** common commensal is the date of the element used to determine the Date of Event.<br><br>6/1/2014 \| 6/2/2014 \| 6/3/2014 \| 6/4/2014 \| Date of LCBI Event = 6/1/2014<br>*S. epidermidis* (1 of 2) \| *S. epidermidis* (2 of 2) \| No LCBI elements \| apnea documented |

| Criterion | **Mucosal Barrier Injury Laboratory-Confirmed Bloodstream Infection (MBI-LCBI)**<br><br>***For MBI-LCBIs, ANC/WBC levels should not be used to set the IWP or to identify the date of event. MBI-LCBIs are subsets of LCBIs and therefore the date of the LCBI would be the date of the MBI-LCBI event.***<br><br>Must meet ***one*** of the following criteria: |
|---|---|
| **MBI-LCBI 1** | Patient of any age meets criterion 1 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method, with any of the following intestinal organisms (but no other organisms). (See Comment #8): *Bacteroides* spp., *Candida* spp., *Clostridium* spp., *Enterococcus* spp., *Fusobacterium* spp., *Peptostreptococcus* spp., *Prevotella* spp., *Veillonella* spp., or Enterobacteriaceae*<br><br>**And patient meets at least *one* of the following:**<br><br>1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:<br>a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]<br>b. ≥1 liter diarrhea in a 24-hour period (or ≥20 mL/kg in a 24-hour period for patients <18 years of age) with onset on or within 7 calendar days before the date the positive blood specimen was collected.<br><br>2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/$mm^3$ within a 7-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before *and* the 3 calendar days after (See Table 4 for example).<br><br>*See Table 3 for partial list of eligible Enterobacteriaceae genera. |

| | |
|---|---|
| **MBI-LCBI 2** | Patient of any age meets criterion 2 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method, with only viridans group streptococci and no other organisms.<br><br>**And patient meets at least *one* of the following:**<br><br>1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:<br>a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]<br>b. ≥1 liter diarrhea in a 24-hour period (or ≥20 mL/kg in a 24-hour period for patients <18 years of age) with onset on or within 7 calendar days before the date the first positive blood specimen was collected.<br><br>2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/$mm^3$ within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before *and* the 3 calendar days after (See Table 4 for example). |
| **MBI-LCBI 3** | Patient ≤1 year of age meets criterion 3 for LCBI with at least one blood specimen are identified by a culture or non-culture based microbiologic testing method, with only viridans group streptococci and no other organisms.<br><br>**And patient meets at least *one* of the following:**<br><br>1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:<br>a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]<br>b. ≥20 mL/kg diarrhea in a 24-hour period with onset on or within 7 calendar days before the date the first positive blood specimen is collected.<br><br>2. Is neutropenic, defined as at least two separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) <500 cells/$mm^3$ on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before *and* the 3 calendar days after. (See Table 4 for example) |

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|---|---|
| **Comments** | 1. A positive blood specimen meeting LCBI criteria, that is accompanied by **documentation** of observed or suspected patient accession into vascular access lines, within the BSI infection window period, will be considered an LCBI, but not CLABSI for NHSN reporting purposes. A BSI RIT will be created. If reporting the BSI to NHSN, answer "No" to the event field "Central line?" If a facility is reporting CLABSIs electronically to NHSN via Clinical Document Architecture (CDA), no CLABSI should be reported for this event, since this BSI is not considered associated to the central line. If blood cultures collected after the BSI RIT are again positive, they must be investigated as a part of any BSI surveillance, Documentation of observed or suspected patient accession into vascular access lines, within the BSI infection window period, will again be necessary in order to determine that the LCBI is not central-line associated.<br><br>2. In LCBI criterion 1, the term "recognized pathogen" includes any organism not included on the common commensal list (see criteria 2 and 3 or Supporting Material section at http://www.cdc.gov/nhsn/XLS/master-organism-Com-Commensals-Lists.xlsx) for the list of common commensals). Exceptions:<br>a. *Salmonella* spp. are excluded as pathogens for LCBI. These organisms may be secondary BSIs but will not be reported as the sole pathogen in a primary BSI.<br>b. Organisms belonging to the following genera cannot be used to meet any NHSN definition: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.* These organisms are typically causes of community-associated infections and are rarely known to cause healthcare-associated infections, and therefore are excluded.<br>3. LCBI criteria 1 and 2 and MCI-LCBI criteria 1 and 2 may be used for patients of any age, including those patients ≤1 year of age.<br>4. In LCBI criteria 2 and 3, if the pathogen or common commensal is identified to the species level from one blood specimen, and a companion blood specimen is identified with only a descriptive name, which is complementary to the companion culture (e.g., to the genus level), then it is assumed that the organisms are the same. The organism identified to the species level should be reported as the infecting organism along with its antibiogram if available (see |

| | |
|---|---|
| | Table 2 below). Only genus and species identification should be used to determine the sameness of organisms (i.e., matching organisms). No additional comparative methods should be used (e.g., morphology or antibiograms) because laboratory testing capabilities and protocols may vary between facilities. This will reduce reporting variability, solely due to laboratory practice, between facilities reporting LCBIs meeting criterion 2. Report the organism to the genus/species level only once, and if antibiogram data are available, report the results from the most resistant panel.<br>5. In LCBI criteria 2 and 3, the phrase "two or more blood specimens drawn on separate occasions" means, 1) that blood from at least two separate blood draws were collected on the same or consecutive calendar days, and 2) were collected in a manner which suggests that two separate blood draw site preparations were performed. This will reduce misidentification of contaminated blood specimens as LCBI. For example, blood specimens drawn from different sites (e.g., different venipunctures, a combination of venipuncture and lumen withdrawal, or different lumens of the same central line), or at different times, should undergo separate decontaminations and are therefore considered drawn on "separate occasions".<br>6. For pediatric patients, due to volume constraints, a blood specimen may consist of a single bottle. Therefore, to meet this part of the criterion, each bottle from two, single bottle blood draws would have to be positive for the same common commensal.<br>7. Specimen Collection Considerations: Although blood specimens drawn through central lines can have a higher rate of contamination than blood specimens collected through peripheral venipuncture [3, 4] all positive blood specimens, regardless of the sites from which they were collected, must be included when conducting in-plan CLABSI surveillance.<br>8. In MBI-LCBI 1, 2 and 3, "No other organisms" means there is no identification of a non-MBI-LCBI pathogens (e.g., *S. aureus*) or 2 matching common commensals (e.g., coagulase-negative staphylococci)collected from blood on separate occasions that would otherwise meet LCBI criteria. If this occurs, the infection should not be classified as MBI-LCBI. |
| **Reporting Instructions** | 1. Report organisms identified from blood as BSI–LCBI when no other site of infection is evident (see Appendix 1. Secondary Bloodstream Infection [BSI] Guide). Note: VASC infections with |

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|---|---|
| | positive blood specimens should be reported as BSI-LCBI (see Reporting Instruction 5 below for exception).<br>2. When another blood specimen is collected during the RIT of an identified MBI-LCBI, which is positive for an organism excluded from MBI-LCBI criteria, the MBI-LCBI event is edited to become an LCBI and the organism is added.<br>3. Catheter tip cultures are not used to determine whether a patient has a primary BSI.<br>4. Purulent phlebitis confirmed with a positive semiquantitative culture of a catheter tip, **but with either negative or no blood culture** is considered a CVS-VASC, not an LCBI, SST-SKIN, or an SST-ST infection.<br>5. Occasionally, a patient with both a central line and another vascular access device develops a primary bloodstream infection (LCBI) that can clearly be attributed to the other vascular access site. If both pus at the insertion site and a culture of that pus, collected during the LCBI infection window period, has at least one matching organism to the blood specimen, the LCBI will not be considered associated with the central line. In this situation, enter "No" for the filed "Central Line?" in the NHSN application. You should, however, include the patient's central line days in the summary denominator count. Vascular access devices included in this exception are limited to:<br>a. Peripheral IV<br>b. Arteriovenous fistula<br>c. Arteriovenous graft<br>d. Non-accessed central line (not accessed nor inserted during the hospitalization) |

Table 2: Examples of How to Report Speciated and Unspeciated Organisms Identified from Blood Specimens

| **Culture Report** | **Companion Culture Report** | **Report as…** |
|---|---|---|
| Coagulase-positive staphylococci | *S. aureus* | *S. aureus* |
| *S. epidermidis* | Coagulase-negative staphylococci | *S. epidermidis* |
| *Enterococcus* spp. | *E. faecium* | *E. faecium* |
| *Bacillus* spp. (not *anthracis*) | *B. cereus* | *B. cereus* |
| *S. salivarius* | Strep viridans | *S. salivarius* |

Table 3: Partial List of Criterion 1 MBI-LCBI Eligible Enterobacteriaceae Genera

| |
|---|
| *Citrobacter* |
| *Enterobacter* |
| *Escherichia* |
| *Klebsiella* |
| *Proteus* |
| *Providencia* |
| *Salmonella* |
| *Serratia* |
| *Shigella* |
| *Yersina* |

**Note:** See complete list of MBI Pathogens by selecting the MBI Organisms tab at the bottom of the Excel worksheet at http://www.cdc.gov/nhsn/XLS/master-organism-Com-Commensals-Lists.xlsx

Table 4: Examples Illustrating the MBI-LCBI Criteria for Neutropenia

| | | Day -7 | Day -6 | Day -5 | Day -4 | Day -3 | Day -2 | Day -1 | Day 1* | Day 2 | Day 3 | Day 4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pt. A** | **WBC** | **100** | **800** | **400** | **300** | **ND** | **ND** | **320** | **400+ BC* w/ *Candida* spp. x1** | **ND** | **550** | **600** |
| **Pt. B** | **ANC** | **ND** | **410** | **130** | **ND** | **ND** | **120** | **110** | **ND+BC* w/ viridans strep x2 and fever >38°C** | **110** | **300** | **320** |
| **Pt. C** | **WBC** | **100** | **800** | **400** | **300** | **ND** | **ND** | **ND** | **600+ BC* w/ *Candida* spp. x1** | **230** | **ND** | **400** |

*ND = not done; *Day the blood specimen that was positive was collected*

Patient A meets MBI-LCBI criterion 1, sub-criterion 2: Positive blood specimen with intestinal organism (*Candida* spp.) and neutropenia (2 separate days of WBC <500 cells/mm$^3$ occurring on the date the positive blood specimen was collected [Day 1] or during the 3 days before or the 3 days after that date). In this case, the Day 1 value = 400, and Day -1 value = 320.

Patient B meets MBI-LCBI criterion 2, sub-criterion 2: At least two positive blood specimens with viridans group streptococci (in this case, two positive), and fever >38°C and neutropenia (two separate days of ANC <500 cells/mm$^3$ occurring on the date the positive blood specimen was collected [Day 1] or during the 3 days before or the 3 days after that date). In this case, the Day -1 value = 110 and Day -2 value = 120.

**Note:** any two of Days -2,-1, 2, 3, and 4 could be used to meet this requirement since WBC or ANC under 500 were present on those days.

Patient C meets MBI-LCBI criterion 1, sub-criterion 2: Positive blood specimen with intestinal organism (*Candida* spp.) and neutropenia (2 separate days of WBC <500 cells/mm$^3$ occurring on the date the positive blood specimen was collected [Day 1] or during the 3 days before or the 3 days after that date). In this case, Day 2 value =230 and Day 4value = 400])

**Numerator Data:** The *Primary Bloodstream Infection (BSI)* form (CDC 57.108) is used to collect and report each CLABSI that is identified during the month selected for surveillance. All LCBI and MBI-LCBI that are identified as central-line associated must be included. MBI-LCBI will be excluded from the numerator for CMS reporting pending implementation of a new baseline risk-adjustment, expected late 2016. The Instructions for Completion of Primary Bloodstream Infection (BSI) form contains brief instructions for collection and entry of each data element on the form. The *Primary BSI* form includes patient demographic information and whether a central line was present, and, if so, the type of central line the patient had if appropriate to the location; these data will be used to calculate line-specific infection rates. Additional data include the specific criteria met for identifying the primary BSI, whether the patient died, organisms identified from blood specimens, and the organisms' antimicrobial susceptibilities.

**Reporting Instruction:**

If no CLABSIs are identified during the month of surveillance, the "Report No Events" box must be checked on the appropriate denominator summary screen, e.g., Denominators for Intensive Care Unit (ICU)/other locations (Not NICU or SCA), etc.

**Denominator Data:** Device days and patient days are used for denominators. Device-day denominator data that are collected differ according to the location of the patients being monitored. The following methods can be used for the collection of denominator data:

| **Denominator Data Collection Method** | **Details** |
|---|---|
| **Manual, Daily** (i.e., collected at the same time every day of the month) | Denominator data are collected at the same time, every day, per location.<br><br>For locations other than specialty care areas/oncology (SCA/ONC) and NICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day, during the month and recorded on the *Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or SCA/ONC)* form (CDC 57.118). Only the totals for the month are entered into NHSN.<br><br>For specialty care areas/oncology, the number of patients with one or more central lines is dichotomized into those with permanent central lines and those with temporary central lines on the *Denominators for Specialty Care Area* |

| Denominator Data Collection Method | Details |
|---|---|
| | *(SCA)/Oncology (ONC)* form (CDC 57.117). Each is collected daily, at the same time each day. Only the totals for the month are entered into NHSN. This distinction in lines is made because permanent lines are commonly used in patients frequenting these areas and may be associated with lower rates of BSI than central lines inserted for temporary use. If a patient has both a temporary and a permanent central line, count the day only as a temporary line day. The Instructions for Completion of Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU and SCA/ONC) and Instructions for Completion of Denominators for Specialty Care Areas (SCA)/Oncology (ONC) contain brief instructions for collection and entry of each data element on the forms.<br><br>In NICUs, the number of patients with one or more central lines is stratified by birth weight in five categories since risk of BSI varies by birth weight. These data are collected on the *Denominators for Neonatal Intensive Care Unit (NICU)* form (CDC 57.116).<br><br>**Note:** The weight of the infant at the time of BSI is not used and should not be reported. For example, if a neonate weighs 1006 grams at birth but remains in the NICU for two months and has a body weight of 1650 grams when a CLABSI develops, record the birth weight of 1006 grams on the BSI form. The Instructions for Completion of Denominators for Neonatal Intensive Care Unit (NICU) form contains brief instructions for collection and entry of each data element on the forms. |
| **Manual, sampled once/week** (i.e., collected at the same time on the same designated day, once per week) | For locations other than specialty care areas/oncology (SCA/ONC) and NICUs (e.g., ICUs, step-down units, wards), the denominator sampling method can be used.<br><br>To reduce staff time spent collecting surveillance data, once weekly sampling of denominator data to generate estimated central line days, may be used as an alternative to daily collection in non-oncology ICUs and wards. The number of |

| Denominator Data Collection Method | Details |
|---|---|
| | patients in the location (patient-days) and the number of patients with one or more central lines of any type (central line days) is collected on a designated day each week (e.g., every Tuesday), at the same time during the month.<br><br>Evaluations of this method have repeatedly shown that use of Saturday or Sunday generate the least accurate estimates of denominator data, therefore, these days should not be selected as the designated day.[6-8] If the day designated for the collection of sampled data is missed, collect the data on the next available day instead.<br><br>The following must be collected and entered into NHSN:<br><br>1. The monthly total for patient-days, based on collection daily<br>2. The sampled total for patient-days<br>3. The sampled total central line-days<br><br>When these data are entered, the NHSN application will calculate an estimate of central line-days.<br><br>**Notes:**<br><br>• To ensure the accuracy of estimated denominator data obtained by sampling, only ICU and ward location types with an average of 75 or more central line-days per month are eligible to use this method. A review of each location's central line denominator data for the past twelve months in NHSN will help determine which locations are eligible.<br>• The accuracy of estimated denominator data generated by sampling can be heavily influenced by incorrect or missing data. Careful implementation of data collection following the guidance in this protocol is essential to avoid erroneous fluctuations in rates or SIRs. |

| Denominator Data Collection Method | Details |
|---|---|
| **Electronic** | For any location, when denominator data are available from electronic sources (e.g., central line days from electronic charting), these sources may be used as long as the counts are not substantially different (+/- 5%) from manually-collected, once a day counts, pre-validated for a minimum of three months.<br><br>The validation of electronic counts should be performed for each location separately. |

**Data Analyses**: The Standardized Infection Ratio (SIR) [9] is calculated by dividing the number of observed infections by the number of predicted infections. The number of predicted infections is calculated using CLABSI rates from a standard population during a baseline time period, which represents a standard population's CLABSI experience.[10, 11]

**Note:** The SIR will be calculated only if the number of predicted CLABSIs (numExp) is ≥1 to help enforce a minimum precision criterion.

**Note**: In the NHSN application, "predicted" is referred to as "expected".

$$SIR = \frac{\text{Observed (O) HAIs}}{\text{Expected (E) HAIs}}$$

While the CLABSI SIR can be calculated for single locations, the measure also allows you to summarize your data across multiple locations, adjusting for differences in the incidence of infection among the location types. For example, you can obtain one CLABSI SIR adjusting for all locations reported. Similarly, you can obtain one CLABSI SIR for all ICUs in your facility.
**Note:** Only those locations for which baseline data have been published will be included in the SIR calculations. For acute care hospitals, the baseline time period is 2006-2008; for long term acute care hospitals, the baseline time period is 2013.[10,11]

The CLABSI rate per 1000 central line days is calculated by dividing the number of CLABSIs by the number of central line days and multiplying the result by 1000. The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. These calculations will be performed separately for different types of ICUs, specialty care areas, oncology units, and other locations in the institution. Separate rates and ratios will also be calculated for different types of catheters in specialty care areas/oncology locations and for birth weight categories in NICUs.

Descriptive analysis output options of numerator and denominator data, such as line listings, frequency tables, and bar and pie charts are available in the NHSN application. CLABSI SIRs, rates, and run charts are also available. Guides on using NHSN analysis features are available from: http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html.

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# Appendix1: Secondary Bloodstream Infection (BSI) Guide (*not applicable to Ventilator-associated Events [VAE]*)

The purpose of using the CDC/NHSN infection criteria is to identify and consistently categorize infections that are healthcare-associated into major and specific infection sites or types. LCBI criteria include the caveat that the organism(s) identified from the blood cannot be related to infection at another site (i.e., must be a primary BSI). One must be sure that there is no other CDC/NHSN defined primary site-specific infection that may have seeded the bloodstream secondarily; otherwise the bloodstream infection may be misclassified as a primary BSI and erroneously associated with the use of a central line, i.e., called a CLABSI. For locations performing in-plan VAE surveillance, refer to Figure 4 in this appendix, as well as the VAE chapter for specific guidance on assigning a secondary BSI to a VAE.

## Secondary BSI Scenarios

For purposes of NHSN, in order for a bloodstream infection to be determined secondary to another site of infection the following requirements must be met: ‡

**The patient must meet one of the NHSN site-specific definitions (CDC/NHSN Surveillance Definitions for Specific Types of Infections, UTI, PNEU or SSI),**

***AND***

**Either "1" or "2" below must also be true:**

1. An organism identified from the site specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site specific specimen, and is collected during the secondary BSI attribution period.

   ***OR***

2. The positive blood specimen is an element used to meet the site-specific infection criterion, and is collected during the site specific infection's infection window period

**‡Exception:**

Necrotizing enterocolitis (NEC) criteria include neither a site-specific specimen nor organism identified from blood specimen, however an exception for assigning a BSI secondary to NEC is provided.

A BSI is considered secondary to NEC if the patient meets one of the two NEC criteria AND an organism identified from blood specimen collected during the secondary BSI

attribution period is an LCBI pathogen, or the same common commensal is identified from two or more blood specimens drawn on separate occasions on the same or consecutive days.

Below are examples with guidance on how to distinguish between the primary or secondary nature of a BSI. The definition of "matching organisms" and important notes and reporting instructions are also provided.

See Figure 3: Secondary BSI Guide for algorithmic display of the following instructions.

**Scenario 1: An organism identified from the site-specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site specific specimen. The positive blood specimen must be collected during the site-specific infection's secondary BSI attribution period.**

**Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and blood specimen collected during the SUTI secondary BSI attribution period is positive for *E. coli*. This is a SUTI with a secondary BSI and the reported organism is *E. coli.*

a. **Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and blood specimen collected during the SUTI secondary BSI attribution period grows *E. coli* and *P. aeruginosa*. This is a SUTI with a secondary BSI and the reported organisms are *E. coli* and *P. aeruginosa,* since both site and blood specimens are positive for at least one matching pathogen.

b. **Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and a single blood specimen collected during the SUTI secondary BSI attribution period *E. coli* and *S. epidermidis*. This is a SUTI with a secondary BSI and the reported organism is only *E. coli*, since the single common commensal *S. epidermidis* positive blood specimen by itself does not meet BSI criteria.

**Scenario 2: The positive blood culture is an element used to meet the site-specific infection criterion, and is collected during the site specific infection's infection window period.** (For your convenience, a list of infection criteria that include positive blood culture as an element are included in Table 5 below).

a. **Example:** Patient becomes febrile and complains of nausea and abdominal pain. CT scan done that day shows fluid collection suggestive of infection. Blood specimen collected that day results in identification of *Bacteroides fragilis.* Because the patient meets IAB criterion 3b, using the identification of an organisms from the blood specimen as an element (fever, nausea or abdominal pain, positive blood specimen and CT scan showing infection in abdominal cavity), the BSI is considered secondary to IAB.

b. **Example:** Patient is febrile, has a new onset of cough and has positive chest imaging test indicating the presence of an infiltrate. Blood specimens collected identify *Pseudomonas aeruginosa.* Because the patient can meet PNU2 definition by using identification of organisms from blood specimen as one of the elements of the infection criterion (i.e., infiltrate on chest imaging test, fever, new onset of cough and organism identified from blood specimen ), the BSI is considered secondary to PNEU.

**NOTE: In scenarios where an NHSN infection definition can be met using more than one criterion of the infection definition, it is possible that identification of organism from blood and site-specific specimens may not match and a BSI may still be considered as a secondary BSI. Consider the following:**

c. **Example:** During the SSI surveillance period, a postoperative patient becomes febrile and complains of nausea and abdominal pain. CT scan done that day shows fluid collection suggestive of infection. Culture results show *Escherichia coli* from the T-tube drainage specimen and the blood specimen grows *Bacteroides fragilis.* Although the organisms in the blood culture and site-specific culture do not match for at least one organism, the blood culture is considered secondary to IAB. This is because the patient meets organ/space SSI IAB criterion 3b, using the identification of organism in blood specimen as an element (fever, nausea or abdominal pain, organisms identified from blood specimen and CT scan showing infection in abdominal cavity). This patient also meets IAB criterion 3a using the positive site culture plus fever, and nausea or abdominal pain even though the organism involved is different from that used for IAB criterion 3b. In this case, the BSI is considered secondary to the organ/space SSI IAB and both organisms would be listed as IAB infection pathogens.

**d. Example:** Patient is febrile, has a new onset of cough and has positive chest imaging test indicating the presence of an infiltrate. Blood and bronchoalveolar lavage (BAL) specimens are collected. Results identify *Klebsiella pneumoniae* > $10^4$ CFU/ml from the BAL and *Pseudomonas aeruginosa* from the blood. Although the organisms in the blood specimen and site-specific specimen do not match for at least one organism, because the patient can meet PNU2 definition using either the identification of organism from blood specimen or BAL specimen as one of the elements of the infection criterion (i.e. infiltrate on chest imaging test, fever, new onset of cough and organism identified from blood specimen or identified from BAL specimen), the blood is considered a secondary BSI to PNEU and both organisms would be listed as PNEU pathogens.

**If there is no matching organism identified from blood and site-specific specimen which is used to meet the site-specific infection definition, nor is an organism identified from blood specimen used to meet the site-specific infection criterion, secondary <u>BSI attribution cannot be assigned</u>.**

a. **Example:** Patient has pustules on their abdomen with tenderness and swelling. Purulent material is obtained from the pustules and is positive for *Streptococccus* Group B. A blood specimen collected the same day identifies methicillin resistant *Staphylococcus aureus.* Because the organisms from the site and blood specimens do not match, and there is no site-specific criterion for SKIN that includes organisms identified from blood specimen, both a site-specific infection, SKIN (criteria 1 and 2a) and a primary BSI would be reported.

b. **Example:** A patient has an abscess in the soft tissue around a percutaneous endoscopic gastrostomy (PEG) tube, identified by CT scan, and there is also purulent drainage from that site. No site-specific specimen was collected, but a blood specimen is positive for *Staphylococcus aureus.* No other sites of infection are identified. Because no culture of the site was collected, and the patient therefore cannot meet ST criterion 1, and because there is no ST criterion which uses identification of organism from blood specimen as an element, this patient has a ST infection with unknown pathogen (criterion 2), and a primary BSI with the pathogen *Staphylococcus aureus* for NHSN purposes.

Table 5: Site-specific criteria that require positive blood specimens

**Organisms identified from blood as an element**

| Site | Element | Page |
|---|---|---|
| BURN | 1 | 17-23 |
| IAB | 2b | 17-19 |
| JNT | 3c | 17- 6 |
| MEN | 2c & 3c | 17-8 |
| OREP | 3a | 17-22 |
| PNU2 | Lab finding | 6-6 |
| PNU3 | Lab finding | 6-8 |
| UMB | 1b | 17-25 |

**Organisms identified from blood <u>with</u> imaging test evidence of infection**

| Site | Element | Page |
|---|---|---|
| BONE | 3a | 17-5 |
| DISC | 3a | 17-5 |
| GIT | 2c | 17-18 |
| IAB | 3b | 17-19 |
| SA | 3a | 17-9 |
| USI | 3b & 4b | 17-26 |
| ENDO | *4*a, 4b, 5a & 5b (specific organisms) 6e & 7e plus other criteria as listed | 17-10 |

A **matching organism** is defined as one of the following:

1. If genus and species are identified in both specimens, they must be the same.
    a. **Example:** A blood specimen reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter cloacae* are matching organisms.
    b. **Example:** A blood specimen reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter aerogenes* are NOT matching organisms as the species are different.

2. If the organism is less definitively identified in one specimen than the other, the identifications must be complementary.
    a. **Example:** A surgical wound growing *Pseudomonas* spp. and a blood specimen growing *Pseudomonas aeruginosa* are considered a match at the genus level and therefore the BSI is reported as secondary to the SSI.
    b. **Example:** A blood specimen reported as *Candida albicans* and a culture from a decubitus reported as yeast not otherwise specified are considered to have

matching organisms because the organisms are complementary, i.e. Candida is a type of yeast.

**Notes**:

1. Antibiograms of the blood and potential primary site isolates do not have to match.
2. If the blood specimen by itself does not meet BSI criteria (e.g., only one positive blood specimen positive for a common commensal), then that specimen may not be used to indicate the presence of a secondary BSI (see scenario 1b).

**Reporting Instructions**:

- For reporting secondary BSI for possible VAP (PVAP), see Figure 4 and Chapter 10.
- Do not report secondary bloodstream infection for vascular (VASC) infections, Ventilator-Associated Conditions (VAC), or Infection-related Ventilator-Associated Complications (IVAC), pneumonia 1 (PNEU 1).
- When a BSI is suspected to be secondary to a lower respiratory tract infection and the BSI cannot be determined to be secondary to VAE, the PNEU definitions are available for secondary BSI assignment (see Figure 4).
- Site-specific organism exclusions apply to secondary BSI attribution as well.

**Pathogen Assignment**

Pathogens identified from secondary BSIs, should be added to those pathogens reported for the primary infection type. The Secondary BSI data collection field should be checked yes.

A secondary BSI pathogen may be assigned to two different primary site infections (e.g., UTI and an IAB infection). In example 1 below, two primary site infections have been identified and a blood culture is collected within both the SUTI and the IAB secondary BSI attribution period. The blood culture pathogen matches both primary site infection pathogens (SUTI and IAB). Therefore the pathogen is reported for both primary sites of infection as a secondary bloodstream infection.

Example 1: Pathogen Assignment

| Hospital Day | BSI | RIT | Infection Window Period | Infection Window Period | | BSI |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | 1 | **Urine culture**: >100,000 cfu/ml *K. pneumoniae* | | | |
| 5 | | 2 | Fever > 38.0 C | | | |
| 6 | | 3 | | | | |
| 7 | | 4 | | | | |
| 8 | | 5 | | Fever >38.0 C, Abdominal pain | | |
| 9 | | 6 | | CT Scan : Abdominal abscess | | |
| 10 | | 7 | Blood culture: *K. pneumoniae* | Blood culture: *K. pneumoniae* | | |
| 11 | | 8 | | | | |
| 12 | | 9 | | | | |
| 13 | | 10 | | | | |
| 14 | | 11 | | | | |
| 15 | | 12 | | | | |
| 16 | | 13 | | | | |
| 17 | | 14 | | | | |
| 18 | | | | | | |
| 19 | | | | | | |
| 20 | | | | | | |
| 21 | | | | | | |
| 22 | | | | | | |
| 23 | | | | | | |
| | | | **SUTI & Secondary BSI Date of Event = 4 Pathogen: *K. pneumoniae*** | **IAB & Secondary BSI Date of Event = 8 Pathogen: *K. pneumoniae*** | | |

**Infection Window Period**

(First positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period** (Infection Window Period + RIT)

**Date of Event (DOE)**
(Date the first element occurs for the first time within the infection window period)

Pathogens excluded from specific infection definitions (e.g., yeast in UTI, or Enterococcus spp. for PNEU) are also excluded as pathogens for BSIs secondary to that type of infection (i.e., they cannot be added on to one of these infections as a pathogen). In example 2 below, the excluded organism must be accounted for as either 1) a primary bloodstream infection (BSI/CLABSI) or, 2) a secondary bloodstream infection attributed to another primary infection (e.g., IAB, SINU). A blood culture with yeast and *E. faecalis* is collected during the SUTI RIT. A BSI secondary to SUTI is identified. *E. faecalis* is already documented as a pathogen, but the yeast will not be reported as a secondary BSI pathogen, because yeasts are excluded as organisms in the UTI definition. Because no other primary source of infection for which the yeast BSI can be assigned as secondary is found, a primary BSI with yeast is identified.

Note: The *Enterococcus faecalis* is not reported as a pathogen for the primary BSI because if an excluded organism had not been identified, a primary BSI would not have been reported.

Example 2: Pathogen Assignment (continued)

| Hospital Day | BSI | RIT | Infection Window Period | Infection Window Period | RIT |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | 1 | Dysuria | | |
| 4 | | 2 | **Urine culture**: > 100,000 cfu/ml *E. faecalis* | | |
| 5 | | 3 | | | |
| 6 | | 4 | | | |
| 7 | | 5 | | | |
| 8 | | 6 | | | |
| 9 | | 7 | | | |
| 10 | | 8 | | | |
| 11 | | 9 | Blood culture: *E.faecalis* / Yeast | **Blood culture:** *E. faecalis* / Yeast | 1 |
| 12 | | 10 | | | 2 |
| 13 | | 11 | | | 3 |
| 14 | | 12 | | | 4 |
| 15 | | 13 | | | 5 |
| 16 | | 14 | | | 6 |
| 17 | | | | | 7 |
| 18 | | | | | 8 |
| 19 | | | | | 9 |
| 20 | | | | | 10 |
| 21 | | | | | 11 |
| 22 | | | | | 12 |
| 23 | | | | | 13 |
| 24 | | | | | 14 |
| 25 | | | | | |
| | | | **UTI & Secondary BSI**<br>**Date of Event = 3**<br>**Pathogen: *E. faecalis*** | **Primary BSI**<br>**Date of Event = 11**<br>**Pathogen: Yeast** | |

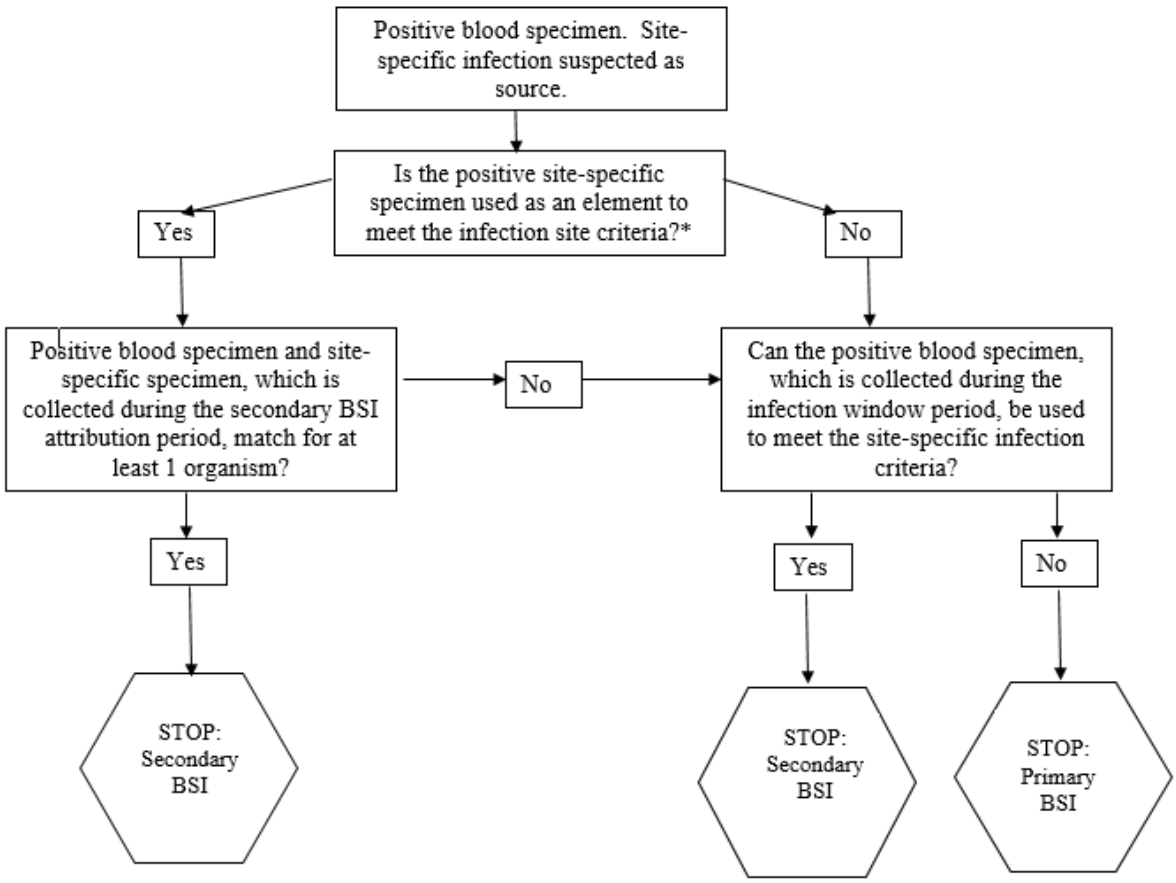
**Infection Window Period**
(First positive diagnostic test, 3 days before and 3 days after)

**Repeat Infection Timeframe (RIT)**
(date of event = day 1)

**Secondary BSI Attribution Period**
(Infection Window Period + RIT)

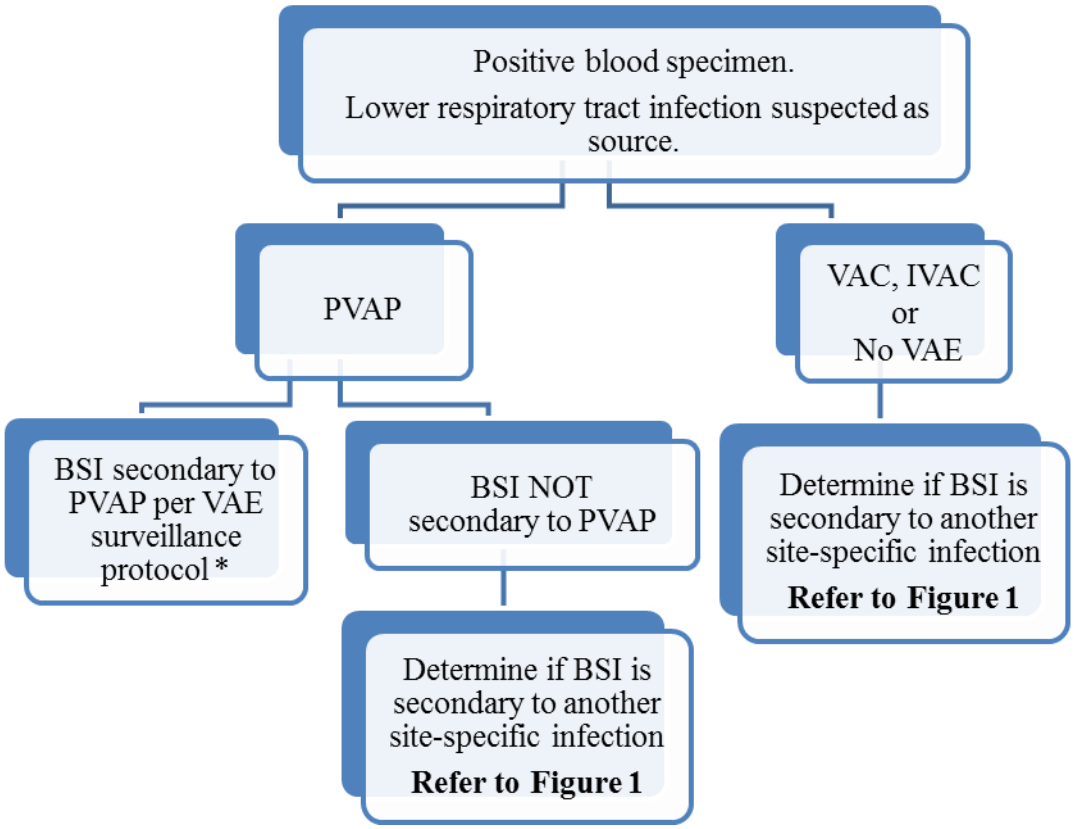
**Date of Event (DOE)**
(Date the first element occurs for the first time within the infection window period)

**Figure 3: Secondary BSI Guide for eligible organisms*‡**
***(Not applicable to Ventilator-associated Events [VAE], See Figure 4)***




‡**Exception:** Necrotizing enterocolitis (NEC) criteria include neither a site-specific specimen nor organism identified from blood specimen, however an exception for assigning a BSI secondary to NEC is provided. A BSI is considered secondary to NEC if the patient meets one of the 2 NEC criteria AND an organism identified from blood specimen collected during the secondary BSI attribution period is an LCBI pathogen or the same common commensal is identified from 2 or more blood specimens drawn on separate occasions on the same or consecutive days.

**Figure 4: VAE Guidance for Secondary BSI Determination**




*Secondary BSIs may be reported for possible VAP (PVAP) events, provided that at least one organism identified from the blood specimen matches an organism identified from an appropriate respiratory tract specimen (including respiratory secretions, pleural fluid and lung tissue). The respiratory tract specimen must have been collected on or after the 3rd day of mechanical ventilation and within 2 calendar days before or after the day of onset of worsening oxygenation to be considered as a criterion for meeting the PVAP definitions. In addition, the blood specimen must have been collected during the 14-day event period, where day 1 is the day of onset of worsening oxygenation.

- In cases where PVAP is met with only the histopathology criterion and no culture or non-culture based test is performed on an eligible respiratory specimen, and there is also a positive blood specimen, a secondary BSI to VAE is not reported.

- In cases where a culture or non-culture based test of respiratory secretions, pleural fluid or lung tissue is performed and does not identify an organism that matches an organism identified from blood, a secondary BSI to VAE is not reported.

**Note:** Candida species or yeast not otherwise specified, coagulase-negative Staphylococcus species, and Enterococcus species identified from blood cannot be deemed secondary to a PVAP, unless the organism was also identified from pleural fluid or lung tissue.

# Central Line Insertion Practices (CLIP) Adherence Monitoring

**Introduction**: Central line-associated bloodstream infections (CLABSIs) may be prevented through proper placement and management of the central line. The CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011[i] recommend evidence-based central line insertion practices known to reduce the risk of subsequent central line-associated bloodstream infection. These include hand hygiene by inserters, use of maximal sterile barriers during insertion, proper use of a skin antiseptic prior to insertion, and time to allow the skin antiseptic to dry before catheter insertion.

Several centers have found it useful to monitor adherence to evidence-based central line insertion practices as a method for identifying quality improvement opportunities and strategically targeting interventions. Feedback of adherence data has been a component of multifaceted interventions that have successfully reduced CLABSI rates.

Participation in NHSN CLIP surveillance enables participating facilities and CDC to:

- Monitor central line insertion practices in individual patient care units and facilities and provide aggregate adherence data for all participating facilities. Facilities have the option of recording inserter-specific adherence data.
- Facilitate quality improvement by identifying specific gaps in adherence to recommended prevention practices, thereby helping to target intervention strategies for reducing CLABSI rates.

Participating facilities may perform surveillance for insertion practices during the following:

- a month when concurrent CLABSI surveillance is being conducted;
- a month when no CLABSI surveillance is being conducted;

If participating facilities wish to identify associations between insertion practices and outcomes (i.e., CLABSI), surveillance for insertion practices and CLABSI must be done concurrently.

**Settings**: Surveillance may occur in any type of patient care location where central lines are inserted.

**Numerator and Denominator Data**: The *Central Line Insertion Practices Adherence Monitoring Form* (CDC 57.125) is used to collect and report central line insertion practices for every central line insertion attempt, including unsuccessful attempts, occurring during the month in the unit(s) selected for surveillance. The *Table of Instructions for Completion of the Central Line Insertion Practices Adherence Monitoring Form* contains directions for collection and entry of each data element on the form. The form can be completed at or near the time of insertion either by the inserter or an observer present at the insertion (e.g., nurse assisting with the catheter insertion), or the form can be completed from documentation in the patient chart (only if all elements of the monitoring form have been incorporated into standard central-line insertion procedure notes). The form includes information pertaining to demographics of the patient, information pertaining to the inserter, information on maximal sterile barriers used, the reason for central line insertion, whether the insertion was successful, skin antisepsis, hand hygiene practice before insertion, type of central line including whether it was antimicrobial coated, insertion site and, if placed because of suspected existing central line infection, the use of a guide wire. Elements of these data will be used to calculate adherence to recommended insertion practices.

**Data Analyses**: Adherence rates for specific insertion practices will be calculated by dividing the number of central line insertions during which the recommended practice was followed by the total number of central line insertions and multiplying the result by 100. Such calculations can also be done for a bundle of practices that have been shown to reduce the incidence of CLABSI (i.e. NHSN CLIP Bundle). In NHSN for CLIP insertions dated January 1, 2014 and forward, adherence to the bundle requires a "Yes" to all of the following:

- Hand hygiene performed
- Appropriate skin prep*
    - Chlorhexidine gluconate (CHG) for patients ≥60 days old unless there is a documented contraindication to CHG
    - Povidone iodine, alcohol, CHG, or other specified for children <60 days old
- Skin prep agent has completely dried before insertion
- **All** 5 maximal sterile barriers used
    - Sterile gloves
    - Sterile gown
    - Cap
    - Mask worn
    - Large sterile drape (a large sterile drape covers the patient's entire body)

**Note:** These calculations are performed separately for different types of locations in the institution. Participants have the option of calculating inserter-specific adherence rates.

*The Food and Drug Administration (FDA) has labeled CHG to be used with care in premature infants and infants < 2 months of age.

## REFERENCES

[1]O'Grady, NP., Alexander, M., Burns, LA., Dellinger, EP., Garland, J., Heard, SO., Maki, DG., et al. "Guidelines for the Prevention of Intravascular Catheter-related Infections". *Clinical Infectious Diseases* 52 (a): (2011): 1087-99

# Pneumonia (Ventilator-associated [VAP] and non-ventilator-associated Pneumonia [PNEU]) Event

**Introduction:** In 2011, an estimated 157,000 healthcare-associated pneumonias occurred in acute care hospitals in U.S.[1] Patients with mechanically-assisted ventilation have a high risk of developing healthcare-associated pneumonia.

Prevention and control of healthcare-associated pneumonia is discussed in the CDC/HICPAC document, *Guidelines for Prevention of Healthcare-Associated Pneumonia, 2003*[2]. The Guideline strongly recommends that surveillance be conducted for bacterial pneumonia in ICU patients who are mechanically ventilated to facilitate identification of trends and for inter-hospital comparisons.

**Settings:** Surveillance may occur in any inpatient pediatric location where denominator data can be collected, such as critical/intensive care units (pedICUs), specialty care areas (SCA), step-down units, wards, and long term care units. In-plan surveillance for ventilator-associated pneumonia (pedVAP) using the criteria found in this chapter is restricted to patients of any age in pediatric locations (excludes neonatal locations). In-plan surveillance conducted for mechanically-ventilated patients in adult locations (regardless of age) will use the Ventilator-Associated Event (VAE) protocol (see VAE chapter). The PNEU definitions are still available for those units seeking to conduct off-plan PNEU surveillance for mechanically-ventilated adult, pediatric and neonatal patients and non-ventilated adults, pediatric or neonatal patients. A complete listing of inpatient locations and instructions for mapping can be found in the CDC Locations and Descriptions chapter.

**Note:** If you are following pedVAP in your monthly reporting plan it is not required to monitor for VAPs after the patient is discharged from the facility. However, if discovered, any VAPs with event date on the day of discharge or day after discharge should be reported to NHSN (see Transfer Rule below). No additional ventilator days are reported.

**Definitions:**

Present on Admission (POA): Infections that are POA, as defined in Chapter 2, are not considered HAIs and therefore are never reported to NHSN.
**Note:** POA reporting exception for PNEU/VAP: One chest radiograph is acceptable to meet POA criteria for PNEU/VAP protocol, regardless of whether the patient has underlying pulmonary or cardiac disease.

Healthcare-associated infections (HAI): All NHSN site-specific infections must first meet the HAI definition as defined in Chapter 2 before a site-specific infection (e.g., PNEU/VAP) can be reported to NHSN.

**Note:** For patients with underlying pulmonary or cardiac disease who are required to have serial imaging test results, to satisfy the PNEU/VAP definitions, the second imaging test must occur within seven days of the first but is not required to occur within the Infection Window Period. The date of the first CXR will be utilized when determining if the PNEU/VAP criteria are met within the infection window period. All other elements of PNEU/VAP definition must be present within the infection window period.

Pneumonia (PNEU) is identified by using a combination of imaging, clinical and laboratory criteria. The following pages detail the various criteria that may be used for meeting the surveillance definition of healthcare-associated pneumonia (Tables 1-4 and Figures 1 and 2), general comments applicable to all site-specific criteria, and reporting instructions. Table 5 shows threshold values for cultured specimens used in the surveillance diagnosis of pneumonia.

Date of event: For a PNEU/VAP the date of event is the date when the first element used to meet the PNEU infection criterion occurred for the first time within the 7-day Infection Window Period.

Ventilator: A device to assist or control respiration inclusive of the weaning period, through a tracheostomy or by endotracheal intubation.

**Note:** Lung expansion devices such as intermittent positive-pressure breathing (IPPB); nasal positive end-expiratory pressure (PEEP); and continuous nasal positive airway pressure

(CPAP, hypoCPAP) are not considered ventilators unless delivered via tracheostomy or endotracheal intubation (e.g., ET-CPAP).

Ventilator-associated pneumonia (VAP): A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1,

**AND**

the ventilator was in place on the date of event or the day before.

Location of attribution: The inpatient location where the patient was assigned on the date of the PNEU/VAP event (see Date of Event). See Exception of Location Attribution below.

**Exception to Location of Attribution:**

*Transfer Rule*: If the date of event for a PNEU/VAP is on the date of transfer or the next day, the infection is attributed to the transferring/discharging location. If the patient was in multiple locations within the transfer rule time frame, attribute the infection to the original location initiating the transfer. This is called the Transfer Rule and examples are shown below:

- Child has been on a ventilator for 7 days in the PICU and is transferred on the ventilator to the pediatric surgical ward. The criteria for PNEU are met and the date of event is the day following the transfer. This is reported to NHSN as a VAP for the PICU.
- Child has been on a ventilator for 5 days and is transferred in the morning to the pediatric medical ward from the pediatric medical critical care unit after having ventilator discontinued. The criteria for a PNEU are met and the date of event is the day of transfer. This is reported to NHSN as a VAP for the pediatric medical critical care unit.
- Pediatric patient on a ventilator is transferred from the neonatal intensive care unit (NICU) to the pediatric intensive care unit (PICU). The patient meets the criteria for a PNEU and the date of event is 4 days post transfer. This is reported to NHSN as a VAP for the PICU.

**General Comments Applicable to All Pneumonia Specific Site Criteria:**

- Physician's diagnosis of pneumonia alone is not an acceptable criterion for POA (present on admission) or HAI (healthcare-associated) pneumonia.
- Although specific criteria are included for infants and children and immunocompromised patients, all patients may meet any of the other pneumonia site-specific criteria.
- Pneumonia due to gross aspiration (for example, in the setting of intubation in the field, emergency department, or operating room) that meets the PNEU/VAP definition with a date of event during the HAI timeframe is considered healthcare-associated (HAI).
- Multiple episodes of healthcare-associated pneumonia may occur in critically ill patients with lengthy hospital stays. When determining whether to report multiple episodes of healthcare-associated pneumonia in a single patient, follow the Repeat Infection Timeframe (RIT) guidance found in Chapter 2.
- Excluded organisms and culture results that cannot be used to meet the PNEU/VAP definition are as follows:
    1. "Normal respiratory flora," "normal oral flora," "mixed respiratory flora," "mixed oral flora," "altered oral flora" or other similar results indicating isolation of commensal flora of the oral cavity or upper respiratory tract

2. The following organisms unless isolated from cultures of lung tissue or pleural fluid
    i. *Candida* species* or yeast not otherwise specified
    ii. coagulase-negative *Staphylococcus* species
    iii. *Enterococcus* species

    **Note**: *Candida* species* or yeast not otherwise specified, coagulase-negative *Staphylococcus* species, and *Enterococcus* species cultured from blood cannot be deemed secondary to a PNU2 or PNU3, unless the organism was also cultured from pleural fluid or lung tissue

    **Candida* species isolated from sputum, endotracheal aspirate, broncho-alveolar lavage (BAL) or protected specimen brushing cultures combined with a matching blood culture can be used to satisfy the PNU3 definition.

3. Additionally, because organisms belonging to the following genera are typically causes of community-associated infections and are rarely or are not known to be causes of healthcare-associated infections, they are also excluded, and cannot be used to meet any NHSN definition: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.*

- Abbreviations used in the PNEU laboratory criteria:

    BAL–bronchoalveolar lavage
    EIA–enzyme immunoassay
    IFA–immunofluorescent antibody
    LRT–lower respiratory tract
    PMN–polymorphonuclear leukocyte
    RIA–radioimmunoassay

**Reporting Instructions:**

- There is a hierarchy of specific categories within the major site pneumonia. If the patient meets criteria for more than one specific site during the infection window period or the RIT, report only one:
    - If a patient meets criteria for both PNU1 and PNU2, report PNU2.
    - If a patient meets criteria for both PNU2 and PNU3, report PNU3.
    - If a patient meets criteria for both PNU1 and PNU3, report PNU3.
- Pathogens and secondary bloodstream infections can only be reported for PNU2 and PNU3 specific events.

- Report concurrent LUNG (e.g., abscess or empyema) and PNEU with at least one matching organism(s) as PNEU.
- Lung abscess or empyema without pneumonia is classified as LUNG

Table 1: Specific Site Algorithms for Clinically Defined Pneumonia (PNU1)

| **Imaging Test Evidence** | **Signs/Symptoms/Laboratory** |
|---|---|
| Two or more serial chest imaging test results with at least ***one*** of the following[1,2]:<br><br>• New or progressive and persistent infiltrate<br><br>• Consolidation<br><br>• Cavitation<br><br>• Pneumatoceles, in infants ≤1 year old<br><br>**Note:** In patients ***without*** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.[1] | For ANY PATIENT, at least ***one*** of the following:<br><br>• Fever (>38.0°C or >100.4°F)<br>• Leukopenia (≤4000 WBC/mm$^3$) or leukocytosis (≥12,000 WBC/mm$^3$)<br>• For adults ≥70 years old, altered mental status with no other recognized cause<br><br>And at least ***two*** of the following:<br><br>• New onset of purulent sputum[3] or change in character of sputum[4], or increased respiratory secretions, or increased suctioning requirements<br>• New onset or worsening cough, or dyspnea, or tachypnea[5]<br>• Rales[6] or bronchial breath sounds<br>• Worsening gas exchange (e.g., $O_2$ desaturations (e.g., $PaO_2/FiO_2$ ≤240)[7], increased oxygen requirements, or increased ventilator demand) |
| | ALTERNATE CRITERIA, for infants ≤1 year old:<br><br>Worsening gas exchange (e.g., $O_2$ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)<br><br>And at least ***three*** of the following:<br><br>• Temperature instability<br>• Leukopenia (≤4000 WBC/mm$^3$) or leukocytosis (≥15,000 WBC/mm$^3$) and left shift (≥10% band forms)<br>• New onset of purulent sputum[3] or change in character of sputum[4], or increased respiratory secretions or increased suctioning requirements<br>• Apnea, tachypnea[5], nasal flaring with retraction of chest wall or nasal flaring with grunting<br>• Wheezing, rales[6], or rhonchi<br>• Cough<br>• Bradycardia (<100 beats/min) or tachycardia (>170 beats/min) |
| | ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least ***three*** of the following:<br><br>• Fever (>38. 0°C or >100. 4°F) or hypothermia (<36. 0°C or <96. 8°F)<br>• Leukopenia (≤4000 WBC/mm$^3$) or leukocytosis (≥15,000 WBC/mm$^3$)<br>• New onset of purulent sputum[3] or change in character of sputum[4], or increased respiratory secretions, or increased suctioning requirements<br>• New onset or worsening cough, or dyspnea, apnea, or tachypnea[5].<br>• Rales[6] or bronchial breath sounds<br>• Worsening gas exchange (e.g., $O_2$ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) |

Table 2: Specific Site Algorithms for Pneumonia with Common Bacterial or Filamentous Fungal Pathogens and Specific Laboratory Findings (PNU2)

| **Imaging Test Evidence** | **Signs/Symptoms** | **Laboratory** |
|---|---|---|
| Two or more serial chest imaging test results with at least ***one*** of the following[1,2]:<br>• New or progressive and persistent infiltrate<br>• Consolidation<br>• Cavitation<br>• Pneumatoceles, in infants ≤1 year old<br><br>**Note**: In patients ***without*** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.[1] | At least ***one*** of the following:<br>• Fever (>38.0°C or >100.4°F)<br>• Leukopenia (≤4000 WBC/mm$^3$) or leukocytosis (≥12,000 WBC/mm$^3$)<br>• For adults ≥70 years old, altered mental status with no other recognized cause<br><br>And at least ***one*** of the following:<br>• New onset of purulent sputum[3] or change in character of sputum[4], or increased respiratory secretions, or increased suctioning requirements<br>• New onset or worsening cough, or dyspnea or tachypnea[5]<br>• Rales[6] or bronchial breath sounds<br>• Worsening gas exchange (e.g., $O_2$ desaturations [e.g., $PaO_2/FiO_2$ ≤240][7], increased oxygen requirements, or increased ventilator demand) | At least ***one*** of the following:<br>• Organism identified from blood [8,13]<br>• Organism identified from pleural fluid[9,13]<br>• Positive quantitative culture[9] from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)<br>• ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)<br>• Positive quantitative culture[9] of lung tissue<br>• Histopathologic exam shows at least ***one*** of the following evidences of pneumonia:<br>  ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli<br>  ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae |

Table 3: Specific Site Algorithms for Viral, Legionella, and other Bacterial Pneumonias with Definitive Laboratory Findings (PNU2)

| **Imaging Test Evidence** | **Signs/Symptoms** | **Laboratory** |
|---|---|---|
| Two or more serial chest imaging test results with at least ***one*** of the following[1,2]:<br>• New or progressive and persistent infiltrate<br>• Consolidation<br>• Cavitation<br>• Pneumatoceles, in infants ≤1 year old<br><br>**Note:** In patients ***without*** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.[1] | At least ***one*** of the following:<br>• Fever (>38.0°C or >100.4°F)<br>• Leukopenia (≤4000 WBC/mm$^3$) or leukocytosis (≥12,000 WBC/mm$^3$)<br>• For adults ≥70 years old, altered mental status with no other recognized cause<br><br>And at least ***one*** of the following:<br>• New onset of purulent sputum[3] or change in character of sputum[4], or increased respiratory secretions, or increased suctioning requirements<br>• New onset or worsening cough or dyspnea, or tachypnea[5]<br>• Rales[6] or bronchial breath sounds<br>• Worsening gas exchange (e.g., $O_2$ desaturations [e.g., $PaO_2/FiO_2$ ≤240][7], increased oxygen requirements, or increased ventilator demand) | At least ***one*** of the following:<br>• Virus, *Bordetella*, *Legionella*, *Chlamydia or Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).<br>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*)<br>• Fourfold rise in *Legionella pneumophila* serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA.<br>• Detection of *L. pneumophila* serogroup 1 antigens in urine by RIA or EIA |

Table 4: Specific Site Algorithm for Pneumonia in Immunocompromised Patients (PNU3)

| **Imaging Test Evidence** | **Signs/Symptoms** | **Laboratory** |
|---|---|---|
| Two or more serial chest imaging test results with at least ***one*** of the following[1,2]:<br>• New or progressive and persistent infiltrate<br>• Consolidation<br>• Cavitation<br>• Pneumatoceles, in infants ≤1 year old<br><br>**Note:** In patients ***without*** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.[1] | Patient who is immunocompromised (see definition in footnote [10] ) has at least ***one*** of the following:<br>• Fever (>38.0°C or >100.4°F)<br>• For adults ≥70 years old, altered mental status with no other recognized cause<br>• New onset of purulent sputum[3], or change in character ofsputum[4], or increased respiratory secretions, or increased suctioning requirements<br>• New onset or worsening cough, or dyspnea, or tachypnea[5]<br>• Rales[6] or bronchial breath sounds<br>• Worsening gas exchange (e.g., $O_2$ desaturations [e.g., $PaO_2/FiO_2$ ≤240][7], increased oxygen requirements, or increased ventilator demand)<br>• Hemoptysis<br>• Pleuritic chest pain | At least ***one*** of the following:<br>• Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.[11,12,13]<br>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:<br>– Direct microscopic exam<br>– Positive culture of fungi<br>– Non-culture diagnostic laboratory test<br><br>Any of the following from:<br>**LABORATORY CRITERIA DEFINED UNDER PNU2** |

Figure 3: Pneumonia Flow Diagram for Patients of Any Age

**Facility ID# _____ Event #_____Event Date __/__/___**

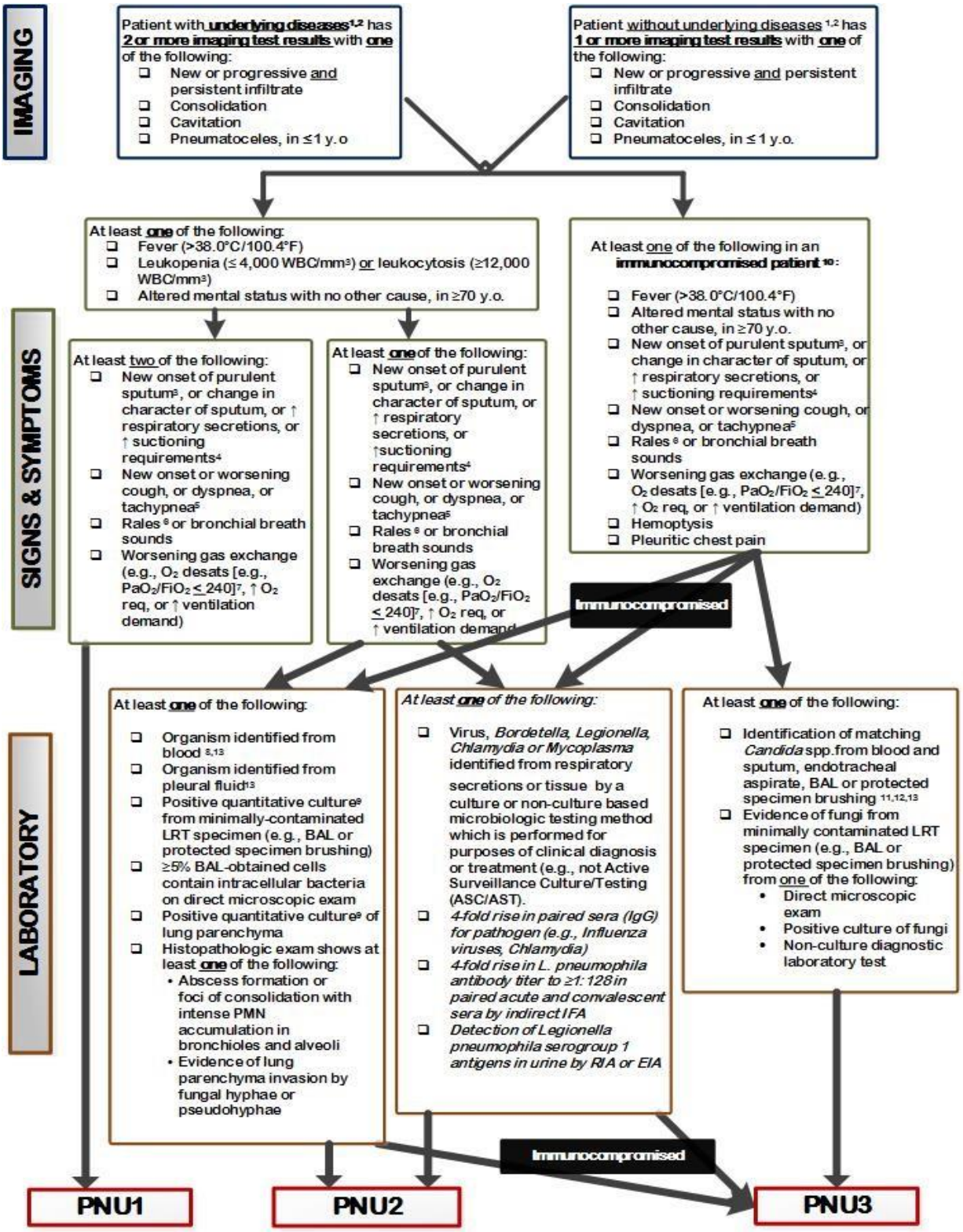
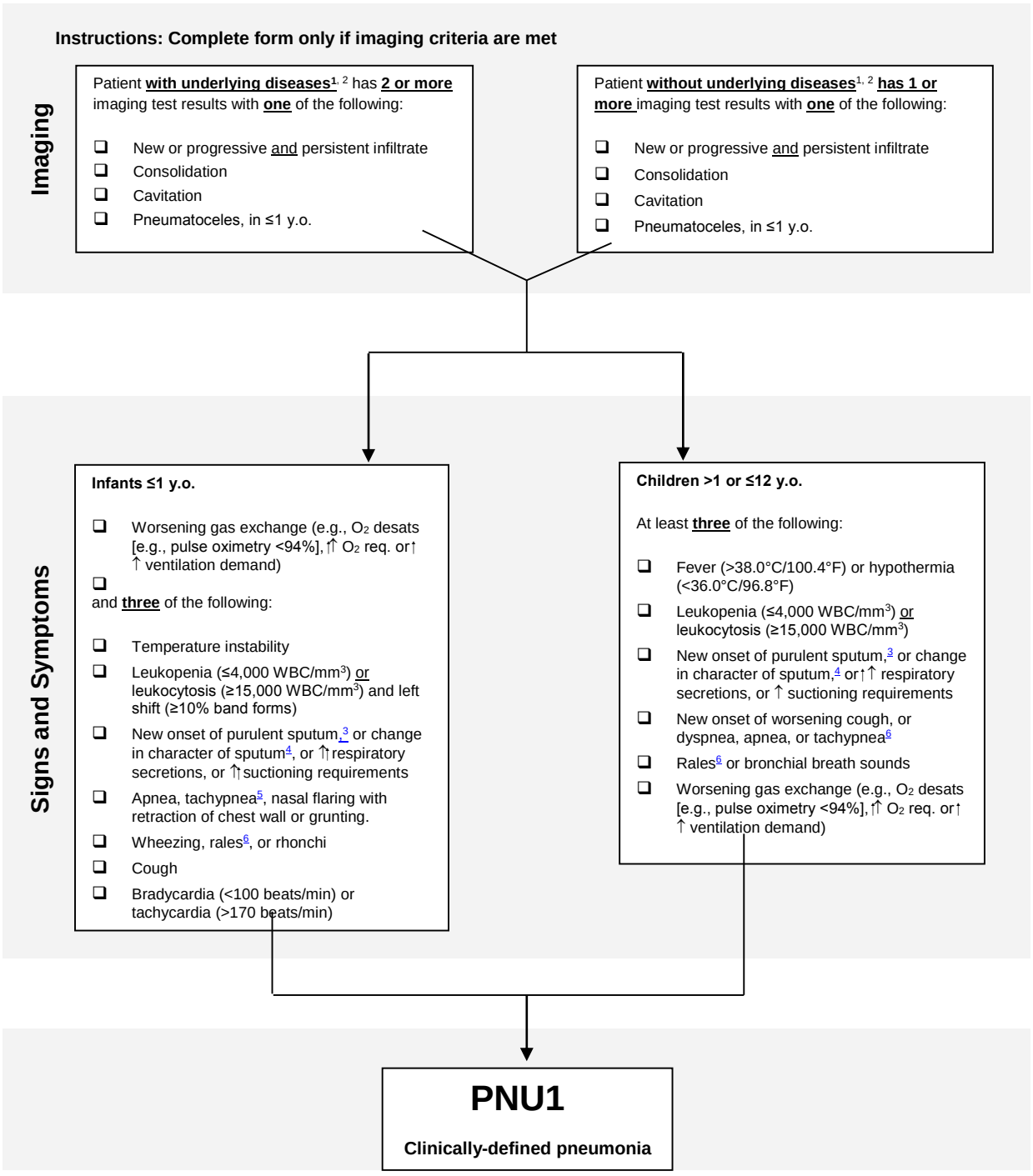


Figure 4: Pneumonia Flow Diagram, Alternative Criteria for Infants and Children

**Facility ID#_____Event #_____Event Date __/__/____**



**Footnotes to Algorithms and Flow Diagrams**:

1. Occasionally, in non-ventilated patients, the diagnosis of healthcare-associated pneumonia may be quite clear on the basis of symptoms, signs, and a single definitive chest imaging test result. However, in patients with pulmonary or cardiac disease (e.g., interstitial lung disease or congestive heart failure), the diagnosis of pneumonia may be particularly difficult. Other non-infectious conditions (e.g., pulmonary edema from decompensated congestive heart failure) may simulate the presentation of pneumonia. In these more difficult cases, serial chest imaging test results must be examined to help separate infectious from non-infectious pulmonary processes. To help confirm difficult cases, it may be useful to review multiple imaging test results spanning over several calendar days. Pneumonia may have rapid onset and progression, but does not resolve quickly. Imaging test evidence of pneumonia will persist. Rapid imaging resolution suggests that the patient does not have pneumonia, but rather a non-infectious process such as atelectasis or congestive heart failure.

2. Note that there are many ways of describing the imaging appearance of pneumonia. Examples include, but are not limited to, "air-space disease", "focal opacification", "patchy areas of increased density". Although perhaps not specifically delineated as pneumonia by the radiologist, in the appropriate clinical setting these alternative descriptive wordings should be seriously considered as potentially positive findings.

3. Purulent sputum is defined as secretions from the lungs, bronchi, or trachea that contain ≥25 neutrophils and ≤10 squamous epithelial cells per low power field (x100). Refer to the table below if your laboratory reports these data semi-quantitatively or uses a different format for reporting Gram stain or direct examination results (e.g., "many WBCs" or "few squamous epithelial cells"). This laboratory confirmation is required since written clinical descriptions of purulence are highly variable.

| **How do I use the purulent respiratory secretions criterion if …** | **Instruction** |
|---|---|
| My laboratory reports counts of "white blood cells" or "polymorphonuclear leukocytes" or "leukocytes" rather than counts of "neutrophils"? | Assume that counts of cells identified by these other descriptors (e.g., "white blood cells") are equivalent to counts of neutrophils, unless the laboratory tells you this is not the case. |
| My laboratory reports semi-quantitative results (not quantitative results) for numbers of neutrophils and squamous epithelial cells? | Check with the laboratory to get information about what quantitative ranges the semi-quantitative reports correspond to. |
| My laboratory cannot provide additional information on how its semi-quantitative reporting corresponds to quantitative reporting ranges for neutrophils and squamous epithelial cells? | Use the following direct examination results to meet the purulent respiratory secretions criterion: heavy, 4+, or ≥25 neutrophils per low power field (lpf) [x100], AND rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per lpf [x100] [19]. |
| My laboratory reports only the numbers of neutrophils present, without reporting the number of squamous epithelial cells? | In this situation, the purulent secretions criterion may be met using the specified quantitative and semi-quantitative thresholds for neutrophils alone (i.e., heavy, 4+, or ≥25 neutrophils per lpf [x100]). |
| My laboratory uses different reporting thresholds for neutrophils and squamous epithelial cells (e.g., maximum report of ≥ 20 neutrophils per low power field [x100], or minimum report of ≤ 15 squamous epithelial cells per low power field [x100])? | In this situation, the purulent secretions criterion may be met using the laboratory's specified maximum quantitative threshold for neutrophils, and/or minimum quantitative threshold for squamous epithelial cells. |

| | |
|---|---|
| My laboratory processes respiratory specimens such as bronchoalveolar lavage fluid using a centrifugation procedure (e.g., "cytospin"), and there is no quantitation or semi-quantitation of neutrophils or white blood cells in the direct examination report? | In this situation, a report indicating the presence of white blood cells, without quantitation, is sufficient to meet the purulent secretions criterion. |

4. Change in character of sputum refers to the color, consistency, odor and quantity.

5. In adults, tachypnea is defined as respiration rate >25 breaths per minute. Tachypnea is defined as >75 breaths per minute in premature infants born at <37 weeks gestation and until the 40$^{th}$ week; >60 breaths per minute in patients <2 months old; >50 breaths per minute in patients 2-12 months old; and >30 breaths per minute in children >1 year old.

6. Rales may be described as "crackles".

7. This measure of arterial oxygenation is defined as the ratio of the arterial tension ($PaO_2$) to the inspiratory fraction of oxygen ($FiO_2$).

8. Coagulase-negative *Staphylococcus* species, *Enterococcus* species and *Candida* species or yeast not otherwise specified that are identified from blood cannot be deemed secondary to a PNEU, unless the organism was also identified from pleural fluid (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube) or lung tissue. Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing can be used to satisfy PNU3 definition for immunocompromised patients.

9. Refer to threshold values for cultured specimens with growth of eligible pathogens. (Table 5).

**Notes:**

- A sputum and endotracheal aspirate are not minimally-contaminated specimens and therefore, organisms identified from these specimens do not meet the laboratory criteria for PNU2.
- Because they are an indication of commensal flora of the oral cavity or upper respiratory tract, the following organisms can only be used to meet PNEU definitions when identified from pleural fluid obtained during thoracentesis or initial placement of chest tube (not from an indwelling chest tube) or lung tissue:
    - Coagulase-negative *Staphylococcus* species
    - *Enterococcus* species
    - *Candida* species or yeast not otherwise specified. Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing can be used to satisfy PNU3 definition for immunocompromised patients.

10. Immunocompromised patients include those with neutropenia (absolute neutrophil count or total white blood cell count (WBC) <500/mm$^3$), leukemia, lymphoma, HIV with CD4 count <200, or splenectomy; those who are early post-transplant, are on cytotoxic chemotherapy, or are on high dose steroids (e.g., >40mg of prednisone or its equivalent (>160mg hydrocortisone, >32mg methylprednisolone, >6mg dexamethasone, >200mg cortisone) daily for >2weeks).

11. Cultures of blood and sputum, endotracheal aspirate, BAL or protected specimen brushing must have a collection date that occurs within the Infection Window Period.

12. Semi-quantitative or non-quantitative cultures of sputum obtained by deep cough, induction, aspiration, or lavage are acceptable.

13. Identification of organism by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

Table 5: Threshold values for cultured specimens used in the diagnosis of pneumonia

| **Specimen collection/technique** | **Values**† |
|---|---|
| Lung tissue* | ≥$10^4$ CFU/g tissue |
| | |
| Bronchoscopically (B) obtained specimens | |
| Bronchoalveolar lavage (B-BAL) | ≥$10^4$ CFU/ml |
| Protected BAL (B-PBAL) | ≥$10^4$ CFU/ml |
| Protected specimen brushing (B-PSB) | ≥$10^3$ CFU/ml |
| | |
| Nonbronchoscopically (NB) obtained (blind)specimens | |
| NB-BAL | ≥$10^4$ CFU/ml |
| NB-PSB | ≥$10^3$ CFU/ml |

CFU = colony forming units
g = gram
ml = milliliter

*Open-lung biopsy specimens and immediate post-mortem specimens obtained by transthoracic or transbronchial biopsy

† Consult with your laboratory to determine if reported semi-quantitative results match the quantitative thresholds. In the absence of additional information available from your laboratory, a semi-quantitative result of "moderate" or "heavy" growth, or 2+, 3+ or 4+ growth is considered to correspond.

**Numerator Data:** The *Pneumonia (PNEU)* form (CDC 57.111) is used to collect and report each VAP that is identified during the month selected for surveillance. The Instructions for Completion of Pneumonia (PNEU) form contains brief instructions for collection and entry of each data element on the form. The pneumonia form includes patient demographic information and information on whether or not mechanically-assisted ventilation was present. Additional data include the specific criteria met for identifying pneumonia, whether the patient developed a secondary bloodstream infection, whether the patient died, the organisms identified from culture or non-culture based microbiologic testing methods, and the organisms' antimicrobial susceptibilities.

**Reporting Instruction:**

If no VAPs are identified during the month of surveillance, the "*Report No Events"* box must be checked on the appropriate denominator summary screen, e.g., Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or SCA/ONC), etc.

**Denominator Data:** Device days and patient days are used for denominators (see Key Terms chapter). Ventilator days, which are the number of patients managed with a ventilatory device, are collected daily, at the same time each day, according to the chosen location using the appropriate form (CDC 57.116, 57.117, and 57.118). These daily counts are summed and only the total for the month is entered into NHSN. Ventilator days and patient days are collected for each of the locations where VAP is monitored. When denominator data are available from electronic sources (e.g., ventilator days from respiratory therapy), these sources may be used as long as the counts are not substantially different (+/- 5%) from manually-collected counts, validated for a minimum of three months.

**Data Analyses:** The VAP rate per 1000 ventilator days is calculated by dividing the number of VAPs by the number of ventilator days and multiplying the result by 1000. The Ventilator Utilization Ratio is calculated by dividing the number of ventilator days by the number of patient days. These calculations will be performed separately for the different types of ICUs, SCAs, and other locations in the institution.

The Standardized Infection Ratio (SIR[3]) is another measure of VAP incidence that can be calculated by dividing the number of observed infections by the number of predicted infections. The number of predicted infections can be calculated using VAP rates from a standard population during a baseline time period, which represents a standard population's VAP experience.[4]

**Note:** The SIR should be calculated only if the number of expected HAIs (numExp) is ≥1 in order to enforce a minimum precision criterion
**Note**: The VAP SIR is not available from within the NHSN application, but can be calculated using the methods described above.

While the VAP SIR can be calculated for single locations, the measure also allows you to summarize your data by multiple locations, adjusting for differences in the incidence of infection among the location types. For example, you can calculate one VAP SIR adjusting for all locations reported. Similarly, you can calculate one VAP SIR for all oncology locations in your facility.

Descriptive analysis options of numerator and denominator data are available in the NHSN application, such as line listings, frequency tables, and bar and pie charts. VAP

rates and run charts are also available. Guides on using NHSN analysis features are available from: http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html.

**References:**

[1]Magill SS., Edwards, JR., Bamberg, W., et al. "Multistate Point-Prevalence Survey of Health Care-Associated Infections, 2011". New England Journal of Medicine. 370: (2014): 1198-1208.

[2]Centers for Disease Control and Prevention. Guidelines for preventing health-care-associated pneumonia, 2003: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee. MMWR 2004; 53(No. RR-3).

[3]Your guide to the Standardized Infection Ratio (SIR). October 2010. http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN_NL_OCT_2010SE_final.pdf

[4]Edwards, JR., Peterson, KD., Mu, Y., et al. National Healthcare Safety Network (NHSN) Report: Data Summary for 2006 through 2008, issued December 2009. American Journal of Infection Control 37: (2009):783-805. Available at: http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.PDF

# Urinary Tract Infection (Catheter-Associated Urinary Tract Infection [CAUTI] and Non-Catheter-Associated Urinary Tract Infection [UTI]) and Other Urinary System Infection (USI) Events

**Introduction:** Urinary tract infections (UTIs) are the fourth most common type of healthcare-associated infection, with an estimated 93,300 UTIs in acute care hospitals in 2011and account for more than 12% of infections reported by acute care hospitals[1]. Virtually all healthcare-associated UTIs are caused by instrumentation of the urinary tract.

CAUTI can lead to such complications as prostatitis, epididymitis, and orchitis in males, and cystitis, pyelonephritis, gram-negative bacteremia, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality[2]. It has been estimated that each year, more than 13,000 deaths are associated with UTIs.[3]

Prevention of CAUTI is discussed in the CDC/HICPAC document, *Guideline for Prevention of Catheter-associated Urinary Tract Infection*[4].

**Settings:** Surveillance may occur in any inpatient location(s) where denominator data can be collected, such as critical intensive care units (ICU), specialty care areas (SCA), step- down units, wards, inpatient rehabilitation locations, and long term acute care locations. Neonatal ICUs may participate, but only off plan (not as a part of their monthly reporting plan). A complete listing of inpatient locations and instructions for mapping can be found in the CDC Locations and Descriptions chapter.

**Note:** Surveillance for CAUTIs after the patient is discharged from the facility is not required. However, if discovered, any CAUTIs with a date of event on the day of discharge or the next day is attributable to the discharging location and should be included in any CAUTIs reported to NHSN for that location (see Transfer Rule). No additional indwelling catheter days are reported.

**Definitions:**

Present on Admission (POA): Infections that are POA, as defined in Chapter 2, are not considered HAIs and therefore are never reported to NHSN.

Healthcare-associated infections (HAI): All NHSN site specific infections must first meet the HAI definition as defined in Chapter 2 before a site specific infection (e.g., CAUTI) can be reported to NHSN.

Urinary tract infections (UTI) are defined using Symptomatic Urinary Tract Infection (SUTI) criteria, Asymptomatic Bacteremic UTI (ABUTI), or Urinary System Infection (USI) criteria (See Table 1 and Figure 3).

Date of event (DOE): For a UTI, the date of event is the date when the first element used to meet the UTI infection criterion occurred for the first time within the 7-day Infection Window Period. See definition of Infection Window Period in Chapter 2. Synonyms: infection date, event date.

Indwelling catheter: A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a drainage bag (including leg bags). These devices are also called Foley catheters. Condom or straight in-and-out catheters are not included nor are nephrostomy tubes, ileoconduits, or suprapubic catheters unless a Foley catheter is also present. Indwelling urethral catheters that are used for intermittent or continuous irrigation are included in CAUTI surveillance.

Catheter-associated UTI (CAUTI): A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

***AND***

an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

**Example of Associating Catheter Use to UTI:**

A patient in an inpatient unit has a Foley catheter inserted and the following day is the date of event for a UTI. Because the catheter has not been in place >2 calendar days on the date of event, this is not a CAUTI. However, depending on the date of admission, this may be a healthcare-associated UTI.

**Notes:**

- SUTI 1b and USI cannot be catheter-associated.
- Indwelling urinary catheters that are removed and reinserted: If, after indwelling urinary catheter removal, the patient is without an indwelling urinary catheter for at least 1 full calendar day (NOT to be read as 24 hours), then the urinary catheter day count will start anew. If instead, a new indwelling urinary catheter is inserted before a full calendar day has passed without an indwelling urinary catheter being present, the urinary catheter day count will continue.

**Figure 5: Associating Catheter Use to UTI**

| | March 31 (Hospital day 3) | April 1 | April 2 | April 3 | April 4 | April 5 | April 6 |
|---|---|---|---|---|---|---|---|
| Patient A | Foley **Day 3** | Foley **Day 4** | Foley removed (**Foley Day 5)** | Foley replaced **(Foley Day 6)** | Foley **Day 7** | Foley removed **Day 8** | No Foley |
| Patient B | Foley **Day 3** | Foley **Day 4** | Foley removed **(Foley Day 5)** | No Foley | Foley replaced (**Foley Day 1)** | Foley **Day 2** | Foley **Day 3** |

**Rationale:** NHSN surveillance for infection is not aimed at a specific device. Instead surveillance is aimed at identifying risk to the patient that is the result of device use in general.

- In the examples above, Patient A is eligible for a CAUTI beginning on March 31, through April 6th, since a Foley was in place for some portion of each calendar day until April 6th. A UTI with date of event on April 6th would be a CAUTI since the catheter had been in place greater than 2 days and was removed the day before the date of event.
- Patient B is eligible for a CAUTI on March 31 (Foley Day 3) through April 3. The catheter had been in place > 2 days and an HAI occurring on the day of device discontinuation or the following calendar day is considered a device-associated infection.
- IF the patient did not have a CAUTI by April 3, the patient is not eligible for a CAUTI until April 6, when the second indwelling urinary catheter had been in place for greater than 2 days. (Note: NHSN will not require the UTI to be attributed to a specific indwelling urinary catheter when reporting.)

Location of attribution: The inpatient location where the patient was assigned on the date of the UTI event. See Date of Event definition (above). See Exception to Location of Attribution (below).

**Exception to Location of Attribution**

*Transfer Rule*: If the date of event for a UTI is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location. This is called the **Transfer Rule** and examples are shown below. Receiving facilities should share information about such HAIs with the transferring location or facility to enable accurate reporting.

**Examples of the Transfer Rule:**

- Patient is transferred in the morning to the medical ward from the MSICU after having the Foley catheter removed, which had been in place for 6 days. The day of transfer is the date of event for the CAUTI. This is reported to NHSN as a CAUTI for the MSICU because the date of event (date when the first element of UTI criteria first appeared during the infection window) was the day of transfer from that location.
- On Monday, patient with a Foley catheter in place is transferred from the medical ward to the coronary care unit (CCU). Wednesday in the CCU, patient has a fever and urine culture collected that day is positive for 100,000 CFU/ml of *E. coli*. This is reported to NHSN as a CAUTI for the CCU, because the UTI date of event is LATER THAN the day after transfer.
- A patient has a Foley catheter removed on catheter day 5 and is discharged the same day from hospital A's urology ward. The next day, the IP from Hospital B calls to report that this patient has been admitted to Hospital B meeting UTI criteria. This CAUTI should be reported to NHSN for Hospital A and attributed to the urology ward because the date of event is the next day after transfer.
- Patient in the MICU with a Foley catheter, which has been in place for 4 days, is transferred to the medical ward. The day after transfer is determined to be the date of event for a catheter-associated ABUTI. This is reported to NHSN as an ABUTI for the MICU because the date of event was the next day after transfer.

**Multiple Transfers**

In instances where a patient has been transferred to more than one location on the date of a UTI, or the day before, attribute the UTI to the **first** location in which the patient was housed the **day before** the UTI's date of event.

Figure 6: Multiple Transfers within the Transfer Rule Time Frame

| | 3/22 | 3/23 | 3/24 |
|---|---|---|---|
| Locations in which patient was housed | Unit A | Unit A<br>Unit B<br>Unit C | Unit C<br>Unit D<br>This is also the date of event for a CAUTI. CAUTI is attributed to Unit A since Unit A was the first location in which the patient was housed the day before the date of event. |

Table 1. Urinary Tract Infection Criteria

| Criterion | Urinary Tract Infection (UTI) |
|---|---|
| | **Symptomatic UTI (SUTI)**<br>Must meet at least ***one*** of the following criteria: |
| **SUTI 1a**<br><br>**Catheter-associated Urinary Tract Infection (CAUTI)** | Patient must meet 1, 2, and 3 below:<br><br>1. Patient had an indwelling urinary catheter that had been in place for > 2 days on the date of event (day of device placement = Day 1) AND was either:<br>• Present for any portion of the calendar day on the date of event†, OR<br>• Removed the day before the date of event‡<br><br>2. Patient has at least ***one*** of the following signs or symptoms:<br>• fever (>38.0°C)<br>• suprapubic tenderness*****<br>• costovertebral angle pain or tenderness*<br>• urinary urgency ^<br>• urinary frequency ^<br>• dysuria ^<br><br>3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml (See Comment Section on page 7-8). All elements of the UTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN).<br><br>† When entering event into NHSN choose "INPLACE" for Risk Factor for Urinary Catheter<br>‡ When entering event into NHSN choose "REMOVE" for Risk Factor for Urinary Catheter<br>*****With no other recognized cause (see Notes below)<br>^ These symptoms cannot be used when catheter is in place<br><br>**Notes:**<br><br>• An indwelling urinary catheter in place could cause patient complaints of "frequency" "urgency" or "dysuria" and therefore these cannot be used as symptoms when catheter is in place.<br><br>• Fever is a non-specific symptom of infection and cannot be excluded from UTI determination because it is clinically deemed due to another recognized cause. |

| | |
|---|---|
| **SUTI 1b Non-Catheter-associated Urinary Tract Infection (Non-CAUTI)** | Patient must meet 1, 2, and 3 below:<br><br>1. One of the following is true:<br>• Patient has/had an indwelling urinary catheter but it has/had not been in place >2 calendar days on the date of event†<br>**OR**<br>• Patient did not have a urinary catheter in place on the date of event nor the day before the date of event †<br><br>2. Patient has at least ***one*** of the following signs or symptoms:<br><br>• fever (>38°C) in a patient that is ≤ 65 years of age<br>• suprapubic tenderness*****<br>• costovertebral angle pain or tenderness*****<br>• urinary frequency ^<br>• urinary urgency ^<br>• dysuria ^<br><br>3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml. (See comment section on page 7-8) All elements of the SUTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN).<br><br>† When entering event into NHSN choose "NEITHER" for Risk Factor for Urinary Catheter<br>*****With no other recognized cause (see Notes below)<br>^These symptoms cannot be used when catheter is in place.<br><br>**Notes:**<br><br>• An indwelling urinary catheter in place could cause patient complaints of "frequency" "urgency" or "dysuria" and therefore these cannot be used as symptoms when catheter is in place.<br><br>• Fever is a non-specific symptom of infection and cannot be excluded from UTI determination because it is clinically deemed due to another recognized cause. |

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| **SUTI 2**<br><br>**CAUTI or Non-CAUTI in patients 1 year of age or less** | Patient must meet 1, 2, and 3 below:<br><br>1. Patient is ≤1 year of age (with‡ or without an indwelling urinary catheter)<br><br>2. Patient has at least ***one*** of the following signs or symptoms:<br>• fever (>38.0°C)<br>• hypothermia (<36.0°C)<br>• apnea*****<br>• bradycardia*****<br>• lethargy*****<br>• vomiting*<br>• suprapubic tenderness*<br><br>3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of ≥$10^5$ CFU/ml. (See comment section on page 7-8) All elements of the SUTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN).<br><br>‡ If patient had an indwelling urinary catheter in place for >2 calendar days, and catheter was in place on the date of event or the previous day the CAUTI criterion is met. If no such indwelling urinary catheter was in place, UTI (non-catheter associated) criterion is met.<br><br>*****With no other recognized cause<br><br>**Note:** Fever and hypothermia are non-specific symptoms of infection and cannot be excluded from UTI determination because they are clinically deemed due to another recognized cause. |
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| | **Asymptomatic Bacteremic Urinary Tract Infection (ABUTI)** |
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| | Patient must meet 1, 2, and 3 below:<br><br>1. Patient with***** or without an indwelling urinary catheter has no signs or symptoms of SUTI 1 or 2 according to age (**Note**: Patients > 65 years of age with a non-catheter-associated ABUTI **may** have a fever and still meet the ABUTI criterion)<br><br>2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml (see Comment section below)<br><br>3. Patient has organism identified** from blood specimen with at least ***one*** matching bacterium to the bacterium identified in the urine specimen, or meets LCBI criterion 2 (without fever) and matching common commensal(s) in the urine. All elements of the ABUTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN).<br><br>*****Patient had an indwelling urinary catheter in place for >2 calendar days, with day of device placement being Day 1, and catheter was in place on the date of event or the day before.<br><br>** Organisms identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). |
| **Comment** | "Mixed flora" is not available in the pathogen list within NSHN. Therefore it cannot be reported as a pathogen to meet the NHSN UTI criteria. Additionally, "mixed flora" represent at least two species of organisms. Therefore, an additional organism recovered from the same culture would represent >2 species of microorganisms. Such a specimen also cannot be used to meet the UTI criteria.<br><br>The following excluded organisms cannot be used to meet the UTI definition:<br><br>• *Candida* species or yeast not otherwise specified<br>• mold<br>• dimorphic fungi or<br>• parasites<br><br>An acceptable urine specimen may include these organisms as long as one bacterium of greater than or equal to 100,000 CFU/ml is also present. |

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| | Additionally, these non-bacterial organisms identified from blood cannot be deemed secondary to a UTI since they are excluded as organisms in the UTI definition. |

Table 2. Urinary System Infection Criteria

| Criterion | **Urinary System Infection (USI) (kidney, ureter, bladder, urethra, or tissue surrounding the retroperitoneal or perinephric space)**<br><br>Other infections of the urinary system must meet at least ***one*** of the following criteria: |
|---|---|
| | 1. Patient has microorganisms identified** from fluid (excluding urine) or tissue from affected site<br><br>2. Patient has an abscess or other evidence of infection on gross anatomical exam, during invasive procedure, or on histopathologic exam<br><br>3. Patient has at least ***one*** of the following signs or symptoms:<br><br>• fever (>38.0°C)<br>• localized pain or tenderness*<br><br>**And at least *one* of the following:**<br><br>a) purulent drainage from affected site<br>b) organisms identified** from blood and imaging test evidence of infection (e.g., ultrasound, CT scan, magnetic resonance imaging [MRI], or radiolabel scan [gallium, technetium])<br><br>1. Patient ≤1 year of age has at least ***one*** of the following signs or symptoms:<br><br>• fever (>38.0°C)<br>• hypothermia (<36.0°C)<br>• apnea*<br>• bradycardia*<br>• lethargy*<br>• vomiting*<br><br>**And at least *one* of the following:**<br><br>a) purulent drainage from affected site<br>b) organisms identified** from blood and imaging test evidence of infection, (e.g., ultrasound, CT scans, magnetic resonance imaging [MRI], or radiolabel scan [gallium, technetium])<br><br>* With no other recognized cause |

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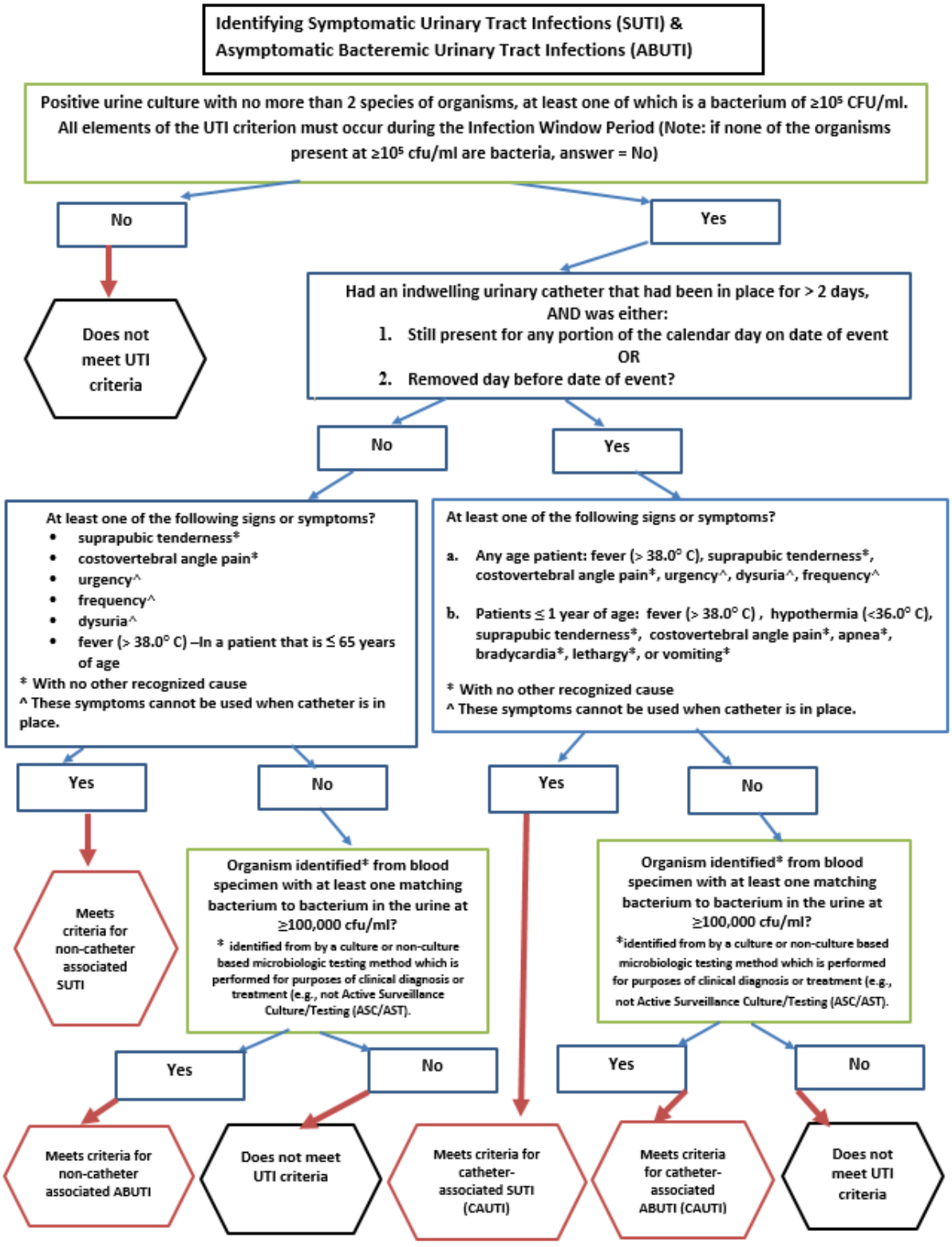
| | ** Organisms identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).<br><br>**Notes:**<br><br>• Fever and hypothermia are non-specific symptoms of infection and cannot be excluded from USI determination because they are clinically deemed due to another recognized cause.<br>• All elements of the USI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN). |
| **Comments** | • Report infections following circumcision in newborns as SST-CIRC.<br>• If patient meets USI criteria and they also meet UTI criteria, report UTI only, unless the USI is a surgical site organ/space infection, in which case, only USI should be reported.<br>• For NHSN reporting purposes, Urinary System Infection (USI) cannot be catheter associated, therefore, USI will only present as specific event type if urinary catheter status is marked "Neither". |

Figure 3: Identifying SUTI and ABUTI Flowchart



**Numerator Data:** The *Urinary Tract Infection (UTI)* form is used to collect and report each CAUTI that is identified during the month selected for surveillance. The Instructions for Completion of Urinary Tract Infection form include brief instructions for collection and entry of each data element on the form. USIs are never included in CAUTI data and are reported separately on the HAI Custom Event Form. The UTI form includes patient demographic information and information on whether or not an indwelling urinary catheter was present. Additional data include the specific criteria met for identifying the UTI, whether the patient developed a secondary bloodstream infection, whether the patient died, and the organisms isolated from cultures and their antimicrobial susceptibilities.

**Reporting Instructions:**
If no CAUTIs are identified during the month of surveillance, the" Report No Events" box must be checked on the appropriate denominator summary screen, (e.g., *Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or SCA/ONC).*

**Denominator Data:** Device days and patient days are used for denominators (See Key Terms chapter).The method of collecting device-day denominator data may differ depending on the location of patients being monitored. The following methods may be used:

| **Denominator Data Collection Method** | **Details** |
|---|---|
| **Manual, Daily** (i.e., collected at the same time every day of the month) | Denominator data are collected at the same time, every day, per location.<br><br>Indwelling urinary catheter days, which are the number of patients with an indwelling urinary catheter device, are collected daily, at the same time each day, according to the chosen location using the appropriate form (CDC 57.117 and 57.118). These daily counts are summed and only the total for the month is entered into NHSN. Indwelling urinary catheter days and patient days are collected separately for each of the locations monitored. |
| **Manual, sampled once/week** (i.e., collected at the same time on the same designated day, once per week) | For locations other than specialty care areas/oncology (SCA/ONC) and NICUs (e.g., ICUs, step-down units, wards), the denominator sampling method can be used.<br><br>To reduce staff time spent collecting surveillance data, once weekly sampling of denominator data to generate estimated urinary catheter days may be used as an alternative to daily collection in non-oncology ICUs and wards. The number of patients in the location (patient-days) and the number of patients with an indwelling urinary catheter (urinary catheter-days) is collected on a designated day each week (e.g., every Tuesday), at the same time during the month. |

| Denominator Data Collection Method | Details |
|---|---|
| | Evaluations of this method have repeatedly shown that use of Saturday or Sunday generate the least accurate estimates of denominator data, and, therefore, these days should not be selected as the designated day.[5-7] If the day designated for the collection of sampled data is missed, collect the data on the next available day instead.<br><br>The following must be collected and entered into NHSN:<br><br>1. The monthly total for patient-days, based on collection daily<br>2. The sampled total for patient-days<br>3. The sampled total urinary catheter-days<br><br>When these data are entered, the NHSN application will calculate an estimate of urinary catheter-days.<br><br>**Notes:**<br><br>• To ensure the accuracy of estimated denominator data obtained by sampling, only ICU and ward location types with an average of 75 or more urinary catheter-days per month are eligible to use this method. A review of each location's urinary catheter denominator data for the past 12 months in NHSN will help determine which locations are eligible.<br>• The accuracy of estimated denominator data generated by sampling can be heavily influenced by incorrect or missing data. Careful implementation of data collection following the guidance in this protocol is essential to avoid erroneous fluctuations in rates or Standardized Infection Ratios (SIRs). |
| **Electronic** | For ***any*** location, when denominator data are available from electronic sources (e.g., urinary catheter days from electronic charting), these sources may be used as long as the counts are not substantially different (+/- 5%) from manually-collected, once a day counts, pre-validated for a minimum of three months.<br><br>The validation of electronic counts should be performed for each location separately. |

**Data Analyses:** The Standardized Infection Ratio (SIR) is calculated by dividing the number of observed infections by the number of predicted infections. The number of predicted infections is calculated using CAUTI rates from a standard population during a baseline time period, which represents a standard population's CAUTI experience.[8, 9]

**Notes:**

- The SIR will be calculated only if the number of predicted CAUTIs (numExp) is ≥1 to help enforce a minimum precision criterion.
- In the NHSN application, "predicted" is referred to as "expected".

$$\text{SIR} = \frac{\text{Observed (O) HAIs}}{\text{Expected (E) HAIs}}$$

While the CAUTI SIR can be calculated for single locations, the measure also allows you to summarize your data by multiple locations, adjusting for differences in the incidence of infection among the location types. For example, you will be able to obtain one CAUTI SIR adjusting for all locations reported. Similarly, you can obtain one CAUTI SIR for all ICUs in your facility.

**Note:** Only those locations for which baseline data have been published will be included in the SIR calculations. For acute care hospitals, the baseline time period is 2009; for long term acute care hospitals and inpatient rehabilitation facilities (IRFs) and IRF units, the baseline time period is 2013.[8,9]

The CAUTI rate per 1000 urinary catheter days is calculated by dividing the number of CAUTIs by the number of catheter days and multiplying the result by 1000. The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter days by the number of patient days. These calculations will be performed separately for the different types of ICUs, specialty care areas, and other locations in the institution, except for neonatal locations.

Descriptive analysis output options of numerator and denominator data, such as line listings, frequency tables, and bar and pie charts are available in the NHSN application. SIRs and CAUTI rates and run charts are also available. Guides on using NHSN analysis features are available at: http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html.

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# Surgical Site Infection (SSI) Event

**Introduction:** In 2010, an estimated 16 million operative procedures were performed in acute care hospitals in the United States[1]. A recent prevalence study found that SSIs were the most common healthcare-associated infection, accounting for 31% of all HAIs among hospitalized patients[2]. The CDC healthcare-associated infection (HAI) prevalence survey found that there were an estimated 157,500 surgical site infections associated with inpatient surgeries in 2011[3]. NHSN data included 16,147 SSIs following 849,659 operative procedures in all groups reported, for an overall SSI rate of 1.9% between 2006-2008[4]. A 19% decrease in SSI related to 10 select procedures was reported between 2008 and 2013[5].

While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death. SSI is associated with a mortality rate of 3%, and 75% of SSI-associated deaths are directly attributable to the SSI[6].

Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk[7-10]. A successful surveillance program includes the use of epidemiologically-sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback[8,9]. A new CDC and Healthcare Infection Control Practices Advisory Committee guideline for the prevention of surgical site infection is scheduled for publication soon, and will replace the previous *Guideline for Prevention of Surgical Site Infection, 1999*[10].

**Settings:** Surveillance of surgical patients will occur in any inpatient and/or outpatient setting where the selected NHSN operative procedure(s) are performed.

**Requirements:** Perform surveillance for SSI following at least one NHSN operative procedure category (ICD-10-PCS and CPT Mapping) as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106). Collect SSI (numerator) and operative procedure category (denominator) data on all procedures included in the selected procedure categories for at least one month to meet NHSN requirements, or as otherwise specified by mandates and other reporting requirements. A procedure must meet the NHSN definition of an operative procedure in order to be included in the surveillance. All procedures included in the NHSN monthly surveillance plan are followed for superficial, deep, and organ/space SSIs.

SSI monitoring requires active, patient-based, prospective surveillance. Post-discharge and ante-discharge surveillance methods should be used to detect SSIs following inpatient and outpatient operative procedures. These methods include: 1) direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices, 2) review of medical records or surgery clinic patient records, 3) surgeon surveys by mail or telephone, and 4) patient surveys by mail or telephone (though patients may have a difficult time assessing their infections). Any

combination of these methods is acceptable for use; however, CDC criteria for SSI must be used. To minimize Infection Preventionists' (IPs) workload of collecting denominator data, operating room data may be downloaded (See file specifications at: http://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/importingproceduredata_2015v.8.5.pdf).

An SSI will be associated with a particular NHSN operative procedure and the facility in which that procedure was performed. Refer to the NHSN application's Help system for instruction on linking an SSI to an operative procedure.

The *International Classification of Diseases, 10th Revision Clinical Modifications* (ICD-10-CM/PCS) codes, which are defined by the ICD-10 Coordination and Maintenance Committee of the National Center for Health Statistics and the Centers for Medicare and Medicaid Services (CMS), are developed as a tool for classification of morbidity data. Their wide use enables the grouping of surgery types for the purpose of determining SSI rates. The ICD-10-PCS mapping is located on the NHSN website in the SSI Protocol under "Supporting Materials". NHSN has also mapped Current Procedural Terminology (CPT) codes to NHSN operative procedure categories to assist users in determining the correct NHSN code to report for facilities which use CPT codes. The CPT NHSN operative procedure mapping is also found in the "Supporting Materials" section of the SSI Protocol on the NHSN website. Both the ICD-10-PCS and the CPT codes include a general description of the types of operations contained in the NHSN operative procedure categories.

**Notes:**

- The Infection Window Period, Present on Admission, Hospital Associated Infection and Repeat Infection Timeframe definitions should **not** be applied to the SSI protocol.
- ICD-10-PCS and CPT code fields remain as optional fields in 2016.
- ICD-10-PCS and CPT codes do not differentiate between spinal fusions (FUSN) and repeat spinal fusions (RFUSN). Therefore the NHSN procedure group FUSN will include both fusion and re-fusion procedures and the RFUSN category should not be used for procedures performed on or after October 1, 2015.
- The NHSN Category "OTH" will not be mapped to ICD-10-PCS and CPT codes. Any infections associated with procedures in that group will not be considered an NHSN surgical site infection, beginning with October 1, 2015 procedures.

## Definition of an NHSN Operative Procedure

An NHSN Operative Procedure is a procedure:

- that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping.
  **And**
- takes place during an operation where at least one incision (including laparoscopic approach) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure
  **And**

- takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated[11]. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab.

**Exclusions:** Otherwise eligible procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance

**Note:** Incisional closure method is NOT a part of the NHSN operative procedure definition; all otherwise eligible procedures are included, regardless of closure type. Therefore both primarily closed procedures and those that are not closed primarily should be entered into the denominator data for procedures in the facility's monthly reporting plan. Any SSIs attributable to either primarily closed or non-primarily closed procedures should be reported.

**NHSN Operative Procedure Category Mappings to ICD-10-PCS and CPT Codes:**

ICD-10-PCS and CPT Code Mappings to NHSN Operative Procedures

**Denominator for Procedure Definitions:**

ASA physical status: Assessment by the anesthesiologist of the patient's preoperative physical condition using the American Society of Anesthesiologists' (ASA) Classification of Physical Status[12,13]. Patient is assigned one of the following:

1. A normally healthy patient
2. A patient with mild systemic disease
3. A patient with severe systemic disease
4. A patient with severe systemic disease that is a constant threat to life
5. A moribund patient who is not expected to survive without the operation.

**Note:** Do NOT report procedures with an ASA physical status of 6 (a declared brain-dead patient whose organs are being removed for donor purposes) to NHSN.

Date of event (DOE): For an SSI the date of event is the date when the first element used to meet the SSI infection criterion occurs for the first time during the surveillance period. Synonym: infection date.

Diabetes: The NHSN SSI surveillance definition of diabetes indicates that the patient has a diagnosis of diabetes requiring management with insulin or a non-insulin anti-diabetic agent. This includes patients with "insulin resistance" who are on management with anti-diabetic agents. This also includes patients with a diagnosis of diabetes who are noncompliant with their diabetes medications. The ICD-10-CM diagnosis codes that reflect the diagnosis of diabetes are also acceptable for use to answer YES to the diabetes field question on the denominator for procedure entry. These codes are found on the NHSN website in the SSI section under

"Supporting Materials". The NHSN definition excludes patients with no diagnosis of diabetes. The definition also excludes patients who receive insulin for perioperative control of hyperglycemia but have no diagnosis of diabetes.

Duration of operative procedure: The interval in hours and minutes between the Procedure/Surgery Start Time, and the Procedure/Surgery Finish Time, as defined by the Association of Anesthesia Clinical Directors (AACD)[14]:

- Procedure/Surgery Start Time (PST): Time when the procedure is begun (*e.g.*, incision for a surgical procedure).
- Procedure/Surgery Finish (PF): Time when all instrument and sponge counts are completed and verified as correct, all postoperative radiologic studies to be done in the OR are completed, all dressings and drains are secured, and the physicians/surgeons have completed all procedure-related activities on the patient.

Emergency operative procedure: A nonelective, unscheduled operative procedure. Emergency operative procedures are those that do not allow for the standard immediate preoperative preparation normally done within the facility for a scheduled operation (e.g., stable vital signs, adequate antiseptic skin preparation, etc.).

General anesthesia: The administration of drugs or gases that enter the general circulation and affect the central nervous system to render the patient pain free, amnesic, unconscious, and often paralyzed with relaxed muscles. This does not include conscious sedation.

Height: The patient's most recent height documented in the medical record in feet (ft) and inches (in.), or meters (m).

NHSN Inpatient Operative Procedure: An NHSN operative procedure performed on a patient whose date of admission to the healthcare facility and the date of discharge are different calendar days.

NHSN Outpatient Operative Procedure: An NHSN operative procedure performed on a patient whose date of admission to the healthcare facility and date of discharge are the same calendar day. Procedures performed at an ASC should be designated as outpatient procedures.

Non-primary Closure is defined as closure that is other than primary and includes surgeries in which the skin level is left completely open during the original surgery and therefore cannot be classified as having primary closure. For surgeries with non-primary closure, the deep tissue layers may be closed by some means (with the skin level left open), or the deep and superficial layers may both be left completely open. An example of a surgery with non-primary closure would be a laparotomy in which the incision was closed to the level of the deep tissue layers, sometimes called "fascial layers" or "deep fascia," but the skin level was left open. Another example would be an "open abdomen" case in which the abdomen is left completely open after the surgery. Wounds with non-primary closure may or may not be described as "packed" with gauze or other material, and may or may not be covered with plastic, "wound vacs," or other synthetic devices or materials.

Primary Closure is defined as closure of the skin level during the original surgery, regardless of the presence of wires, wicks, drains, or other devices or objects extruding through the incision. This category includes surgeries where the skin is closed by some means. Thus, if any portion of the incision is closed at the skin level, by any manner, a designation of primary closure should be assigned to the surgery.

**Note**: If a procedure has multiple incision/laparoscopic trocar sites and any of the incisions are closed primarily then the procedure technique is recorded as primary closed.

Scope: An instrument used to visualize the interior of a body cavity or organ. In the context of an NHSN operative procedure, use of a scope involves creation of several small incisions to perform or assist in the performance of an operation rather than use of a traditional larger incision (i.e., open approach). Robotic assistance is considered equivalent to use of a scope for NHSN SSI surveillance. See also Instructions for Completion of *Denominator for Procedure* Form and both Numerator Data and Denominator Data reporting instructions in this chapter.

**Note:** If a scope site has to be extended for hand assist or removal of specimen this will still meet scope = Yes. If the procedure is converted to an open procedure it will be scope = No.

Secondary BSI Attribution Period for SSI: The secondary BSI attribution period for SSI is a 17-day period that includes the date of event, 3 days prior and 13 days after. For detailed instructions on determining whether identification of an organisms from a blood specimen represents a secondary BSI, refer to the Secondary BSI Guide (Appendix 1 of the BSI Event Protocol).

Trauma: Blunt or penetrating injury occurring prior to the start of the procedure.

Weight: The patient's most recent weight documented in the medical record in pounds (lbs.) or kilograms (kg) prior to or otherwise closest to the procedure.

Wound class: An assessment of the degree of contamination of a surgical wound at the time of the operation. Wound class should be assigned by a person involved in the surgical procedure (e.g., surgeon, circulating nurse, etc.). The wound class system used in NHSN is an adaptation of the American College of Surgeons wound classification schema.

There are a group of NHSN procedures that can never be coded as clean. NHSN reached the decision regarding which NHSN operative procedures can never be classified as clean based on feedback from external experts in the field of surgery.

The procedures that can never be entered as clean are: APPY, BILI, CHOL, COLO, REC, SB and VHYS. Therefore, for these procedures in the application clean is not an option on the drop down menu.

For all other procedures clean is available as a choice and if the surgical team deems the procedure to be clean it can be entered as such into the NHSN application. For example CSEC, HYST, or OVRY can be a clean wound class if documented as such.

Wounds are divided into four classes:

1. **Clean:** An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary, genital, or uninfected urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet the criteria.

   **Note:** The clean wound classification level will not be available for denominator data entry for the following NHSN operative procedure categories: APPY, BILI, CHOL, COLO, REC, SB, and VHYS

2. **Clean-Contaminated:** Operative wounds in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.

3. **Contaminated:** Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from the gastrointestinal tract, and incisions in which acute, nonpurulent inflammation is encountered including necrotic tissue without evidence of purulent drainage (e.g., dry gangrene) are included in this category.

4. **Dirty or Infected:** Includes old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.

**Table 1. Surgical Site Infection Criteria**

| Criterion | Surgical Site Infection (SSI) |
|---|---|
| | **Superficial incisional SSI**<br>Must meet the following criteria: |
| | Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)<br>**AND**<br>involves only skin and subcutaneous tissue of the incision<br>**AND**<br>patient has at least ***one*** of the following:<br>a. purulent drainage from the superficial incision.<br>b. organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).<br>c. superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.<br>**AND**<br>patient has at least ***one*** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.<br>d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.<br><br>http://www.cdc.gov/nhsn/xls/icd10-pcs-pcm-nhsn-opc.xlsx<br>http://www.cdc.gov/nhsn/xls/cpt-pcm-nhsn.xlsx<br><br>** The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician or physician's designee (nurse practitioner or physician's assistant). |

| | |
|---|---|
| **Comments** | There are two specific types of superficial incisional SSIs:<br>1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)<br>2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB) |
| **Reporting Instructions for Superficial SSI** | **The following do not qualify as criteria for meeting the NHSN definition of superficial SSI:**<br>• Diagnosis/treatment of cellulitis (redness/warmth/swelling), by itself, does not meet criterion d for superficial incisional SSI. An incision that is draining or that has organisms identified by culture or non-culture based testing is not considered a cellulitis.<br>• A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration)<br>• A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this module.<br>**Note:** A laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound.<br>• Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module.<br>• An infected burn wound is classified as BURN and is not reportable under this module. |

| | |
|---|---|
| | **Deep incisional SSI**<br>Must meet the following criteria:<br>Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2<br>**AND**<br>involves deep soft tissues of the incision (e.g., fascial and muscle layers)<br>**AND**<br>patient has at least ***one*** of the following:<br>a. purulent drainage from the deep incision.<br>b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed<br>**AND**<br>patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.<br>c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test<br><br>** The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency |
| **Comments** | There are two specific types of deep incisional SSIs:<br>1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)<br>2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB) |

| | |
|---|---|
| | **Organ/Space SSI**<br>Must meet the following criteria:<br><br>Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2<br>**AND**<br>infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure<br>**AND**<br>patient has at least ***one*** of the following:<br>a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)<br>b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).<br>c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test<br>**AND**<br>meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter. |

**Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.**

| **30-day Surveillance** | | | |
|---|---|---|---|
| **Code** | **Operative Procedure** | **Code** | **Operative Procedure** |
| AAA | Abdominal aortic aneurysm repair | LAM | Laminectomy |
| AMP | Limb amputation | LTP | Liver transplant |
| APPY | Appendix surgery | NECK | Neck surgery |
| AVSD | Shunt for dialysis | NEPH | Kidney surgery |
| BILI | Bile duct, liver or pancreatic surgery | OVRY | Ovarian surgery |
| CEA | Carotid endarterectomy | PRST | Prostate surgery |
| CHOL | Gallbladder surgery | REC | Rectal surgery |
| COLO | Colon surgery | SB | Small bowel surgery |
| CSEC | Cesarean section | SPLE | Spleen surgery |
| GAST | Gastric surgery | THOR | Thoracic surgery |
| HTP | Heart transplant | THYR | Thyroid and/or parathyroid surgery |
| HYST | Abdominal hysterectomy | VHYS | Vaginal hysterectomy |
| KTP | Kidney transplant | XLAP | Exploratory Laparotomy |
| **90-day Surveillance** | | | |
| **Code** | **Operative Procedure** | | |
| BRST | Breast surgery | | |
| CARD | Cardiac surgery | | |
| CBGB | Coronary artery bypass graft with both chest and donor site incisions | | |
| CBGC | Coronary artery bypass graft with chest incision only | | |
| CRAN | Craniotomy | | |
| FUSN | Spinal fusion | | |
| FX | Open reduction of fracture | | |
| HER | Herniorrhaphy | | |
| HPRO | Hip prosthesis | | |
| KPRO | Knee prosthesis | | |
| PACE | Pacemaker surgery | | |
| PVBY | Peripheral vascular bypass surgery | | |
| VSHN | Ventricular shunt | | |

**Note:** Superficial incisional SSIs are only followed for a 30-day period for all procedure types.

**Table 3. Specific Sites of an Organ/Space SSI.**

| Code | Site | Code | Site |
|---|---|---|---|
| BONE | Osteomyelitis | LUNG | Other infections of the respiratory tract |
| BRST | Breast abscess or mastitis | MED | Mediastinitis |
| CARD | Myocarditis or pericarditis | MEN | Meningitis or ventriculitis |
| DISC | Disc space | ORAL | Oral cavity (mouth, tongue, or gums) |
| EAR | Ear, mastoid | OREP | Other infections of the male or female reproductive tract |
| EMET | Endometritis | PJI | Periprosthetic Joint Infection |
| ENDO | Endocarditis | SA | Spinal abscess without meningitis |
| EYE | Eye, other than conjunctivitis | SINU | Sinusitis |
| GIT | GI tract | UR | Upper respiratory tract |
| HEP | Hepatitis | USI | Urinary System Infection |
| IAB | Intraabdominal, not specified | VASC | Arterial or venous infection |
| IC | Intracranial, brain abscess or dura | VCUF | Vaginal cuff |
| JNT | Joint or bursa | | |

(Criteria for these sites can be found in the Surveillance Definitions for Specific Types of Infections chapter).

**Note:** Appendix 1 contains a list of all NHSN operative procedure groups and the site specific SSIs that are available as events for each group.

**Numerator Data:** All patients having any of the procedures included in the selected NHSN operative procedure category(s) are monitored for signs of SSI. The *Surgical Site Infection (SSI)* form is completed for each such patient found to have an SSI. If no SSI events are identified during the surveillance month, check the "Report No Events" field in the Missing PA Events tab of the Incomplete/Missing List.

The Instructions for Completion of the Surgical Site Infection form include brief instructions for collection and entry of each data element on the form. The SSI form includes patient demographic information and information about the operative procedure, including the date and type of procedure. Information about the SSI includes the date of SSI, specific criteria met for identifying the SSI, when/how the SSI was detected, whether the patient developed a secondary bloodstream infection, whether the patient died, the organisms identified and the organisms' antimicrobial susceptibilities.

**SSI Event Reporting Instructions:**

1. **Excluded organisms:** Organisms belonging to the following genera cannot be used to meet any NHSN definition: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.* These organisms are typically causes of community-associated infections and are rarely known to cause healthcare-associated infections, and therefore are excluded.

2. **Attributing SSI to an NHSN procedure when there is evidence of infection at the time of the primary surgery:** POA definition does not apply to the SSI protocol. If there was evidence of infection at the time of the procedure and then later in the surveillance period the patient develops an infection that meets the NHSN SSI criteria it is attributed to the procedure (see PATOS below). A high wound class is not an exclusion for a patient later meeting criteria for an SSI.

3. **Infection present at time of surgery (PATOS):** PATOS denotes that there is evidence of an infection or abscess at the start of or during the index surgical procedure (in other words, it is present preoperatively). PATOS is a YES/NO field on the SSI Event form. PATOS does not apply if there is a period of wellness between the time of a preoperative condition and surgery. The evidence of infection or abscess must be noted/documented intraoperatively in an intraoperative note (immediate postoperative note). Only select PATOS = YES if it applies to the depth of SSI that is being attributed to the procedures (e.g., if a patient has evidence of an intraabdominal infection at the time of surgery and then later returns with an organ/space SSI the PATOS field would be selected as a YES. If the patient returned with a superficial or deep incisional SSI the PATOS field would be selected as a NO). The patient does not have to meet the NHSN definition of an SSI at the time of the primary procedure but there must be notation that there is evidence of an infection or abscess present at the time of surgery. PATOS is not diagnosis driven (e.g. diverticulitis, peritonitis, and appendicitis). Identification of an organism alone using culture or non-culture based microbiologic testing method or on a pathology report from a surgical specimen does not = PATOS. Additionally, the following verbiage <u>alone</u> without specific mention of infection does not meet the PATOS definition: colon perforation, necrosis, gangrene, fecal spillage, nicked bowel during procedure, or a note of inflammation. Fresh traumas that are contaminated cases do not necessarily meet PATOS. For example, a gunshot wound to the abdomen will be a trauma case with a high wound class but there would not have been time for infection to develop. PATOS can be met when an abscess is noted, there is mention of infection in the OR note, purulence or pus is noted, septic/feculent peritonitis is noted. An infected appendix that has ruptured will meet PATOS =Yes, if the patient has a subsequent intraabdominal organ space SSI.

    a) **Example:** Patient admitted with an acute abdomen. Sent to OR for an XLAP where there is a finding of an abscess due to ruptured appendix and an APPY is performed.

Patient returns two weeks later and meets criteria for an organ/space IAB SSI. The PATOS field would be selected as YES on the SSI event.

b) **Example:** Patient is admitted with a ruptured diverticulum. In the OR note the surgeon documents that there are multiple abscesses in the intraabdominal cavity. Patient returns three weeks later and meets criteria for a superficial SSI. The PATOS field would be selected as NO since there was no documentation of evidence of infection or abscess of the superficial area at the time of the procedure.

c) **Example:** During an unplanned cesarean section (CSEC) the surgeon nicks the bowel and there is contamination of the intraabdominal cavity. One week later the patient returns and meets criteria for an organ/space OREP (other reproductive) SSI. The PATOS field would be selected as NO since there was no documentation of evidence of infection or abscess at the time of the CSEC. The colon nick was a complication but there was no infection present at the time of surgery.

4. **Multiple tissue levels are involved in the infection:** The type of SSI (superficial incisional, deep incisional, or organ/space) reported should reflect the deepest tissue layer involved in the infection during the surveillance period:
   a) Report infection that involves the organ/space as an organ/space SSI, whether or not it also involves the superficial or deep incision sites.
   b) Report infection that involves the superficial and deep incisional sites as a deep incisional SSI.
   c) If an SSI started as a superficial SSI on day 10 of the SSI surveillance period and then a week later, (day 17 of the SSI surveillance period) meets criteria for a deep incisional SSI the date of event would be the date the of deep incisional SSI.

5. **Reporting of SSI after a non-primary closure:** If a patient develops an SSI after a non-primary closure it should be reported as attributable to that procedure if it meets criteria for an SSI within the appropriate surveillance period.

6. **Attributing SSI to a NHSN procedure when several are performed on different dates:** If a patient has several NHSN operative procedures performed on different dates prior to an infection, report the operative procedure code of the operation that was performed most closely in time prior to the infection date, unless there is evidence that the infection was associated with a different operation.

   **Note:** For multiple NHSN operative procedures performed within a 24 hour period, see Denominator Reporting Instruction #9.

7. **Attributing SSI to NHSN procedures that involve multiple primary incision sites:** If multiple primary incision sites of the same NHSN operative procedure become infected, only report as a single SSI, and assign the type of SSI (superficial incisional, deep incisional, or organ/space) that represents the deepest tissue level involved at any of the infected sites. For example:

a) If one laparoscopic incision meets criteria for a superficial incisional SSI and another meets criteria for a deep incisional SSI, only report one deep incisional SSI.
b) If one or more laparoscopic incision sites meet criteria for superficial incisional SSI but the patient also has an organ/space SSI related to the laparoscopic procedure, only report one organ/space SSI.
c) If an operative procedure is limited to a single breast and involves multiple incisions in that breast that become infected, only report a single SSI.
d) In a colostomy formation or reversal (take down) procedure, the stoma and other abdominal incision sites are considered primary incisions. If both the stoma and another abdominal incision site develop superficial incisional SSI, report only as one SSI (SIP).

8. **Attributing SSI to NHSN procedures that have secondary incision sites**: Certain procedures can involve secondary incisions (i.e., BRST, CBGB, CEA, FUSN, PVBY, REC, and VSHN). The surveillance period for all secondary sites is 30 days, regardless of the required deep incisional or organ/space SSI surveillance period for the primary incision site(s) (Table 2). Procedures meeting this designation are reported as only one operative procedure. For example:
    a) A saphenous vein harvest incision site in a CBGB procedure is considered the secondary incision. One CBGB procedure is reported, the saphenous vein harvest site is monitored for 30 days after surgery for SSI, and the chest incision is monitored for 90 days. If the patient has a superficial infection of the leg site and a deep incisional SSI of the chest site two SSIs are reported.
    b) A tissue harvest site (e.g., Transverse Rectus Abdominis Myocutaneous [TRAM] flap) in a BRST procedure is considered the secondary incision site. One BRST procedure is reported, and if the secondary incision gets infected, report as either SIS or DIS as appropriate.

9. **SSI detected at another facility:** It is required that if an SSI is detected at a facility other than the one in which the operation was performed, notify the IP of the index facility with enough detail so the infection can be reported to NHSN. When reporting the SSI, the index facility should indicate that Detected = RO – (Readmission to facility other than where procedure was performed).

10. **SSI Attribution after Multiple types of NHSN procedures are performed during a single trip to the OR:** If more than one NHSN operative procedure category was performed through a single incision/laparoscopic sites during a single trip to the operating room, attribute the SSI to the procedure that is thought to be associated with the infection. If it is not clear, as is often the case when the infection is an incisional SSI, use the NHSN Principal Operative Procedure Category Selection Lists (Table 4) to select the operative procedure to which the SSI should be attributed. For example, if a patient develops SSI after a single trip to the OR in which both a COLO and SB were performed, and the source of the SSI is not apparent, assign the SSI to the COLO procedure.

11. **SSI following invasive manipulation/accession of the operative site:** If during the post-operative period the surgical site has an invasive manipulation/accession for diagnostic or therapeutic purposes (e.g., needle aspiration), and following this manipulation/accession an SSI develops, the infection is not attributed to the operation. This reporting instruction does NOT apply to closed manipulation (e.g., closed reduction of a dislocated hip after an orthopedic procedure). Invasive manipulation does not include wound packing, or changing of wound packing materials as part of postoperative care.

12. **Reporting instructions for specific post-operative infection scenarios:** An SSI that otherwise meets the NHSN definitions should be reported to NHSN without regard to post-operative accidents, falls, inappropriate showering or bathing practices, or other occurrences that may or may not be attributable to patients' intentional or unintentional postoperative actions. Also, SSI should also be reported regardless of the presence of certain skin conditions (e.g., dermatitis, blister, impetigo) that occur near an incision, and regardless of the possible occurrence of a "seeding" event from an unrelated procedure (e.g., dental work). This instruction concerning various postoperative circumstances is necessary to reduce subjectivity and data collection burden associated with the previously exempted scenarios.

**Table 4. NHSN Principal Operative Procedure Category Selection Lists**
(The categories with the highest risk of SSI are listed before those with lower risks).

| Priority | Code | Abdominal Operations |
|---|---|---|
| 1 | LTP | Liver transplant |
| 2 | COLO | Colon surgery |
| 3 | BILI | Bile duct, liver or pancreatic surgery |
| 4 | SB | Small bowel surgery |
| 5 | REC | Rectal surgery |
| 6 | KTP | Kidney transplant |
| 7 | GAST | Gastric surgery |
| 8 | AAA | Abdominal aortic aneurysm repair |
| 9 | HYST | Abdominal hysterectomy |
| 10 | CSEC | Cesarean section |
| 11 | XLAP | Laparotomy |
| 12 | APPY | Appendix surgery |
| 13 | HER | Herniorrhaphy |
| 14 | NEPH | Kidney surgery |
| 15 | VHYS | Vaginal Hysterectomy |
| 16 | SPLE | Spleen surgery |
| 17 | CHOL | Gall bladder surgery |
| 18 | OVRY | Ovarian surgery |
| **Priority** | **Code** | **Thoracic Operations** |
| 1 | HTP | Heart transplant |
| 2 | CBGB | Coronary artery bypass graft with donor incision(s) |
| 3 | CBGC | Coronary artery bypass graft, chest incision only |
| 4 | CARD | Cardiac surgery |
| 5 | THOR | Thoracic surgery |
| **Priority** | **Code** | **Neurosurgical (Brain/Spine) Operations** |
| 1 | VSHN | Ventricular shunt |
| 2 | CRAN | Craniotomy |
| 3 | FUSN | Spinal fusion |
| 4 | LAM | Laminectomy |
| **Priority** | **Code** | **Neck Operations** |
| 1 | NECK | Neck surgery |
| 2 | THYR | Thyroid and or parathyroid surgery |

**Denominator Data:** For all patients having any of the procedures included in the NHSN Operative Procedure category(s) selected for surveillance during the month, complete the *Denominator for Procedure* form. The data are collected individually for each operative procedure performed during the month specified on the *Patient Safety Monthly Reporting Plan*. The Instructions for Completion of the Denominator for Procedure Form include brief instructions for collection and entry of each data element on the form.

**Denominator Reporting Instructions:**

1. **Closure type**: Incisional closure is NOT a part of the NHSN operative procedure definition; all otherwise eligible procedures are included in the denominator reporting, regardless of closure type. The closure technique is entered for each denominator for procedure. If a procedure has multiple incision sites and any of the incisions are closed primarily then the procedure is entered as a primary closure.

   **Note:** When the patient returns to the OR within 24 hours of the end of the first procedure assign the surgical wound closure that applies when the patient leaves the OR from the first operative procedure.

2. **Wound class**: A high wound class is not an exclusion for denominator reporting. If the procedure meets the definition of an NHSN operative procedure it should be reported in the denominator data regardless of wound class. NHSN will use the wound class for risk adjustment, as appropriate.

3. **Different operative procedure categories performed during same trip to the OR:** If procedures in more than one NHSN operative procedure category are performed during the same trip to the operating room through the same or different incisions, a *Denominator for Procedure* form is reported for each NHSN operative procedure category being monitored. For example, if a CARD and CBGC are done through the same incision, a *Denominator for Procedure* form is reported for each. In another example, if following a motor vehicle accident, a patient has an open reduction of fracture (FX) and splenectomy (SPLE) performed during the same trip to the operating room and both procedure categories are being monitored, complete a *Denominator for Procedure* form for each.
   **EXCEPTION:** If a patient has both a CBGC and CBGB during the same trip to the operating room, report only as a CBGB. Only report as a CBGC if there is only a chest incision. CBGB and CBGC are never reported for the same patient for the same trip to the operating room.

4. **Duration of the procedure when more than one category of NHSN operative procedure is performed through the same incision:** If more than one NHSN operative procedure category is performed through the same incision during the same trip to the operating room, record the combined duration of all procedures, which is the time from procedure/surgery start time to procedure/surgery finish time. For example, if a CBGC and a CARD are

performed on a patient during the same trip to the operating room, the time from start time to finish time is reported for both operative procedures.

5. **Duration of Operative procedures if patient has two different NHSN operative procedures performed via separate incisions on the same trip to the OR;** try to determine the correct duration for each separate procedure (if this is documented), otherwise, take the time for both procedures and split it evenly between the two.

6. **Same operative procedure category but different ICD-10-PCS or CPT codes during same trip to the OR:** If procedures of different ICD-10-PCS or CPT codes from the same NHSN operative procedure category are performed through the same incision/laparoscopic sites, record only one procedure for that category. For example, a facility is performing surveillance for CARD procedures. A patient undergoes a replacement of both the mitral and tricuspid valves during the same trip to the operating room. Complete one CARD *Denominator for Procedure* form because both procedures are in the same operative procedure category [CARD].

7. **For revision HPRO and KPRO procedures:** If total or partial revision HPRO or KPRO is performed, evaluate if any of the ICD-10-PCS/CM diagnosis or procedure codes (see link below) were coded for that joint in the 90 days prior to and including the index HPRO or KPRO revision. If any of the specified codes is recorded, indicate on the denominator form that the revision was associated with 'prior infection at index joint' = YES. Note that the 'prior infection at index joint' variable only applies to *revision* HPRO and KPRO. The cases designated 'prior infection at index joint' = yes should be validated before the procedure is submitted to NHSN. This validation is necessary to ensure the code is aligned with the index joint revision. The ICD-10-PCS/CM code mapping guidance is found on the NHSN website in the SSI section under "Supporting Materials."

8. **Same NHSN operative procedure via separate incisions:** For operative procedures that can be performed via separate incisions during same trip to operating room (i.e., AMP, BRST, CEA, FUSN, FX, HER, HPRO, KPRO, LAM, NEPH, OVRY, PVBY, REFUSN), separate *Denominator for Procedure* forms are completed. To document the duration of the procedures, indicate the procedure/surgery start time to procedure/surgery finish time for each procedure separately or, alternatively, take the total time for the procedures and split it evenly between procedures.

   **Notes:**
   1. A COLO procedure with a colostomy formation is entered as one COLO procedure.
   2. Laparoscopic hernia repairs are considered one procedure, regardless of the number of hernias that are repaired in that trip to the OR. In most cases there will be only one incision time documented for this procedure. If more than one time is documented, total the durations. Open (i.e., non-laparoscopic) hernia repairs are reported as one procedure for each hernia repaired via a separate incision, (i.e., if two incisions are made to repair two defects), then two procedures will be reported. It is anticipated that separate incision

times will be recorded for these procedures. If not, take the total time for both procedures and split it evenly between the two.

9. **More than one operative procedure through same incision within 24 hours:** If a patient goes to the operating room more than once during the same admission and another procedure of the same or different NHSN procedure category is performed through the same incision and the start time of the second procedure is within 24 hours of the finish time of the original operative incision, report only one *Denominator for Procedure* form for the original procedure, combining the durations for both procedures based on the procedure start times and finish times for both procedures. For example, a patient has a CBGB lasting 4 hours. He returns to the OR six hours later for another NHSN operative procedure via the same incision (e.g., CARD). The second operation has duration of 1.5 hours. Record the operative procedure as one CBGB and the duration of operation as 5 hour 30 minutes. If the wound class has changed, report the higher wound class. If the ASA class has changed, report the higher ASA class. Do not report the CARD procedure in your denominator data.

   **Note:** When the patient returns to the OR within 24 hours of the end of the first procedure assign the surgical wound closure technique that applies when the patient leaves the OR from the first operative procedure.

10. **Patient expires in the OR:** If a patient expires in the operating room, do not complete a *Denominator for Procedure* form. This operative procedure is excluded from the denominator.

11. **Laparoscopic hysterectomy – HYST or VHYS:** When assigning the correct ICD-10-PCS or CPT hysterectomy procedure codes, a trained coder must determine what structures were detached and how they were detached based on the medical record documentation. The code assignment is based on the surgical technique or approach used for the detachment of those structures, not on the location of where the structures were physically removed from the patient's body.

**Data Analyses:** The Standardized Infection Ratio (SIR) is calculated by dividing the number of observed infections by the number of predicted (i.e., expected) infections. The number of predicted infections is calculated using SSI probabilities estimated from multivariate logistic regression models constructed from NHSN data during a baseline time period, which represents a standard population's SSI experience[4].

There are three SSI SIR models available from NHSN, each briefly described in the table below.

| | |
|---|---|
| All SSI SIR Model | • Includes Superficial, Deep & Organ/Space SSIs<br>• Superficial & Deep incisional SSIs limited to primary incisional SSIs only<br>• Includes SSIs identified on admission, readmission & via post-discharge surveillance |
| Complex A/R SSI Model | • Includes only Deep incisional primary SSIs & Organ/Space SSIs<br>• Includes only SSIs identified on Admission/Readmission to facility where procedure was performed<br>• Includes only inpatient procedures<br>• Used for the HAI Progress Report, published annually by CDC |
| Complex 30-day SSI model (used for CMS IPPS) | • Includes only in-plan, inpatient COLO and HYST procedures in adult patients (i.e., ≥ 18 years of age)<br>• Includes only deep incisional primary SSIs and organ/space SSIs with an event date within 30 days of the procedure<br>• Uses only age and ASA to determine risk<br>• Used only for CMS IPPS reporting and for public reporting on Hospital Compare |

While the SSI SIR can be calculated for single procedure categories and for specific surgeons, the measure also allows you to summarize your data across multiple procedure categories while adjusting for differences in the estimated probability of infection among the patients included across the procedure categories. For example, you will be able to obtain one SSI SIR adjusting for all procedures reported. Alternatively, you can obtain one SSI SIR for all colon surgeries (COLO) only within your facility.

**Additional Notes about SSI SIRS**:

1. **Primary closure:** All of the SSI SIRs that use the 2006-2008 SSI baseline data will include only those procedures that were reported with a primary closure method.[3]
2. **Infection present at time of surgery (PATOS):** All of the SSI SIRs that use the 2006-2008 SSI baseline will include SSIs that are reported as present at time of surgery.
3. **SIRs based on Procedure Date:** SSIs will be included in the numerator of an SIR based on the date of procedure, not the date of event.
4. **Calculation of the SIR:** The SIR will be calculated only if the number of predicted HAIs ("numExp" in the NHSN application) is ≥ 1 to help enforce a minimum precision criterion.

$$\text{SIR} = \frac{\text{Observed (O) HAIs}}{\text{Expected (E) HAIs}}$$

SSI rates per 100 operative procedures are calculated by dividing the number of SSIs by the number of specific operative procedures and multiplying the results by 100. SSIs will be included in the numerator of a rate based on the date of procedure, not the date of event. Using

the advanced analysis feature of the NHSN application, SSI rate calculations can be performed separately for the different types of operative procedures and stratified by the basic risk index.

Descriptive analysis options of numerator and denominator data are available in the NHSN application, such as line listings, frequency tables, and bar and pie charts. SIRs and SSI rates and run charts are also available. Guides on using NHSN analysis features are available from: http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html

**APPENDIX 1:** SSI specific event types attributed to each NHSN procedure category.

| Procedure code | Specific Event Code |
|---|---|
| **AAA - abdominal aortic aneurysm repair** | DIP - Deep Incisional Primary<br>CARD - Myocarditis or pericarditis<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **AMP - Limb amputation** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>JNT - Joint or bursa<br>SIP - Superficial Incisional Primary |
| **APPY - Appendix surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary |
| **AVSD - AV shunt for dialysis** | DIP - Deep Incisional Primary<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **BILI - Bile duct, liver or pancreatic surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary |
| **BRST - Breast surgery** | BRST - Breast abscess or mastitis<br>DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary |
| **CARD - Cardiac surgery** | BONE - Osteomyelitis<br>CARD - Myocarditis or pericarditis<br>DIP - Deep Incisional Primary<br>ENDO - Endocarditis<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>MED - Mediastinitis<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |

| Procedure code | Specific Event Code |
|---|---|
| **CBGB - Coronary bypass with chest & donor incisions** | BONE - Osteomyelitis<br>CARD - Myocarditis or pericarditis<br>DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>ENDO - Endocarditis<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>MED - Mediastinitis<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary<br>VASC - Arterial or venous infection |
| **CBGC - Coronary bypass graft with chest incision** | BONE - Osteomyelitis<br>CARD - Myocarditis or pericarditis<br>DIP - Deep Incisional Primary<br>ENDO - Endocarditis<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>MED - Mediastinitis<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **CEA - Carotid endarterectomy** | DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>SIS - Superficial Incisional Secondary<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **CHOL - Gallbladder surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary |
| **COLO - Colon surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary<br>OREP - Other infection of the male or female reproductive tract<br>USI - Urinary System Infection |
| **CRAN - Craniotomy** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>IC - Intracranial infection<br>MEN - Meningitis or ventriculitis<br>SINU - Sinusitis<br>SIP - Superficial Incisional Primary |

| Procedure code | Specific Event Code |
|---|---|
| **CSEC - Cesarean section** | DIP - Deep Incisional Primary<br>EMET - Endometritis<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |
| **FUSN - Spinal fusion** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>DISC - Disc space infection<br>IAB - Intraabdominal, not specified elsewhere<br>IC - Intracranial infection<br>LUNG - Other infections of the lower respiratory tract<br>MEN - Meningitis or ventriculitis<br>SA - Spinal abscess without meningitis<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary |
| **FX - Open reduction of fracture** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>JNT - Joint or bursa<br>SIP - Superficial Incisional Primary |
| **GAST - Gastric surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>SIP - Superficial Incisional Primary |
| **HER - Herniorrhaphy** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary |
| **HPRO - Hip prosthesis** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>PJI - Prosthetic joint infection<br>SIP - Superficial Incisional Primary |

| Procedure code | Specific Event Code |
|---|---|
| **HTP - Heart transplant** | BONE - Osteomyelitis<br>CARD - Myocarditis or pericarditis<br>DIP - Deep Incisional Primary<br>ENDO - Endocarditis<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>MED - Mediastinitis<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **HYST - Abdominal hysterectomy** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>VCUF - Vaginal cuff infection |
| **KPRO - Knee prosthesis** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>SIP - Superficial Incisional Primary<br>PJI - Prosthetic joint infection |
| **KTP - Kidney transplant** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection<br>VASC - Arterial or venous infection |
| **LAM - Laminectomy** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>DISC - Disc space infection<br>IAB - Intraabdominal, not specified elsewhere<br>IC - Intracranial infection<br>MEN - Meningitis or ventriculitis<br>SA - Spinal abscess without meningitis<br>SIP - Superficial Incisional Primary |
| **LTP - Liver transplant** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>HEP - Hepatitis<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |

| Procedure code | Specific Event Code |
|---|---|
| **NECK - Neck surgery** | DIP - Deep Incisional Primary<br>EAR - Ear, mastoid infection<br>ORAL - Oral cavity infection (mouth, tongue, or gums)<br>SIP - Superficial Incisional Primary<br>UR - Upper respiratory tract infection, pharyngitis, laryngitis, epiglottitis |
| **NEPH - Kidney surgery** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |
| **OVRY - Ovarian surgery** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |
| **PACE - Pacemaker surgery** | CARD - Myocarditis or pericarditis<br>DIP - Deep Incisional Primary<br>ENDO - Endocarditis<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary<br>VASC - Arterial or venous infection |
| **PRST - Prostate surgery** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |
| **PVBY - Peripheral vascular bypass surgery** | DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary<br>VASC - Arterial or venous infection |
| **REC - Rectal surgery** | DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary<br>USI - Urinary System Infection |

| Procedure code | Specific Event Code |
|---|---|
| **SB - Small bowel surgery** | DIP - Deep Incisional Primary<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |
| **SPLE - Spleen surgery** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>SIP - Superficial Incisional Primary |
| **THOR - Thoracic surgery** | BONE - Osteomyelitis<br>BRST - Breast abscess or mastitis<br>DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>LUNG - Other infections of the lower respiratory tract<br>SIP - Superficial Incisional Primary |
| **THYR - Thyroid and/or parathyroid surgery** | DIP - Deep Incisional Primary<br>EAR - Ear, mastoid infection<br>GIT - Gastrointestinal tract<br>SIP - Superficial Incisional Primary<br>UR - Upper respiratory tract infection, pharyngitis, laryngitis, epiglottitis |
| **VHYS - Vaginal hysterectomy** | DIP - Deep Incisional Primary<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection<br>VCUF - Vaginal cuff infection |
| **VSHN - Ventricular shunt** | BONE - Osteomyelitis<br>DIP - Deep Incisional Primary<br>DIS - Deep Incisional Secondary<br>IAB - Intraabdominal, not specified elsewhere<br>IC - Intracranial infection<br>LUNG - Other infections of the lower respiratory tract<br>MEN - Meningitis or ventriculitis<br>SA - Spinal abscess without meningitis<br>SIP - Superficial Incisional Primary<br>SIS - Superficial Incisional Secondary |

| Procedure code | Specific Event Code |
|---|---|
| **XLAP - Exploratory laparotomy** | DIP - Deep Incisional Primary<br>EMET - Endometritis<br>GIT - Gastrointestinal tract<br>IAB - Intraabdominal, not specified elsewhere<br>OREP - Other infection of the male or female reproductive tract<br>SIP - Superficial Incisional Primary<br>USI - Urinary System Infection |

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# Ventilator-Associated Event (VAE)

*For use in adult locations only*

**Table of Contents:**



Introduction**:** Mechanical ventilation is an essential, life-saving therapy for patients with critical illness and respiratory failure. Studies have estimated that more than 300,000 patients receive mechanical ventilation in the United States each year [1-3]. These patients are at high risk for complications and poor outcomes, including death [1-5]. Ventilator-associated pneumonia (VAP), sepsis, Acute Respiratory Distress Syndrome (ARDS), pulmonary embolism, barotrauma, and pulmonary edema are among the complications that can occur in patients receiving mechanical ventilation; such complications can lead to longer duration of mechanical ventilation, longer stays in the ICU and hospital, increased healthcare costs, and increased risk of disability and death. Mortality in patients with acute lung injury on mechanical ventilation has been estimated to range from 24% in persons 15-19 years of age to 60% for patients 85 years and older [4].

Surveillance for ventilator-associated events in the National Healthcare Safety Network (NHSN) prior to 2013 was limited to VAP. For the year 2012, VAP incidence for various types of hospital units ranged from 0.0-4.4 per 1,000 ventilator days [6]. However, there is currently no valid, reliable definition for VAP, and even the most widely-used VAP criteria and definitions are neither sensitive nor specific [7-10].

A particular difficulty with many commonly-used VAP definitions, including the NHSN PNEU definitions (revised in 2002), is that they require radiographic findings of pneumonia. Evidence suggests that chest radiograph findings do not accurately identify VAP. The subjectivity and variability inherent in chest radiograph technique, interpretation, and reporting make chest imaging ill-suited for inclusion in a definition algorithm to be used for the potential purposes of public reporting, inter-facility comparisons, and pay-for-reporting and pay-for-performance programs. Another major difficulty with available VAP definitions is their reliance on specific clinical signs or symptoms, which are subjective and may be poorly or inconsistently

documented in the medical record. The NHSN PNEU protocol includes multiple definition pathways and special criteria for selected patient populations (e.g., children, immunocompromised patients), increasing its complexity.

The limitations of VAP surveillance definitions have implications for prevention. Valid and reliable surveillance data are necessary for assessing the effectiveness of prevention strategies. It is notable that some of the most effective measures for improving outcomes of patients on mechanical ventilation do not specifically target pneumonia prevention [11-14].

In 2011, CDC convened a Working Group composed of members of several stakeholder organizations to address the limitations of the NHSN PNEU definitions and propose a new approach to surveillance for Ventilator-Associated Events (VAE) for NHSN [15]. The organizations represented in the Working Group include: the Critical Care Societies Collaborative (the American Association of Critical-Care Nurses, the American College of Chest Physicians, the American Thoracic Society, and the Society for Critical Care Medicine); the American Association for Respiratory Care; the Association of Professionals in Infection Control and Epidemiology; the Council of State and Territorial Epidemiologists; the Healthcare Infection Control Practices Advisory Committee's Surveillance Working Group; the Infectious Diseases Society of America; and the Society for Healthcare Epidemiology of America.

The VAE surveillance definition algorithm developed by the Working Group and implemented in the NHSN in January 2013 is based on objective, streamlined, and potentially automatable criteria that identify a broad range of conditions and complications occurring in mechanically-ventilated adult patients [16]. Several modifications to the VAE definitions have been made since January 2013. These modifications address issues raised by NHSN users and discussed with the Working Group. There are three definition tiers within the VAE algorithm: 1) Ventilator-Associated Condition (VAC); 2) Infection-related Ventilator-Associated Complication (IVAC); and 3) Possible VAP (PVAP). Data indicate that streamlined, objective algorithms to detect ventilator-associated complications (similar to the VAC tier of the VAE algorithm) are easily implemented, can make use of electronic health record systems to automate event detection, and identify events that are clinically important and associated with outcomes such as ICU and hospital length of stay and mortality [16,17]. Research suggests that most VACs are due to pneumonia, ARDS, atelectasis, and pulmonary edema [16]. These are significant clinical conditions that may be preventable.

NOTE: The VAE definition algorithm is for use in surveillance; it is not a clinical definition algorithm and is not intended for use in the clinical management of patients. Examples provided throughout this protocol and in the VAE "Frequently-Asked Questions" are for illustration purposes only and are not intended to represent actual clinical scenarios.

**Settings:** Inpatient locations eligible to participate in VAE surveillance are those adult locations in acute care hospitals, long term acute care hospitals, and inpatient rehabilitation facilities where denominator data (ventilator and patient days) can be collected for patients. Such locations may include critical/intensive care units (ICU), specialty care areas (SCA), step-down units, wards, and long term care units. A complete listing of adult inpatient locations can be found in Chapter 15.

NOTE: It is not required to monitor for VAEs after discharge if a patient is transferred to another facility while still on mechanical ventilation. However, VAEs discovered within 2 calendar days of discharge (where the day of discharge is day 1) should be reported to NHSN. No additional ventilator days are reported.

**Definitions:**

VAE: VAEs are identified by using a combination of objective criteria: deterioration in respiratory status after a period of stability or improvement on the ventilator, evidence of infection or inflammation, and laboratory evidence of respiratory infection. The following pages outline the criteria that must be used for meeting the VAE surveillance definitions (Figures 1-4). To report VAEs, use the *Ventilator-Associated Event* form (CDC 57.112) and *Instructions for Completion*.

> NOTE: Patients must be mechanically ventilated for more than 2 calendar days to be eligible for VAE. The earliest day on which VAE criteria can be fulfilled is day 4 of mechanical ventilation (where the day of intubation and initiation of mechanical ventilation is day 1). The earliest date of event for VAE (the date of onset of worsening oxygenation) is day 3 of mechanical ventilation. Line lists of VAE data elements demonstrating scenarios that meet and do not meet the VAE definitions are presented in "Frequently-Asked Questions (FAQs)" number (no.) 2 at the end of this chapter.
>
> NOTE: The baseline period of stability or improvement on the ventilator is defined as the 2 calendar days immediately preceding the first day of increased daily minimum PEEP or $FiO_2$, and must be characterized by ≥ 2 calendar days of stable or decreasing daily minimum $FiO_2$ or PEEP values (i.e., the daily minimum PEEP or $FiO_2$ on the second day of the baseline period of stability or improvement must be equal to or less than the daily minimum PEEP or $FiO_2$ on the first day of the baseline period of stability or improvement). The definitions of "daily minimum PEEP" and "daily minimum $FiO_2$" are included below. Note that the minimum daily PEEP or FiO2 used for VAE surveillance is the lowest setting during a calendar day that was maintained for at least 1 hour (see daily minimum PEEP and FiO2 definitions for exception to 1 hour requirement).
>
> For the purposes of VAE surveillance, PEEP values between 0 $cmH_2O$ and 5 $cmH_2O$ will be considered equivalent. This means that patients with daily minimum PEEP values

from 0 to 5 $cmH_2O$ must then have an increase in the daily minimum PEEP to at least 8 $cmH_2O$, sustained for at least 2 calendar days, to meet the VAC definition.

EXAMPLE: In the example below, the baseline period is defined by mechanical ventilation (MV) days 1 through 4 (shaded in light gray), and the period of worsening oxygenation by MV days 5 and 6 (shaded in darker gray), where the daily minimum PEEP is $\geq$ 3 $cmH_2O$ greater than the daily minimum PEEP during the baseline period. Note that there is no VAC on MV day 3, because PEEP values 0-5 $cmH_2O$ are considered equivalent for the purposes of this surveillance.

| MV Day | Daily minimum PEEP ($cmH_2O$) | Daily minimum $FiO_2$ (oxygen concentration, %) | VAE |
|---|---|---|---|
| 1 | 0 | 1.00 (100%) | |
| 2 | 0 | 0.50 (50%) | |
| 3 | **5** | 0.50 (50%) | |
| 4 | **5** | 0.50 (50%) | |
| 5 | **8** | 0.50 (50%) | **VAC** |
| 6 | **8** | 0.50 (50%) | |

EXAMPLE: In the example below, the baseline period is defined by mechanical ventilation (MV) days 1 through 4 (shaded in light gray), and the period of worsening oxygenation by MV days 5 and 6 (shaded in darker gray), where the daily minimum PEEP is $\geq$ 3 $cmH_2O$ greater than the daily minimum PEEP during the baseline period. In this example, note that MV days 1-4 are considered a baseline period even though the daily minimum PEEP increases from 0 to 3 to 5 $cmH_2O$ during this time period—because PEEP values from 0-5 $cmH_2O$ are considered equivalent for the purposes of this surveillance.

| MV Day | Daily minimum PEEP ($cmH_2O$) | Daily minimum $FiO_2$ (oxygen concentration, %) | VAE |
|---|---|---|---|
| 1 | 0 | 1.00 (100%) | |
| 2 | 0 | 0.50 (50%) | |
| 3 | **3** | 0.50 (50%) | |
| 4 | **5** | 0.50 (50%) | |
| 5 | **8** | 0.50 (50%) | **VAC** |
| 6 | **8** | 0.50 (50%) | |

EXAMPLE: In the example below, the baseline period is defined by mechanical ventilation (MV) days 3 and 4 (shaded in light gray), and the period of worsening oxygenation by MV days 5 and 6 (shaded in darker gray), where the daily minimum $FiO_2$ is ≥ 0.20 (20 points) over the daily minimum $FiO_2$ during the baseline period.

| MV Day | Daily minimum PEEP ($cmH_2O$) | Daily minimum $FiO_2$ (oxygen concentration, %) | VAE |
|---|---|---|---|
| 1 | 8 | 1.00 (100%) | |
| 2 | 6 | 0.50 (50%) | |
| 3 | 5 | **0.40 (40%)** | |
| 4 | 5 | **0.40 (40%)** | |
| 5 | 6 | **0.70 (70%)** | **VAC** |
| 6 | 6 | **0.70 (70%)** | |

EXAMPLE: In the example below, there is no VAC, because the $FiO_2$ on MV day 4 is higher than the $FiO_2$ on MV day 3 (and therefore not stable or decreasing) – even though the $FiO_2$ on MV days 3 and 4 meets the 20-point threshold when compared with the daily minimum $FiO_2$ on MV days 5 and 6.

| MV Day | Daily minimum PEEP ($cmH_2O$) | Daily minimum $FiO_2$ (oxygen concentration, %) | VAE |
|---|---|---|---|
| 1 | 8 | 1.0 (100%) | |
| 2 | 6 | 0.50 (50%) | |
| 3 | 5 | 0.35 (35%) | |
| 4 | 5 | 0.40 (40%) | |
| 5 | 6 | 0.70 (70%) | No event |
| 6 | 6 | 0.70 (70%) | |

NOTE: Patients on high frequency ventilation or extracorporeal life support are EXCLUDED from VAE surveillance.

NOTE: Patients who are receiving a conventional mode of mechanical ventilation while in the prone position and patients who are receiving a conventional mode of mechanical ventilation while receiving nitric oxide therapy, helium-oxygen mixtures (heliox) or epoprostenol therapy are INCLUDED in VAE surveillance.

NOTE: Patients on Airway Pressure Release Ventilation (APRV) or related modes (see FAQ nos. 22 and 23), are INCLUDED, but the VAE period of stability or improvement on the ventilator and the period of worsening oxygenation should be determined by changes in $FiO_2$ only, since changes in PEEP as indicated in this surveillance algorithm may not be applicable to APRV. In addition, patients with VAE who are on APRV or

related modes of mechanical ventilation should be indicated as such on the VAE Form (CDC 57.112).

NOTE: VAEs are defined by a 14-day period, starting on the day of onset of worsening oxygenation (the event date, day 1). A new VAE cannot be identified or reported until this 14-day period has elapsed. See FAQ no. 4.

Date of event: The date of onset of worsening oxygenation. This is defined as the first calendar day in which the daily minimum PEEP or $FiO_2$ increases above the thresholds outlined in the VAE definition algorithm (i.e., day 1 of the required ≥ 2-day period of worsening oxygenation following a ≥ 2-day period of stability or improvement on the ventilator).

EXAMPLE: A patient is intubated in the Emergency Room for severe community-acquired pneumonia and admitted to the MICU (day 1). The patient stabilizes and improves on days 2-5, with a daily minimum $FiO_2$ of 0.35 (35%) on days 4 and 5. On day 6, the patient experiences respiratory deterioration, and requires a minimum $FiO_2$ of 0.60 (60%) on days 6 and 7, meeting the criteria for a VAC. The date of the VAC event is day 6.

NOTE: The "date of event" is NOT the date on which all VAE criteria have been met. It is the first day (of a ≥ 2-day period) on which either of the worsening oxygenation thresholds (for PEEP or $FiO_2$) is met.

VAE Window Period: This is the period of days around the event date (i.e., the day of onset of worsening oxygenation) within which other VAE criteria must be met. It is usually a 5-day period and includes the 2 days before, the day of, and the 2 days after the VAE event date (i.e., the first day of worsening oxygenation, the day of VAE onset). There is an exception, however, in which the VAE Window Period is only 3 or 4 days, as follows:

In cases where the VAE event date corresponds to MV day 3 or day 4, the window period described above may only be a 3-day or a 4-day window, because it can NOT include any days before the 3rd day of MV. For example, if the VAE event date is MV day 3, then the window period includes only the day of VAE onset and the 2 days after VAE onset (because the 2 days before VAE onset are before the 3rd day of MV).

Positive End-Expiratory Pressure (PEEP): "A technique used in respiratory therapy in which airway pressure greater than atmospheric pressure is achieved at the end of exhalation by the introduction of a mechanical impedance to exhalation" [18]. In patients on mechanical ventilation, PEEP is one of the key parameters that can be adjusted depending on the patient's oxygenation needs, and is typically in the range of 0 to 15 $cmH_2O$. A sustained increase (defined later in this protocol) in the daily minimum PEEP of ≥ 3 $cmH_2O$ following a period of stability or improvement on the ventilator is one of two criteria that can be used in meeting the VAC

definition. For the purposes of this surveillance, PEEP values from 0 to 5 $cmH_2O$ are considered equivalent.

Fraction of inspired oxygen ($FiO_2$): The fraction of oxygen in inspired gas. For example, the $FiO_2$ of ambient air is 0.21; the oxygen concentration of ambient air is 21%. In patients on mechanical ventilation, the $FiO_2$ is one of the key parameters that can be adjusted depending on the patient's oxygenation needs, and is typically in the range of 0.30 (oxygen concentration of 30%) to 1.0 (oxygen concentration of 100%). A sustained increase (defined later in this protocol) in the daily minimum $FiO_2$ of $\geq$ 0.20 (20%) following a period of stability or improvement on the ventilator is the second of the two criteria that can be used in meeting the VAC definition.

Daily minimum PEEP: The lowest value of PEEP during a calendar day that is set on the ventilator and *maintained for at least 1 hour*. This requirement that the daily minimum PEEP be the lowest setting maintained for at least 1 hour will ensure that units monitoring and recording PEEP settings hourly or more frequently than once per hour are able to apply the VAE surveillance PEEP criterion in a standardized way. In the event that ventilator settings are monitored and recorded less frequently than once per hour, the daily minimum PEEP is simply the lowest value of PEEP set on the ventilator during the calendar day. In circumstances where there is no value that is documented to have been maintained for at least one hour (e.g., the lowest value of PEEP is set late in the calendar day, mechanical ventilation is discontinued early in the calendar day, PEEP settings are changed very frequently throughout the calendar day) the daily minimum PEEP should default to the lowest PEEP setting during the calendar day (regardless of how long that setting was maintained). For example, a patient who is intubated and started on mechanical ventilation at 11:30 pm on June 1, with a PEEP setting of 10 $cmH_2O$ from 11:30 pm to midnight, would have a daily minimum PEEP of 10 $cmH_2O$ on June 1 for the purposes of VAE surveillance.

> NOTE: In units tracking PEEP settings every hour or more frequently than every hour, there must be sufficient consecutive recordings of a specific PEEP setting to meet the minimum required duration of 1 hour. For example, in units tracking PEEP every 15 minutes, 5 consecutive recordings of PEEP at a certain level would be needed to meet the required 1 hour minimum duration (e.g., at 09:00, 09:15, 09:30, 09:45 and 10:00). In units tracking PEEP every 30 minutes, 3 consecutive recordings of PEEP at a certain level would be needed to meet the required 1 hour minimum duration (e.g., at 09:00, 09:30, and 10:00). In units tracking PEEP every hour, 2 consecutive recordings of PEEP at a certain level would be needed to meet the required 1 hour minimum duration (e.g., at 09:00 and 10:00).

EXAMPLE: The patient is intubated at 6 pm. PEEP is set at the following values through the remainder of the calendar day:

| **Time** | **6 pm** | **7 pm** | **8 pm** | **9 pm** | **10 pm** | **11 pm** |
|---|---|---|---|---|---|---|
| **PEEP ($cmH_2O$)** | 10 | 8 | 5 | 5 | 8 | 8 |

In this example, the daily minimum PEEP for the purposes of VAE surveillance is 5 $cmH_2O$. PEEP settings are being monitored and recorded every hour. There are two consecutive hours where the PEEP setting is noted to be 5 $cmH_2O$ (8 pm and 9 pm), and therefore required minimum duration of 1 hour is met.

EXAMPLE: The patient is intubated at 6 pm. PEEP is set at the following values through the remainder of the calendar day:

| **Time** | **6 pm** | **7 pm** | **8 pm** | **9 pm** | **10 pm** | **11 pm** |
|---|---|---|---|---|---|---|
| **PEEP ($cmH_2O$)** | 8 | 8 | 5 | 8 | 5 | 8 |

In this example, the daily minimum PEEP for the purposes of VAE surveillance is 8 $cmH_2O$. PEEP settings are being monitored and recorded every hour. Although the lowest PEEP is 5 $cmH_2O$, it is recorded at two non-consecutive time points only (8 pm, then 10 pm), and so the required 1 hour minimum duration is not met. There are two consecutive hours where the PEEP setting is noted to be 8 $cmH_2O$ (6 pm and 7 pm), and therefore the required minimum duration of 1 hour is met to allow use of this setting as the daily minimum value for VAE surveillance.

EXAMPLE: PEEP is set at the following values through the course of a calendar day:

| **Time** | **12 am** | **4 am** | **8 am** | **12 pm** | **4 pm** | **8 pm** |
|---|---|---|---|---|---|---|
| **PEEP ($cmH_2O$)** | 5 | 8 | 5 | 8 | 8 | 10 |

In this example, the daily minimum PEEP is 5 $cmH_2O$. PEEP settings are being monitored and recorded every 4 hours; therefore the lowest recorded PEEP setting for the calendar day is the value used in VAE surveillance.

EXAMPLE: You are reviewing a patient's ventilator settings on Wednesday morning to determine the daily minimum PEEP values for Monday and Tuesday. The MICU monitors and records PEEP settings for mechanically ventilated patients every 30 minutes. You see that the lowest PEEP setting on Monday (5 $cmH_2O$) was recorded at 11:30 pm when the episode of mechanical ventilation was initiated for this patient. The patient remained at this PEEP setting for an additional 30 minutes on Tuesday morning, and was then maintained on PEEP 10 $cmH_2O$ for the rest of the day on Tuesday. What do you record as the daily minimum PEEP for Monday and for Tuesday? In this example, the only PEEP setting recorded on Monday was 5 $cmH_2O$. Because there is no value on Monday that has been maintained for at least one hour, the lowest (and only) setting of 5 $cmH_20$ is recorded as the daily minimum PEEP for that calendar day. On Tuesday, the daily minimum PEEP should be recorded as 10 $cmH_2O$, which is the lowest PEEP setting maintained for at least 1 hour on Tuesday.

| **Day** | **Time** | **PEEP ($cmH_2O$)** |
|---|---|---|
| Monday | 23:30 | 5 |
| Tuesday | 00:00 | 5 |
| Tuesday | 00:30 | 5 |
| Tuesday | 01:00 | 10 |
| Tuesday | 01:30 | 10 |
| Tuesday | 02:00 through 23:30 | 10 |

Daily minimum $FiO_2$: The lowest value of $FiO_2$ during a calendar day that is set on the ventilator and *maintained for at least 1 hour*. This requirement that the daily minimum $FiO_2$ be the lowest setting maintained for at least 1 hour will ensure that units monitoring and recording $FiO_2$ settings hourly or more frequently than once per hour are able to apply the VAE surveillance $FiO_2$ criterion in a standardized way. In the event that ventilator settings are monitored and recorded less frequently than once per hour, the daily minimum $FiO_2$ is simply the lowest value of $FiO_2$ set on the ventilator during the calendar day. Similarly, in circumstances where there is no value that has been maintained for at least one hour (e.g., the lowest value of $FiO_2$ is set late in the calendar day, mechanical ventilation is discontinued early in the calendar day) the daily minimum $FiO_2$ is the lowest value of $FiO_2$ set on the ventilator during the calendar day.

NOTE: In units tracking $FiO_2$ settings every hour or more frequently than every hour, there must be sufficient consecutive recordings of a specific $FiO_2$ setting to meet the minimum required duration of 1 hour. For example, in units tracking $FiO_2$ every 15 minutes, 5 consecutive recordings of $FiO_2$ at a certain level would be needed to meet the required 1 hour minimum duration (e.g., 09:00, 09:15, 09:30, 09:45 and 10:00). In units tracking $FiO_2$ every 30 minutes, 3 consecutive recordings of $FiO_2$ at a certain level would be needed to meet the required 1 hour minimum duration (e.g., 09:00, 09:30, and 10:00).

In units tracking $FiO_2$ every hour, 2 consecutive recordings of $FiO_2$ at a certain level would be needed to meet the required 1 hour minimum duration (e.g., 09:00 and 10:00).

EXAMPLE: The patient is intubated at 6 pm. $FiO_2$ is set at the following values through the remainder of the calendar day:

| **Time** | **6 pm** | **7 pm** | **8 pm** | **9 pm** | **10 pm** | **11 pm** |
|---|---|---|---|---|---|---|
| **$FiO_2$** | 1.0 | 0.8 | 0.5 | 0.5 | 0.8 | 0.8 |

In this example, the daily minimum $FiO_2$ for the purposes of VAE surveillance is 0.5. $FiO_2$ settings are being monitored and recorded every hour. There are two consecutive hours where the $FiO_2$ setting is noted to be 0.5 (8 pm and 9 pm), and therefore required minimum duration of 1 hour is met.

EXAMPLE: The patient is intubated at 6 pm. $FiO_2$ is set at the following values through the remainder of the calendar day:

| **Time** | **6 pm** | **7 pm** | **8 pm** | **9 pm** | **10 pm** | **11 pm** |
|---|---|---|---|---|---|---|
| **$FiO_2$** | 0.8 | 0.8 | 0.5 | 0.8 | 0.5 | 0.8 |

In this example, the daily minimum $FiO_2$ for the purposes of VAE surveillance is 0.8. $FiO_2$ settings are being monitored and recorded every hour. Although the lowest $FiO_2$ is 0.5, it is recorded at two non-consecutive time points only (8 pm, and then 10 pm), and so the required 1 hour minimum duration is not met. There are two consecutive hours where the $FiO_2$ setting is noted to be 0.8 (6 pm and 7 pm), and therefore the required minimum duration of 1 hour is met to allow use of this setting as the daily minimum value for VAE surveillance.

EXAMPLE: $FiO_2$ is set at the following values through the course of a calendar day:

| **Time** | **2 pm** | **4 pm** | **6 pm** | **8 pm** | **10 pm** | **12 am** |
|---|---|---|---|---|---|---|
| **$FiO_2$** | 1.0 | 0.60 | 0.40 | 0.50 | 0.55 | 0.60 |

In this example, the patient was intubated at 2 pm. The daily minimum $FiO_2$ is 0.40. $FiO_2$ settings are being monitored and recorded every 2 hours; therefore, the lowest recorded $FiO_2$ setting for the calendar day is the value used in VAE surveillance.

EXAMPLE: You are reviewing a patient's ventilator settings on Friday morning to determine the daily minimum FiO2 value for Thursday. The patient was intubated and initiated on mechanical ventilation at 21:45 hours on Thursday. The ICU monitored and recorded FiO2 settings for the patient every 15 minutes during the remainder of the day on Thursday. Based on the information recorded in the table below, what should you

record as the daily minimum FiO2 for Thursday? In this example, since there is no setting that is maintained for at least 1 hour during the calendar day, the daily minimum FiO2 for Thursday is 0.70 (70%). This is the lowest value of FiO2 set on the ventilator during the calendar day.

| **Day** | **Time** | **$FiO_2$** |
|---|---|---|
| Thursday | 21:45 | Intubated; 1.0 |
| | 22:00 | 1.0 |
| | 22:15 | 0.90 |
| | 22:30 | 0.90 |
| | 22:45 | 0.70 |
| | 23:00 | 0.80 |
| | 23:15 | 0.85 |
| | 23:30 | 0.85 |
| | 23:45 | 0.85 |

Ventilator: A device to assist or control respiration, inclusive of the weaning period, through a tracheostomy or by endotracheal intubation.

NOTE: Lung expansion devices such as intermittent positive-pressure breathing (IPPB); nasal positive end-expiratory pressure (nasal PEEP); and continuous nasal positive airway pressure (CPAP, hypoCPAP) are not considered ventilators unless delivered via tracheostomy or endotracheal intubation (e.g., ET-CPAP).

Episode of mechanical ventilation: Defined as a period of days during which the patient was mechanically ventilated for some portion of each consecutive day.

NOTE: A break in mechanical ventilation of at least one full calendar day, followed by reintubation and/or reinitiation of mechanical ventilation during the same hospitalization, defines a new episode of mechanical ventilation.

EXAMPLE: A patient is intubated and mechanical ventilation is initiated at 11 pm on hospital day 1. The patient remains intubated and mechanically ventilated from hospital days 2-10. The patient is extubated at 9 am on hospital day 11, and remains extubated on hospital day 12. The patient is reintubated and mechanical ventilation is reinitiated on hospital day 13. The patient remains intubated and mechanically ventilated from hospital day 14-18. This patient has had two episodes of mechanical ventilation (days 1-11 and days 13-18), separated by at least one full calendar day off of mechanical ventilation.

New antimicrobial agent: Defined as any agent listed in the Appendix that is initiated on or after the third calendar day of mechanical ventilation AND in the VAE Window Period (i.e., the period typically defined by the 2 calendar days before, the day of, and the 2 calendar days after

the onset date of the VAE). The agent is considered new for the purposes of this definition if it was NOT given to the patient on either of the 2 days preceding the current start date.

> EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1 in the MSICU. Ceftriaxone and azithromycin are started on day 1 and administered daily. After 3 days of improving respiratory status, the patient's oxygenation deteriorates on days 4 and 5, with a daily minimum PEEP that is 4 $cmH_2O$ higher than it was on days 2 and 3. Criteria for the VAC definition are met; the date of the event is hospital day 4. Ceftriaxone is discontinued and meropenem is begun on day 5. Azithromycin is continued. In this case, meropenem is a new antimicrobial agent: 1) it was begun on day 5 of mechanical ventilation, and 2) within the VAE Window Period (on the day after VAE onset), and 3) it was not given to the patient on either of the 2 days preceding the current start date. By contrast, ceftriaxone and azithromycin would not be considered new antimicrobial agents, since they were begun on day 1 of mechanical ventilation and continued daily into the VAE Window Period.

The antimicrobial agent(s) must have been given by one of the routes of administration outlined in Table 1, and therapy with one or more new antimicrobial agents must be continued for at least 4 calendar days (referred to as 4 "qualifying antimicrobial days" or "QADs"). For further guidance on identification of new antimicrobial agents and on how to determine whether the requirement for 4 QADs is met, refer to FAQs nos. 6-10 at the end of this chapter.

**Table 1: Definitions of routes of administration**

| **Route of Administration[a]** | **Definition[b]** |
|---|---|
| Intravenous | An intravascular route that begins with a vein. |
| Intramuscular | A route that begins within a muscle. |
| Digestive Tract | A route that begins anywhere in the digestive tract extending from the mouth through rectum. |
| Respiratory Tract | A route that begins within the respiratory tract, including the oropharynx and nasopharynx. |

[a]Other routes of administration are excluded (e.g., antibiotic locks, intraperitoneal, intraventricular, irrigation, topical).
[b]Definitions per SNOMED Reference Terminology

Qualifying Antimicrobial Day (QAD): A day on which the patient was administered an antimicrobial agent that was determined to be "new" within the VAE Window Period. Four consecutive QADs are needed to meet the IVAC antimicrobial criterion—starting within the VAE Window Period. Days on which a new antimicrobial agent is administered count as QADs. Days between administrations of a new antimicrobial agent also count as QADs as long as there is a gap of no more than 1 calendar day between administrations. For example, if levofloxacin is given on VAE Day 1, has not been given in the 2 preceding calendar days, and is given again on

VAE Days 3, 5 and 7, there are 7 QADs—because the days between levofloxacin doses also count as QADs. By contrast, days between administrations of different antimicrobial agents do NOT count as QADs; for example, if levofloxacin is given to the patient on VAE Days -2 and -1 only, no antimicrobials are given on VAE Day 1, and meropenem is given only on VAE Day 2 (remember there is no VAE Day 0), then there are not 4 consecutive QADs. VAE Days -2 and -1 count as 2 consecutive QADs, but VAE Day 1 cannot be counted as a QAD because it is a day between different antimicrobial agents.

Purulent Respiratory Secretions: Defined as secretions from the lungs, bronchi, or trachea that contain ≥25 neutrophils and ≤10 squamous epithelial cells per low power field [lpf, x100].

> NOTE: Some clinical laboratories may use different results reporting formats for direct examinations of respiratory secretions. Additional instructions for using the purulent respiratory secretions criterion are provided in Table 2, below (see also FAQ no. 19).

**Table 2: Instructions for using the purulent respiratory secretions criterion, based on laboratory reporting of respiratory secretion direct examination results.**

| How do I use the purulent respiratory secretions criterion if … | Instruction |
|---|---|
| My laboratory reports counts of "white blood cells" or "polymorphonuclear leukocytes" or "leukocytes" rather than counts of "neutrophils"? | Assume that counts of cells identified by these other descriptors (e.g., "white blood cells") are equivalent to counts of neutrophils, unless the laboratory tells you this is not the case. |
| My laboratory reports semi-quantitative results (not quantitative results) for numbers of neutrophils and squamous epithelial cells? | Check with the laboratory to get information about what quantitative ranges the semi-quantitative reports correspond to. |
| My laboratory cannot provide additional information on how its semi-quantitative reporting corresponds to quantitative reporting ranges for neutrophils and squamous epithelial cells? | Use the following direct examination results to meet the purulent respiratory secretions criterion: heavy, 4+, or ≥25 neutrophils per low power field (lpf) [x100], AND rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per lpf [x100] [19]. |
| My laboratory reports only the numbers of neutrophils present, without reporting the number of squamous epithelial cells? | In this situation, the purulent secretions criterion may be met using the specified quantitative and semi-quantitative thresholds for neutrophils alone (i.e., heavy, 4+, or ≥25 neutrophils per lpf [x100]). |
| My laboratory uses different reporting thresholds for neutrophils and squamous epithelial cells (e.g., maximum report of ≥ 20 neutrophils per low power field [x100], or minimum report of ≤ 15 squamous epithelial cells per low power field [x100])? | In this situation, the purulent secretions criterion may be met using the laboratory's specified maximum quantitative threshold for neutrophils, and/or minimum quantitative threshold for squamous epithelial cells. |
| My laboratory processes respiratory specimens such as bronchoalveolar lavage fluid using a centrifugation procedure (e.g., "cytospin"), and there is no quantitation or semi-quantitation of neutrophils or white blood cells in the direct examination report? | In this situation, a report indicating the presence of white blood cells, without quantitation, is sufficient to meet the purulent secretions criterion. |

Location of attribution: The inpatient location where the patient was assigned on the date of the VAE, which is further defined as the date of onset of worsening oxygenation.

> EXAMPLE: Patient is intubated and ventilated in the Operating Room on hospital day 1, and then is admitted post-operatively to the SICU on hospital day 1, still on the ventilator. On hospital day 3, the patient experiences the onset of worsening

oxygenation, manifested by an increase in the daily minimum $FiO_2$ of ≥ 0.20 (20%). On day 4 (also the 4th day of mechanical ventilation) the patient meets criteria for a VAC. This is reported to NHSN as a VAC for the SICU.

EXCEPTION:
*Transfer Rule*: If a VAE develops on the day of transfer or the day following transfer from one inpatient location to another in the same facility or to a new facility (where the day of transfer is day 1), the event is attributed to the transferring location. This is called the Transfer Rule, and examples are shown below:

EXAMPLE: Patient on a ventilator in the SICU who has had improving oxygenation for 3 days is transferred to the MICU, still on the ventilator. On the day of transfer, after the patient has arrived in the MICU, the patient experiences an acute decompensation, requiring an increase of 0.30 (30 points) in $FiO_2$ that persists during the following calendar day. VAC criteria are met on calendar day 2 in the MICU. Because the onset of worsening oxygenation occurred on the day of transfer to the MICU, the VAC event is attributed to the SICU.

EXAMPLE: Patient is extubated in the MICU and transferred to the medical stepdown unit on hospital day 6. The next day, while in the stepdown unit (day 7), the patient experiences worsening oxygenation and is reintubated and transferred back to the MICU. Criteria for VAC are met the next day (day 8). In this case, the day prior to extubation and the day of extubation (hospital days 5 and 6) count as the required 2-day period of stability or improvement. The day of reintubation (day 7) and the following day (day 8) count as the required 2-day period of worsening oxygenation. Because the onset of worsening oxygenation occurred on the day following transfer out of the MICU, the event is reported to NHSN as a VAC for the MICU.

EXAMPLE: Patient intubated and mechanically ventilated for 8 days in the MSICU of Hospital A is transferred for further care on day 8 to the MSICU of Hospital B. The patient was stable on the ventilator in Hospital A from days 3-8. On the day of transfer to Hospital B (day 1 in Hospital B), the patient's respiratory status deteriorates. The day after transfer (day 2 in Hospital B), the patient meets criteria for VAC. The date of the event is day 1 in Hospital B, the first day of the period of worsening oxygenation meeting VAE PEEP or $FiO_2$ thresholds. The infection preventionist (IP) from Hospital B calls the Hospital A IP to report that this patient was admitted to Hospital B with a VAC. This VAC should be reported to NHSN for and by Hospital A, and attributed to the Hospital A MSICU. No additional ventilator days are reported by Hospital A.

REPORTING INSTRUCTIONS (additional guidance may be found in the FAQs at the end of this chapter):

- Conducting in-plan VAE surveillance means assessing patients for the presence of ALL events included in the algorithm—from VAC to IVAC to PVAP. At this time, a unit conducting in-plan VAE surveillance cannot decide, for example, that only surveillance for VAC (and not for IVAC or PVAP) will be performed.
- There is a hierarchy of definitions within VAE:
  - If a patient meets criteria for VAC and IVAC, report as IVAC.
  - If a patient meets criteria for VAC, IVAC and PVAP, report PVAP.
- Pathogens are not reported for VAC or IVAC events.
- Secondary BSIs are not reported for VAC or IVAC events (see FAQ no.11).
- Pathogens may be reported for PVAP events, provided they are isolated or identified from appropriate specimen types according to the requirements of the algorithm and are NOT on the list of excluded organisms and culture or non-culture based microbiologic testing method results:
  - Excluded organisms and culture or non-culture based microbiologic testing method results that cannot be used to meet the PVAP definition are as follows: "Normal respiratory flora," "normal oral flora," "mixed respiratory flora," "mixed oral flora," "altered oral flora" or other similar results indicating isolation of commensal flora of the oral cavity or upper respiratory tract; *Candida* species or yeast not otherwise specified; coagulase-negative *Staphylococcus* species; and *Enterococcus* species, when identified from sputum, endotracheal aspirates, bronchoalveolar lavage, or protected specimen brushings specimens. These organisms can be reported as PVAP pathogens if identified from lung tissue or pleural fluid specimens.
  - Additionally, because organisms belonging to the following genera are typically causes of community-associated respiratory infections and are rarely or are not known to be causes of healthcare-associated infections, they are also excluded, and cannot be used to meet the PVAP definition when isolated from any eligible specimen type (to include lung and pleural fluid): *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.*
- There are three criteria that can be used to meet the PVAP definition (Figure 4):
  - Criterion 1: Positive culture meeting specific quantitative or semi-quantitative threshold (Table 3);
  - Criterion 2: Purulent respiratory secretions AND identification of organisms NOT meeting the quantitative or semi-quantitative thresholds specified in Table 3;
  - Criterion 3: Organisms identified from pleural fluid specimen, positive lung histopathology, and positive diagnostic test for *Legionella* species or selected respiratory viruses.
- See Table 3 for the required quantitative culture thresholds meeting the PVAP definition (Criterion 1). Note that if your laboratory reports semi-quantitative culture results, you should check with your laboratory to confirm that semi-quantitative results match the quantitative thresholds noted in Table 3 (see also FAQ no. 24).

**Table 3: Threshold values for cultured specimens used in the PVAP definition**

| Specimen collection/technique | Values |
|---|---|
| Lung tissue | $\geq 10^4$ cfu/g tissue* |
| Bronchoscopically (B) obtained specimens | |
| Bronchoalveolar lavage (B-BAL) | $\geq 10^4$ cfu/ml* |
| Protected BAL (B-PBAL) | $\geq 10^4$ cfu/ml* |
| Protected specimen brushing (B-PSB) | $\geq 10^3$ cfu/ml* |
| Nonbronchoscopically (NB) obtained (blind) specimens | |
| NB-BAL | $\geq 10^4$ cfu/ml* |
| NB-PSB | $\geq 10^3$ cfu/ml* |
| Endotracheal aspirate (ETA) | $\geq 10^5$ cfu/ml* |

cfu = colony forming units, g = gram, ml = milliliter
*Or corresponding semi-quantitative result.

- Secondary BSIs may be reported for PVAP events, provided that at least one organism identified from the blood matches an organism isolated from an appropriate respiratory tract specimen (including respiratory secretions, pleural fluid and lung tissue). The respiratory tract specimen must have been collected on or after the 3rd day of mechanical ventilation and within 2 calendar days before or after the day of onset of worsening oxygenation to be considered as a criterion for meeting the PVAP definition. In addition, the organisms identified from blood must have been collected during the 14-day event period, where day 1 is the day of onset of worsening oxygenation (See FAQ no.13).
  - In cases where PVAP is met with only the histopathology criterion and no culture or non-culture based testing is performed on an eligible respiratory specimen, and there is also a positive blood specimen a secondary BSI is not reported.
  - In cases where a culture or non-culture based testing of respiratory secretions, pleural fluid or lung tissue is performed and does not identify an organism that matches an organism identified from blood, a secondary BSI is not reported.
  - A matching organism is defined as one of the following:

    1. If genus and species are identified in both specimens, they must be the same.
       a. Example: A blood specimen resulted with *Enterobacter cloacae* and a BAL specimen resulted with *Enterobacter cloacae* are matching organisms.
       b. Example: A blood specimen resulted with *Enterobacter cloacae* and a BAL specimen resulted with *Enterobacter aerogenes* are NOT matching organisms as the species are different.

    2. If the organism is less definitively identified in one specimen than the other, the identifications must be complementary.
       a. Example: A BAL resulted with *Pseudomonas spp*. and a blood specimen resulted with *Pseudomonas aeruginosa* are considered a match at the genus level and therefore the BSI can be reported as secondary BSI to VAE

b. Example: A blood specimen reported as *Candida albicans* and a lung tissue resulted with yeast not otherwise specified are considered to have matching organisms because the organisms are complementary, i.e. *Candida* is a type of yeast.

NOTE: *Candida* species or yeast not otherwise specified, coagulase-negative *Staphylococcus* species, and *Enterococcus* species identified from blood cannot be deemed secondary to a PVAP, unless the organism was also identified from pleural fluid or lung tissue.

- If the date of event (date of onset of worsening oxygenation) is on or after the date the patient is declared brain dead AND the patient is being supported for organ donation purposes, the event should not be reported as a VAE.

## Figure 1: Ventilator-Associated Events (VAE) Surveillance Algorithm

Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* $FiO_2$ or PEEP values. The baseline period is defined as the 2 calendar days immediately preceding the first day of increased daily minimum PEEP

*Daily minimum defined by lowest value of $FiO_2$ or PEEP during a calendar day that is maintained for at least 1 hour.

After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:
1) Increase in daily minimum* $FiO_2$ of ≥ 0.20 (20 points) over the daily minimum $FiO_2$ in the baseline period, sustained for ≥ 2 calendar days.
2) Increase in daily minimum* PEEP values of ≥ 3 $cmH_2O$ over the daily minimum PEEP in the baseline period†, sustained for ≥ 2 calendar days.
*Daily minimum defined by lowest value of $FiO_2$ or PEEP during a calendar day that is maintained for at least 1 hour.
†Daily minimum PEEP values of 0-5 $cmH_2O$ are considered equivalent for the purposes of VAE surveillance.

**Ventilator-Associated Condition (VAC)**

On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets both of the following criteria:

1) Temperature > 38 °C or < 36°C, **OR** white blood cell count ≥ 12,000 cells/$mm^3$ or ≤ 4,000 cells/$mm^3$.
**AND**
2) A new antimicrobial agent(s) (see Appendix for eligible antimicrobial agents) is started, and is continued for ≥ 4 calendar days.

**Infection-related Ventilator-Associated Complication (IVAC)**

On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (**taking into account organism exclusions specified in the protocol**):

1) Criterion 1: Positive culture of one of the following specimens, meeting quantitative or semi-quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions:
   - Endotracheal aspirate, ≥ $10^5$ CFU/ml or corresponding semi-quantitative result
   - Bronchoalveolar lavage, ≥ $10^4$ CFU/ml or corresponding semi-quantitative result
   - Lung tissue, ≥ $10^4$ CFU/g or corresponding semi-quantitative result
   - Protected specimen brush, ≥ $10^3$ CFU/ml or corresponding semi-quantitative result
2) Criterion 2: Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain ≥25 neutrophils and ≤10 squamous epithelial cells per low power field [lpf, x100])† plus organism identified from one of the following specimens (to include qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):
   - Sputum
   - Endotracheal aspirate
   - Bronchoalveolar lavage
   - Lung tissue
   - Protected specimen brush

   † If the laboratory reports semi-quantitative results, those results must correspond to the above quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.
3) Criterion 3: One of the following positive tests:
   - Organism identified from pleural fluid (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
   - Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudohyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
   - Diagnostic test for *Legionella* species
   - Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

**Possible Ventilator-Associated Pneumonia (PVAP)**

**Figure 2: Ventilator-Associated Condition (VAC)**

Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* $FiO_2$ or PEEP values. The baseline period is defined as the 2 calendar days immediately preceding the first day of increased daily minimum PEEP or $FiO_2$

*Daily minimum defined by lowest value of $FiO_2$ or PEEP during a calendar day that is maintained for at least 1 hour.

AND

After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:

1) Increase in daily minimum* $FiO_2$ of ≥ 0.20 (20 points) over the daily minimum $FiO_2$ in the baseline period, sustained for ≥ 2 calendar days.

2) Increase in daily minimum* PEEP values of ≥ 3 $cmH_2O$ over the daily minimum PEEP in the baseline period†, sustained for ≥ 2 calendar days.

*Daily minimum defined by lowest value of $FiO_2$ or PEEP during a calendar day that is maintained for at least 1 hour.

†Daily minimum PEEP values of 0-5 $cmH_2O$ are considered equivalent for the purposes of VAE surveillance.

**Figure 3: Infection-related Ventilator-Associated Complication (IVAC)**

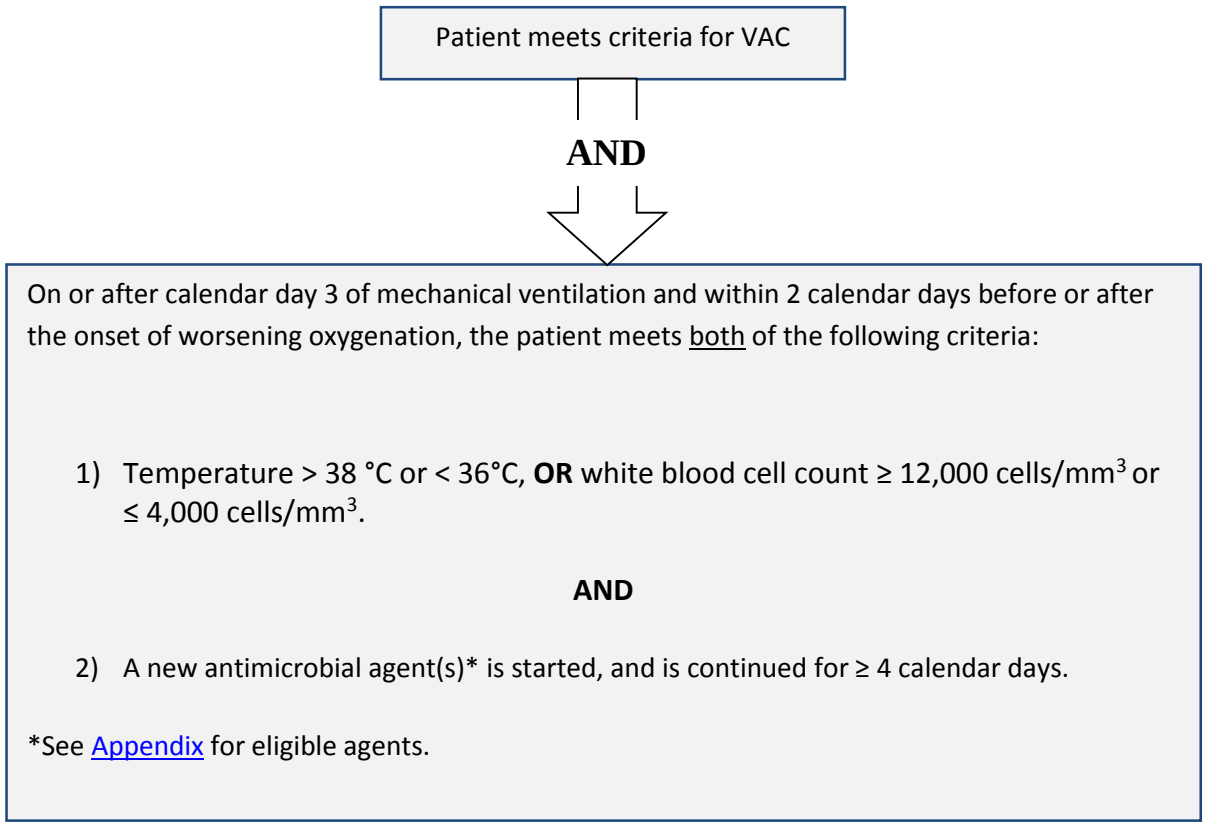
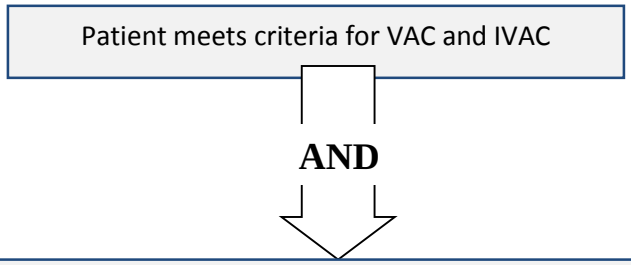


**Figure 4: Possible Ventilator-Associated Pneumonia (PVAP)**




On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (**taking into account organism exclusions specified in the protocol**):

1) Criterion 1: Positive culture of one of the following specimens, meeting quantitative or semi-quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions:
   - Endotracheal aspirate, ≥ $10^5$ CFU/ml or corresponding semi-quantitative result
   - Bronchoalveolar lavage, ≥ $10^4$ CFU/ml or corresponding semi-quantitative result
   - Lung tissue, ≥ $10^4$ CFU/g or corresponding semi-quantitative result
   - Protected specimen brush, ≥ $10^3$ CFU/ml or corresponding semi-quantitative result
2) Criterion 2: Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain ≥25 neutrophils and ≤10 squamous epithelial cells per low power field [lpf, x100])[†] plus organism identified from one of the following specimens (to include qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):
   - Sputum
   - Endotracheal aspirate
   - Bronchoalveolar lavage
   - Lung tissue
   - Protected specimen brush

   [†] If the laboratory reports semi-quantitative results, those results must correspond to the quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.
3) Criterion 3: One of the following positive tests:
   - Organism identified from pleural fluid (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
   - Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudohyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
   - Diagnostic test for *Legionella* species
   - Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

Numerator Data**:** The *Ventilator-Associated Event* form (CDC 57.112) is used to collect and report each VAE that is identified during the month selected for surveillance. The Instructions for Completion of Ventilator-Associated Event Form includes brief instructions for collection and entry of each data element on the form. The VAE form includes patient demographic information and information on the start date and location of initiation of mechanical ventilation. Additional data include the specific criteria met for identifying VAE, whether the patient developed a secondary bloodstream infection, whether the patient died, and, where applicable, the organisms detected and their antimicrobial susceptibilities.

REPORTING INSTRUCTION:

- If no VAEs are identified during the month of surveillance, the "Report No Events" box must be checked on the appropriate denominator summary screen, e.g., Denominators for Intensive Care Unit (ICU)/other locations (Not NICU or SCA), etc.

Denominator Data**:** Device days and patient days are used for denominators (see Chapter 16 Key Terms). Ventilator days, which are the numbers of patients managed with ventilatory devices, are collected daily, at the same time each day, according to the chosen location using the appropriate form (CDC 57.117 and 57.118). These daily counts are summed and only the total for the month is entered into NHSN. Ventilator and patient days are collected for each of the locations monitored. When denominator data are available from electronic sources (e.g., ventilator days from respiratory therapy), these sources may be used as long as the counts are not substantially different (+/- 5%) from manually-collected counts, pre-validated for a minimum of 3 months.

Collection of an additional denominator, episodes of mechanical ventilation (EMV), is optionally available for VAE surveillance. The EMV denominator represents the sum of the number of episodes of mechanical ventilation that occurred in that location during the month. A single episode of mechanical ventilation for each patient is to be counted only once per month. Do note, it is possible for a patient to have more than one episode of ventilation occur during a month (e.g., discontinuation of mechanical ventilation for greater than 1 calendar day followed by re-initiation of mechanical ventilation). The EMV denominator is determined by counting all patients in the location who are on mechanical ventilation on the first day of the month. Then, on each subsequent day of the month, count each additional patient that is started on mechanical ventilation. This would include those that are admitted to the location already on mechanical ventilation, those that are newly ventilated and any previously ventilated patients who have new episodes of mechanical ventilation occurring during the same month. The sum of the count for the first day and each subsequent day of the month is entered in NHSN.

EXAMPLE: On January 1, there are 5 patients on mechanical ventilation in the MICU (2 patients were started on mechanical ventilation on December 24, 2 patients on December 31, and 1 patient on January 1). During the rest of the month, the following are noted: 1 patient is started on mechanical ventilation on January 8; 2 patients are

transferred to the MICU on mechanical ventilation on January 15, and 1 patient who was previously ventilated (from January 1 through January 12) goes back on mechanical ventilation on January 20. No other patients are on mechanical ventilation during the month of January. The number of EMV for January is nine. This is calculated as follows: 5 patients(on mechanical ventilation on the first day of the month) + 4 patients who were either started on mechanical ventilation, transferred into the MICU on mechanical ventilation, or re-initiated on mechanical ventilation after being off of the vent for at least 1 calendar day = 9 EMV.

NOTE: All ventilator days are counted, including ventilator days for patients on mechanical ventilation for < 3 days, and patients on high frequency ventilation and other therapies excluded from VAE surveillance. Patients with tracheostomies who are undergoing weaning from mechanical ventilation using tracheostomy collar trials are included in ventilator day counts as long as they spend some portion of the day on mechanical ventilation at a time that overlaps with the daily time during which ventilator day counts are performed.

NOTE: In addition to the total number of patients on ventilators on each day of surveillance, the number of patients on ventilators who are on the APRV mode of mechanical ventilation or related modes (which is a subset of all patients on ventilators) should also be indicated on the appropriate form (CDC 57.117 and 57.118). See FAQ nos. 22 and 23.

**Data Analyses:** The VAE rate per 1000 ventilator days is calculated by dividing the number of VAEs by the number of ventilator days and multiplying the result by 1000 (ventilator days). The rate per 100 episodes of mechanical ventilation is calculated by dividing the number of VAEs by the number of episodes of mechanical ventilation and multiplying the result by 100 (episodes of mechanical ventilation). Rates that may be appropriate for use in public reporting, inter-facility comparisons, and pay-for-reporting/pay-for-performance programs are the overall VAE rate (where the numerator consists of all events meeting at least the VAC definition) and the "IVAC-plus" rate (where the numerator consists of all events meeting at least the IVAC definition). Rates that may be appropriate for internal use within an individual unit or facility include rates of specific event types (e.g., events meeting only the VAC definition, events meeting only the IVAC definition, events meeting only the PVAP definition),. The Ventilator Utilization Ratio is calculated by dividing the number of ventilator days by the number of patient days. These calculations will be performed separately for the different types of ICUs, SCAs, and other locations in the institution.

****The information that follows regarding the Standardized Infection Ratio (SIR) is for informational purposes only, until a baseline period of VAE reporting has been established.****

The Standardized Infection Ratio (SIR) is calculated by dividing the number of observed events by the number of expected (or predicted) events. The number of predicted events, in the context of statistical prediction, is calculated using VAE rates from a standard population during a baseline time period as reported in the NHSN Report.

**NOTE: The SIR should be calculated only if the number of predicted VAEs is ≥ 1.**

SIR = Observed (O) VAEs / Expected (E) VAEs

While the VAE SIR can be calculated for single locations, the measure also allows you to summarize your data by multiple locations, adjusting for differences in the incidence of VAEs among the location types. For example, you can calculate one VAE SIR adjusting for all locations reported. Similarly, you can calculate one VAE SIR for all specialty care areas in your facility.

Descriptive analysis options of numerator and denominator data are available in the NHSN application, such as line listings, frequency tables, and bar and pie charts. VAE rates and run charts are also available. Guides on using NHSN analysis features are available from: http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html.

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## Appendix. List of Antimicrobials Agents Eligible for IVAC, PVAP

| Antimicrobial Agent |
|---|
| AMIKACIN |
| AMPHOTERICIN B |
| AMPHOTERICIN B LIPOSOMAL |
| AMPICILLIN |
| AMPICILLIN/SULBACTAM |
| ANIDULAFUNGIN |
| AZITHROMYCIN |
| AZTREONAM |
| CASPOFUNGIN |
| CEFAZOLIN |
| CEFEPIME |
| CEFOTAXIME |
| CEFOTETAN |
| CEFOXITIN |
| CEFTAROLINE |
| CEFTAZIDIME |
| CEFTAZIDIME/AVIBACTAM |
| CEFTIZOXIME |
| CEFTOLOZANE/TAZOBACTAM |
| CEFTRIAXONE |
| CEFUROXIME |
| CIPROFLOXACIN |
| CLARITHROMYCIN |
| CLINDAMYCIN |
| COLISTIMETHATE |
| DALBAVANCIN |
| DORIPENEM |
| DOXYCYCLINE |
| ERTAPENEM |
| FLUCONAZOLE |
| FOSFOMYCIN |

| |
|---|
| GEMIFLOXACIN |
| GENTAMICIN |
| IMIPENEM/CILASTATIN |
| ISAVUCONAZONIUM |
| ITRACONAZOLE |
| LEVOFLOXACIN |
| LINEZOLID |
| MEROPENEM |
| METRONIDAZOLE |
| MICAFUNGIN |
| MINOCYCLINE |
| MOXIFLOXACIN |
| NAFCILLIN |
| ORITAVANCIN |
| OSELTAMIVIR |
| OXACILLIN |
| PENICILLIN G |
| PERAMIVIR |
| PIPERACILLIN |
| PIPERACILLIN/TAZOBACTAM |
| POLYMYXIN B |
| POSACONAZOLE |
| QUINUPRISTIN/DALFOPRISTIN |
| RIFAMPIN |
| SULFAMETHOXAZOLE/TRIMETHOPRIM |
| SULFISOXAZOLE |
| TEDIZOLID |
| TELAVANCIN |
| TELITHROMYCIN |
| TETRACYCLINE |
| TICARCILLIN/CLAVULANATE |
| TIGECYCLINE |
| TOBRAMYCIN |
| VANCOMYIN, intravenous only |

| |
|---|
| VORICONAZOLE |
| ZANAMIVIR |

## VAE FREQUENTLY ASKED QUESTIONS (FAQS)

1) When should I use VAE? Are there circumstances in which I should still use PNEU?

- VAE surveillance is location based, and restricted to adult inpatient units only.
- Pediatric and neonatal units are excluded from VAE surveillance (even in circumstances where a pediatric unit may occasionally care for patients who are 18 years of age and older).
- Locations mapped to mixed age CDC location codes are excluded from VAE surveillance.
- Ventilated patients who are 18 years of age and older and who are cared for in pediatric units should be included in any in-plan PedVAP surveillance for that location.

  NOTE: It is NOT recommended to include in VAE surveillance young children housed in adult ICU locations who are not thought to be physiologically similar to the location's adult patient population. Facilities may want to evaluate their location mapping to be sure that locations are mapped appropriately to the correct CDC location codes. In circumstances where the populations of adults and children cared for in the same physical location is more mixed (e.g., 50% adult patients and 50% pediatric patients), it is recommended that facilities weigh the possibility of establishing a virtual pediatric location for the purposes of surveillance. More information on virtual locations and location mapping can be found here: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf

- While on high frequency ventilation or extracorporeal life support, patients are EXCLUDED from VAE surveillance.

  NOTE: Patients who are receiving a conventional mode of mechanical ventilation while in the prone position and patients who are receiving a conventional mode of mechanical ventilation while receiving nitric oxide therapy, helium-oxygen mixtures (heliox), or epoprostenol therapy are INCLUDED.

  NOTE: Patients on Airway Pressure Release Ventilation (APRV) and related modes of mechanical ventilation (see FAQ nos. 22 and 23) are INCLUDED; however, during periods of time while the patient is on APRV, the VAE period of stability or improvement on the ventilator and the period of worsening oxygenation should be determined by changes in $FiO_2$ only, since changes in PEEP as indicated in this surveillance algorithm may not be applicable to APRV. In addition, patients with VAE who are on APRV or a related mode of mechanical ventilation at the time of VAE onset should be indicated as such on the VAE Form (CDC 57.112).

- In-plan surveillance for ventilator-associated PNEU may still be conducted for pediatric patients ONLY ("PedVAP" surveillance).

- The PNEU definitions are still available for those units seeking to conduct off-plan PNEU/VAP surveillance for patients of any age and for assignment of a secondary BSI.

2) I am having difficulty visualizing how to arrange the VAE data elements to facilitate easy identification of events. Can you provide some additional guidance?
   - For units in which VAE surveillance will be conducted manually, we recommend that you organize the necessary data elements in a table or spreadsheet to assist in identifying VAEs. There are a number of different ways in which to organize the data – you may consider limiting your spreadsheet to just include the daily minimum PEEP and $FiO_2$ values, and then, if a VAC event is identified, utilize other data sources to gather information on the data elements included in the IVAC and PVAP definitions. Alternatively, you may choose to include columns for all data elements (from VAC through PVAP) in a single spreadsheet.

     NOTE: For most patients under surveillance for VAE, the only data elements you will need to record are the ventilator days, minimum daily PEEP, and minimum daily $FiO_2$. The maximum and minimum daily temperatures and white blood cell counts only need to be recorded for those patients who are identified as having met criteria for VAC. The antimicrobial criterion only needs to be assessed for those patients with VAC and with an abnormal temperature or white blood cell count that meets the criteria within the IVAC definition. Microbiology and related data elements included as criteria in the PVAP definition only need to be assessed for those patients who have met the IVAC definition.

     NOTE: Keep in mind that the baseline period of stability or improvement on the ventilator is defined as the 2 calendar days immediately preceding the first day of increased daily minimum PEEP or $FiO_2$, and must be characterized by $\geq$ 2 calendar days of stable or decreasing daily minimum $FiO_2$ or PEEP values (i.e., the daily minimum PEEP or $FiO_2$ on the second day of the baseline period of stability or improvement must be equal to or less than the daily minimum PEEP or $FiO_2$ on the first day of the baseline period of stability or improvement). Keep in mind, too, that PEEP values of 0 to 5 $cmH_2O$ are considered equivalent for the purposes of VAE surveillance. This means that any daily minimum value of 0 to 5 $cmH_2O$ will be evaluated as if it were 5 $cmH_2O$ when determining whether a VAC has occurred or not. Also, the daily minimum PEEP or FiO2 is defined as the lowest setting during a calendar day that is maintained for at least 1 hour.

     EXAMPLE: In the table below, the data elements used to meet VAC, IVAC and PVAP definition are organized in a fashion that facilitates identification of an event, highlighted in the shaded region. In this example, MV days 3 and 4 constitute the baseline period, with stable minimum PEEP of 5 $cmH_2O$ on each day. On MV days 5 and 6, the daily minimum PEEP is 8 $cmH_2O$, which meets the VAC criterion for worsening oxygenation. If we scan across the table, we can see that the IVAC temperature/white blood cell count criterion is not met (there are no temperatures < 36°C or > 38°C, and no white blood cell

counts ≤ 4,000 cells/mm$^3$ or ≥ 12,000 cells/mm$^3$) – so even though the patient was started on a new antimicrobial agent and continued on that agent for 4 calendar days, IVAC is not met. Therefore, this event would be reported as a VAC, with the date of event being MV day 5.

| Patient | MV Day | $PEEP_{min}$ | $FiO_{2min}$ | $Temp_{min}$ | $Temp_{max}$ | $WBC_{min}$ | $WBC_{max}$ | Abx | Specimen | Polys / Epis | Organism | VAE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 10 | 1.0 | 37.1 | 37.6 | 4.3 | 4.3 | None | -- | -- | -- | -- |
| 1 | 2 | 5 | 0.60 | 36.8 | 37.2 | 4.6 | 4.6 | None | -- | -- | -- | -- |
| 1 | 3 | 5 | 0.40 | 37.0 | 37.9 | 5.4 | 5.4 | None | -- | -- | -- | -- |
| 1 | 4 | 5 | 0.40 | 36.5 | 37.3 | 9.2 | 9.2 | Yes | -- | -- | -- | -- |
| 1 | 5 | 8 | 0.50 | 36.3 | 36.9 | 8.4 | 8.4 | Yes | ETA | ≥ 25 / ≤ 10 | *S.aureus* | **VAC** |
| 1 | 6 | 8 | 0.40 | 37.2 | 37.5 | 8.5 | 8.8 | Yes | -- | -- | -- | |
| 1 | 7 | 5 | 0.40 | 37.8 | 37.9 | 7.6 | 7.6 | Yes | -- | -- | -- | |

MV = mechanical ventilation. $PEEP_{min}$ = Daily minimum PEEP. $FiO_{2min}$ = Daily minimum $FiO_2$. $Temp_{min}$ = Daily minimum temperature. $Temp_{max}$ = Daily maximum temperature. $WBC_{min}$ = Daily minimum white blood cell count. $WBC_{max}$ = Daily maximum white blood cell count. Abx = antimicrobial agents. Polys / epis = Polymorphonuclear leukocytes and squamous epithelial cells from respiratory specimen.

EXAMPLE: In the table below, by scanning across the data elements, you can see that there are no periods in which there is a stable, 2-day baseline period followed by a 2-day period where the PEEP or $FiO_2$ are increased 3 $cmH_2O$ or 20 points over baseline. On MV days 2 and 3, the PEEP values are 7 $cmH_2O$ and 6 $cmH_2O$ respectively, and then increase to 9 $cmH_2O$ on MV days 4 and 5 – but the difference between day 4 or day 5 and day 2 is only 2 $cmH_2O$, rather than the required 3 $cmH_2O$. Also, the gradual increase in $FiO_2$ from the time of initiation of mechanical ventilation means that there are not two days on which the $FiO_2$ is at least 20 points higher than on the 2 previous days. Therefore, although the temperature and white blood cell counts exceed the required thresholds for IVAC on several occasions, and the patient appears to have received a new antimicrobial agent for several days in the setting of a positive blood culture, the VAC definition is not met, and so no VAE is reported.

| Patient | MV Day | $PEEP_{min}$ | $FiO_{2min}$ | $Temp_{min}$ | $Temp_{max}$ | $WBC_{min}$ | $WBC_{max}$ | Abx | Specimen | Polys / Epis | Organism | VAE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | 1 | 5 | 0.30 | 37.1 | 37.6 | 4.3 | 4.3 | None | -- | -- | -- | -- |
| 2 | 2 | 7 | 0.30 | 36.8 | 37.2 | 4.6 | 4.6 | None | -- | -- | -- | -- |
| 2 | 3 | 6 | 0.45 | 37.0 | 37.9 | 5.4 | 5.4 | None | -- | -- | -- | -- |
| 2 | 4 | 9 | 0.45 | 36.5 | 37.3 | 9.2 | 9.2 | None | -- | -- | -- | -- |
| 2 | 5 | 9 | 0.60 | 36.3 | 36.9 | 8.4 | 8.4 | None | ETA | ≥ 25 / ≤ 10 | *S.aureus* | -- |
| 2 | 6 | 8 | 0.60 | 37.2 | 37.5 | 8.5 | 8.8 | None | -- | -- | -- | -- |
| 2 | 7 | 6 | 0.75 | 37.8 | 37.9 | 7.6 | 7.6 | None | -- | -- | -- | -- |
| 2 | 8 | 6 | 0.75 | 38.2 | 38.4 | 10.5 | 11.9 | Yes | Blood | -- | *S. aureus* | -- |
| 2 | 9 | 5 | 0.80 | 38.5 | 38.9 | 12.7 | 12.7 | Yes | -- | -- | -- | -- |
| 2 | 10 | 5 | 0.75 | 37.4 | 38.1 | 12.9 | 12.9 | Yes | -- | -- | -- | -- |
| 2 | 11 | 5 | 0.70 | 37.2 | 37.9 | 9.4 | 9.4 | Yes | -- | -- | -- | -- |
| 2 | 12 | 5 | 0.60 | 37.3 | 37.5 | 9.5 | 9.5 | Yes | -- | -- | -- | -- |
| 2 | 13 | 7 | 0.60 | 37.2 | 37.8 | 8.2 | 8.2 | Yes | -- | -- | -- | -- |
| 2 | 14 | 8 | 0.60 | 37.0 | 37.7 | 8.6 | 8.6 | Yes | -- | -- | -- | -- |

3) Is there a hierarchy of reporting for VAE? How do I know whether to report a VAC, an IVAC or a PVAP?
   - Conducting in-plan VAE surveillance means assessing patients for the presence of ALL events included in the algorithm—from VAC to IVAC to PVAP. At this time, a unit participating in in-plan VAE surveillance cannot decide, for example, that only surveillance for VAC (and not for IVAC or PVAP) will be performed.
   - There is a hierarchy of definitions within VAE:
     - If a patient meets criteria for VAC and IVAC, report as IVAC.
     - If a patient meets criteria for VAC, IVAC and PVAP, report PVAP.

4) How do I determine the duration of a VAE? Can a patient have more than one VAE during a hospitalization?
   - Patients may have multiple VAEs during a single hospitalization. The event period is defined by the 14-day period that starts on the date of onset of worsening oxygenation. VAE criteria met during that 14-day period are attributed to the current VAE.

     EXAMPLE: Patient is intubated and mechanical ventilation is initiated in the MICU (day 1). The patient is stable during the following 4 calendar days (days 2 through 5). On days 6 and 7 the patient's minimum daily $FiO_2$ is increased more than 0.20 (20 points) over baseline, therefore meeting the VAC $FiO_2$ threshold. The VAC episode is defined by the period encompassing days 6 through 19 (14 days, starting on day 1 of worsening oxygenation, which in this case is day 6). If the patient were to experience a period of stability or improvement on the ventilator on days 18 and 19, followed by another 2-day period of worsening on days 20 and 21, a new VAE would be reported, since the second period of worsening oxygenation has occurred more than 14 days after the start of the initial period of worsening oxygenation.

5) Sometimes patients are intubated, extubated, and reintubated several times during a single hospitalization. How do I define an episode of mechanical ventilation, and can a VAE occur in a patient who has recently been extubated?
   - An episode of mechanical ventilation is defined as a period of days during which the patient was mechanically ventilated for some portion of each consecutive day during the period.

     EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1. The patient remains on mechanical ventilation from hospital day 2 through 12 noon on hospital day 6. At noon on hospital day 6, the patient is extubated. The patient remains extubated on hospital day 7, and is then reintubated on hospital day 8. In this case, the first episode of mechanical ventilation is defined by days 1 through 6. Since the patient was extubated on day 6 and remained extubated for a full calendar day on day 7, the re-intubation of the patient on day 8 defines the start of a second episode of mechanical ventilation. See figure, below.

| Hosp Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| MV Episode | 1 | 1 | 1 | 1 | 1 | 1 | -- | 2 | 2 | 2 |
| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6—extubated at noon | -- | 1--reintubated | 2 | 3 |

1 full calendar day off mechanical ventilation, followed by reintubation, defines a new episode of mechanical ventilation.

EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1. The patient remains on mechanical ventilation from hospital day 2 through hospital day 6 at 12 noon. At noon on hospital day 6, the patient is extubated. The patient is reintubated at 9 pm on hospital day 7, and remains intubated and mechanically ventilated till 2 pm on day 10. The patient is extubated at 2 pm on day 10 and remains extubated until hospital discharge on day 15. In this case, there is only a single episode of mechanical ventilation, defined by days 1 through 10, because the patient was extubated on day 6 but reintubated the next calendar day (day 7). See figure, below.

| Hosp Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| MV Episode | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6—extubated at noon | 7—reintubated at 9 pm | 8 | 9 | 10—extubated at 2 pm |

Patient was reintubated on the calendar day following extubation (days 6-7). Because there is not 1 calendar day off mechanical ventilation, there is only 1 episode of mechanical ventilation.

- A VAE can occur in a patient who has been extubated and is then reintubated, subject to the amount of time the patient was off the ventilator, as noted in the examples below.

EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1. The patient remains on mechanical ventilation from hospital day 2 through 12 noon on hospital day 6. At noon on hospital day 6, the patient is extubated. The patient remains extubated on hospital day 7, and is then reintubated on hospital day 8. In this case, because the patient has been extubated for 1 full calendar day (day 7), the "VAE clock" starts over with reintubation on hospital day 8. To meet VAE during this second episode of mechanical ventilation, the patient would have to have at least 2 days of stability or improvement and at least 2 days of worsening oxygenation on the ventilator; therefore, the earliest date on which the patient could meet VAE criteria would be hospital day 11 (stable or improving settings on days 8 and 9, increased ventilator settings on days 10 and 11). The VAE event date would be reported as day 10—the first day of worsening oxygenation meeting VAE criteria. See figure, below.

| Hosp Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MV Episode | 1 | 1 | 1 | 1 | 1 | 1 | -- | 2 | 2 | 2 | 2 |
| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6—extubated at noon | -- | 1--reintubated | 2 | 3 | 4 |
| VAE Criterion | -- | -- | -- | -- | -- | -- | -- | Day 1 of stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation |

EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1. The patient remains on mechanical ventilation from hospital day 2 through 12 noon on hospital day 6, when the patient is extubated. The patient is reintubated at 9 pm on hospital day 7. In this case, there is no "new" episode of mechanical ventilation, since there was not a full, ventilator-free calendar day. Therefore, the period of worsening oxygenation may be determined to have started on day 7, the day of reintubation, as long as PEEP or $FiO_2$ criteria are met. PEEP and $FiO_2$ data from hospital days 5 and 6 (through the time of extubation) may be used to determine whether a period of stability and improvement occurred, and these data may be compared to PEEP and $FiO_2$ data obtained from the time of reintubation on day 7 and beyond to determine whether at least 2 days of worsening oxygenation occurred. The earliest that the patient could meet VAE criteria would be day 8 (assuming stable or improving ventilator settings on days 5 and 6, and two days of worsening oxygenation meeting criteria on days 7 and 8). The VAE event date would be reported as day 7—the first day of worsening oxygenation meeting VAE criteria. See figure, below.

| Hosp Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| MV Episode | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6—extubated at noon | 7—reintubated at 9 pm | 8 | 9 | 10 |
| VAE Criterion | | | | | Day 1 of stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |

- A patient may also meet criteria for VAC while intubated, and then meet criteria for IVAC (or PVAP) following extubation.

  EXAMPLE: A patient is intubated and mechanically ventilated on hospital day 1. The patient remains on mechanical ventilation till 11 am on hospital day 10, when the patient is extubated. Criteria for VAC are met during the episode of mechanical ventilation, based on 2 days of stability or improvement (MV days 5 and 6) followed by 2 days of worsening oxygenation (MV days 7 and 8). The date of the event is MV day 7, the day of onset of worsening oxygenation. Within the 2 days before and 2 days after the day of onset of worsening oxygenation, the patient has a temperature of 38.4°C, and a new antimicrobial agent is started (meropenem, on MV day 9—see FAQ no. 6-10). The new antimicrobial agent is continued for at least 4 days (hospital days 8 through 11). Therefore, even though the patient was extubated on hospital day 10 and remained extubated on hospital day 11 (the day on which all IVAC criteria were fulfilled), the event should be reported as an IVAC. See figure, below.

| Hosp Day No. | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|
| **MV Day No.** | **4** | **5** | **6** | **7** | **8** | **9** | **Extubated at 11 am** | **--** |
| **VAE Criterion** | -- | Day 1 of stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | Temp 38.4°C | -- | -- |
| **Antimicrobial agent** | Ceftriaxone | Ceftriaxone | Ceftriaxone | **Ceftriaxone** | **Meropenem** | **Meropenem** | **Meropenem** | **Meropenem** |

Patient has fulfilled all IVAC criteria, and IVAC should be reported. Date of the IVAC event is hospital day/MV day 7.

6) What antimicrobial agents are included in the IVAC definition?
   - See the Appendix for a list of the antimicrobial agents eligible for consideration in the IVAC definition (as well as the PVAP definition).
   - See Table 1 for eligible routes of administration.

7) How do I figure out if an antimicrobial agent is "new" for the IVAC definition?
   - A new antimicrobial agent is defined as any agent listed in the Appendix that is initiated on or after 3 days of mechanical ventilation AND in the VAE Window Period (defined by the two days before, the day of, and the two days after the onset date of the VAE—as long as all of these days are on or after the 3rd day of mechanical ventilation). The agent is considered new for the purposes of this definition if it was NOT given to the patient on either of the 2 days preceding the current start date. The agent must be administered via one of the routes listed in Table 1.
     See the example in the figure below:

| MV Day No. | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|
| **VAE Criterion** | | | | Onset (day 1) of worsening oxygenation meeting VAE PEEP or $FiO_2$ thresholds | Day 2 of worsening oxygenation meeting VAE PEEP or $FiO_2$ thresholds | | | |

Example of the 5-day period during which the first dose of a new antimicrobial agent must be given to meet requirements of IVAC definition

EXAMPLE: A single dose of intravenous vancomycin is given to a patient on the VAE onset date (which is the day of onset of worsening oxygenation meeting VAE criteria, in this case MV day 7), and was not given to the patient during the 2 previous days (MV days 5 and 6). Vancomycin is therefore considered a new antimicrobial agent (see figure below).

| MV Day No. | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | Day 1 of stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | None | None | None | **Single dose of vancomycin ordered and administered** | **None** | **None** | **Single dose of vancomycin ordered and administered** |

A single dose of vancomycin is ordered and administered to the patient within the period defined by the two days before, the day of, and the two days after the VAE onset date. Note that no vancomycin was given in the 2 preceding days, and so vancomycin is a "new" antimicrobial agent for the purposes of the VAE definition.

EXAMPLE: If meropenem is given to a patient on the VAE onset date (which is the day of onset of worsening oxygenation meeting VAE criteria, in this case MV day 7), and was not given to the patient during the 2 previous days (MV days 5 and 6), then meropenem is considered a new antimicrobial agent (see figure below). Note that the patient is also receiving ceftriaxone, and receives doses during the 5-day period around the onset of worsening oxygenation (first dose during the 5-day period was on MV day 5). However, because ceftriaxone was given to the patient the day before the 5-day period (on MV day 4), ceftriaxone does not count as a new antimicrobial agent for the purposes of the IVAC definition.

| MV Day No. | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | Day 1 of stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | Ceftriaxone | Ceftriaxone | Ceftriaxone | **Meropenem** | **Meropenem** | **Meropenem** | **Meropenem** |

First dose of meropenem during the 5-day period around the onset of worsening oxygenation. Note that no meropenem was given in the 2 preceding days, and so meropenem is a "new" antimicrobial agent for the purposes of the VAE definition.

8) I have figured out that a new antimicrobial agent was given to the patient. How do I determine whether it was continued for 4 days?
   - Make sure you are using the Medication Administration Record. You need to know which antimicrobial agents were actually administered to the patient. Antimicrobial orders or dispensing information is not sufficient.
   - You do not need to know the dose or frequency of administration.
   - Four consecutive Qualifying Antimicrobial Days (QADs)—starting within the VAE Window Period—are needed to meet the IVAC criterion. A QAD is a day on which the patient was administered an antimicrobial agent that was determined to be "new" within the VAE Window Period. Days between administrations of a new antimicrobial agent

also count as QADs as long as there is a gap of no more than 1 calendar day between administrations of the same antimicrobial agent. For example, if levofloxacin is given on VAE Day 1, has not been given in the 2 preceding calendar days, and is given again on VAE Days 3, 5 and 7, there are 7 QADs—because the days between levofloxacin doses also count as QADs.

- The requirement for 4 consecutive QADs can be met with 4 days of therapy with the same antimicrobial (with a gap of no more than 1 calendar day between administrations of that antimicrobial)—or it can be met with 4 days of therapy with multiple antimicrobial agents, as long as each antimicrobial was started within the VAE Window Period.

EXAMPLE: In the figure below, meropenem would meet the antimicrobial criterion of the IVAC definition because at least one dose was given on 4 consecutive days.

| **MV Day No.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | Ceftriaxone | Ceftriaxone | Ceftriaxone | **Meropenem** | **Meropenem** | **Meropenem** | **Meropenem** |
| **QAD** | No | No | No | **Yes** | **Yes** | **Yes** | **Yes** |

EXAMPLE: In the figure below, the 3 drugs shown in bold lettering all qualify as new antimicrobial agents, and therefore the antimicrobial criterion of IVAC is met, since the patient is given 4 consecutive days of new antimicrobial agents.

| **MV Day No.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | Ceftriaxone | Ceftriaxone | Ceftriaxone | **Meropenem** | **Imipenem** | **Piperacillin/ Tazobactam** | **Piperacillin/ Tazobactam** |
| **QAD** | No | No | No | **Yes** | **Yes** | **Yes** | **Yes** |

EXAMPLE: In the figure below, levofloxacin is a new antimicrobial agent (it was started during the VAE Window Period, on MV day 3, and was not given in the 2 days preceding the first day of administration). There are gaps of no more than 1 calendar days between days on which levofloxacin is given, and so the intervening days also count as QADs. In this example, there are 5 QADs (MV days 3-7); therefore the antimicrobial criterion of IVAC is met.

| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | | | **Levofloxacin** | | **Levofloxacin** | | **Levofloxacin** |
| **QAD** | No | No | **Yes** | **Yes** | **Yes** | **Yes** | **Yes** |

9) There are many patients in my ICU with renal insufficiency and/or who are receiving hemodialysis. These patients may receive certain antimicrobial agents on an infrequent dosing schedule (for example, every 48 hours). How do I determine whether they have received 4 consecutive days of new antimicrobial therapy?
   - See above. You do not need to know the patient's renal function, the dose of the antimicrobial agent, or the frequency of administration. The antimicrobial criterion rules remain the same, regardless of whether patients have renal dysfunction or not.

10) What if the patient is being given one-time doses of intravenous vancomycin? How do I take that into account when using the IVAC surveillance definition?
   - The rules for determining whether the antimicrobial criterion is met do not require that you know the dose or frequency of administration.
   - Make sure that vancomycin qualifies as a new antimicrobial agent—that it was not given in the 2 days preceding the day on which vancomycin was given during the VAE Window Period.
   - Check to see whether there are 4 consecutive QADs with vancomycin; if there are gaps of no more than 1 calendar day between days on which vancomycin is given, the intervening days may be counted as QADs. If there are gaps of longer than 1 calendar day between days of vancomycin therapy, the requirement for 4 consecutive QADs cannot be met using vancomycin alone—but make sure to check whether the 4 consecutive QAD requirement is met by considering any other antimicrobials being administered to the patient.

     EXAMPLE: A patient is given a single dose of vancomycin 1 gram IV on MV day 5. Since vancomycin was started on or after day 3 of mechanical ventilation, and no vancomycin was administered on MV days 2, 3 or 4, vancomycin qualifies as a new antimicrobial agent. A second, single dose of vancomycin 1 gram IV is administered on MV day 8. Because there is a gap of more than 1 calendar day between days of vancomycin administration (there is a gap of 2 days in this example), the requirement for 4 consecutive QADs is not met, and therefore the IVAC antimicrobial criterion is not met.

| MV Day No. | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| **VAE Criterion** | -- | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Antimicrobial agent** | None | None | None | **Vancomycin 1 gram IV x 1 dose** | None | None | **Vancomycin 1 gram IV x 1 dose** | None |
| **QAD** | No | No | No | **Yes** | No | No | **Yes** | No |

11) Can I report pathogens or secondary BSIs for VAC and IVAC?

- Pathogens are NOT reported for VAC or IVAC events.
- Secondary BSIs are NOT reported for VAC or IVAC events.

EXAMPLE: A patient hospitalized and mechanically-ventilated in the MICU for 14 days develops worsening oxygenation following a 7-day period of stability on the ventilator. VAC criteria are met on hospital day 15 (stable ventilator settings on days 12 and 13, increased ventilator settings on days 14 and 15). The onset date is day 14. The white blood cell count is noted to be 15,500 cells/$mm^3$ on day 14. Meropenem and intravenous vancomycin are begun on day 15, administered through the patient's right-sided central line, which was inserted on ICU admission. The antibiotics continue to be administered on day 18, meeting IVAC criteria. Endotracheal aspirate cultures done on days 15 and 16 grow scant upper respiratory flora. A blood culture collected on day 15 is positive for *Klebsiella oxytoca*. There are no other signs or symptoms of infection. This patient should be reported as having an IVAC and a central line-associated BSI if the BSI cannot be attributed as secondary to another primary site of infection. The BSI cannot be reported as secondary to the IVAC event.

12) Can I report pathogens for PVAP?

- Pathogens may be reported for PVAP events, provided they are isolated or identified from appropriate specimen types according to the requirements of the algorithm and are NOT on the list of excluded organisms and culture results:
    - Excluded organisms and culture results that cannot be used to meet the PVAP definition are as follows: "Normal respiratory flora," "normal oral flora," "mixed respiratory flora," "mixed oral flora," "altered oral flora" or other similar results indicating isolation of commensal flora of the oral cavity or upper respiratory tract; *Candida* species or yeast not otherwise specified; coagulase-negative *Staphylococcus* species; and *Enterococcus* species, when identified from sputum, endotracheal aspirates, bronchoalveolar lavage, or protected specimen brushings.

NOTE: When *Candida* species or yeast not otherwise specified, coagulase-negative *Staphylococcus* species or *Enterococcus* species are identified from lung tissue or pleural fluid, these organisms may be reported as PVAP pathogens.

Additionally, because organisms belonging to the following genera are usually causes of community-associated respiratory infections and rarely or are not known to be causes of healthcare-associated infections, they are also excluded, and cannot be used to meet the PVAP definition when isolated from any eligible specimen type (to include lung and pleural fluid): *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.*

- See Table 3 for the required quantitative culture thresholds associated with various specimen types in the PVAP definition. Note that if your laboratory reports semi-quantitative culture results, you should check with your laboratory to confirm that semi-quantitative results match the quantitative thresholds noted in Table 3.

13) Can I report secondary BSIs for PVAP?

- Secondary BSIs may be reported for PVAP events, provided that the organism identified from blood specimen matches an organism identified from an appropriate respiratory tract specimen (including respiratory secretions, pleural fluid and lung tissue). The respiratory tract specimen must have been collected within 2 calendar days before or after the day of onset of worsening oxygenation to be considered as a criterion for meeting the PVAP definition. In addition, the positive blood specimen must have been collected during the 14-day event period, where day 1 is the day of onset of worsening oxygenation.
    - In cases where PVAP is met with only the histopathology criterion and no culture or non-culture based test is performed on an eligible respiratory specimen, and there is also a positive blood specimen, a secondary BSI for VAE is not reported.
    - In cases where a culture or non-culture based test of respiratory secretions, pleural fluid or lung tissue is performed and does not identify an organism that matches an organism identified from blood, a secondary BSI for VAE is not reported.

  NOTE: *Candida* species or yeast not otherwise specified, coagulase-negative *Staphylococcus* species, and *Enterococcus* species identified from blood cannot be deemed secondary to a PVAP, unless the organism was also identified from pleural fluid or lung tissue.

  EXAMPLE: Patient hospitalized and mechanically ventilated in the MICU for 14 days develops worsening oxygenation following a 7-day period of stability on the ventilator. VAC criteria are met on hospital day 15 (stable ventilator settings on days 12 and 13, increased ventilator settings on days 14 and 15). The onset date is day 14. The white blood cell count is noted to be 15,500 cells/$mm^3$ on day 14. Meropenem and vancomycin are begun on day 15, administered through the patient's right-sided central line (inserted on ICU admission). The antibiotics continue to be administered on day 18, meeting IVAC criteria. Endotracheal aspirate specimens collected on days 15 and 16 grow $\geq 10^5$ CFU/ml *Klebsiella oxytoca*. A blood culture collected on day

15 is positive for *K. oxytoca*. This patient should be reported as having a PVAP with a secondary BSI due to *K. oxytoca*.

EXAMPLE: Patient hospitalized and mechanically ventilated in the MICU for 14 days develops worsening oxygenation following a 7-day period of stability on the ventilator. VAC criteria are met on hospital day 15 (stable ventilator settings on days 12 and 13, increased ventilator settings on days 14 and 15). The onset date is day 14. The white blood cell count is noted to be 15,500 cells/$mm^3$ on day 14. Meropenem and vancomycin are begun on day 15, administered through the patient's right-sided central line (inserted on ICU admission). The antibiotics continue to be administered on day 18, meeting IVAC criteria. A thoracentesis is performed on day 15 at the patient's bedside using aseptic technique. Pleural fluid is sent for culture and grows *Candida albicans*. A blood culture collected on day 16 is positive for *C. albicans*. This patient should be reported as having a PVAP with a secondary BSI due to *C. albicans.*

EXAMPLE: Patient hospitalized and mechanically ventilated in the MICU for 14 days develops worsening oxygenation following a 7-day period of stability on the ventilator. VAC criteria are met on hospital day 15 (stable ventilator settings on days 12 and 13, increased ventilator settings on days 14 and 15). The onset date is day 14. The white blood cell count is noted to be 15,500 cells/$mm^3$ on day 14. Meropenem and vancomycin are begun on day 15, administered through the patient's right-sided central line (inserted on ICU admission). The antibiotics continue to be administered on day 18, meeting IVAC criteria. An endotracheal aspirate collected on day 15 is a good quality specimen, with $\geq$ 25 neutrophils and $\leq$ 10 squamous epithelial cells per low power field, and grows *Staphylococcus aureus* (qualitative result). A blood culture collected on day 24 is positive for *S. aureus* and for coagulase-negative staphylococci (CoNS). This patient should be reported as having a PVAP, with *S. aureus* reported as the pathogen. A secondary BSI should also be reported for the PVAP, since the positive blood culture was collected within the 14-day period of the VAE, and an organism isolated from blood (*S. aureus*) matched an organism isolated from culture of the endotracheal aspirate. The CoNS also isolated from the blood culture on day 24 is <u>not</u> reported as a pathogen for the PVAP because it is an excluded organism.

14) <u>Can I only report pathogens if they are isolated in cultures of appropriate specimens? What about pathogens identified by non-culture-based diagnostic testing?</u>

- PVAP incorporates results of non-culture-based microbiological diagnostic testing. For PVAP, pathogens that are grown in culture OR selected pathogens that are identified as a result of other laboratory testing (e.g., antigen testing, PCR, immunohistochemistry, etc.) should be reported. Do not limit reporting to just those organisms isolated in culture. For example, influenza A identified by polymerase chain reaction (PCR) in a patient meeting PVAP criteria should be reported as a pathogen for that event.

15) The "PVAP" criterion 3 includes "positive diagnostic tests" for *Legionella* species, and selected viruses. What kinds of diagnostic tests can be used to meet the definition?

- Diagnostic testing practices may vary from facility to facility and change over time as better tests are developed. Listed here are some examples of diagnostic tests for specific pathogens included in the PVAP definition. Positive results of these tests may be used in meeting the PVAP definition. Your facility may use other testing methods; positive results obtained using these methods may also be appropriate for use in meeting the PVAP definition. If you have a question regarding a diagnostic test method, check with your laboratory.
- For *Legionella* species, positive results of any of the following, performed on the appropriate specimen: urinary antigen, *Legionella*-specific respiratory culture, paired serology (4-fold rise in titer between acute and convalescent specimens), direct fluorescent antibody stain, immunohistochemistry stain, or nucleic acid detection assays (such as PCR) performed on a respiratory specimen.
- For respiratory viruses (influenza, respiratory syncytial virus [RSV], parainfluenza viruses, human metapneumovirus, coronaviruses, rhinoviruses and adenovirus), positive results for any of the following:
    - Performed on an appropriate respiratory specimens – PCR or other viral nucleic acid detection methods, antigen detection methods, including rapid tests, viral cell culture, or
    - Performed on appropriate pathologic specimens – immunohistochemical assays, cytology, microscopy, or
    - Performed on appropriately timed paired sera (acute and convalescent) – serological assays demonstrating seroconversion or a significant rise in antibody titer.

16) What about pneumonitis that occurs in a mechanically-ventilated patient and is determined to be due to herpes simplex virus (HSV) or cytomegalovirus (CMV)? Can these infections be reported as VAEs?

- In most cases pneumonitis due to HSV and CMV represents reactivation of a latent infection, and therefore would not be considered healthcare-associated, according to the NHSN definition of a healthcare-associated infection.

17) Are there any culture results or microorganisms that CANNOT be used to meet the PVAP definition?

- The following pathogens and culture results may NOT be used to meet the definition and may NOT be reported as causes of PVAP when they are identified from sputum, endotracheal aspirates, bronchoalveolar lavages or protected specimen brushings:
    - Culture results reported as "Normal respiratory flora," "normal oral flora," "mixed respiratory flora," "mixed oral flora," "altered oral flora" or other similar results indicating isolation of commensal flora of the oral cavity or upper respiratory tract.
    - *Candida* species or yeast not otherwise specified

- Coagulase-negative *Staphylococcus* species
- *Enterococcus* species

NOTE: These organisms are excluded because they are common upper respiratory tract commensals, colonizers or contaminants, and are unusual causes of VAP. Their exclusion from the surveillance definitions should NOT be used in clinical decision-making regarding patient treatment. Providers must independently determine the clinical significance of these organisms identified from respiratory specimens and the need for treatment.

NOTE: When *Candida* species or yeast not otherwise specified, coagulase-negative *Staphylococcus* species or *Enterococcus* species are identified from lung tissue or pleural fluid, these organisms may be reported as PVAP pathogens.

Additionally, because organisms belonging to the following genera are typically causes of community-associated respiratory infections and are rarely or are not known to be causes of healthcare-associated infections, they are also excluded, and cannot be used to meet the PVAP definition when isolated from any eligible specimen type (to include lung and pleural fluid): *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis.*

- When sputum, endotracheal aspirate, bronchoalveolar lavage or protected specimen brushing culture or non-culture based testing results are mixed and contain one or more of the excluded pathogens in addition to one or more non-excluded pathogens, the culture may be used to meet the PVAP definition (depending on whether a qualitative, semi-quantitative or quantitative culture was performed, and whether the semi-quantitative or quantitative cfu/ml thresholds were met) BUT only the non-excluded pathogen(s) should be reported.

  EXAMPLE: Patient intubated and mechanically ventilated in the MSICU meets IVAC criteria on day 8 of mechanical ventilation. On the day after the onset of worsening oxygenation, an endotracheal aspirate is collected. The Gram stain shows ≥ 25 neutrophils and ≤ 10 squamous epithelial cells per low power field, and the culture grows "heavy *Staphylococcus aureus*" and "heavy *Candida albicans*." This patient should be reported as having a PVAP (criterion1) due to *Staphylococcus aureus* – as long as the semi-quantitative result "heavy" is equivalent to the quantitative threshold of $\geq 10^5$ cfu/ml for endotracheal aspirates. If the semi-quantitative result is not equivalent to the quantitative threshold of $\geq 10^5$ cfu/ml for endotracheal aspirates, the patient should still be reported as PVAP (criterion 2). *Candida albicans* from the endotracheal aspirate culture is not reported, because it is an excluded result.

18) What about organisms identified from pleural fluid and lung tissue specimens? Can I report any pathogen identified from a lung tissue, or from a pleural fluid specimen, assuming the specimen was obtained during thoracentesis or at the time of chest tube insertion?

- Any pathogen identified from lung tissue, when that lung tissue was obtained during an open lung biopsy, video-assisted thoracoscopic surgery, or via other transthoracic or transbronchial biopsy approach, may be reported with the exception of the excluded pathogens belonging to the following genera: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis*.
- Any pathogen identified from pleural fluid, when that fluid was obtained during thoracentesis or at the time of initial chest tube insertion, may be reported with the exception of the excluded pathogens belonging to the following genera: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis*.

19) How are "purulent respiratory secretions" defined?

- Purulent respiratory secretions used to meet Criterion #2 of the PVAP definition are defined as:
    - Secretions from the lungs, bronchi, or trachea with ≥ 25 neutrophils and ≤ 10 squamous epithelial cells per low power field [lpf, x100].
    - If the laboratory reports semi-quantitative results, you should check with your laboratory to be certain that the semi-quantitative results match the quantitative thresholds noted above.
- If your laboratory is not able to provide additional information on how a semi-quantitative reporting system corresponds to quantitative reporting ranges for neutrophils and squamous epithelial cells, here is some guidance from the *Clinical Microbiology Procedures Handbook* (3rd ed., 2010)*:

    1+ = occasional or rare = <1 cell per low power field [lpf, x100]
    2+ = few = 1-9 cells per low power field [lpf, x100]
    3+ = moderate = 10-25 cells per low power field [lpf, x100]
    4+ = heavy = >25 cells per low power field [lpf, x100]

*Reference: Garcia, LS (Ed.). (2010). Clinical Microbiology Procedures Handbook. Herndon, VA: ASM Press, page 3.2.1.16.

    - With this range in mind, and in the absence of additional information from your laboratory, "purulent respiratory secretions" are defined as secretions that contain heavy, 4+ or ≥25 neutrophils per low power field [lpf, x100] AND rare, occasional, few, 1+ or 2+, or ≤10 squamous epithelial cells per low power field [lpf, x100].

- If your laboratory uses a different reporting format for results of direct examination of respiratory secretions, you may still be able to use the purulent respiratory secretions in meeting the PVAP definition. See the instructions available in the VAE Protocol, Table 2.

20) What is the definition of "positive lung histopathology" that can be used to meet the PVAP definition?
    - If the lung tissue specimen was obtained via open lung biopsy, video-assisted thoracoscopic surgery, or via other transthoracic or transbronchial biopsy approach, it is eligible for consideration in meeting the PVAP definition (Criterion 3).
    - Histopathological findings that can be used to meet the PVAP definition include:
        - Abscess formation or foci of consolidation with intense neutrophil accumulation in bronchioles and alveoli;
        - Evidence of lung parenchyma invasion by fungi (hyphae, pseudohyphae or yeast forms);
        - Evidence of infection with the viral pathogens listed in FAQ no. 14 based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue.

21) I am still having trouble understanding the time frame that defines a VAE. Can you explain what is meant by this statement that appears in the algorithm: *"On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation"*?
    - The intent of these criteria is to determine whether a VAC is due to an infectious process (IVAC) and/or pneumonia (PVAP) by looking for corroborating inflammatory and infectious signs at the time of VAC onset. The criterion, "on or after calendar day 3" is intended to exclude inflammatory and infectious signs present on the first two days of mechanical ventilation because they are more likely to be due to pre-existing conditions than ventilator-acquired complications. The criterion, "within 2 calendar days before or after the onset of worsening oxygenation," is intended to identify infectious and inflammatory signs that arise at the same time as VAC and may therefore point to the cause of the VAC. +
    - The figures below illustrate the time frame that defines a VAE. The event date is the first day of worsening oxygenation, defined by the PEEP and $FiO_2$ thresholds outlined in the algorithm. The event date defines the time frame within which all other criteria must be met. In the examples below, the shaded area defines the VAE Window Period in which IVAC criteria (temperature or white count abnormalities, plus a new antimicrobial agent started and continued for at least 4 days) must be met, and in which a PVAP criterion must be met.

      NOTE: Keep in mind that VAE criteria must be met based on specimens collected or antimicrobial agents started after day 2 of mechanical ventilation.

      EXAMPLE 1: When the onset date of the VAE occurs early in the course of mechanical ventilation (e.g., day 3 or 4 of mechanical ventilation), the period in which certain inflammatory and infectious criteria are sought for IVAC and PVAP is shorter, because the first 2 days of mechanical ventilation are excluded from the normal 5 day window surrounding the day of increased ventilator support.

| MV Day No. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| **Worsening oxygenation** | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Temperature abnormality or white blood cell count abnormality** | | | ←An abnormal temperature or white blood cell count, according to the algorithm parameters, must be documented within this shaded period→ | | | | |
| **Antimicrobial agent** | | | ←New agent must be started on any day within this shaded period, and then continued for at least 4 days→ | | | | |
| **Purulent respiratory secretions, positive culture, positive histopathology** | | | ←Specimen must be collected on any day within this shaded period→ | | | | |

EXAMPLE 2: When the onset date of the VAE occurs later in the course of mechanical ventilation, the period in which certain criteria must be met is a day longer, because the patient has already been on mechanical ventilation for more than 3 days and therefore inflammatory and infectious signs arising anywhere in the full 5-day window surrounding the day of increased ventilator settings can count towards IVAC and PVAP.

| MV Day No. | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|
| **Worsening oxygenation** | -- | Day 1 of Stability or improvement | Day 2 of stability or improvement | Day 1 of worsening oxygenation | Day 2 of worsening oxygenation | | |
| **Temperature abnormality or white blood cell count abnormality** | | ←An abnormal temperature or white blood cell count, according to the algorithm parameters, must be documented within this shaded period→ | | | | | |
| **Antimicrobial agent** | | ←New agent must be started on any day within this shaded period, and then continued for at least 4 days→ | | | | | |
| **Purulent respiratory secretions, positive culture, positive histopathology** | | ←Specimen must be collected on any day within this shaded period→ | | | | | |

22) <u>Providers in my ICU use different types of mechanical ventilation for different patients. Can you explain the circumstances in which mechanically-ventilated patients are to be excluded from VAE surveillance, and the circumstances in which mechanically-ventilated patients should be included in VAE surveillance?</u>

- VAE surveillance is restricted to adult inpatient locations. Patients on mechanical ventilation who are in adult inpatient locations in acute care and long-term acute care hospitals and inpatient rehabilitation facilities are eligible for inclusion in VAE surveillance.
- Patients are excluded from VAE surveillance during periods of time when they are receiving high frequency ventilation, or if they are receiving extracorporeal life support (extracorporeal membrane oxygenation).
- Patients are included in surveillance if they are on a ventilator (as defined in the VAE surveillance protocol), and are being mechanically ventilated through an endotracheal or tracheostomy tube using a conventional mode of mechanical ventilation (such as volume controlled, pressure controlled, or pressure support mechanical ventilation).

    - Patients on conventional mechanical ventilation who are receiving nitric oxide, helium-oxygen mixtures (heliox) or epoprostenol therapy are included in surveillance.
    - Patients on conventional mechanical ventilation who are being ventilated in the prone position are included in surveillance.
- Patients are also included in surveillance if they are on a ventilator (as defined in the VAE surveillance protocol), and are being mechanically ventilated through an endotracheal or tracheostomy tube using Airway Pressure Release Ventilation (APRV) or related modes. Some terms that are used to indicate APRV or a related mode of mechanical ventilation include (but may not be limited to): BiLevel, Bi Vent, BiPhasic, PCV+, and DuoPAP.
    - For patients on APRV or related modes, the period of worsening oxygenation following a period of stability or improvement on the ventilator that is required for identification of a VAE will be defined by the $FiO_2$ criterion within the VAE surveillance definition algorithm. The PEEP criterion may not be applicable in patients on APRV or related modes of mechanical ventilation.
- If you have questions about mechanical ventilation, you should check with the Respiratory Care or Respiratory Therapy and/or Critical Care departments in your facility.

23) Why do I need to indicate if a patient was on APRV at the time of VAE onset, and why do I need to indicate the number of patients on APRV in my ICU for each day of VAE surveillance?
- We are trying to find out more about how frequently APRV and related modes of mechanical ventilation are being used, and the frequency with which VAEs are identified in patients on APRV and related modes, to determine whether the VAE surveillance definition algorithm may need to be modified in the future.
- If the VAE occurred in a patient on Airway Pressure Release Ventilation (APRV) or a related mode of mechanical ventilation (e.g., BiLevel, Bi Vent, BiPhasic, PCV+, DuoPAP) at the time of VAE onset, indicate "Yes" in the "APRV" field on the VAE Form (CDC 57.112). Otherwise, indicate "No."
- On the appropriate denominator form (CDC 57.117 or 57.118); in the column for "Number of patients on a ventilator," you will see that there are two sub-columns. In the sub-column, "Total patients," enter the total number of patients on a ventilator on that day. In the sub-column, "Number on APRV," enter the number for the subset of patients on a ventilator on that day who are on the APRV mode of mechanical ventilation or related modes (e.g., BiLevel, Bi Vent, BiPhasic, PCV+, DuoPAP) at the time the count is performed. If there are no patients on APRV or a related mode of mechanical ventilation, enter "0" (zero).

24) My laboratory only performs semi-quantitative cultures of lower respiratory tract specimens, and cannot provide me with additional guidance to help me know what semi-quantitative

culture result corresponds to the quantitative thresholds specified in Criterion1 of the PVAP definition. Can you provide more information?

- For the purposes of this surveillance, and in the absence of additional information available from your laboratory, a semi-quantitative result of "moderate" or "heavy" growth, or 2+, 3+ or 4+ growth, meets the PVAP definition (Criterion 1).

# Multidrug-Resistant Organism & *Clostridium difficile* Infection (MDRO/CDI) Module

## Table of Contents

**Background**: Methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococcus* spp. (VRE), and certain gram-negative bacilli have increased in prevalence in U.S. hospitals over the last three decades, and have important implications for patient safety. A primary reason for concern about these multidrug-resistant organisms (MDROs) is that options for treating patients with these infections are often extremely limited, and MDRO infections are associated with increased lengths of stay, costs, and mortality. Many of these traits have also been observed for *Clostridium difficile* infection (CDI). The Healthcare Infection Control Practices Advisory Committee (HICPAC) has approved guidelines for the control of MDROs.[1] These guidelines are available at: http://www.cdc.gov/hicpac/mdro/mdro_toc.html). The MDRO and CDI module of the NHSN can provide a tool to assist facilities in meeting some of the criteria outlined in the guidelines. In addition, many of the metrics used in this module are consistent with "Recommendations for Metrics for Multidrug-Resistant Organisms in Healthcare Settings: SHEA/HICPAC Position Paper."[2]

*Clostridium difficile (C. difficile)* is responsible for a spectrum of *C. difficile* infections (CDI), including uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon, which can, in some instances, lead to sepsis and even death. Although CDI represents a subset of gastroenteritis and gastrointestinal tract infections in the current CDC definitions for HAIs, specific standard definitions for CDI [3] should be incorporated to obtain a more complete understanding of how *C. difficile* is being transmitted in a healthcare facility.

As outlined in the HICPAC guideline[1], these MDRO and *C. difficile* pathogens may require specialized monitoring to evaluate if intensified infection control efforts are required to reduce the occurrence of these organisms and related infections. The goal of this module is to provide a mechanism for facilities to report and analyze these data that will inform infection prevention professionals of the impact of targeted prevention efforts.

This module contains two reporting options for MDRO and *C. difficile*, one focused on Laboratory-identified (LabID) Events reporting and the second on Infection Surveillance reporting. Reporting options are summarized in Table 1. Participants may choose either one or both of the two core reporting options and then may also choose to participate in any of the supplemental monitoring methods described in Table 1.

**Note:** LabID Event reporting and Infection Surveillance reporting are two separate and independent reporting options. See Appendix 3: *Differentiating Between LabID Event and Infection Surveillance* for key differences between the two options.

Table 1. Core and Supplemental Reporting Choices for MDRO and CDI Module

| | MDRO | | | CDI |
|---|---|---|---|---|
| **Reporting Choices** | **MRSA or MRSA/MSSA** | **VRE** | **CephR-*Klebsiella*, CRE (*E. coli, Enterobacter, Klebsiella*), *Acinetobacter* spp. (MDR)** | ***C. difficile*** |
| **Core** | **Method** | **Method** | **Method** | **Method** |
| Proxy Infection Measures LabID Event Choose ≥1 organism | A, B, C, D | A, B, C, D | A, B, C, D | ±A, B, C |
| **AND/OR** | | | | |
| Infection Surveillance Choose ≥1 organism | A, B | A, B | A, B | ±A, B |
| **Supplemental** | **Method** | **Method** | **Method** | **Method** |
| Prevention Process Measures Options: | | | | |
| • Hand Hygiene Adherence | B | B | B | B |
| • Gown and Gloves Use Adherence | B | B | B | B |
| • Active Surveillance Testing (AST) Adherence | B | B | N/A | N/A |
| AST Outcome Measures | | | | |
| • Incident and Prevalent Cases using AST | B | B | N/A | N/A |

N/A – not available or contraindicated

±No surveillance for CDI will be performed in Neonatal Intensive Care Units (NICU), Specialty Care Nurseries (SCN), babies in LDRP (Labor, Delivery, Recovery, and Post-partum), well-baby nurseries, or well-baby clinics. And, if conducting facility-wide monitoring (Method C) the denominator counts (admissions, patient-days, encounters) for these locations must be removed.

Reporting Method (must choose to monitor by LabID Event or Infection Surveillance reporting before supplemental methods can also be used for monitoring):

**A:** **Facility-wide by location.** Report for each location separately and cover all locations in a facility. This reporting method requires the most effort, but provides the most detail for local and national statistical data.

**B:** **Selected locations within the facility (1 or more).** Report separately for one or more specific locations within a facility. This includes reporting individual Events and denominator data for each of the selected locations. This reporting method is ideal for use during targeted prevention programs. Note: MDRO "blood specimens only" is the sole MDRO LabID event option for IRF, ED and 24-hour Observation locations.

**C:** **Overall facility-wide.** Report individual LabID events from each inpatient location and aggregate denominator counts for the entire facility. Options include: (1) Overall Facility-wide Inpatient (FacWideIN) to cover all inpatient locations. When using FacWideIN reporting, facilities must also include location specific reporting for outpatient emergency department (i.e., adult and pediatric) and 24-hour observation location(s). NOTE: When following FacWideIN, facilities will be required to enter denominators for all inpatient locations physically located in the hospital, as well as denominators for all inpatient locations minus any inpatient rehabilitation facility (IRF) and inpatient psychiatric facility (IPF) locations with separate CCNs. Totals reported should not include facilities affiliated with the hospital that are enrolled separately. Additionally, separate denominator data will be required to capture encounters for each mapped emergency department and 24-hour observation location. (2) Overall Facility-wide Outpatient (FacWideOUT) to cover all outpatient locations affiliated with the facility. Facilities may choose to monitor both FacWideIN and FacWideOUT.

**D:** **Overall facility-wide: *Blood Specimens* Only.** This method is available for MDRO LabID Events only and targets the most invasive events. Report individual LabID events from each inpatient location and aggregate denominator counts for the entire facility. Options include: (1) Overall Facility-wide Inpatient (FacWideIN) to cover all inpatient locations. Using this option, facilities must also include location specific reporting for outpatient emergency department (i.e., adult and pediatric) and 24-hour observation location(s). NOTE: When following FacWideIN, facilities will be required to enter denominators for all inpatient locations physically located in the hospital, as well as denominators for all inpatient locations minus any inpatient rehabilitation facility (IRF) and inpatient psychiatric facility (IPF) locations with separate CCNs. Totals reported should not include facilities affiliated with the hospital that are enrolled separately. Additionally, separate denominator data will be required to capture encounters for each mapped emergency department and 24-hour observation location. (2) Overall Facility-wide Outpatient (FacWideOUT) to cover all outpatient locations affiliated with the facility. Facilities may choose to monitor both FacWideIN and FacWideOUT.

# I. Core Reporting

## Option 1: Laboratory-Identified (LabID) Event Reporting

**Introduction:** LabID Event reporting option allows laboratory testing data to be used without clinical evaluation of the patient, and therefore is a much less labor-intensive method to track MDROs and *C. difficile*. These provide proxy infection measures of MDRO and/or *C. difficile* healthcare acquisition, exposure burden, and infection burden based almost exclusively on laboratory data and limited admission date data, including patient care location. LabID Event reporting is ONLY for collecting and tracking positive laboratory results (e.g., cultures) that are collected for "clinical" purposes (i.e., for diagnosis and treatment). This means that the results of laboratory specimens collected for active surveillance testing (AST) purposes only should not be reported as LabID Events.

LabID Events can be monitored at the overall facility-wide level for inpatient areas (FacWideIN), and/or at the overall facility-wide level for outpatient areas (FacWideOUT). At the overall FacWide levels and for IRF, ED, and 24-hour observation, MDROs can be monitored for all specimen types or for *blood specimens* only. LabID Events can also be monitored for specific locations with unique denominator data required from each of the specific locations (i.e., facility-wide locations monitored separately [Method A] allowing for both facility-wide and location-specific data, or by selected locations only [Method B]). If a facility chooses to conduct FacWideIN surveillance for LabID Events, the facility must also follow location-specific surveillance for that same organism in each outpatient emergency department (pediatric and adult) and 24-hour observation location.

Laboratory and admission data can be used to calculate a variety of distinct proxy measures including: admission prevalence rate and overall patient prevalence rate (measures of exposure burden), MDRO bloodstream infection incidence rate (measure of infection burden and healthcare acquisition), overall MDRO infection/colonization incidence rate (measure of healthcare acquisition), and CDI incidence rate (measure of infection burden and healthcare acquisition).

Use NHSN forms to collect all required data, using the definitions of each data field as indicated in the Tables of Instructions. When denominator data are available from electronic databases, these sources may be used as long as the counts are not substantially different (+ or – 5%) from manually collected counts.

## A. MDRO LabID Event Reporting

**Methodology:** Facilities may choose to monitor one or more of the following MDROs: MRSA, MRSA and MSSA, VRE, CephR- *Klebsiella*, CRE, and/or multidrug-resistant *Acinetobacter* spp. (see definitions below). For *S. aureus*, both the resistant (MRSA) and the susceptible (MSSA) phenotypes can be tracked to provide concurrent measures of the susceptible pathogens as a comparison to those of the resistant pathogens in a setting of active MRSA prevention efforts.

**Note:** No Active Surveillance Culture/Testing (ASC/AST) results are to be included in this reporting of individual results (See *General Key Terms chapter*). Do NOT enter surveillance nasal swabs or other surveillance cultures as reports of LabID Events. AST tracking should be recorded under Process & Outcome Measures.

**MDRO Definitions:** MDROs included in this module are defined below.

MRSA: Includes ***S. aureus*** cultured from any specimen that tests oxacillin-resistant, cefoxitin-resistant, or methicillin-resistant by standard susceptibility testing methods, or by a laboratory test that is FDA-approved for MRSA detection from isolated colonies; these methods may also include a positive result by any FDA-approved test for MRSA detection from specific sources.

MSSA: ***S. aureus*** cultured from any specimen testing intermediate or susceptible to oxacillin, cefoxitin, or methicillin by standard susceptibility testing methods, or by a negative result from a test that is FDA-approved for MRSA detection from isolated colonies; these methods may also include a positive result from any FDA-approved test for MSSA detection from specific specimen sources.

VRE: ***Enterococcus faecalis, Enterococcus faecium, or Enterococcus species unspecified*** *(only those not identified to the species level)* that is resistant to vancomycin, by standard susceptibility testing methods or by results from any FDA-approved test for VRE detection from specific specimen sources.

CephR-*Klebsiella*: ***Klebsiella oxytoca or Klebsiella pneumoniae*** testing non-susceptible (i.e., resistant or intermediate) to ceftazidime, cefotaxime, ceftriaxone, or cefepime.

CRE: Any ***Escherichia coli***, ***Klebsiella oxytoca, Klebsiella pneumoniae***, or ***Enterobacter* spp**. testing resistant to imipenem, meropenem, doripenem, or ertapenem by standard susceptibility testing methods (i.e., minimum inhibitory concentrations of ≥4 mcg/mL for doripenem, imipenem and meropenem or ≥2 mcg/mL for ertapenem) OR by production of a carbapenemase (i.e., KPC, NDM, VIM, IMP, OXA-48) demonstrated using a recognized test (e.g., polymerase chain reaction, metallo-β-lactamase test, modified-Hodge test, Carba-NP). **Note**: For in-plan CRE surveillance, facilities must conduct surveillance for all three organisms CRE-*E. coli*, CRE-*Enterobacter*, **and** CRE-*Klebsiella (Klebsiella oxytoca* and *Klebsiella pneumoniae*).

MDR-*Acinetobacter:* Any ***Acinetobacter*** spp. testing non-susceptible (i.e., resistant or intermediate) to at least one agent in at least 3 antimicrobial classes of the following 6 antimicrobial classes:

| **β-lactam/β-lactam β-lactamase inhibitor combination** | **Aminoglycosides** | **Carbapenems** | **Fluoroquinolones** |
|---|---|---|---|
| Piperacillin<br>Piperacillin/tazobactam | Amikacin<br>Gentamicin<br>Tobramycin | Imipenem<br>Meropenem<br>Doripenem | Ciprofloxacin<br>Levofloxacin |
| **Cephalosporins** | **Sulbactam** | | |
| Cefepime<br>Ceftazidime | Ampicillin/sulbactam | | |

**Settings:** MDRO LabID Event reporting can occur in any location: inpatient or outpatient.

**Requirements**: Facilities choose at least one of the reporting methods listed below and report data accordingly:

| **Method** | **Numerator Data Reporting** | **Denominator Data Reporting** |
|---|---|---|
| Facility-wide by location<br><br>**Note:** Must monitor *All Specimen* sources | Enter each MDRO LabID Event from all locations separately | Report separate denominators for each location in the facility as specified in the NHSN Monthly Reporting Plan |
| Selected locations<br><br>**Note:** Must monitor *All Specimen* sources with the exception of IRF units, 24-hour observation, and emergency department | Enter each MDRO LabID Event from selected locations separately | Report separate denominators for each location monitored as specified in the NHSN Monthly Reporting Plan |
| Overall Facility-wide Inpatient (FacWideIN), *All Specimens* | Enter each MDRO LabID Specimen Event from all inpatient locations AND separately for outpatient emergency department, and 24-hour observation location(s). | Report aggregate denominator data for all inpatient locations physically located in the hospital (e.g., total number of admissions and total number of patient days), as well as denominators for all inpatient locations minus inpatient rehabilitation facility and inpatient psychiatric facility locations with separate CCNs. Separate denominators should be entered to capture encounters for each mapped |

| | | |
|---|---|---|
| | | outpatient emergency department and 24-hour observation location. |
| Overall Facility-wide Outpatient (FacWideOUT), *All Specimen* sources | Enter each MDRO LabID Event from all affiliated outpatient locations separately. | Report only one denominator for all outpatient locations (e.g., total number of encounters, including ED and OBS encounters in addition to other outpatient locations.) |
| Overall Facility-wide Inpatient (FacWideIN), *Blood Specimens* Only | Enter each MDRO LabID Blood Specimen Event from all inpatient locations AND separately for outpatient emergency department, and 24-hour observation location(s). | Report aggregate denominator data for all inpatient locations physically located in the hospital (e.g., total number of admissions and total number of patient days), as well as denominators for all locations minus inpatient rehabilitation facility and inpatient psychiatric facility locations with separate CCNs. Separate denominators should be entered to capture encounters for each mapped outpatient emergency department and 24-hour observation location. |
| Overall Facility-wide Outpatient (FacWideOUT), *Blood Specimens* Only | Enter each MDRO LabID Blood Specimen Event from all affiliated outpatient locations separately | Report only one denominator for all outpatient locations (e.g., total number of encounters). |

**Note:** Facilities must indicate each reporting choice chosen for the calendar month on the *Patient Safety Monthly Reporting Plan* (CDC 57.106).

For each MDRO being monitored, all MDRO test results are evaluated using either the algorithm in Figure 1 (*All Specimens*) or Figure 2 (*Blood Specimens only*) to determine reportable LabID events for each calendar month, for each facility location as determined by the reporting method chosen. If monitoring *all specimens*, all first MDRO isolates (chronologically) per patient, per month, per location are reported as a LabID event regardless of specimen source [EXCLUDES tests related to active surveillance testing] (Figure 1); if a duplicate MDRO isolate is from blood, or if monitoring *blood specimens* only, it is reported as a LabID event only if it represents a unique blood source [i.e., no prior isolation of the MDRO in blood from the same patient and location in ≤2 weeks, even across calendar months] (Figures **1** & **2**). As a general rule, at a maximum, there should be no more than 3 blood isolates reported, which would be very rare. If monitoring *all specimens* and a blood isolate is entered as the first specimen of the month, then no non-*blood specimens* can be entered that month for that patient and location. Report each LabID Event individually on a separate form.

**Definitions:**

MDRO Isolate: Any specimen, obtained for clinical decision making, testing positive for an MDRO (as defined above). **Note**: Excludes tests related to active surveillance testing.

Duplicate MDRO Isolate: If monitoring *all specimens*, any MDRO isolate from the same patient and location after an initial isolation of the specific MDRO during a calendar month, regardless of specimen source, except unique blood source (Figure 1).

> EXAMPLE: On January 2, a newly admitted ICU patient has a positive MRSA urine culture. The following week, while still in the ICU, the same patient has MRSA cultured from an infected decubitus ulcer. The MRSA wound culture is considered a duplicate MDRO isolate, since it is the second non-blood MRSA isolate collected from the same patient and location during the same calendar month.

Unique Blood Source: A MDRO isolate from blood in a patient with no prior positive blood culture for the same MDRO and location in ≤2 weeks, even across calendar months and different facility admissions (Figure 2). There should be 14 days with no positive blood culture result for the patient, MDRO, and location before another Blood LabID Event is entered into NHSN for the patient, MDRO, and location. Additionally, if following *all specimens*, the first MDRO for the patient, month, and location should be reported. **Note:** The date of specimen collection is considered Day 1. NHSN recommends facilities keep an internal line listing log of all positive isolates for reference in LabID event reporting.

> EXAMPLE: (For *blood specimens only* reporting): On January 1, an ICU patient has a positive MRSA blood culture which **is** entered into NHSN. On January 4, while in the same location (ICU), the same patient has another positive MRSA blood culture which is **not** entered into NHSN because it has not been 14 days since the original positive MRSA blood culture while in the same location. On January 16, while in the same location (ICU), the same patient has another positive MRSA blood culture. While it has been more than 14 days since the initial positive MRSA blood culture from the same patient and location was entered into NHSN (January 1), it has not been >14 days since the patient's most recent positive MRSA blood culture (January 4) while in the same location. Therefore, the positive blood culture for January 16 is **not** entered into NHSN. On February 1, the patient has another positive MRSA blood culture while in the same location (ICU). Since it has been >14 days since the patient's most recent positive culture (January 16) while in the same location, this event **is** entered into NHSN.
>
> EXAMPLE :( For *all specimens* reporting)*:* For the same scenario as above, report the January 1 positive MRSA blood culture and do not report any additional January events. Additionally, report February 1 positive MRSA blood culture as this represents the first MDRO for the patient, month and location.

Laboratory-Identified (LabID) Event: All non-duplicate MDRO isolates from any specimen source and unique blood source MDRO isolates. [EXCLUDES tests related to active surveillance testing]. Even if reporting at the FacWide level, all reporting must follow rules by location for reporting.

**Notes:**

- A LabID Event calculator is available on the NHSN website to help with data entry decision making around the 14-day rule.
- If a facility is participating in FacWideIN surveillance and reporting, the facility must also conduct separate location-specific surveillance in all outpatient emergency department and 24-hour observation locations. This means LabID Events for the same organism and LabID Event type (i.e., *all specimens* or *blood specimens* only) must be reported from these locations even if the patient is not subsequently admitted to an inpatient location during the same encounter.
- All emergency department and 24-hour observation locations must be identified and mapped as outpatient locations within NHSN. For more information about mapping locations, see Locations chapter in the NHSN manual.

EXAMPLE: If monitoring blood specimens for FacWideIN (which requires surveillance in the emergency department and 24-hour observation locations), a patient has a positive MRSA laboratory isolate while in the emergency department. This specimen represents an MRSA LabID Event and should be entered for the outpatient emergency department. The next calendar day, the same patient is admitted to ICU and three days later, has a second positive MRSA blood specimen. This specimen also represents a unique LabID Event, because it is the first positive blood specimen in *this location* (ICU). Note that while this patient has two LabID Events, the second specimen that was taken from the ICU will be removed from most analysis reports.

EXAMPLE: If monitoring *all specimens*, on January 2, a newly admitted ICU patient with no previous positive laboratory isolates during this admission has a positive MRSA urine culture. This specimen represents a LabID Event since it is the first MRSA isolate for the patient, the location, and the calendar month.

EXAMPLE: If monitoring *all specimens* for FacWideIN surveillance, on January 2, a VRE wound culture is collected from the facility's own ED. The patient is then admitted to 4W the next calendar day. The ED culture result must be entered as an outpatient LabID event for the ED location for January 2, since the ED location is included in FacWideIN surveillance and reporting.

EXAMPLE: If monitoring *blood specimens only*, on January 26, a newly admitted ICU patient with no previous positive laboratory isolates during this admission has a positive MRSA urine culture which is not entered as a LabID Events since *blood specimens* only are being monitored. The following day, while in the same location, the same patient has

a positive MRSA blood culture. This specimen represents a LabID Event since it is a unique blood source (the first MRSA **blood** isolate for the same patient and same location). While remaining in ICU, the same patient has another positive blood culture on February 5. This does **not** represent a new LabID Event since it has not been >14 days since the most recent MRSA positive blood isolate for this patient and location.

**Reporting Instructions**: All LabID Events must be reported by location and separately and independently of Events reported through MDRO Infection Surveillance reporting and/or HAIs reported through the Device-associated and/or Procedure-associated Modules. See *Appendix 1. Guidance for Handling MDRO and CDI Module Infection Surveillance and LabID Event Reporting When Also Following Other NHSN Modules* for instructions on unique reporting scenarios. See *Appendix 3. Differentiating Between LabID Event and Infection Surveillance* for additional reporting information.

**Numerator Data:** Data will be reported using the *Laboratory-identified MDRO or CDI Event* form (CDC 57.128).

**Denominator Data:** Patient days, admissions (for inpatient locations), and encounters for emergency department, observation units, and other affiliated outpatient locations are reported using the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127). Beginning in 2015 for FacWideIN surveillance, facilities will be required to enter denominators for all locations physically located in the hospital, as well as denominators for all locations minus inpatient rehabilitation facility and inpatient psychiatric facility locations with a separate CCN. The totals should not include other facility types within the hospital that are enrolled and reporting separately (e.g., LTAC). See Table of Instructions for completion instructions.

An encounter is defined as a patient visit to an outpatient location. When determining a patient's admission dates to both the facility and specific inpatient location, the NHSN user must take into account any days spent in an inpatient location as an "observation" patient before being officially admitted as an inpatient to the facility, as these days contribute to exposure risk. Therefore, all days spent in an inpatient unit, regardless of admission and/or billing status are included in the counts of admissions and inpatient days for the facility and specific location; facility and specific location admission dates must be moved back to the first day spent in the inpatient location. For further information on counting patient days and admissions, see Appendix 2.

**Data Analysis:** Based on data provided on the LabID Event form, each event will be categorized by NHSN to populate different measures. By classifying positive cultures obtained on day 1 (admission date), day 2, and day 3 of admission as CO LabID Events and positive cultures obtained on or after day 4 as HO LabID Events, all HO LabID Events will have occurred more than 48 hours after admission.

The following categorizations and prevalence and incidence calculations are built into the analysis capabilities of NHSN, and are based on timing of admission to a facility and/or location, specimen collection, and location where specimen was collected. Descriptions are provided to explain how the categories and metrics are defined in NHSN.

**Categorizing MDRO LabID Events – *Based on Date Admitted to Facility and Date Specimen Collected:***

Community-Onset (CO): LabID Event specimen collected in an outpatient location or an inpatient location ≤3 days after admission to the facility (i.e., days 1, 2, or 3 of admission).

Healthcare Facility-Onset (HO): LabID Event specimen collected >3 days after admission to the facility (i.e., on or after day 4).

**The following section describes the various measures calculated for MDRO LabID event surveillance.**

**Note**: Beginning with 2015 data analysis, the number of FacWideIN admissions and number of FacWideIN patient days used in the various MDRO rate and SIR calculations will reflect data reported for the facility minus admissions and patient days from inpatient rehabilitation facility (IRF) and inpatient psychiatric facility (IPF) locations with unique CCNs.

**Proxy Measures for Exposure Burden of MDROs – *All specimens*:**

**Inpatient Reporting:**

- Admission Prevalence Rate = Number of 1st LabID Events per patient per month identified ≤3 days after admission to the location (if monitoring by inpatient location), or the facility (if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100

- Location Percent Admission Prevalence that is Community-Onset = Number of Admission Prevalent LabID Events to a location that are CO / Total number Admission Prevalent LabID Events x 100

- Location Percent Admission Prevalence that is Healthcare Facility-Onset = Number of Admission Prevalent LabID Events to a location that are HO / Total number of Admission Prevalent LabID Events x 100

- Overall Patient Prevalence Rate = Number of 1st LabID Events per patient per month regardless of time spent in location (i.e., prevalent + incident, if monitoring by inpatient location), or facility (i.e., CO + HO, if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100

**Outpatient Reporting:**

- Outpatient Prevalence Rate = Number of 1st LabID Events per patient per month for the location (if monitoring by outpatient location), or the facility (if monitoring by overall facility-wide outpatient = FacWideOUT) / Number of patient encounters for the location or facility x 100

**Measures for MDRO Bloodstream Infection:** Calculated when monitoring either *all specimens* or *blood specimens* only. NOTE: except for certain locations (i.e., inpatient rehabilitation facilities, emergency department, and 24-hour observation locations), the Blood specimens only option can only be used at the FacWideIN and FacWideOUT levels.

MRSA Bloodstream Infection Standardized Infection Ratio (SIR):

The SIR is calculated by dividing the number of observed events by the number of predicted events. The number of predicted events is calculated using LabID probabilities estimated from negative binomial models constructed from NHSN data during a baseline time period, which represents a standard population.[4] MRSA Bloodstream Infection SIRs are calculated for FacWideIN surveillance only.

**Note:** In the NHSN application, "predicted" is referred to as "expected".

**Note:** The SIR will be calculated only if the number of expected events (numExp) is ≥1 to help enforce a minimum precision criterion.

Facility MRSA Bloodstream Infection Incidence SIR = Number of all unique blood source LabID Events identified >3 days after admission to the facility (i.e., HO events, when monitoring by overall facility-wide inpatient = FacWideIN) / Number of expected HO MRSA blood LabID Events

**Inpatient Reporting:**

- MDRO Bloodstream Infection Admission Prevalence Rate = Number of all unique blood source LabID Events per patient per month identified ≤3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN)/ Number of patient admissions to the location or facility x 100

- MDRO Bloodstream Infection Incidence Rate = Number of all unique blood source LabID Events per patient per month identified >3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100 (will be removed from NHSN analysis in July 2013)

- MDRO Bloodstream Infection Incidence Density Rate = Number of all unique blood source LabID Events per patient per month identified >3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient days for the location or facility x 1,000 (will be referred to in NHSN analysis as Incidence Rate after July 2013)

- MDRO Bloodstream Infection Overall Patient Prevalence Rate = Number of 1st Blood LabID Events per patient per month regardless of time spent in location (i.e., prevalent + incident, if monitoring by inpatient location), or facility (i.e., CO + HO, if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100

  **MRSA Bloodstream Reporting for CMS-certified Inpatient Rehabilitation Facilities (IRFs) mapped as units within a hospital:**
  IRF units within a hospital that participate in the CMS Inpatient Rehabilitation Facility Quality Reporting Program will be given a single MRSA bacteremia Incidence rate for each type of CMS-certified IRF unit (adult and pediatric) mapped within the hospital according to CCN.

  - Inpatient MRSA Bacteremia Incidence Density Rate for IRF units: Number of all incident blood source MRSA LabID events identified > 3 days after admission to an IRF unit and where the patient had no positive MRSA bacteremia LabID events in the prior 14 days in any CMS-certified IRF unit of that type / Total number of patient days for that type of IRF unit x 1,000

**Outpatient Reporting:**

- MDRO Bloodstream Infection Outpatient Prevalence Rate = Number of all unique blood source LabID Events per patient per month for the location (if monitoring by outpatient location), or the facility (if monitoring by overall facility-wide outpatient=FacWideOUT) / Number of patient encounters for the location or facility x 100

**Measures for MDRO-CRE surveillance**: the above incidence and prevalence rates are calculated separately for each species of CRE (i.e., *Klebsiella, E.coli,* and *Enterobacter)* as well as for all species combined. The following additional metrics is available for CRE LabID event reporting:

Percent Positive for Carbapenemase: number CRE positive for carbapenemase / number CRE tested for carbapenemase x 100

**Proxy Measures for MDRO Healthcare Acquisition:**

- Overall MDRO Infection/Colonization Incidence Rate = Number of 1st LabID Events per patient per month among those with no documented prior evidence of previous infection

or colonization with this specific organism type from a previously reported LabID Event, and identified >3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100 (will be removed from NHSN analysis in July 2013)

- Overall MDRO Infection/Colonization Incidence Density Rate = Number of 1st LabID Events per patient per month among those with no documented prior evidence of previous infection or colonization with this specific organism type from a previously reported LabID Event, and identified >3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient days for the location or facility x 1,000 (will be referred to in NHSN analysis as Incidence Rate after July 2013)

## *Clostridium difficile* (C. *difficile*) LabID Event Reporting

**Methodology:** Facilities may choose to monitor *C. difficile* where *C. difficile* testing in the laboratory is performed routinely only on unformed (i.e., conforming to the shape of the container) stool samples. *C. difficile* LabID events may be monitored from all available inpatient locations as well as all available affiliated outpatient locations where care is provided to patients post discharge or prior to admission (e.g., emergency departments, outpatient clinics, and physician offices that submit samples to the facility's laboratory).

**Settings:** *C. difficile* LabID Event reporting can occur in any location: inpatient or outpatient. Surveillance will NOT be performed in NICU, SCN, babies in LDRP, well-baby nurseries, or well-baby clinics. If LDRP locations are being monitored, baby counts must be removed.

**Requirements:** Facilities must choose one or more of the reporting choices listed below and report data accordingly:

| Method | Numerator Data Reporting | Denominator Data Reporting |
|---|---|---|
| Facility-wide by location | Enter each CDI LabID Event from all locations separately | Report separate denominators for each location in the facility as specified in the NHSN Monthly Reporting Plan |
| Selected locations | Enter each CDI LabID Event from selected locations separately | Report separate denominators for each location monitored as specified in the NHSN Monthly Reporting Plan |
| Overall Facility-wide Inpatient (FacWideIN) | Enter each CDI LabID Event from all inpatient locations AND separately for outpatient emergency department, and 24-hour observation location(s). | Report aggregate denominator data for all inpatient locations physically located in the hospital (e.g., total number of admissions and total number of patient days), as well as denominators for all inpatient locations minus inpatient rehabilitation facility and inpatient psychiatric facility locations with separate CCNs. Separate denominators should be entered to capture encounters for each mapped outpatient emergency department and 24-hour observation location. |
| Overall Facility-wide Outpatient (FacWideOUT) | Enter each CDI LabID Event from all affiliated outpatient locations separately | Report only one denominator for all outpatient locations (e.g., total number of encounters including ED and OBS encounters in addition to other outpatient locations). |

**Note:** Facilities must indicate each reporting choice chosen for the calendar month on the *Patient Safety Monthly Reporting Plan* (CDC 57.106).

**Definitions:**

CDI-positive laboratory assay:
A positive laboratory test result for *C. difficile* toxin A and/or B, (includes molecular assays [PCR] and/or toxin assays) tested on an unformed stool specimen (must conform to the container)
*OR*
A toxin-producing *C. difficile* organism detected by culture or other laboratory means performed on an unformed stool sample (must conform to the container).

Duplicate C. *difficile*-positive test: Any *C. difficile* toxin-positive laboratory result from the same patient and location, following a previous *C. difficile* toxin-positive laboratory result within the past two weeks [14 days] (even across calendar months and readmissions to the same facility). There should be 14 days with no *C. difficile* toxin-positive laboratory result for the patient and location before another *C. difficile* LabID Event is entered into NHSN for the patient and location. The date of specimen collection is considered Day 1. NHSN recommends each facility keep an internal line listing log of all positive toxin tests as a reference in LabID event reporting.

EXAMPLE: On January 1, an ICU patient has a *C. difficile* toxin-positive laboratory result which **is** entered into NHSN. On January 4, while in the same location (ICU), the same patient has another positive *C. difficile* toxin-positive laboratory result which is **not** entered into NHSN because it has not been >14 days since the original *C. difficile* toxin-positive laboratory result while in the same location. On January 16, while in the same location (ICU), the same patient has another *C. difficile* toxin-positive laboratory result. While it has been more than 14 days since the initial positive *C. difficile* toxin-positive laboratory result was entered into NHSN (January 1) for the same patient and same location, it has not been >14 days since the patient's most recent *C. difficile* toxin-positive laboratory result (January 4) while in the same location. Therefore, the *C. difficile* toxin-positive laboratory result for January 16 is **not** entered into NHSN. On January 31, the patient has another *C. difficile* toxin-positive laboratory result while in the same location (ICU). Since it has been >14 days since the patient's most recent *C. difficile* toxin-positive laboratory result (January 16) while in the same location, this event **is** entered into NHSN.

Laboratory-Identified (LabID) Event*:* All non-duplicate *C. difficile* toxin-positive laboratory results. Even if reporting at the FacWide level, all reporting must follow rules by location for reporting.

**Notes:**

- A LabID Event calculator is available on the NHSN website to help with data entry decision making around the 14-day rule.
- If a facility is participating in FacWideIN surveillance and reporting, the facility must also conduct separate location-specific surveillance in all outpatient emergency department and

24-hour observation locations. This means LabID Events for the same organism and LabID Event type must be reported from these locations even if the patient is not subsequently admitted to an inpatient location during the same encounter.

- All emergency department and 24-hour observation locations must be identified and mapped as outpatient locations within NHSN. For more information about mapping locations, see Chapter 15 in the NHSN manual.

**Reporting Instructions:** All *C. difficile* LabID Events must be reported by location and separately and independently of Events reported using the *C. difficile* Infection Surveillance reporting option and/or HAI reporting.

**Numerator:** Data will be reported using the *Laboratory-Identified MDRO or CDI Event* form (CDC 57.128).

**Denominator Data:** Patient days, admissions (for inpatient locations), and encounters for emergency departments, observation units, and other affiliated outpatient locations are reported using the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127). See Tables of Instructions for completion instructions. Beginning in 2015 for FacWideIN surveillance, facilities will be required to enter denominators for all locations physically located in the hospital, as well as denominators for all locations minus inpatient rehabilitation facility and inpatient psychiatric facility locations with a separate CCN. The totals should not include other facility types within the hospital that are enrolled and reporting separately (e.g., LTAC). See Tables of Instructions for completion instructions.

An encounter is defined as a patient visit to an outpatient location for care. When determining a patient's admission dates to both the facility and specific inpatient location, the NHSN user must take into account all days, including any days spent in an inpatient location as an "observation" patient before being officially admitted as an inpatient to the facility, as these days contribute to exposure risk. Therefore, all days spent in an inpatient unit, regardless of admission and/or billing status are included in the counts of admissions and inpatient days for the facility and specific location; facility and specific location admission dates must be moved back to the first day spent in the inpatient location. For further information on counting patient days and admissions, see ***Appendix 2: Determining Patient Days for Summary Data Collection: Observation vs. Inpatients***

**CDI Data Analysis:** Based on data provided on the LabID Event form, each event will be categorized by NHSN to populate different measures. Positive toxin tests obtained on hospital day 1 (admission date), hospital day 2 or hospital day 3 are classified as CO events. Positive toxin tests obtained on or after hospital day 4 are classified as HO LabID Events.

The following categorizations and prevalence and incidence calculations are built into the analysis capabilities of NHSN, and are based on timing of admission to a facility and/or location,

specimen collection, and location where specimen was collected. Descriptions are provided to explain how the categories and metrics are defined in NHSN.

**Categorization Based on Current Date Specimen Collected and Prior Date Specimen Collected of a previous CDI LabID Event:**

- Incident CDI Assay: Any CDI LabID Event from a specimen obtained >8 weeks after the most recent CDI LabID Event (or with no previous CDI LabID Event documented) for that patient.

- Recurrent CDI Assay: Any CDI LabID Event from a specimen obtained >2 weeks and ≤8 weeks after the most recent CDI LabID Event for that patient.

**Note:** Beginning in 2015, for FacWideIN surveillance, CDI Assay is assigned based on Events from inpatient locations, emergency departments, and 24-hour observation locations. For data reported prior to 2015, CDI Assay was assigned based on events from within the same setting only. For example, in 2014, if performing both FacWideIN and FacWideOUT surveillance, CDI Assay of inpatient CDI LabID Events was determined by a review of previously-entered CDI LabID Events from inpatient locations only.

The incident and recurrent CDI LabID Events are further categorized within NHSN. The following categorizations, as well as prevalence and incidence calculations are built into the analysis capabilities of NHSN, and are based on timing of admission to facility and/or location, specimen collection, location where specimen was collected, and previous discharge. Descriptions are provided to explain how the categories and metrics are defined in NHSN.

**Categorizing CDI LabID Events – Based on Date Admitted to Facility and Date Specimen Collected:**

- Community-Onset (CO): LabID Event collected in an outpatient location or an inpatient location ≤3 days after admission to the facility (i.e., days 1, 2, or 3 of admission).

- Community-Onset Healthcare Facility-Associated (CO-HCFA): CO LabID Event collected from a patient who was discharged from the facility ≤4 weeks prior to current date of stool specimen collection. Data from outpatient locations (e.g., outpatient encounters) are not included in this definition.

- Healthcare Facility-Onset (HO): LabID Event collected >3 days after admission to the facility (i.e., on or after day 4).

**The following section describes the various measures calculated for CDI LabID event surveillance.**

**Note**: Beginning with 2015 data, the number of FacWideIN admissions and number of FacWideIN patient days used in the various CDI rate and SIR calculations will represent those

reported for the facility minus admissions and patient days from the following: locations with unique CCNs (i.e., IRF and IPF units) separate from the reporting facility, neonatal ICUs, special care nurseries, and well-baby locations.

## CDI Standardized Infection Ratio (SIR):

The SIR is calculated by dividing the number of observed events by the number of predicted events. The number of predicted events is calculated using LabID probabilities estimated from negative binomial models constructed from NHSN data during a baseline time period, which represents a standard population. CDI SIRs are calculated for FacWideIN surveillance only.[4]

**Note:** In the NHSN application, "predicted" is referred to as "expected".
**Note:** The SIR will be calculated only if the number of expected events (numExp) is ≥1, to help enforce a minimum precision criterion. The CDI SIRs are only calculated at the quarter level or higher. In addition, SIRs will not be calculated for a quarter until the CDI Test type has been reported. When the "MDRO/CDI Prevention Process and Outcome Measures Monthly Reporting" form is completed for the last month of each quarter, users are asked to report the primary type of test that was used to identify CDI in the hospital for that quarter. That test type is then used in the calculation of the CDI SIR for that quarter. More information about the calculation of the CDI SIR can be found here: http://www.cdc.gov/nhsn/pdfs/mrsa-cdi/riskadjustment-mrsa-cdi.pdf

Facility CDI Incidence SIR = Number of all Incident CDI LabID Events identified >3 days after admission to the facility (i.e., HO events when monitoring by overall facility-wide inpatient = FacWideIN) / Number of expected Incident HO CDI LabID Events

## Calculated CDI Prevalence Rates:

### Inpatient Reporting:

- Admission Prevalence Rate = Number of non-duplicate CDI LabID Events per patient per month identified ≤3 days after admission to the location (if monitoring by inpatient location), or facility (if monitoring by overall facility-wide inpatient=FacWideIN) (includes CO and CO-HCFA events) / Number of patient admissions to the location or facility x 100

- Community-Onset Admission Prevalence Rate = Number of CDI LabID events that are CO, per month, in the facility / Number of patient admissions to the facility x 100 (this calculation is only accurate for Overall Facility-wide Inpatient reporting)

- Location Percent Admission Prevalence that is Community-Onset = Number of Admission Prevalent LabID Events to a location that are CO / Total number Admission

Prevalent LabID Events x 100 (Note: The numerator in this formula does not include Admission Prevalent LabID Events that are CO-HFCA.)

- Location Percent Admission Prevalence that is Community-Onset Healthcare Facility-Associated = Number of Admission Prevalent LabID Events to a location that are CO-HCFA / Total number Admission Prevalent LabID Events x 100

- Location Percent Admission Prevalence that is Healthcare Facility-Onset = Number of Admission Prevalent LabID Events to a location that are HO / Total number of Admission Prevalent LabID Events x 100

- Overall Patient Prevalence Rate = Number of 1st CDI LabID Events per patient per month regardless of time spent in location (i.e., prevalent + incident, if monitoring by inpatient location), or facility (i.e., CO + CO-HCFA + HO, if monitoring by overall facility-wide inpatient=FacWideIN) / Number of patient admissions to the location or facility x 100

**Outpatient Reporting:**

- Outpatient Prevalence Rate = Number of all non-duplicate CDI LabID Events per patient per month for the location (if monitoring by outpatient location), or the facility (if monitoring by overall facility-wide outpatient=FacWideOUT) / Number of patient encounters for the location or facility x 100

**Calculated CDI Incidence Rates**: (see categorization of Incident, HO, and CO-HCFA above).

- Location CDI Incidence Rate = Number of Incident CDI LabID Events per month identified >3 days after admission to the location / Number of patient days for the location x 10,000

- Facility CDI Healthcare Facility-Onset Incidence Rate = Number of all Incident HO CDI LabID Events per month in the facility/ Number of patient days for the facility x 10,000 (this calculation is only accurate for Overall Facility-wide Inpatient reporting)

- Facility CDI Combined Incidence Rate = Number of all Incident HO and CO-HCFA CDI LabID Events per month in the facility / Number of patient days for the facility x 10,000 (this calculation is only accurate for Overall Facility-wide Inpatient reporting)

**_C.difficile_ Reporting for CMS-certified Inpatient Rehabilitation Facilities (IRFs) mapped as units within a hospital:**

IRF units within a hospital that participate in the CMS Inpatient Rehabilitation Facility Quality Reporting Program will be given a single CDI LabID event Incidence rate for each type of CMS-certified IRF unit (adult and pediatric) mapped within the hospital according to CCN.

- Inpatient CDI Incidence Density Rate for IRF units: Number of all incident CDI LabID events identified > 3 days after admission to an IRF unit and where the patient had no positive CDI LabID events in the prior 14 days in any CMS-certified IRF unit of that type / Total number of patient days for that type of IRF unit x 10,000

Figure 1. MDRO Test Result Algorithm for *All Specimens* Laboratory-Identified (LabID) Events

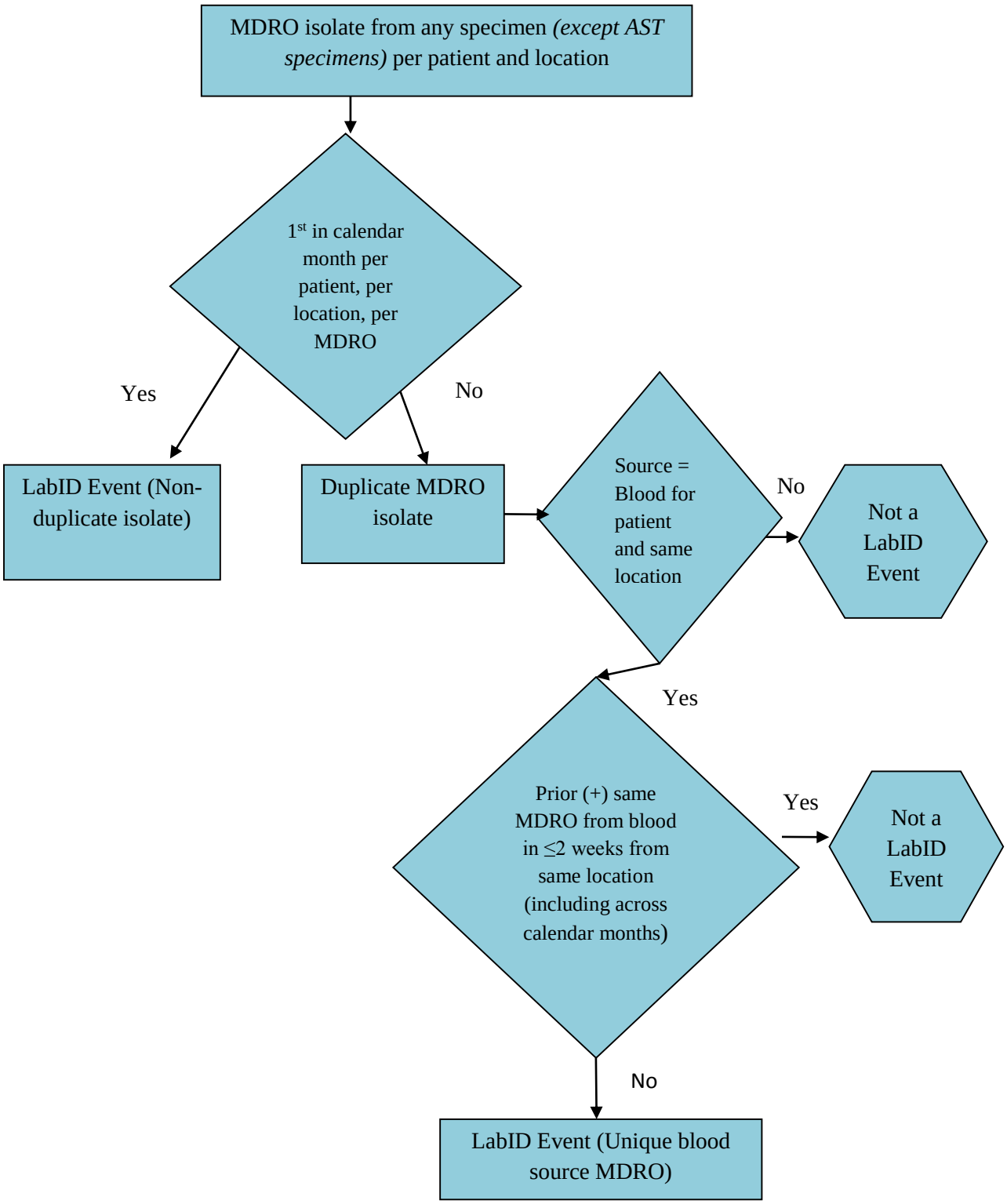


Figure 2. MDRO Test Result Algorithm for *Blood Specimens Only* Laboratory-Identified (LabID) Events

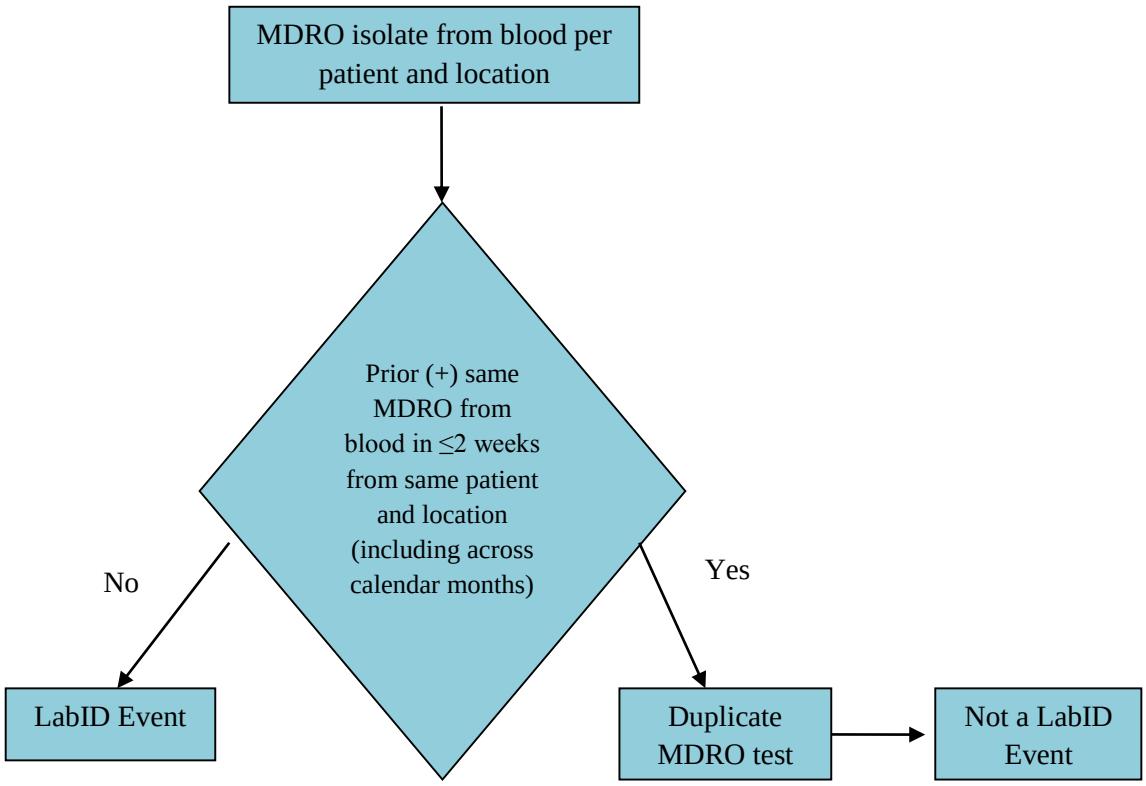
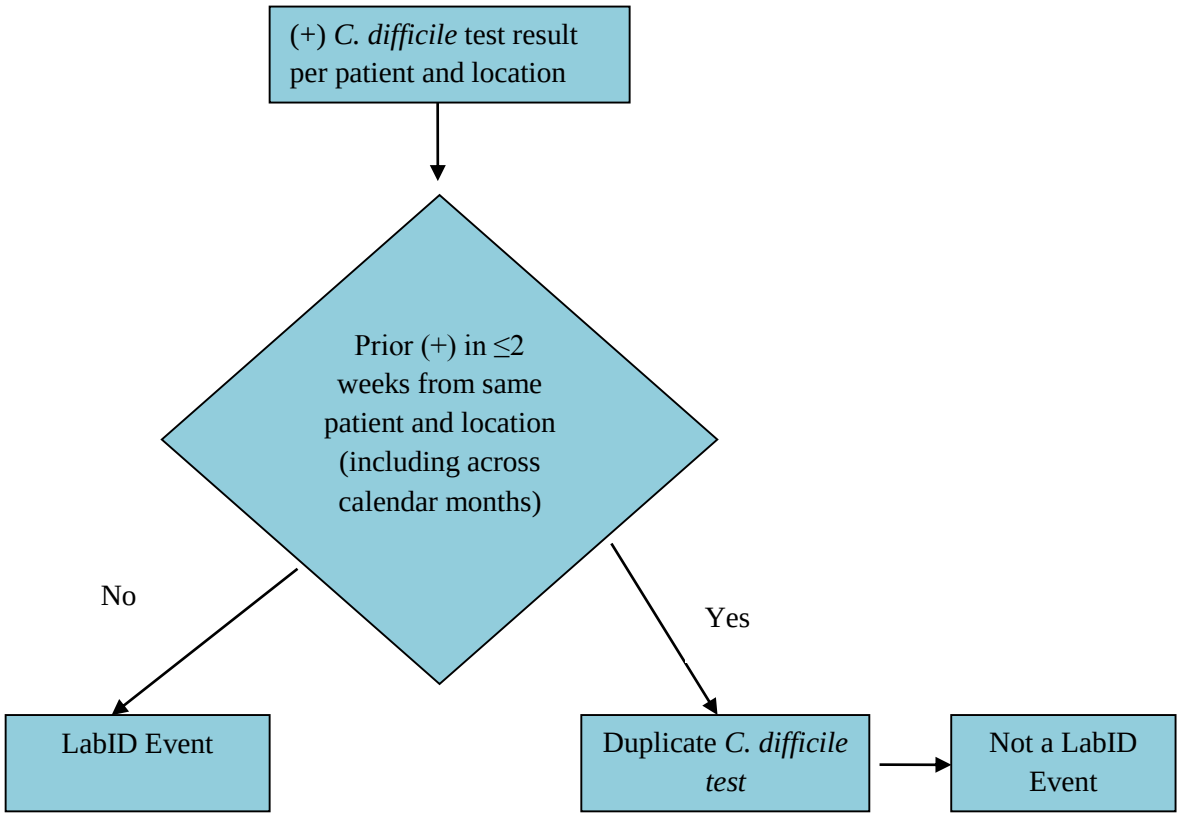


Figure 3. *C. difficile* Test Result Algorithm for Laboratory Identified (LabID) Events



## Option 2: Infection Surveillance Reporting

**Introduction:** The Infection Surveillance reporting option for MDRO and *C. difficile* infections enables users to utilize the CDC/NHSN healthcare-associated infections definitions for identifying and reporting infections associated with MDROs and/or *C. difficile*. Surveillance must occur from at least one patient care area and requires active, patient-based, prospective surveillance of the chosen MDRO(s) and/or *C. difficile* infections (CDIs) by a trained Infection Preventionists (IP). This means that the IP shall seek to confirm and classify infections caused by the chosen MDRO(s) and/or *C. difficile* for monitoring during a patient's stay in at least one patient care location during the surveillance period. These data will enhance the ability of NHSN to aggregate national data on MDROs and CDIs.

### A. MDRO Infection Surveillance Reporting

**Methodology:** Facilities may choose to monitor one or more of the following MDROs: MRSA, MRSA and MSSA, VRE, CephR- *Klebsiella*, CRE (CRE-*Klebsiella*, CRE-*E. coli*, **and** CRE-*Enterobacter),* and multidrug-resistant *Acinetobacter* spp. (See definitions in Section I, Option 1A). For S. *aureus*, both the resistant (MRSA) and the susceptible (MSSA) phenotypes can be tracked to provide concurrent measures of the susceptible pathogens as a comparison to those of the resistant pathogens in a setting of active MRSA prevention efforts. REMEMBER: No Active Surveillance Culture/Testing (ASC/AST) results are to be included in this reporting of individual results.

**Settings:** Infection Surveillance can occur in any inpatient location where such infections may be identified and where denominator data can be collected, which may include critical/intensive care units (ICU), specialty care areas (SCA), neonatal units, step-down units, wards, and chronic care units. In Labor, Delivery, Recovery, & Post-partum (LDRP) locations, where mom and babies are housed together, users must count both mom and baby in the denominator. If moms only are being counted, then multiply moms times two to include both mom and baby in denominators.

**Requirements:** Surveillance for all types of NHSN-defined healthcare-associated infections (HAIs), regardless if HAI is included in "in-plan" or "off- plan" surveillance, of the MDRO selected for monitoring in at least one location in the healthcare facility as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106).

**Definitions:** MDROs included in this module are defined in Section I, Option 1A. Refer to *CDC/NHSN Surveillance Definitions for Specific Types of Infections* for infection site criteria.

Location of Attribution and Transfer Rule applies – See Identifying HAIs in NHSN chapter (Chapter 2).

**Reporting Instructions**: If participating in MDRO/CDI Infection Surveillance and/or LabID Event Reporting, along with the reporting of HAIs through the Device-Associated and/or

Procedure-Associated Modules, see *Appendix 1: Guidance for Handling MDRO/CDI Module Infection Surveillance and LabID Event Reporting When Also Following Other NHSN Modules*, for instructions on unique reporting scenarios.

**Numerator Data:** Number of healthcare-associated infections, by MDRO type. Infections are reported on the appropriate NHSN forms: *Primary Bloodstream Infection, Pneumonia, Ventilator-Associated Event, Urinary Tract Infection, Surgical Site Infection, or MDRO or CDI Infection Event (CDC 57.108, 57.111, 57.112, 57.114, 57.120, and 57.126, respectively.).* See the *Table of Instructions,* located in each of the applicable chapters, for completion instructions.

**Denominator Data:** Number of patient days and admissions. Patient days and admissions are reported by location using the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127). See *Table of Instructions* for completion instructions.

**Data Analysis:** Data are stratified by time (e.g., month, quarter, etc.) and patient care location. *MDRO Infection Incidence Rate* = Number of HAIs by MDRO type/ Number of patient days x 1000

## B. *Clostridium difficile* Infection Surveillance Reporting

**Methodology:** *C. difficile* Infection (CDI) Surveillance, reporting on all NHSN-defined healthcare-associated CDIs from at least one patient care area, is one reporting option for *C. difficile* (i.e., part of your facility's Monthly Reporting Plan). These data will enhance the ability of NHSN to aggregate national data on CDIs.

**Settings:** Infection Surveillance will occur in any inpatient location where denominator data can be collected, which may include critical/intensive care units (ICU), specialty care areas (SCA), step-down units, wards, and chronic care units. Surveillance will NOT be performed in Neonatal Intensive Care Units (NICU), Specialty Care Nurseries (SCN), babies in LDRP, or well-baby nurseries. If LDRP locations are being monitored, baby counts must be removed.

**Requirements:** Surveillance for CDI must be performed in at least one location in the healthcare institution as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106).

**Definitions:** Report all healthcare-associated infections where *C. difficile*, identified by a positive toxin result, including toxin producing gene [PCR]), is the associated pathogen, according to the Repeat Infection Timeframe (RIT) rule for HAIs (See Identifying HAIs in NHSN chapter). Refer to specific definitions in *CDC/NHSN Surveillance Definitions for Specific Types of Infections* chapter for *C. difficile* gastrointestinal system infection (GI-CDI).

HAI cases of CDI that meet criteria for a healthcare-associated infection should be reported as *Clostridium difficile* gastrointestinal system infection (GI-CDI). Report the pathogen as C. *difficile* on the *MDRO or CDI Infection Event* form (CDC 57.126). If the patient develops GI-CDI, and GI-GE or GI-GIT, report the GI-CDI and the GI-GE or GI-GIT only if additional

enteric organisms are identified and applicable criteria are met. **Note:** CDI laboratory-identified event (LabID Event) categorizations (e.g., recurrent CDI assay, incident CDI assay, healthcare facility-onset, community-onset, community-onset healthcare facility-associated) do **not** apply to HAIs; including *C. difficile* associated gastrointestinal system infections (GI-CDI). Each new GI-CDI must be reported according to the HAI rules outlined in Identifying HAIs in NHSN chapter.

CDI Complications: CDI in a case patient within 30 days after CDI symptom onset with at least one of the following:

1. Admission to an intensive care unit for complications associated with CDI (e.g., for shock that requires vasopressor therapy);
2. Surgery (e.g., colectomy) for toxic megacolon, perforation, or refractory colitis
   ***AND/OR***
3. Death caused by CDI within 30 days after symptom onset and occurring during the hospital admission.

Location of Attribution and Transfer Rule apply to Infection Surveillance – See Identifying HAIs in NHSN chapter.

**Numerator Data:** Number of healthcare-associated *C. difficile* infections. Infections are reported on the *MDRO or CDI Infection Event* form (CDC 57.126). See *Tables of Instructions* for completion instructions.

**Denominator Data:** Number of patient days and admissions by location are reported using the *MDRO and CDI and Outcome Measures Monthly Monitoring* form (CDC 57.127). See *Tables of Instructions* for completion instructions.

*C. difficile* Infections:

Numerator: The total number of HAI CDI cases identified during the surveillance month for a location.

Denominator: The total number of patient days and admissions during the surveillance month for a location.

**Data Analysis:** Data are stratified by time (e.g., month, quarter, etc.) and by patient care location.

*C. difficile* Infection Incidence Rate = Number of HAI CDI cases / Number of patient days x 10,000

## II. Supplemental Reporting

### 1. Prevention Process Measures Surveillance

#### a. Monitoring Adherence to Hand Hygiene

**Introduction:** This option will allow facilities to monitor adherence to hand hygiene after a healthcare worker (HCW) has contact with a patient or inanimate objects in the immediate vicinity of the patient. Research studies have reported data suggesting that improved after-contact hand hygiene is associated with reduced MDRO transmission. While there are multiple opportunities for hand hygiene during patient care, for the purpose of this option, only hand hygiene after contact with a patient or inanimate objects in the immediate vicinity of the patient will be observed and reported. (http://www.cdc.gov/handhygiene/)

**Settings:** Surveillance will occur in any location: inpatient or outpatient.

**Requirements:** Surveillance for adherence to hand hygiene in at least one location in the healthcare institution for at least one calendar month as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106). This should be done in patient care locations also selected for Infection Surveillance or LabID Event reporting.

In participating patient care locations, perform at least 30 different unannounced observations after contact with patients for as many individual HCWs as possible. For example, try to observe all types of HCWs performing a variety of patient care tasks during the course of the month, not only nurses, or not only during catheter or wound care. No personal identifiers will be collected or reported.

**Definitions:**
Antiseptic handwash: Washing hands with water and soap or other detergents containing an antiseptic agent.

Antiseptic hand-rub: Applying an antiseptic hand-rub product to all surfaces of the hands to reduce the number of microorganisms present.

Hand hygiene: A general term that applies to either: handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Handwashing: Washing hands with plain (i.e., non-antimicrobial) soap and water.

**Numerator:** Hand Hygiene Performed = Total number of observed contacts during which a HCW touched either the patient or inanimate objects in the immediate vicinity of the patient and appropriate hand hygiene was performed.

**Denominator:** Hand Hygiene Indicated = Total number of observed contacts during which a HCW touched either the patient or inanimate objects in the immediate vicinity of the patient and therefore, appropriate hand hygiene was indicated.
Hand hygiene process measure data are reported using the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57. 127). See Tables of Instructions for completion instructions.

**Data Analysis:** Data are stratified by time (e.g., month, quarter, etc.) and patient care location.

Hand Hygiene Percent Adherence = Number of contacts for which hand hygiene was performed / Number of contacts for which hand hygiene was indicated x 100

### b. Monitoring Adherence to Gown and Gloves Use as Part of Contact Precautions

**Introduction:** This option will allow facilities to monitor adherence to gown and gloves use when a HCW has contact with a patient or inanimate objects in the immediate vicinity of the patient, when that patient is on Transmission-based Contact Precautions. While numerous aspects of adherence to Contact Precautions could be monitored, this surveillance option is only focused on the use of gown and gloves.
(http://www.cdc.gov/ncidod/dhqp/gl_isolation_contact.html)

**Settings:** Surveillance can occur in any of 4 types of inpatient locations: (1) intensive care units (ICU), (2) specialty care areas, (3) neonatal intensive care units (NICU), and (4) any other inpatient care location in the institution (e.g., surgical wards).

**Requirements:** Surveillance for adherence to gown and gloves use in at least one location in the healthcare institution for at least 1 calendar month as indicated in the Patient Safety Monthly Reporting Plan (CDC 57.106). Ideally, this should be done in patient care locations also selected for Infection Surveillance or LabID Event reporting.

Among patients on Transmission-based Contact Precautions in participating patient care locations, perform at least 30 unannounced observations. A total of thirty different contacts must be observed monthly among HCWs of varied occupation types. For example, try to observe all types of HCWs performing a variety of patient care tasks during the course of the month, not only nurses, or not only during catheter or wound care. Both gown and gloves must be donned appropriately prior to contact for compliance. No personal identifiers will be collected or reported.

**Definitions:**

Gown and gloves use**:** In the context of Transmission-based Contact Precautions, the donning of both a gown and gloves prior to contact with a patient or inanimate objects in the immediate vicinity of the patient. Both a gown and gloves must be donned appropriately prior to contact for compliance.

**Numerator:** Gown and Gloves Used = Total number of observed contacts between a HCW and a patient or inanimate objects in the immediate vicinity of a patient on Transmission-based Contact Precautions for which gown and gloves had been donned appropriately prior to the contact.

**Denominator:** Gown and Gloves Indicated = Total number of observed contacts between a HCW and a patient on Transmission-based Contact Precautions or inanimate objects in the immediate vicinity of the patient and therefore, gown and gloves were indicated.

Gown and gloves use process measure data are reported using the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127). See *Tables of Instructions* for completion instructions.

**Data Analysis:** Data are stratified by time (e.g., month, quarter, etc.) and patient care location. *Gown and Glove Use Percent Adherence* = Number of contacts for which gown and gloves were used appropriately / Number of contacts for which gown and gloves were indicated x 100

### c. Monitoring Adherence to Active Surveillance Testing

**Introduction:** This option will allow facilities to monitor adherence to active surveillance testing (AST) of MRSA and/or VRE, using culturing or other methods.

**Settings:** Surveillance will occur in any of 4 types of inpatient locations: (1) intensive care units (ICU), (2) specialty care areas, (3) neonatal intensive care units (NICU), and (4) any other inpatient care location in the institution (e.g., surgical wards).

**Requirements:** Surveillance of AST adherence in at least one location in the healthcare facility for at least one calendar month as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106). A facility may choose to report AST for MRSA and/or VRE in one or multiple patient care locations, as the facility deems appropriate. Ideally, this should be done in patient care locations also selected for Infection Surveillance or LabID Event reporting. To improve standardization of timing rules for AST specimen collection, classify admission specimens as those obtained on day 1 (admission date), day 2, or day 3 (i.e., ≤3 days). Classify discharge/transfer AST specimens as those collected on or after day 4 (i.e., >3 days).

**Definitions:**

AST Eligible Patients: Choose one of two methods for identifying patients that are eligible for AST:

All = All patients in the selected patient care area regardless of history of MRSA or VRE infection or colonization.

***OR***

NHx = All patients in the selected patient care area who have NO documented positive MRSA or VRE infection or colonization during the previous 12 months (as ascertained

by either a facility's laboratory records or information provided by referring facilities); and no evidence of MRSA or VRE during stay in the patient care location (i.e., they are not in Contact Precautions).

Timing of AST: Choose one of two methods for reporting the timing of AST:

Adm = Specimens for AST obtained ≤3 days after admission,

***OR***

Both = Specimens for AST obtained ≤3 days after admission and, for patients' stays of >3 days, at the time of discharge/transfer. Discharge/transfer AST should include all discharges (including discharges from the facility or to other wards or deaths) and can include the most recent weekly AST if performed >3 days after admission to the patient care location. Discharge/transfer AST should not be performed on patients who tested positive on AST admission.

**Numerator and Denominator Data**: Use the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127) to indicate: 1) AST was performed during the month for MRSA and/or VRE, 2) AST-eligible patients, and 3) the timing of AST. No personal identifiers will be collected or reported. See Tables of Instructions for completion instructions.

**Numerator:** For each month during which AST is performed:

Admission AST Performed = Number of patients eligible for admission AST who had a specimen obtained for testing ≤3 days after admission,

*AND/OR*

Discharge/Transfer AST Performed = For patients' stays >3 days, the number of discharged or transferred patients eligible for AST who had a specimen obtained for testing prior to discharge, not including the admission AST.

**Denominator:** For each month during which AST is performed:

Admission AST Eligible = Number of patients eligible for admission AST (All or NHx),

*AND/OR*

Discharge/Transfer AST Eligible = Number of patients eligible for discharge/transfer AST (All or NHx) AND in the facility location >3 days AND negative if tested on admission.

**Data Analysis:** Data are stratified by patient care location and time (e.g., month, quarter, etc.), according to AST-eligible patients monitored and the timing of AST.

Admission AST Percent Adherence = Number of patients with admission AST Performed / Number of patients admission AST eligible x 100

Discharge/transfer AST Percent Adherence = Number of patients with discharge/transfer AST performed / Number of patients discharge/transfer AST eligible x 100

## 2. Active Surveillance Testing Outcome Measures

**Introduction:** This option will allow facilities to use the results of AST to monitor the prevalent and incident rates of MRSA and/or VRE colonization or infection. This information will assist facilities in assessing the impact of intervention programs on MRSA or VRE transmission.

**Settings:** Surveillance will occur in any of 4 types of inpatient locations: (1) intensive care units (ICU), (2) specialty care, (3) neonatal intensive care units (NICU), and (4) any other inpatient care location in the institution (e.g., surgical wards).

**Requirements:** Surveillance for prevalent and/or incident MRSA or VRE cases in at least one location in the healthcare facility for at least one calendar month as indicated in the *Patient Safety Monthly Reporting Plan* (CDC 57.106). This can be done ONLY in locations where AST adherence is being performed. A minimum AST adherence level will be required for the system to calculate prevalence and incidence. A facility may choose to report AST for MRSA and/or VRE in one or multiple patient care locations, as the facility deems appropriate. Ideally, this should be done in patient care locations also selected for Infection Surveillance or LabID Event reporting. To improve standardization of timing rules for AST specimen collection, classify admission specimens as those obtained on day 1 (admission date), day 2, or day 3 (i.e., ≤3 days). Classify discharge/transfer AST specimens as those collected on or after day 4 (i.e., >3 days). Only the first specimen positive for MRSA or VRE from a given patient in the patient care location is counted, whether obtained for AST or as part of clinical care. If an Admission AST specimen is not collected from an eligible patient, assume the patient has no MRSA or VRE colonization.

**Definitions:**

AST Admission Prevalent case:

Known Positive = A patient with documentation on admission of MRSA or VRE colonization or infection in the previous 12 months (i.e., patient is known to be colonized or infected as ascertained by either a facility's laboratory records or information provided by referring facilities). (All MRSA or VRE colonized patients currently in a location during the month of surveillance should be considered "Known Positive"),
*OR*
Admission AST or Clinical Positive = A patient with MRSA or VRE isolated from a specimen collected for AST ≤3 days after admission or from clinical specimen obtained ≤3 days after admission (i.e., MRSA or VRE cannot be attributed to this patient care location).

AST Incident case: A patient with a stay >3 days:

With no documentation on admission of MRSA or VRE colonization or infection during the previous 12 months (as ascertained either by the facility's laboratory records or information provided by referring facilities); including admission AST or clinical culture obtained ≤3 days after admission (i.e., patient without positive specimen),
*AND*

With MRSA or VRE isolated from a specimen collected for AST or clinical reasons > 3 days after admission to the patient care location or at the time of discharge/transfer from the patient care location (including discharges from the facility or to other locations or deaths).

MRSA colonization: Carriage of MRSA without evidence of infection (e.g., nasal swab test positive for MRSA, without signs or symptoms of infection).

AST Eligible Patients: Choose one of two methods for identifying patients' eligible for AST:

All = All patients in the selected patient care area regardless of history of MRSA or VRE infection or colonization,

***OR***

NHx = All patients in the selected patient care area who have NO documented positive MRSA or VRE infection or colonization during the previous 12 months (as ascertained either by the facility's laboratory records or information provided by referring facilities); and no evidence of MRSA or VRE during stay in the patient care location.

Timing of AST: Choose one of two methods for reporting the timing of AST:

Adm = Specimens for AST obtained ≤3 days after admission,

***OR***

Both = Specimens for AST obtained ≤3 days after admission and, for patients' stays of >3 days, at the time of discharge/transfer. Discharge/transfer AST should include all discharges (including discharges from the facility or to other wards or deaths) and can include the most recent weekly AST if performed >3 days after admission to the patient care location. Discharge/transfer AST should not be performed on patients who tested positive on AST admission.

**Numerator and Denominator Data:** Use the *MDRO and CDI Prevention Process and Outcome Measures Monthly Monitoring* form (CDC 57.127) to indicate: 1) AST outcomes monitoring and adherence was performed during the month for MRSA and/or VRE, 2) AST eligible patients, and 3) the timing of AST. No personal identifiers will be collected or reported. *See Tables of Instructions* for completion instructions.

If only admission AST is performed, only prevalent cases of MRSA or VRE can be detected in that patient care location. If both admission and discharge/transfer AST are performed, both prevalent and incident cases can be detected. No personal identifiers will be collected or reported.

Admission Prevalent Case:
Numerator Sources: (1) Known Positive; (2) Admission AST or Clinical Positive = Cases ≤3 days after admission
Denominator Source: Total number of admissions

Incident Case:
Numerator: Discharge/transfer AST or Clinical Positive = Cases >3 days after admission and without positive test result(s) on admission

Denominator: Total number of patient days

**Note:** For research purposes calculating patient-days at risk (i.e., excluding patient-days in which patients were known to be MRSA or VRE colonized or infected) may be a preferable denominator, but for surveillance purposes and ease of aggregating, total number of patient days is required for this module.

**Data Analysis:** Data are stratified by patient care location and time (e.g., month, quarter, etc.) according to the eligible patients monitored and timing of AST.

AST Admission Prevalence rate =
For Eligible patients = All:
Number of admission AST or clinical positive / Number of admissions x 100

For Eligible patients = NHx:
Number of admission AST or clinical positive + Number of known positive / Number of admissions x 100

AST Incidence rate = Number of discharge/transfer AST or clinical positive / Number of patient days x 1000

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[1]HICPAC, Management of Multidrug-Resistant Organisms in Healthcare Settings. <http://www.cdc.gov/NCIDOD/DHQP/hicpac_pubs.html>.

[2]Cohen AL, et al. *Infection Control and Hospital Epidemiology*. Oct 2008; 29:901-913.

[3]McDonald LC, Coignard B, Dubberke E, Song X. Horan T, Kutty PK. Recommendations for surveillance of Clostridium difficile-associated disease. *Infection Control Hospital Epidemiology* 2007; 28:140-5.

[4]Dudeck MA, Weiner LM, Malpiedi PJ, et al. Risk Adjustment for Healthcare Facility-Onset C. *difficile* and MRSA Bacteremia Laboratory-identified Event Reporting in NHSN. Published March 12, 2013. Available at: http://www.cdc.gov/nhsn/pdfs/mrsa-cdi/RiskAdjustment-MRSA-CDI.pdf.

[6]Cohen SH, Gerding DN, Johnson S, Kelly CP, Loo VG, McDonald LC, et al. Clinical practice guidelines for Clostridium difficile infection in adults: 2010 update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). *Infection Control and Hospital Epidemiology* 2010; 31:431-455.

Table 2. Measures Delivered to CMS For Facilities Participating in Quality Reporting Programs: MRSA Bacteremia and *C.difficile* LabID Events

| **Facility Type** | **CMS Quality Reporting Program** | **MRSA Bacteremia LabID Event Measure Sent to CMS** | ***C.difficile* LabID Event Measure Sent to CMS** |
|---|---|---|---|
| General Acute Care Hospitals | Inpatient Quality Reporting Program | MRSA Bloodstream Infection SIR (FacWideIN) | Facility CDI Incidence SIR (FacWideIN) |
| Long Term Care Hospitals (referred to as Long Term Acute Care Hospitals in NHSN) | Long Term Care Hospital Quality Reporting Program | MRSA Bloodstream Infection Incidence Density Rate (FacWideIN) | Facility CDI Healthcare Facility-Onset Incidence Rate (FacWideIN) |
| Inpatient Rehabilitation Facilities (IRFs) | Inpatient Rehabilitation Facility Quality Reporting Program | **IRF units within a hospital**: MRSA Bloodstream Infection Incidence Density Rate for IRF Units | **IRF units within a hospita**l: CDI Incidence Density Rate for IRF Units |
| | | **Free-standing IRFs**: MRSA Bloodstream Infection Incidence Density Rate (FacWideIN) | **Free-standing IRFs**: Facility CDI Healthcare Facility-Onset Incidence Rate (FacWideIN) |
| PPS-Exempt Cancer Hospital | PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program | MRSA Bloodstream Infection Incidence Density Rate (FacWideIN**)** | Facility CDI Healthcare Facility-Onset Incidence Rate (FacWideIN**)** |

## Appendix 1. Guidance for Handling MDRO and CDI Module Infection Surveillance and LabID Event Reporting When Also Following Other NHSN Modules

If a facility is monitoring CLABSIs, CAUTIs, VAPs, or VAEs within the Device-Associated Module and/or SSIs within the Procedure-Associated Module and is also monitoring MDROs (e.g., MRSA) in the MDRO and CDI Module, then there are a few situations where reporting the infection or LabID event may be confusing. The following scenarios provide guidance to keep the counts and rates consistent throughout your facility and between all of the NHSN Modules. *These rules apply to the reporting of "Big 5" infections (BSI, UTI, PNEU, VAE, and SSI) caused by an MDRO selected for monitoring.*

### Device-Associated Module with MDRO and CDI Module

Scenario 1: Facility is following CLABSI, CAUTI, VAP, or VAE along with MDRO Infection Surveillance and possibly LabID Event Reporting in the same location:
Healthcare-associated Infection identified for this location.

1. Report the infection (BSI, UTI, PNEU, or VAE).
2. Answer "Yes" to the MDRO infection question.

This fulfills the infection reporting requirements of both modules in one entry and lets the NHSN reporting tool know that this infection should be included in both the Device-Associated and the MDRO infection datasets and rates.

3. If following LabID event reporting in the same location, report also (separately) as a LabID Event (if meets the MDRO protocol criteria for LabID event).

Scenario 2: Facility is following BSI (CLABSI), UTI (CAUTI), PNEU/VAP, or VAE along with MDRO Infection Surveillance and possibly LabID Event Reporting in multiple locations:
The event date for the infection is the day of patient transfer from one location (the transferring location) to another location (the new location), or the next day.

1. Report the infection (BSI, UTI, PNEU and VAE) and attribute to the transferring location, if transferring location was following that Event Type (BSI, UTI, PNEU, VAE) on the day of Event, which occurred on the date of transfer, or the following day.
2. Answer "Yes" to the MDRO infection question, if the transferring location was following that MDRO on the day of Event, which occurred on the date of transfer, or the following day.
3. If, on the date of culture collection, the new location is following LabID event reporting, report also (separately) as a LabID Event and attribute to the new location (if meets the MDRO protocol criteria for LabID event).

## Procedure-Associated Module with MDRO and CDI Module

**Note:** SSIs are associated with a procedure and not a patient location, but MDROs are connected with the patient location.

Scenario 3: Facility is following SSI along with MDRO Infection Surveillance and possibly LabID Event Reporting:
Patient has surgery, is transferred to a single unit for the remainder of the stay, and during the current stay acquires an SSI.

1. Report the infection (SSI) and attribute to the post-op location.
2. Answer "Yes" to the MDRO infection question, if the post-op location is following that MDRO during the month of the date of event.
3. If following LabID event reporting in the post-op location, report also (separately) as a LabID Event (if meets the MDRO protocol criteria for LabID event).

Scenario 4: Facility is following SSI along with MDRO Infection Surveillance and possibly LabID Event Reporting:
Patient has surgery, is either discharged immediately (outpatient) or transferred to a unit (inpatient), is discharged, and subsequently is readmitted with an SSI.

1. Report the infection (SSI) and attribute to the discharging (post-op) location (not the readmission location).
2. Answer "Yes" to the MDRO infection question, if the discharging (post-op) location was following that MDRO during the Date of Event.
3. If following LabID event reporting in the readmitting location or outpatient clinic where the specimen was collected, report also (separately) as a LabID Event (if meets the MDRO protocol criteria for LabID event).

## Appendix 2: Determining Patient Days for Summary Data Collection: Observation vs. Inpatients

In response to questions regarding how to count patient days for "observation" patients, the following guidance is offered.

The NHSN instructions for recording the number of patients in an inpatient unit state that for each day of the month selected, at the same time each day, the number of patients on the unit should be recorded. This procedure should be followed regardless of the patient's status as an observation patient or an inpatient.

1. Observation patients in **observation locations**:
An "observation" location (e.g., 24-hour observation area) is considered an outpatient unit, so time spent in this type of unit does not ever contribute to any inpatient counts (i.e., patient days, device days, admissions). Admissions to such outpatient units represent "encounters" for the purposes of outpatient surveillance for LabID Event monitoring in the MDRO/CDI module.

2. Observation patients in **inpatient locations:**
    a. If an observation patient is transferred from an observation location and admitted to an inpatient location, then only patient days beginning with the date of admission to the inpatient location are to be included in patient day counts (for the location or facility-wide inpatient). In this same way, device days accrue beginning when the patient arrives in any location where device-associated surveillance is occurring and in accordance with the location's device-count methods.
    b. If an observation patient is sent to an inpatient location, the patient should be included for all patient and device day counts. The facility assignment of the patient as an observation patient or an inpatient has no bearing in this instance for counting purposes, since the patient is being housed, monitored, and cared for in an inpatient location.

Below is an example of attributing patient days to a patient admitted to an inpatient location, regardless of whether the facility considers the patient an observation patient or an inpatient.

**The examples show counts taken at: A) 12:00 am and B) 11:00 pm.**

**A. Count at 12:00 am (midnight):**

| Date | Mr X Pt Day | Mr Y Pt Day |
|---|---|---|
| 01/01 | Mr X admitted at 8:00 pm<br><br>Mr X not counted because the count for 01/01/10 was taken at 12:00 am on 01/01 10 and he was not yet admitted<br><br>X | Mr Y admitted at 12:00 am<br><br>Mr Y is counted because the count for 01/01 was taken at 12:00 am and that is when he was admitted<br><br>1 |
| 01/02 | 1 | 2 |
| 01/03 | 2 | 3 |
| 01/04 | 3 | 4 |
| 01/05 | Mr X discharged at 5:00 pm<br>4<br>Counted for 01/05 because he was in the hospital at 12:00 am on 01/05 when the count for that day was taken | Mr Y discharged at 12:01 am<br>5<br>Counted for 01/05 because he was in the hospital at 12:00 am on 01/05 when the count for that day was taken |
| **Total** | **4 patient days** | **5 patient days** |

If we use the same admission dates and times for Mr. X, but a different time is selected for the patient day count, say 11:00 pm, the total number of days in the count will be the same; they will simply be coming from different dates.

**B. Count at 11:00 pm:**

| Date | Mr X | Pt Day |
|---|---|---|
| 01/01 | Mr X admitted at 8:00 am | Counted because the count for 01/01 is taken at 11:00 pm on 01/01 and he is in the hospital at that time<br>1 |
| 01/02 | | 2 |
| 01/03 | | 3 |
| 01/04 | | 4 |
| 01/05 | MR X discharged at 5:00 pm | Not counted for 01/05 because he was not in the hospital at 11:00 pm on 01/05 when the count for that day was taken<br>X |
| **Total** | | **4 patient days** |

**Determining Admission Counts for Summary Data Collection:**

In response to questions regarding how to count number of admissions, the following guidance is offered.

Recognizing that there are a variety of ways in which patient day and admission counts are obtained for a facility and for specific locations, this guidance is offered to assist with standardization within and across facilities. It is most important that whatever method is utilized, it should be used each and every month for consistency of data and metrics. How you operationalize this guidance will depend on how you are obtaining the data for your counts. Any patient who meets criteria for new inclusion should be counted, regardless of whether they are coded by the facility as an inpatient or as an observation patient. See below for specific examples. If admissions are calculated electronically, the data must be checked to ensure that all appropriate patients are included or excluded from those counts and that your electronic data are within +/- 5% of the number obtained if doing the calculations manually. If these counts are more than 5% discrepant, then you will need to evaluate and discuss with your IT staff to determine the cause of the discrepancies and methods to address them. The main goal is to accurately count patients in the denominators that are at risk for potentially contributing to the numerator.

1. Facility-Wide Inpatient Admission Count: Include any new patients that are assigned to a bed in any inpatient location within the facility regardless of billing status. Qualification as a new patient means that the patient was not present on the previous calendar day. The daily admission counts are summed at the end of the calendar month for a monthly facility-wide inpatient admission count.

2. Inpatient Location-Specific Admission Count: Include any new patients that are assigned to a bed in the specific inpatient location. Qualification as a new patient means that the patient was not present on the specific inpatient location on the previous calendar day. The daily admission counts are summed at the end of the calendar month for a monthly inpatient location-specific admission count.

## Appendix 3: Differentiating Between LabID Event and Infection Surveillance

| | LabID Event | Infection Surveillance (using HAI surveillance definitions) |
|---|---|---|
| **Protocol** | LabID Event protocol in Chapter 12 of NHSN manual | Infection Surveillance protocol in Chapter 12 of NHSN manual and HAI site-specific definitions in NHSN manual (e.g., BSI, UTI, SSI, PNEU, VAE, and GI-CDI and other HAI definitions) |
| **Signs & Symptoms** | NONE. Laboratory and admission data, without clinical evaluation of patient | Combination of laboratory data and clinical evaluation of patient (signs/symptoms) |
| **Surveillance Rules** | • HAI and POA do **NOT** apply<br>• Transfer Rule does **NOT** apply<br>• Location = location of patient at time of specimen collection<br>• Event date = specimen collection date | • HAI and POA **do** apply<br>• Transfer Rule applies<br>• See NHSN protocol for details regarding location and date of event |
| **Denominator Reporting** | • Number of patient days and admissions<br>• Can be reported by specific location or facility-wide, depending on reporting option(s) selected<br>• Inpatient and/or outpatient | • Device days and patient days must be collected separately for each monitored location<br>• Inpatient reporting only |
| **Categorization of Infections** | • Events categorized based on inpatient or outpatient and admission and specimen collection dates<br>• Healthcare Facility Onset (HO) or Community Onset (CO)<br>• Community Onset Healthcare Facility-Associated (CO-HCFA) for *C. difficile* only<br>• HO and CO LabID Events must be reported to NHSN<br>• Additional categorizations are applied to *C. difficile*, which include Incident CDI Assay and Recurrent CDI Assay | • HAI protocols used<br>• Events are either HAI or not, therefore LabID Event categorizations **do not** apply<br>• Only HAIs are reported to NHSN |

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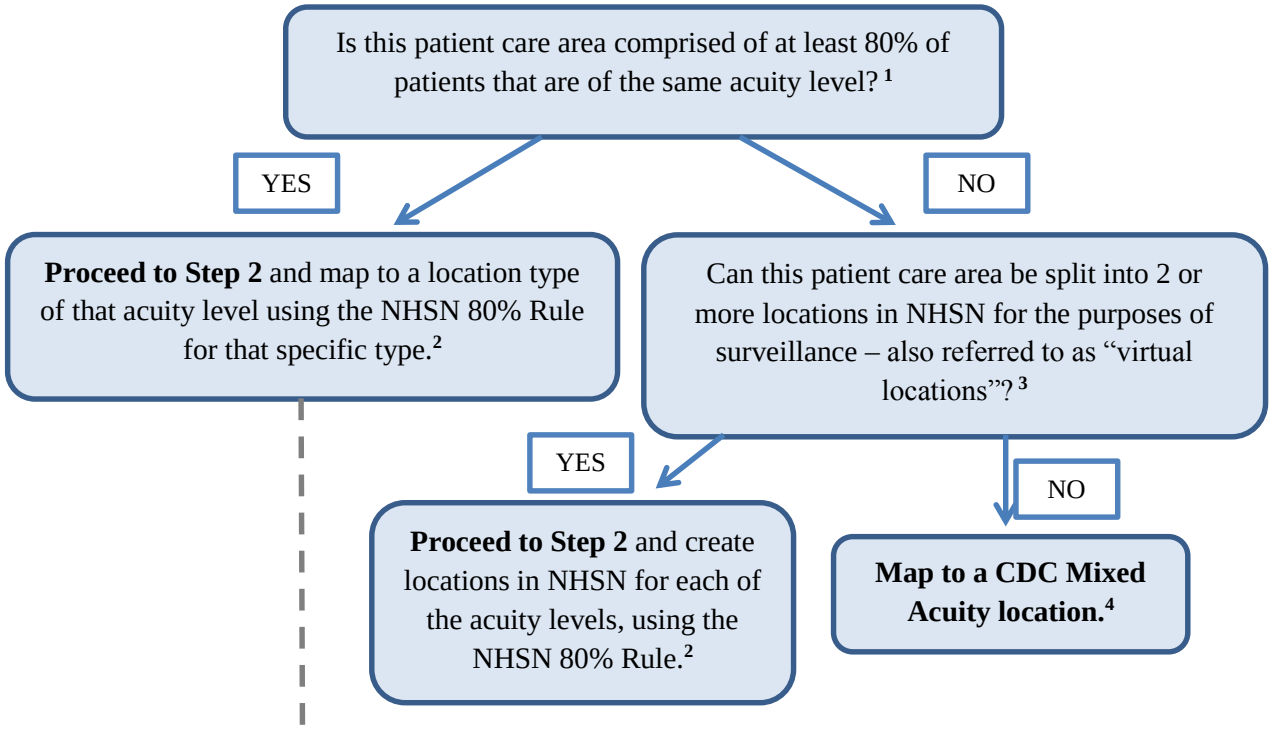
## Instructions for Mapping Patient Care Locations in NHSN

NHSN requires that facilities map each patient care area in their facility to one or more locations as defined by NHSN in order to report surveillance data collected from these areas. This document functions as a decision-making tool when determining the appropriate CDC location for NHSN surveillance, as defined in the NHSN Manual. This process should be followed when adding any new unit to NHSN for surveillance and should be repeated for any unit when there has been a significant change in patient mix (e.g., merging of units, taking on a new service).

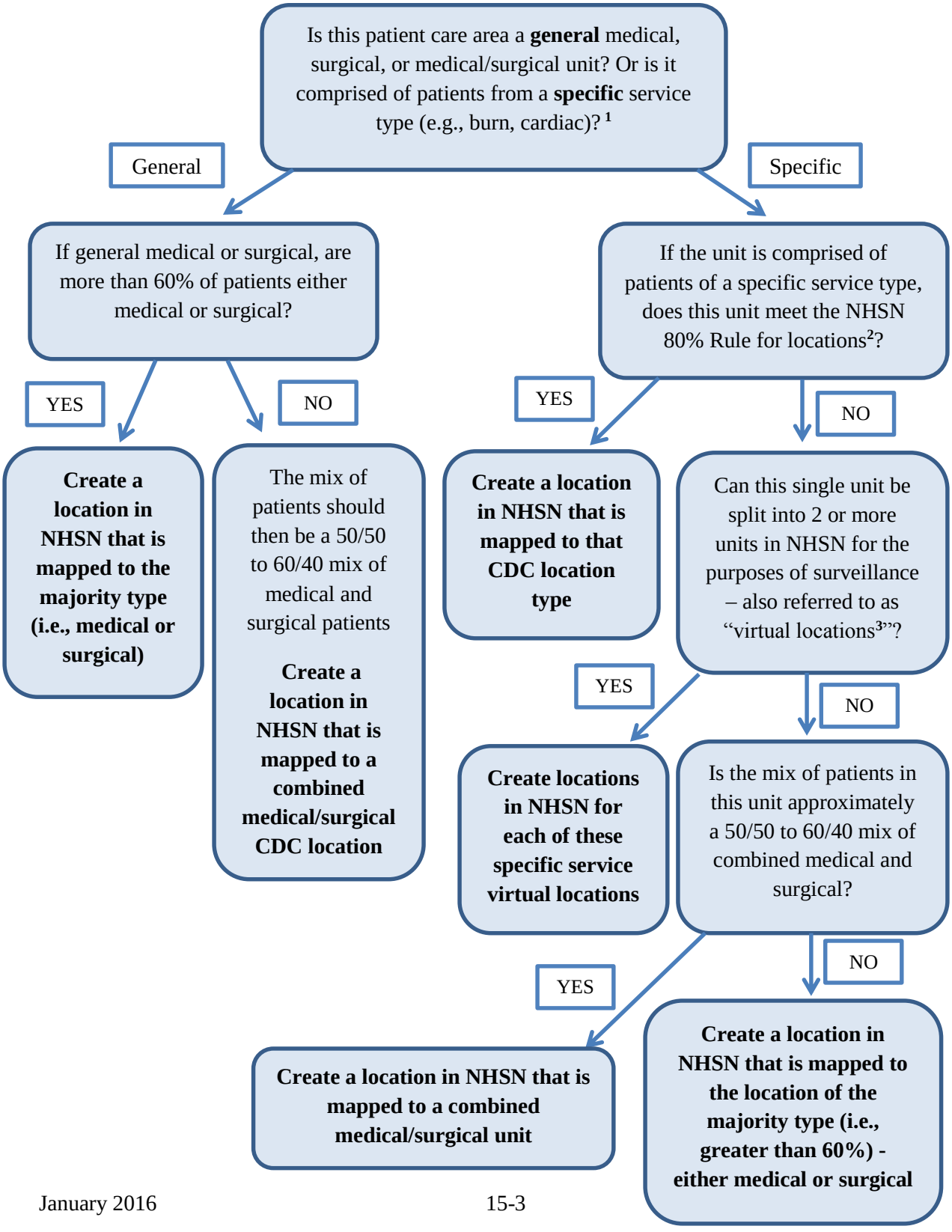
**Step 1:** Define the acuity level for the location




**List of Acuity Levels:**

| | |
|---|---|
| Adult Critical Care Units | Mixed Acuity Units |
| Pediatric Critical Care Units | Operating Rooms |
| Neonatal Critical Care Units | Chronic Care |
| Specialty Care Areas (SCA)/Oncology | Long Term Acute Care |
| Adult Wards | Rehabilitation |
| Pediatric Wards | Outpatient (ACUTE) Locations |
| Neonatal Wards | Clinic (Nonacute) Settings |
| Step Down Units | |

**Step 2:** Define the type of service for the location



**Please see the CDC Location descriptions for definitions of each CDC Location used for NHSN surveillance in this chapter.**

**1. Patient mix:** When determining the appropriate CDC Location mapping for a unit, facilities should review the patient mix in that unit for the last full calendar year. If a full year is not available, facilities should review patient mix based on the data they have available for that unit. When determining the acuity level, as well as the specific service type of a location, the admission/transfer diagnosis should be used when determining the appropriate location mapping. The admission diagnosis is considered the most accurate depiction of the patient's illness and reason for being admitted to a particular unit.

**2. NHSN 80% Rule**: Each patient care area in a facility that is monitored in NHSN is "mapped" to one or more CDC Locations. The specific CDC Location code is determined by the type of patients cared for in that area according to the 80% Rule. That is, if 80% of patients are of a certain type (e.g., pediatric patients with orthopedic problems) then that area is designated as that type of location (in this case, an Inpatient Pediatric Orthopedic Ward).

**3. Virtual locations**: Virtual locations are created in NHSN when a facility is unable to meet the 80% rule for location designation in a single physical unit but would like to report their NHSN surveillance data for each of the major, specific patient types in that unit. The use of virtual locations is recommended only for those physical units that are geographically split by patient service or those in which beds are designated by service. For example, a facility has an ICU – called 5 West – that is comprised of approximately 50% neurology patients and 50% neurosurgery patients. Additionally, the neurology patients are housed in beds 1 thru 10 and the neurosurgery patients are housed in beds 11 thru 20. Rather than map as a medical/surgical critical care unit, the facility decides to create 2 new locations in NHSN:

*5WEST_N: Neurologic Critical Care (10 beds)*
*5WEST_NS: Neurosurgical Critical Care (10 beds)*

This facility will collect and enter data for 5WEST_N and 5WEST_NS separately. The facility will also be able to obtain rates and standardized infection ratios (SIRs) for each location separately. Note that the data collected and reported for each virtual location will be limited to the designated 10 beds assigned (i.e., overflow from 5WEST_N into 5WEST_NS will be counted with **5WEST_NS**). For those facilities that use an electronic source for collecting their data, we recommend that you discuss compatibility of virtual locations in NHSN with your facility's EHR contact prior to reporting data for these locations.

**4. Mixed Acuity Unit**: This location is intended for those units comprised of patients with varying levels of acuity. Mixed acuity units are not included in CLABSI SIRs that use the 2006-2008 NHSN baseline, as well as the CAUTI SIRs that use the 2009 NHSN baseline.

NOTE: Mapping a location in NHSN to the CDC "Mixed Acuity" designation may have implications on data that your facility reports for the CMS Hospital Inpatient Quality Reporting Program and/or your state's reporting mandate(s). Although a Mixed Acuity location may have ICU beds and ICU patients, it is not considered an ICU location type for the purposes of NHSN

reporting and therefore, would not be included in any ICU-specific reporting requirements. Mixed Acuity units are also excluded from ward-specific reporting requirements. For information about how this location designation may impact your facility's compliance with CMS HAI reporting measures, please contact your Quality Improvement Organization (QIO). For information about how this location designation may impact your facility's compliance with your state mandate (if applicable), please contact your state HAI coordinator: http://www.cdc.gov/HAI/state-based/index.html.

**Examples**

Example 1: An ICU that is 85% Burn patients, 15% Trauma

CDC Location: Burn Critical Care (IN:ACUTE:CC:B)

**Why?** Meets 80% rule for critical care acuity level and 80% rule for specific service (burn)

Example 2: An ICU that is 55% medical and 45% Surgical

CDC Location: Medical/Surgical Critical Care (IN:ACUTE:CC:MS)

**Why?** Meets 80% rule for critical care acuity level and does not meet the 60% rule for designation as either medical or surgical service level alone, therefore, use combined medical/surgical designation

Example 3: A unit that is comprised of 60% medical inpatients and 40% general observation patients

CDC Location: Medical Ward (IN:ACUTE:WARD:M)

**Why?** This is a special scenario due to the mix of inpatients and outpatients in this unit. A location where at least 51% of the patients have been formally admitted to the facility should be mapped as in inpatient unit, rather than an outpatient observation unit. The 60% rule for general service and the 80% rule for specific service still apply when deciding on the specific type of inpatient location to use; this location met the 60% rule for medical service. All patients housed in this unit should be included in the surveillance efforts for this location.

Example 4: An ICU that is 40% Neurosurgical, 40% Surgical, and 20% Medical

Option 1 - Single CDC Location: Surgical Critical Care

**Why?** Meets 80% rule for critical care acuity level and does not meet the 80% rule for a specific service level alone, but when surgical patients are combined, that total does equal 80%.

Option 2 - Multiple CDC Virtual Locations: Neurosurgical Critical Care and Surgical Critical Care, with the medical patients reported with the Surgical Critical Care location since the general surgical designation is the least specific of the two

**Why?** By splitting this unit into 2 virtual locations, each meets the 80% rule for critical care acuity level and one meets the 80% rule for designation as Neurosurgical Critical Care, while the other meets the 60% rule as general surgical service (when combining surgical and medical patients).

Example 5: A unit that is comprised of 60% Medical ICU and 40% Step Down patients

Option 1 - Single CDC Location: Mixed Acuity Unit

**Why?** This location is not comprised of at least 80% of the patients of the same acuity level and therefore meets the single location definition of a mixed acuity unit. Note that this location is not considered an ICU location type for the purposes of NHSN reporting and therefore, would not be included in any ICU-specific reporting requirements.

Option 2 - Multiple CDC Virtual Locations: Medical Critical Care and Step Down Unit

**Why?** By splitting this unit into 2 virtual locations, each meets the 80% rule for the appropriate acuity level and each meets the 80% rule for type of service.

Example 6: A pediatric ward that is comprised of 70% neurosurgical patients and 30% orthopedic patients

Option 1 - Single CDC Location: Pediatric Surgical Ward

**Why?** Meets 80% rule for ward-level acuity and does not meet the 80% rule for a specific service level alone, but meets the 60% rule for general surgical service.

Option 2 - Multiple CDC Virtual Locations: Pediatric Neurosurgical Ward and Pediatric Orthopedic Ward

**Why?** By splitting this unit into 2 virtual locations, each meets the 80% rule for the appropriate acuity level and each meets the 80% rule for type of service.

# Appendix: Creation and Management of Locations in NHSN

## Create New Locations:

If there are any operational locations in your hospital that are not already set-up in NHSN, you will need to create these locations for the purposes of NHSN surveillance and reporting.

Locations can be set up by following these steps:

1. Go to Facility > Locations.
2. On the Locations screen, enter a location code ("Your Code") and location label ("Your Label").
3. Select a CDC Location Description from the drop-down menu. NOTE: When selecting a CDC Location Description, your location must meet the 80% Rule in order to be assigned as that CDC Location Description.
4. Make sure the Status is set to "Active" and then enter the number of beds that are set up and staffed in that location.
5. Once all information for this new location is entered, click 'Add'.

## Manage Existing Locations:

Facilities should make sure that the only locations with an "active" status in NHSN are those that are operational units within the facility. The number of beds indicated for each location should also be checked for accuracy and, if necessary, updated to reflect the current number of beds set up and staffed.

Location information can be updated by following these steps:

1. Go to Facility > Locations.
2. On the Locations screen, click 'Find'.
3. Review the information that appears in the Location Table at the bottom of the screen. Review the Status of each location, as well as Bed size.
4. If a location's information needs to be updated, click the location code under the "Your Code" column; the location's information will auto-fill in the fields above the Location Table.
5. Make any modifications to the Status and/or Bed size, then click 'Save'.

## Manage Physically Moved Locations

Units within a facility may physically move to another area of the same facility, and be given a different name. If the staff are moving with these locations, and the type of patients remains the same (i.e., the only difference is the geographical location and/or bedsize), then it's recommended to change "Your Code" and "Your Label" (and bedsize, if appropriate) on the existing location records. These fields can be updated by following the instructions for "Manage Existing Locations" above. Updating the value of "Your Code" will also update all previously-entered records for these locations, allowing for continuous analysis and reporting.

## Inaccurate CDC Location Description

If you believe that the CDC Location Description assigned to your existing location is incorrect, there are additional steps you will need to follow, depending on the scenario:

Scenario 1: The patient population in this unit has changed such that the current CDC Location Description, using the 80% rule, is inaccurate.

> Solution: Because the patient population has changed, a new location should be created in NHSN and should be mapped to a CDC Location Description that most accurately reflects the type of patients receiving care in that location, using the 80% rule. The old location should be put into "Inactive" status. When creating a new location, you will need to use a different "Your Code" and "Your Label" value. Note that data which have been reported from inactive locations can continue to be analyzed within NHSN, however these locations will not be linked to new, active locations.

Scenario 2: The CDC Location Description initially assigned has been inaccurate for much, if not all, of the reporting to NHSN, based on the updated location guidance for 2015.

> Solution: Users cannot change the CDC Location Description on existing locations within NHSN. Facilities should ensure that the locations set up in NHSN are accurate for 2015 reporting per the updated guidance. If a new CDC Location Description is needed, users must create a new location in NHSN and inactivate the old location, per the instructions above. Note that data for the old location can still be analyzed, but these data will not be connected to data reported under the new location. To connect data to the new location, facility administrators must edit the older location event and summary records to the newly created locations. This **must** be done before the old location is put into "Inactive" status. Once the new location is active, facilities need to change their monthly reporting plan to record the change and capture the new location data.

# Master CDC Locations and Descriptions

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **INPATIENT LOCATIONS** | | | |
| **ACUTE CARE FACILITIES GENERAL** | | | |
| **Adult Critical Care Units** | | | |
| Burn Critical Care | 1026-4 | IN:ACUTE:CC:B | Critical care area specializing in the care of patients with significant/major burns. |
| Medical Cardiac Critical Care | 1028-0 | IN:ACUTE:CC:C | Critical care area specializing in the care of patients with serious heart problems that do not require heart surgery. |
| Medical Critical Care | 1027-2 | IN:ACUTE:CC:M | Critical care area for patients who are being treated for nonsurgical conditions. |
| Medical/Surgical Critical Care | 1029-8 | IN:ACUTE:CC:MS | An area where critically ill patients with medical and/or surgical conditions are managed. |
| Neurologic Critical Care | 1035-5 | IN:ACUTE:CC:N | Critical care area for the care of patients with life-threatening neurologic diseases. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Neurosurgical Critical Care | 1031-4 | IN:ACUTE:CC:NS | Critical care area for the surgical management of patients with severe neurologic diseases or those at risk for neurologic injury as a result of surgery. |
| ONC Medical Critical Care | 1223-7 | IN:ACUTE:CC:ONC_M | Critical care area for the care of oncology patients who are being treated for nonsurgical conditions related to their malignancy. |
| ONC Surgical Critical Care | 1224-5 | IN:ACUTE:CC:ONC_S | Critical care area for the evaluation and management of oncology patients with serious illness before and/or after cancer-related surgery. |
| ONC Medical-Surgical Critical Care | 1225-2 | IN:ACUTE:CC:ONC_MS | Critical care area for the care of oncology patients with medical and/or surgical conditions related to their malignancy. |
| Prenatal Critical Care | 1034-8 | IN:ACUTE:CC:PNATL | Critical care area for the care of pregnant patients with complex medical or obstetric problems requiring a high level of care to prevent the loss of the fetus and to protect the life of the mother. |
| Respiratory Critical Care | 1033-0 | IN:ACUTE:CC:R | Critical care area for the evaluation and treatment of patients with severe respiratory conditions. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Surgical Cardiothoracic Critical Care | 1032-2 | IN:ACUTE:CC:CT | Critical care area specializing in the care of patients following cardiac and thoracic surgery. |
| Surgical Critical Care | 1030-6 | IN:ACUTE:CC:S | Critical care area for the evaluation and management of patients with serious illness before and/or after surgery. |
| Trauma Critical Care | 1025-6 | IN:ACUTE:CC:T | Critical care area specializing in the care of patients who require a high level of monitoring and/or intervention following trauma or during critical illness related to trauma. |
| **Pediatric Critical Care Units** | | | |
| ONC Pediatric Critical Care | 1233-6 | IN:ACUTE:CC:ONC_PED | Critical care area for the care of oncology patients ≤18 years old who are being treated for surgical or nonsurgical conditions related to their malignancy. |
| Pediatric Burn Critical Care | 1042-1 | IN:ACUTE:CC:B_PED | Critical care area specializing in the care of patients ≤18 years old with significant/major burns. |
| Pediatric Cardiothoracic Critical Care | 1043-9 | IN:ACUTE:CC:CT_PED | Critical care area specializing in the care of patients ≤18 years old following cardiac and thoracic surgery. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pediatric Medical Critical Care | 1044-7 | IN:ACUTE:CC:M_PED | Critical care area for patients ≤18 years old who are being treated for nonsurgical conditions. In the NNIS system, this was called Pediatric ICU (PICU). |
| Pediatric Medical/Surgical Critical Care | 1045-4 | IN:ACUTE:CC:MS_PED | An area where critically ill patients ≤18 years old with medical and/or surgical conditions are managed. |
| Pediatric Neurosurgical Critical Care | 1046-2 | IN:ACUTE:NS_PED | Critical care area specializing in the surgical management of patients ≤18 years old with severe neurological diseases or those at risk for neurological injury as a result of surgery. |
| Pediatric Respiratory Critical Care | 1047-0 | IN:ACUTE:CC:R_PED | Critical care area for the evaluation and treatment of the patients ≤18 years old with severe respiratory conditions. |
| Pediatric Surgical Critical Care | 1048-8 | IN:ACUTE:CC:S_PED | Critical care area for the evaluation and management of patients ≤18 years old with serious illness before and/or after surgery. |
| Pediatric Trauma Critical Care | 1049-6 | IN:ACUTECC:T_PED | Critical care area specializing in the care of patients ≤18 years old who require a high level of monitoring and/or intervention following trauma or during critical illness related to trauma. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **Neonatal Units** | | | |
| Well Baby Nursery (Level I) | 1038-9 | IN:ACUTE:WARD:NURS | Hospital area for evaluation and postnatal care of healthy newborns. May include neonatal resuscitation and stabilization of ill newborns until transfer to a facility at which specialty neonatal care is provided. |
| Step down Neonatal Nursery (Level II) | 1041-3 | IN:ACUTE:STEP:NURS | The capabilities of Level II, listed below, are from the American Academy of Pediatrics definitions of levels of neonatal care.[1]<br><u>Level II special care nursery</u><br>Level I capabilities plus:<br>• Provide care for infants born ≥32 wks. gestation and weighing ≥1500 g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis<br>• Provide care for infants convalescing after intensive care |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | • Provide mechanical ventilation for brief duration (<24 h) or continuous positive airway pressure or both<br>• Stabilize infants born before 32 wks. gestation and weighing less than 1500 g until transfer to a neonatal intensive care facility |
| Neonatal Critical Care (Level II/III) | 1039-7 | IN:ACUTE:CC_STEP: NURS | Combined nursery housing both Level II and III newborns and infants, as per the NHSN level definitions above and below. This is analogous to a mixed acuity unit specifically for Neonatal Critical Care patients. |
| Neonatal Critical Care (Level III) | 1040-5 | IN:ACUTE:CC:NURS | A hospital neonatal intensive care unit (NICU) organized with personnel and equipment to provide continuous life support and comprehensive care for extremely high-risk newborn infants and those with complex and critical illness.<br><br>The capabilities of Level III and Level IV, listed below, are from the American Academy of Pediatrics definitions of levels of neonatal care.[1] **NOTE: These classifications are <u>all</u> considered Level III NICUs in NHSN.** |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | Level III NICU<br>Level II capabilities plus:<br>• Provide sustained life support<br>• 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<br>• Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists<br>• Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide<br>• Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography<br>Level IV Regional NICU<br>Level III capabilities plus: |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | • Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions<br>• Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists, and pediatric subspecialists at the site<br>• Facilitate transport and provide outreach education |
| **Specialty Care Areas (SCA)** | | | |
| Inpatient Dialysis SCA | 1198-1 | IN:ACUTE:SCA:DIAL | Hospital specialty care area for patients who require dialysis as part of their care. These patients may be chronic or acute dialysis patients. |
| Pediatric Dialysis SCA | 1091-8 | IN:ACUTE:SCA:DIAL_PED | Hospital specialty care area for patients ≤18 years old who require acute dialysis as part of their care. These patients may be chronic or acute dialysis patients. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pediatric Solid Organ Transplant SCA | 1093-4 | IN:ACUTE:SCA:SOTP_PED | Hospital specialty area for the postoperative care of patients ≤18 years old who have had a solid organ transplant (e.g., heart/lung, kidney, liver, pancreas). |
| Solid Organ Transplant SCA | 1092-6 | IN:ACUTE:SCA:SOTP | Hospital specialty area for the postoperative care of patients who have had a solid organ transplant (e.g., heart/lung, kidney, liver, pancreas). |
| **Adult Wards** | | | |
| Antenatal Care Ward | 1205-4 | IN:ACUTE:WARD: ANTENAT | Hospital area for observation, evaluation, treatment or surgery of high risk pregnancy patients. |
| Behavioral Health/Psych Ward | 1051-2 | IN:ACUTE:WARD:BHV | Area for the evaluation and treatment of patients with acute psychiatric or behavioral disorders. This may include those units identified as chemical dependency units. |
| Burn Ward | 1052-0 | IN:ACUTE:WARD:B | Hospital area for evaluation and treatment of patients who have burns. |
| Ear/Nose/Throat Ward | 1053-8 | IN:ACUTE:WARD:ENT | Hospital area for the evaluation, treatment, or surgery of patients with ear, nose, or throat disorders. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Gastrointestinal Ward | 1054-6 | IN:ACUTE:WARD:GI | Hospital area for evaluation, treatment or surgery of patients with disorders of the gastrointestinal tract. |
| Genitourinary Ward | 1055-3 | IN:ACUTE:WARD:GU | Hospital area for the evaluation, treatment or surgery of patients with disorders of the genitourinary system. |
| Gerontology Ward | 1056-1 | IN:ACUTE:WARD:GNT | Hospital area for the evaluation, treatment or surgery of patients with age-related diseases. |
| Gynecology Ward | 1057-9 | IN:ACUTE:WARD:GYN | Hospital area for the evaluation, treatment, or surgery of female patients with reproductive tract disorders. |
| Jail Unit | 1171-8 | IN:ACUTE:WARD:JAL | Overnight stay patient care area of a hospital or correctional facility used only for those who are in custody of law enforcement during their treatment. |
| Labor and Delivery Ward | 1058-7 | IN:ACUTE:WARD:LD | Hospital area where women labor and give birth. |
| Labor, Delivery, Recovery, Postpartum Suite (LDRP) | 1059-5 | IN:ACUTE:WARD:LD_PP | Hospital suite used for labor, delivery, recovery and post-partum (LDRP) -- all within the same suite. |
| Medical Ward | 1060-3 | IN:ACUTE:WARD:M | Hospital area for the evaluation and treatment of patients with medical conditions or disorders. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Medical/Surgical Ward | 1061-1 | IN:ACUTE:WARD:MS | Hospital area for the evaluation of patients with medical and/or surgical conditions. |
| Neurology Ward | 1062-9 | IN:ACUTE:WARD:N | Hospital area where patients with neurological disorders are evaluated and treated. |
| Neurosurgical Ward | 1063-7 | IN:ACUTE:WARD:NS | Hospital area for care of patients whose primary reason for admission is to have neurosurgery or to be cared for by a neurosurgeon after head or spinal trauma. |
| ONC Leukemia Ward | 1226-0 | IN:ACUTE:WARD: ONC_LEUK | Area for the evaluation and treatment of patients with leukemia. |
| ONC Lymphoma Ward | 1228-6 | IN:ACUTE:WARD:ONC_ LYMPH | Area for the evaluation and treatment of patients with lymphoma. |
| ONC Leukemia/Lymphoma Ward | 1229-4 | IN:ACUTE:WARD: ONC_LL | Area for the evaluation and treatment of patients with leukemia and/or lymphoma. |
| ONC Solid Tumor Ward | 1230-2 | IN:ACUTE:WARD:ONC_ST | Area for the evaluation and treatment of oncology patients with solid tumors. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| ONC Hematopoietic Stem Cell Transplant Ward | 1231-0 | IN:ACUTE:WARD: ONC_HSCT | Area for the care of patients who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders. |
| ONC General Hematology/Oncology Ward | 1232-8 | IN:ACUTE:WARD: ONC_HONC | Area for the evaluation and treatment of patients with cancer and/or blood disorders. |
| Ophthalmology Ward | 1064-5 | IN:ACUTE:WARD:OPH | Hospital area for care of patients whose primary reason for admission is to have eye surgery or to be cared for by an ophthalmologist after eye trauma. |
| Orthopedic Ward | 1065-2 | IN:ACUTE:WARD:ORT | Hospital area for evaluation, treatment or surgery on bones, joints, and associated structures by an orthopedist. |
| Orthopedic Trauma Ward | 1066-0 | IN:ACUTE:WARD:T_ORT | Hospital area where patients with orthopedic injuries or disorders are evaluated and treated. |
| Plastic Surgery Ward | 1067-8 | IN:ACUTE:WARD:PLS | Hospital area for the care of patients who have reconstructive surgery performed by a plastic surgeon. |
| Postpartum Ward | 1068-6 | IN:ACUTE:WARD:PP | Hospital area for the patient who is recovering from childbirth. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pulmonary Ward | 1069-4 | IN:ACUTE:WARD:PULM | Hospital area where patients with respiratory system conditions or disorders are evaluated and treated. |
| Rehabilitation Ward – within ACH | 1070-2 | IN:ACUTE:WARD:REHAB | Hospital area for evaluation and restoration of function to patients who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, or catastrophic events resulting in complete or partial paralysis. |
| School Infirmary | 1172-6 | IN:ACUTE:WARD:IFM | Overnight stay patient care area of a school infirmary or health center (e.g., private residential school or college campus). |
| Stroke (Acute) Ward | 1071-0 | IN:ACUTE:WARD:STRK | Hospital area for evaluation, stabilization and treatment of patients who have experienced an acute stroke. |
| Surgical Ward | 1072-8 | IN:ACUTE:WARD:S | Hospital area for evaluation and treatment of patients who have undergone a surgical procedure. |
| Telemetry Ward | 1208-8 | IN:ACUTE:WARD:TEL | Hospital area dedicated to providing evaluation and treatment of patients requiring continuous cardiac monitoring. |
| Vascular Surgery Ward | 1073-6 | IN:ACUTE:WARD:VS | Hospital area for evaluation and treatment of patients who have undergone vascular surgery. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **Pediatric Wards** | | | |
| Adolescent Behavioral Health Ward | 1075-1 | IN:ACUTE:WARD: BHV_ADOL | Hospital area for evaluation and treatment of patients between the ages of 13 and 18 with acute psychiatric or behavioral disorders. |
| ONC Pediatric Hematopoietic Stem Cell Transplant Ward | 1234-4 | IN:ACUTE:WARD: ONC_HSCT_PED | Area for the care of patients ≤18 years old who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders. |
| ONC Pediatric General Hematology/Oncology Ward | 1235-1 | IN:ACUTE:WARD: ONC_HONC_PED | Area for the evaluation and treatment of patients ≤18 years old with cancer and/or blood disorders. |
| Pediatric Behavioral Health Ward | 1077-7 | IN:ACUTE:WARD:BHV_PED | Hospital area for evaluation and management of patients ≤18 years old with acute psychiatric or behavioral disorders. |
| Pediatric Burn Ward | 1078-5 | IN:ACUTE:WARD:B_PED | Hospital area specializing in the evaluation and treatment of patients ≤18 years old who have tissue injury caused by burns. |
| Pediatric Ear, Nose, Throat Ward | 1079-3 | IN:ACUTE:WARD: ENT_PED | Hospital area for evaluation and management of patients ≤18 years old with disorders of the ear, nose and/or throat. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pediatric Genitourinary Ward | 1080-1 | IN:ACUTE:WARD: GU_PED | Hospital area where patients ≤18 years old with disorders of the genitourinary system are evaluated and treated. |
| Pediatric Medical Ward | 1076-9 | IN:ACUTE:WARD:M_PED | Area for the evaluation and treatment of patients ≤18 years of old with medical conditions or disorders. |
| Pediatric Medical/Surgical Ward | 1081-9 | IN:ACUTE:WARD: MS_PED | Hospital area where patients ≤18 years old with medical and/or surgical conditions are managed. |
| Pediatric Neurology Ward | 1082-7 | IN:ACUTE:WARD:N_PED | Area for the evaluation and treatment of patients ≤18 years old with neurologic disorders. |
| Pediatric Neurosurgical Ward | 1083-5 | IN:ACUTE:WARD:NS_PED | Hospital area for care of patients ≤18 years old whose primary reason for admission is to have neurosurgery or to be cared for by a neurosurgeon after head or spinal trauma. |
| Pediatric Orthopedic Ward | 1084-3 | IN:ACUTE:WARD: ORT_PED | Hospital area where patients ≤18 years old with orthopedic injuries or disorders are evaluated and treated. |
| Pediatric Rehabilitation Ward | 1085-0 | IN:ACUTE:WARD: REHAB_PED | Hospital area for evaluation and restoration of function to patients ≤18 years old who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | or catastrophic events resulting in complete or partial paralysis. |
| Pediatric Surgical Ward | 1086-8 | IN:ACUTE:WARD:S_PED | Hospital area for evaluation and treatment of patients ≤18 years old that have undergone a surgical procedure. |
| **Step Down Units** | | | |
| Adult Step Down Unit (e.g., post-critical care) | 1099-1 | IN:ACUTE:STEP | Hospital area for adult patients that are hemodynamically stable who can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks. |
| ONC Step Down Unit (all ages) (e.g., post-critical care) | 1227-8 | IN:ACUTE:STEP:ONC | Area for oncology patients who are hemodynamically stable and can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurologic and neurovascular checks. |
| Pediatric Step Down Unit (e.g., post-critical care) | 1100-7 | IN:ACUTE:STEP:PED | Patients ≤18 years old that are hemodynamically stable who can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **Mixed Acuity Units** | | | |
| Adult Mixed Acuity Unit | 1210-4 | IN:ACUTE:MIXED:ALL_ADULT | Hospital area for the evaluation and treatment of adult patients whose conditions are varying levels of acuity (e.g., critical care, ward-level care, step down type care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in the same bed during all phases of his care, from critical care through lower levels of care). |
| Pediatric Mixed Acuity Unit | 1211-2 | IN:ACUTE:MIXED:ALL_PEDS | Hospital area for the evaluation and treatment of pediatric patients (≤18 years old) whose conditions are of varying levels of acuity (e.g., critical care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in the same bed during all phases of his care, from critical care through lower levels of care). |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Mixed Age Mixed Acuity Unit | 1212-0 | IN:ACUTE:MIXED:ALL | Hospital area for the evaluation and treatment of a mixture of adult and pediatric patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step down type care, etc.). Such a care area may be comprised of patients followed by different hospital services (e.g., coronary, medical, surgical, etc.). This care area may or may not include “acuity adaptable” or “universal” beds (i.e., this model of patient care allows a patient to stay in the same bed during all phases of his care, from critical care through lower levels of care). |
| ONC Mixed Acuity Unit (all ages) | 1236-9 | IN:ACUTE:MIXED:ONC | Area for the evaluation and treatment of a mixture of adult and pediatric oncology patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step down type care, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of care, from critical care through lower levels of care). |
| **Operating Rooms** | | | |
| Cardiac Catheterization Room/Suite | 1005-8 | IN:ACUTE:OR:CATH | A room or rooms in a hospital equipped for the performance of heart catheterizations for diagnostic or |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | therapeutic purposes. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. |
| Cesarean Section Room/Suite | 1095-9 | IN:ACUTE:OR:LD | A room or suite in a hospital equipped for the performance of obstetric and gynecologic surgeries and for the care of the neonate immediately after birth. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. |
| Interventional Radiology | 1203-9 | IN:ACUTE:OR:RAD | A room or suite in a hospital where diagnostic or therapeutic radiologic procedures on outpatients and/or inpatients occurs. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. |
| Operating Room/Suite | 1096-7 | IN:ACUTE:OR | A room or suite in a hospital equipped for the performance of surgical operations. Requirements for air changes, temperature, humidity and surfaces must be met. (For outpatient operating room, use Ambulatory Surgery Center designation or other specialty OR shown in Outpatient Locations section of this chapter). |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Post Anesthesia Care Unit/Recovery Room | 1097-5 | IN:ACUTE:OR_STEP | Hospital area designated for monitoring patients for immediate effects of anesthesia before either going home or on to an in-patient care area. May also be used for pre surgical prep. |
| **Chronic Care Units (Previously named Long Term Care)**<br>***NOTE:*** *These location descriptions should only be used to define chronic care units that share a CCN with the affiliated acute care hospital. Skilled nursing facility (SNF) units located within a hospital that have a CCN that is different from the acute care hospital should be enrolled as a separate NHSN facility within the NHSN Long Term Care Facility Component, and use the long term care locations defined on pages 28-29.* | | | |
| Inpatient Hospice | 1165-0 | IN:NONACUTE:LTC:HSP | Area where palliative care is provided to the dying patient. |
| Chronic Alzheimer's Unit | 1103-1 | IN:NONACUTE:LTC:ALZ | Area where care is provided to patients diagnosed with Alzheimer's syndrome for extended periods of time. Formerly called Long Term Care Alzheimer's Unit. |
| Chronic Behavioral Health/Psych Unit | 1104-9 | IN:NONACUTE:LTC:BHV | Area where care is provided to patients with psychiatric or behavioral-disorder diagnoses for extended periods of time. Formerly called Long Term Care Behavioral Health/Psych Unit. |
| Chronic Rehabilitation Unit | 1105-6 | IN:NONACUTE:LTC: REHAB | Area where evaluation and restoration of function is provided to patients who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, or catastrophic events resulting in complete or partial |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | paralysis. Formerly called Long Term Care Rehabilitation Unit. |
| Chronic Care Unit | 1102-3 | IN:NONACUTE:LTC | Area where care provided for patients with chronic disease or disabilities for extended periods of time. Formerly called Long Term Care Unit. |
| Ventilator Dependent Unit | 1164-3 | IN:NONACUTE:LTC:R | Area where care is provided to patients whose respirations depend on the use of a ventilator for extended periods of time. |
| **LONG TERM CARE FACILITIES** | | | |
| LTCF Inpatient Hospice Unit | 1254-2 | IN:NONACUTE:LTCF:HSP | A unit or designed area which provides palliative and supportive care services to individuals diagnosed with life limiting (terminal) conditions. |
| LTCF Dementia Unit | 1255-9 | IN:NONACUTE:LTCF:DEM | A unit or designed area which provides specialized care for individuals diagnosed with dementia or related conditions, including Alzheimer's disease. |
| LTCF Psychiatric Unit | 1256-7 | IN:NONACUTE:LTCF:PSY | Unit or designated area which provides specialized care for individuals diagnosed with psychiatric or behavioral disorders. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| LTCF Skilled Nursing/Short Term Rehabilitation | 1257-5 | IN:NONACUTE:LTCF: REHAB | A unit or designated area which primarily provides short term (<90 days), medical, skilled nursing or rehabilitation services to individuals requiring restorative care following recent hospitalization. |
| LTCF General Nursing Unit | 1258-3 | IN:NONACUTE:LTCF:GEN | A unit or designated area which primarily provides nursing, rehabilitative or custodial services to individuals with varying levels of chronic conditions or disability requiring long term (>90 days) support. |
| LTCF Ventilator Dependent Unit | 1259-1 | IN:NONACUTE:LTCF:VEN | A unit or designated area which provides nursing and respiratory care to individuals who require mechanical ventilation. |
| LTCF Bariatric Unit | 1260-9 | IN:NONACUTE:LTCF:BAR | A unit or designated area which provides specializing care for individuals who are preparing for or have undergone bariatric surgery. |
| **LONG TERM ACUTE CARE FACILITIES** | | | |
| LTAC ICU | 1220-3 | IN:ACUTE:CC:LTAC | Critical care area specializing in the evaluation, treatment, and management of patients that require high observance/acuity and/or special care that are suffering medically complex conditions or who have suffered |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | recent catastrophic illness or injury and require and extended stay in an acute care environment. |
| LTAC Ward | 1221-1 | IN:ACUTE:WARD:LTAC | Hospital area for the evaluation and treatment of patients suffering medically complex conditions or who have suffered recent catastrophic illness or injury, and require an extended stay in an acute care environment. |
| LTAC Pediatric ICU | 1222-9 | IN:ACUTE:CC:LTAC_PED | Critical care area specializing in the evaluation, treatment, and management of patients ≤18 years old, that require high observation/acuity and/or special care that are suffering medically complex conditions or who have suffered recent catastrophic illness or injury, and require an extended stay in an acute care environment. |
| LTAC Pediatric Ward | 1214-6 | IN:ACUTE:WARD: LTAC_PED | Hospital area for the evaluation and treatment of patients ≤18 years old, suffering medically complex conditions or who have suffered recent catastrophic illness or injury, and require an extended stay in an acute care environment. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **INPATIENT REHABILITATION FACILITIES** | | | |
| Rehabilitation Ward – Freestanding IRF | 1217-9 | IN:ACUTE:IRF | Hospital area for evaluation, treatment, and restoration of function to patients have lost function due to acute or chronic pain, musculoskeletal problems, stroke, brain or spinal cord dysfunction, or catastrophic events resulting in complete or partial paralysis. |
| Rehabilitation Pediatric Ward | 1218-7 | IN:ACUTE:IRF:PED | Hospital area for evaluation, treatment, and restoration of function to patients ≤18 years old who have lost function due to acute or chronic pain, musculoskeletal problems, stroke, brain or spinal cord dysfunction, or catastrophic events results in complete or partial paralysis. |
| **ONCOLOGY FACILITIES** | | | |
| ONC Medical Critical Care | 1223-7 | IN:ACUTE:CC:ONC_M | Critical care area for the care of oncology patients who are being treated for nonsurgical conditions related to their malignancy. |
| ONC Surgical Critical Care | 1224-5 | IN:ACUTE:CC:ONC_S | Critical care area for the evaluation and management of oncology patients with serious illness before and/or after cancer-related surgery. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| ONC Medical-Surgical Critical Care | 1225-2 | IN:ACUTE:CC:ONC_MS | Critical care area for the care of oncology patients with medical and/or surgical conditions related to their malignancy. |
| ONC Pediatric Critical Care | 1233-6 | IN:ACUTE:CC:ONC_PED | Critical care area for the care of oncology patients ≤18 years old who are being treated for surgical or nonsurgical conditions related to their malignancy. |
| ONC Leukemia Ward | 1226-0 | IN:ACUTE:WARD: ONC_LEUK | Area for the evaluation and treatment of patients with leukemia. |
| ONC Lymphoma Ward | 1228-6 | IN:ACUTE:WARD:ONC_ LYMPH | Area for the evaluation and treatment of patients with lymphoma. |
| ONC Leukemia/Lymphoma Ward | 1229-4 | IN:ACUTE:WARD: ONC_LL | Area for the evaluation and treatment of patients with leukemia and/or lymphoma. |
| ONC Solid Tumor Ward | 1230-2 | IN:ACUTE:WARD:ONC_ST | Area for the evaluation and treatment of oncology patients with solid tumors. |
| ONC Hematopoietic Stem Cell Transplant Ward | 1231-0 | IN:ACUTE:WARD: ONC_HSCT | Area for the care of patients who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| ONC General Hematology/Oncology Ward | 1232-8 | IN:ACUTE:WARD: ONC_HONC | Area for the evaluation and treatment of patients with cancer and/or blood disorders. |
| ONC Pediatric Hematopoietic Stem Cell Transplant Ward | 1234-4 | IN:ACUTE:WARD: ONC_HSCT_PED | Area for the care of patients ≤18 years old who undergo stem cell transplant for the treatment of cancers and/or blood or immune system disorders. |
| ONC Pediatric General Hematology/Oncology Ward | 1235-1 | IN:ACUTE:WARD: ONC_HONC_PED | Area for the evaluation and treatment of patients ≤18 years old with cancer and/or blood disorders. |
| ONC Step Down Unit | 1227-8 | IN:ACUTE:STEP:ONC | Area for oncology patients who are hemodynamically stable and can benefit from close supervision and monitoring, such as frequent pulmonary toilet, vital signs, and/or neurologic and neurovascular checks. |
| ONC Mixed Acuity Unit (all ages) | 1236-9 | IN:ACUTE:MIXED:ONC | Area for the evaluation and treatment of a mixture of adult and pediatric oncology patients whose conditions are of varying levels of acuity (e.g., critical care, ward-level care, step down type care, etc.). This care area may or may not include "acuity adaptable" or "universal" beds (i.e., this model of patient care allows a patient to stay in same bed during all phases of care, from critical care through lower levels of care). |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|

In addition to the 14 ONC specific locations, HOSP-ONC facilities can also use the following locations within NHSN (Location codes and descriptions can be found in the appropriate section of the master location table):

Inpatient Locations

- Operating Rooms:
  - Cardiac Catheterization Room/Suite
  - Interventional Radiology
  - Inpatient Operating Room/Suite
  - Post-Anesthesia Care Unit/Recovery Room
  - Facility-wide Areas:
  - FACWIDEIN

  - Miscellaneous Areas:
  - Pulmonary Function Testing
  - Treatment Room
  - Transport Service
  - Float

Outpatient Locations

- Acute Care
  - 24-Hour Observation Area
  - Ambulatory Surgery Center
  - Emergency Department
  - Outpatient Pediatric Surgery Center
  - Outpatient Plastic Surgery Center
  - Outpatient Surgery Recovery Room/Post-Anesthesia Care Unit

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|

- Pediatric Emergency Department
- Clinic (Nonacute) Settings
  - Infusion Center
  - Occupational Health Clinic
  - Outpatient Hematology/Oncology Clinic
  - Pediatric Hematology/Oncology Clinic
  - Radiology (includes Nuclear Medicine)
  - Specimen Collection Area (Healthcare)
- Community Locations
  - Home Care
  - Home-based Hospice
  - Location outside facility
- All Non-Patient Care Locations as designated on page 53 in the location table

## INPATIENT PSYCHIATRIC FACILITIES

HOSP-PSYCH facilities can use the following locations within NHSN (Location codes and descriptions can be found in the appropriate section of the master location table):

Inpatient Locations

- Adult Wards
  - Behavioral Health /Psych Ward
  - Jail Unit
  - Medical Ward
  - Medical/Surgical Ward
- Pediatric Wards

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| • Adolescent Behavioral Health/Psych Ward<br>• Pediatric Behavioral Health/Psych Ward<br>• Mixed Acuity Locations<br>• Adult Mixed Acuity<br>• Pediatric Mixed Acuity<br>• Chronic Care Units<br>• Chronic Alzheimer's Unit<br>• Chronic Behavioral Health/Psych Unit<br>• Facility-wide Areas:<br>• FACWIDEIN<br>• FACWIDEOUT | | | |
| **OUTPATIENT LOCATIONS** | | | |
| **OUTPATIENT AMBULATORY SURGERY CENTERS** | | | |
| Outpatient Ambulatory Surgery Center | 1243-5 | OUT:ASC:OR | Area that is equipped for the performance of surgical operations; can be attached to an ACH or free-standing and has a separate ASC CCN. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Ambulatory Surgery Recovery Room | 1245-0 | OUT:ASC:OR_STEP | Area designated in an ASC for monitoring patients for the immediate effects of anesthesia. |
| Outpatient Ambulatory Pediatric Surgery Center | 1246-8 | OUT:ASC:OR:PED | Area, in an ASC, that is equipped for the performance of surgical operations for patients ≤18 years old; may be free-standing or part of a hospital. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. Patients do not stay overnight. |
| Outpatient Ambulatory Plastic Surgery Center | 1247-8 | OUT:ASC:OR:PED | Area, in an ASC, that is equipped for the performance of plastic surgery operations; may be free-standing or part of a hospital. Operating Room requirements for air changes, temperature, humidity and surfaces must be met. Patients do not stay overnight. |
| **ACUTE CARE FACILITIES GENERAL** | | | |
| **Acute Settings** | | | |
| 24-Hour Observation Area | 1162-7 | OUT:ACUTE:WARD | Area where patients are monitored for suspected or non-life threatening conditions for 24 hours or less. More than 50% of patients in this location must be outpatients who are not expected to be admitted to an inpatient unit. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Emergency Department | 1108-0 | OUT:ACUTE:ED | Area that provides emergency medical services; top priority is given to those with life-threatening illness or injury. |
| Mobile Emergency Services/EMS | 1174-2 | OUT:ACUTE:MOBILE:UE | Mobile unit that provides clinical and emergency medical services to patients who require them in the pre-hospital setting. |
| Post Anesthesia Care Unit | 1169-2 | OUT:ACUTE:OR_STEP | Area designated for monitoring patients for the immediate effects of anesthesia before being sent home. May also be used for pre surgical prep. |
| Outpatient Operating Room/Suite_ Attached | 1242-7 | OUT:ACUTE:OR:HOPD_A | A room or suite equipped for the performance of surgical operations that is physically within the walls of the affiliated ACH. *It is considered a hospital outpatient department used for outpatient surgical procedures.* Requirements for air changes, temperature, humidity, and surfaces must be met. |
| Outpatient Operating Room/Suite_ Detached | 1244-3 | OUT:ACUTE:OR:HOPD_D | A room or suite equipped for the performance of surgical operations that is not physically attached to the affiliated ACH (could be on the same campus or miles away). *It is considered a hospital outpatient department used for outpatient surgical procedures.* Requirements for air changes, temperature, humidity, and surfaces must be met. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pediatric Emergency Department | 1109-8 | OUT:ACUTE:ED:PED | Area that provides emergency medical services to patients ≤18 years old; top priority is given to those with life-threatening illness or injury. |
| Urgent Care Center | 1160-1 | OUT:ACUTE:CLINIC:UE | Area that provides medical care services for illnesses and injuries that are not life-threatening. |
| **Clinic (non-acute) Settings** | | | |
| Allergy Clinic | 1110-6 | OUT:NONACUTE:CLINIC:ALRG | An outpatient setting for the purpose of providing services to patients with allergies. |
| Behavioral Health Clinic | 1145-2 | OUT:NONACUTE:CLINIC:BHV | An outpatient setting for the purpose of providing services to patients with psychiatric or behavior-disorders. |
| Blood Collection Center | 1147-8 | OUT:NONACUTE:CLINIC:BLOOD | An outpatient setting where blood is collected from donors. This does not include donation centers that are temporarily set up in non-clinical settings (e.g., schools, churches) or mobile blood collection centers. |
| Cardiac Rehabilitation Center | 1112-2 | OUT:NONACUTE:CLINIC:C_REHAB | An outpatient setting where patients with cardiac disease, in partnership with a multidisciplinary team of health professionals, are encouraged and supported to achieve |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | and maintain optimal physical health through exercise, nutritional and psychological counseling. |
| Cardiology Clinic | 1113-0 | OUT:NONACUTE:CLINIC:C | An outpatient setting for the evaluation and management of patients with cardiac problems. |
| Continence Clinic | 1148-6 | OUT:NONACUTE:CLINIC: CON | An outpatient setting for the evaluation and management of patients with incontinence problems. |
| Dermatology Clinic | 1115-5 | OUT:NONACUTE:CLINIC: DERM | An outpatient setting for the evaluation and management of dermatologic conditions by a dermatologist. |
| Diabetes/Endocrinology Clinic | 1116-3 | OUT:NONACUTE:CLINIC: DIAB | An outpatient setting for the evaluation, education and management of patients with diabetes. |
| Ear, Nose, Throat Clinic | 1126-2 | OUT:NONACUTE:CLINIC: ENT | An outpatient setting for the evaluation and management of conditions related to the ear, nose and/or throat. |
| Endoscopy Suite | 1007-4 | OUT:NONACUTE:DIAG:GI | An area where endoscopic procedures (e.g., upper gastrointestinal endoscopies, bronchoscopy) are performed on outpatients and/or inpatients. Patient care and processing of equipment may take place in this location. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Family Medicine Clinic | 1117-1 | OUT:NONACUTE:CLINIC:FAM | An outpatient setting for patients who are managed by a family practice physician or group of physicians. Does not include private physician practice. |
| Genetics Clinic | 1122-1 | OUT:NONACUTE:CLINIC:GEN | An outpatient setting for testing and counseling of patients may have genetic or hereditary disorders. |
| Gynecology Clinic | 1121-3 | OUT:NONACUTE:CLINIC:GYN | An outpatient setting for women for the evaluation and management of female reproductive tract conditions. |
| Holistic Medicine Center | 1161-9 | OUT:NONACUTE:CLINIC:HOL | An outpatient setting where alternative healthcare practices are used, focusing on the physical, mental, emotional, social and spiritual aspects of health. |
| Hyperbaric Oxygen Center | 1017-3 | OUT:NONACUTE:CLINIC:HBO | An outpatient setting where therapeutic hyperbaric oxygen is administered. |
| Infusion Center | 1018-1 | OUT:NONACUTE:CLINIC:FUS | An outpatient setting for the administration of fluids, blood products and medications. |
| Mobile Blood Collection Center | 1176-7 | OUT:NONACUTE:MOBILE:BLOOD | A self-contained mobile unit such as a bus or trailer that is specifically designed and equipped for the collection of blood and blood products from public donors. This unit typically moves from location to location. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Mobile MRI/CT | 1175-9 | OUT:NONACUTE: MOBILE_DIAG:RAD | A self-contained mobile unit such as a bus or trailer that is equipped with MRI or CT radiologic equipment and that may be moved between healthcare locations (e.g., hospitals, clinics). |
| Neurology Clinic | 1123-9 | OUT:NONACUTE:CLINIC:N | An outpatient setting for the diagnosis, evaluation, and treatment of patients with neurologic disorders. |
| Occupational Health Clinic | 1151-0 | OUT:NONACUTE:CLINIC: OCC | An outpatient setting where workplace physicals, workplace injury management and immunological evaluations take place |
| Occupational Therapy Clinic | 1152-8 | OUT:NONACUTE:CLINIC: OT_REHAB | An outpatient setting where patients with injury or disability are helped to resume activities of daily living with exercise, massage and other therapies. |
| Ophthalmology Clinic | 1124-7 | OUT:NONACUTE:CLINIC: OPH | An outpatient setting for the diagnosis, evaluation and treatment of ophthalmologic disorders. |
| Orthopedic Clinic | 1125-4 | OUT:NONACUTE:CLINIC: ORT | An outpatient setting for the diagnosis, evaluation and treatment of orthopedic disorders. |
| Ostomy Clinic | 1149-4 | OUT:NONACUTE:CLINIC: OST | An outpatient setting for the management of patients who have had surgical procedure for removing normal bodily |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | wastes through a surgical opening (stoma) on the abdominal wall. |
| Dental Clinic | 1150-2 | OUT:NONACUTE:CLINIC:DENT | An outpatient setting that provides dental services, including preventive teeth cleaning, emergency treatment, and comprehensive oral care. This may be a private or group practice or a teaching facility for dentists and/or dental hygienists. |
| Gastrointestinal (GI) Clinic | 1118-9 | OUT:NONACUTE:CLINIC:GI | An outpatient setting for the diagnosis, evaluation and management of conditions related to the gastrointestinal tract. Usually includes an endoscopy suite. |
| Hematology/Oncology Clinic | 1200-5 | OUT:NONACUTE:CLINIC:HONC | An outpatient setting for the diagnosis, evaluation and treatment of patients with hematologic and/or oncologic disorders. This may include chemotherapy or blood/blood products infusion services. |
| Hemodialysis Clinic | 1153-6 | OUT:NONACUTE:CLINIC:HD | An outpatient setting for chronic maintenance hemodialysis patients where they are evaluated and dialyzed. (Available only for use in the Biovigilance Component) |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| HIV Clinic | 1154-4 | OUT:NONACUTE:CLINIC:HIV | An outpatient setting for the diagnosis, evaluation and treatment of patients who are HIV positive or who have AIDS. |
| Medical Clinic | 1120-5 | OUT:NONACUTE:CLINIC:M | An outpatient setting for the diagnosis, evaluation and treatment of medical disorders. |
| Rehabilitation Clinic | 1151-1 | OUT:NONACUTE:CLINIC:REHAB | An outpatient setting where patients with injury or disability are evaluated and treated to resume activities of daily living, speech and language skills and maximum physical function. This may include social and psychological evaluation and treatment. |
| Pain Clinic | 1127-0 | OUT:NONACUTE:CLINIC:PAIN | An outpatient setting for the evaluation and treatment of patients with chronic or intractable pain. |
| Pediatric Behavioral Health Clinic | 1146-0 | OUT:NONACUTE:CLINIC:BHV_PED | An outpatient setting for the evaluation and management of patients ≤18 years old with psychiatric or behavior disorders. |
| Pediatric Cardiology Center | 1129-6 | OUT:NONACUTE:CLINIC:PED_C | An outpatient setting for the evaluation and management of patients ≤18 years old with cardiac disorders. |
| Pediatric Clinic | 1128-8 | OUT:NONACUTE:CLINIC: | An outpatient setting for the evaluation and treatment of patients ≤18 years old. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | PED | |
| Pediatric Dental Clinic | 1130-4 | OUT:NONACUTE:CLINIC:DENT_PED | An outpatient setting that provides dental services, including preventive teeth cleaning, emergency treatment, and comprehensive oral care to patients ≤18 years old. This may be a private or group practice or a teaching facility for dentists and/or dental hygienists. |
| Pediatric Dermatology Clinic | 1131-2 | OUT:NONACUTE:CLINIC:DERM_PED | An outpatient setting for the evaluation and management of patients ≤18 years old with dermatologic disorders. |
| Pediatric Diabetes/Endocrinology Clinic | 1132-0 | OUT:NONACUTE:CLINIC:DIAB_PED | An outpatient setting for the evaluation and management of patients ≤18 years old with diabetes or other endocrine disorders. |
| Pediatric Gastrointestinal Clinic | 1119-7 | OUT:NONACUTE:CLINIC:GI_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with gastrointestinal disorders. |
| Pediatric Hematology/Oncology Clinic | 1136-1 | OUT:NONACUTE:CLINIC:HONC_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with cancer and/or blood disorders. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Pediatric Nephrology Clinic | 1137-9 | OUT:NONACUTE:CLINIC:PGU_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with disorders of the genitourinary tract. |
| Pediatric Orthopedic Clinic | 1133-8 | OUT:NONACUTE:CLINIC:ORT_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with fractures or other orthopedic disorders. |
| Pediatric Rheumatology Clinic | 1138-7 | OUT:NONACUTE:CLINIC:RHEUM_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with rheumatology disorders. |
| Pediatric Scoliosis Clinic | 1134-6 | OUT:NONACUTE:CLINIC:SCOL_PED | An outpatient setting for the evaluation and treatment of patients ≤18 years old with scoliosis or other growth disorders of the spine. |
| Physical Therapy Clinic | 1202-1 | OUT:NONACUTE:CLINIC:PT_REHAB | An outpatient setting where patients with injury or disability are helped to obtain maximum physical function. |
| Physician's Office | 1141-1 | OUT:NONACUTE:CLINIC | A physician's office practice. |
| Podiatry Clinic | 1140-3 | OUT:NONACUTE:CLINIC:POD | An outpatient setting for the evaluation and treatment of patients with conditions or disorders of the feet. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Prenatal Clinic | 1156-9 | OUT:NONACUTE:CLINIC: PNATL | An outpatient setting for the evaluation and treatment of pregnant women. |
| Pulmonary Clinic | 1157-7 | OUT:NONACUTE:CLINIC: PULM | An outpatient setting for the evaluation and treatment of patients with disorders of the respiratory tract. |
| Pulmonary Function Testing | 1009-0 | OUT:NONACUTE:DIAG: PULM | Area where the evaluation of a patient's respiratory status takes place. |
| Radiology (includes Nuclear Medicine) | 1008-2 | OUT:NONACUTE:DIAG: RAD | An area where diagnostic or therapeutic radiologic procedures are done on outpatients and/or inpatients. Operating room requirements for air changes, temperature, humidity, and surfaces are NOT met. |
| Rheumatology Clinic | 1142-9 | OUT:NONACUTE:CLINIC: RHEUM | An outpatient setting for the evaluation and treatment of patients with autoimmune disorders, primarily rheumatoid arthritis. |
| School or Prison Infirmary | 1170-0 | OUT:NONCUTE:CLINIC: IFM | Area in a school or correctional facility that provides medical care to students/inmates. This area is not staffed or equipped for overnight stay patients. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Speech Therapy Clinic | 1158-5 | OUT:NONACUTE:CLINIC: ST_REHAB | An outpatient setting for the evaluation and treatment of patients with brain injury to maximize their speech, swallow and language functions. |
| Surgical Services Clinic | 1143-7 | OUT:NONACUTE:CLINIC:S | An outpatient setting for the pre-operative evaluation and the postoperative management of patients undergoing a surgical procedure. |
| Well Baby Clinic | 1139-5 | OUT:NONACUTE:CLINC: NURS | An outpatient setting for the examination and treatment of normal newborns. |
| Wound Center | 1144-5 | OUT:NONACUTE:CLINIC: WND | An outpatient setting for the evaluation and treatment of patients with acute or chronic wounds. |
| Wound Ostomy Continence Clinic | 1159-3 | OUT:NONACUTE:CLINIC: WND_OST_CONT | An outpatient area which provides acute and rehabilitative care for patients with selective disorders of the gastrointestinal, genitourinary and integumentary (skin) systems. |
| Therapeutic Apheresis Clinic | 1207-0 | OUT:NONACUTE:CLINIC: THERAPHERSIS | Outpatient setting where blood is collected from patients and therapeutic apheresis procedures are performed. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| **Miscellaneous Outpatient Settings** | | | |
| Specimen Collection Area | 1019-9 | OUT:NA:LAB:SPEC | An area within a healthcare facility where procedures are performed to collect blood, tissue, or other specimens for diagnostic purposes. |
| Transport Service | 1178-3 | OUT:NONACUTE:MOBILE | Mobile unit used to transport patients to their home or from one healthcare setting to another non-emergently. |
| **OUTPATIENT DIALYSIS FACILITIES**<br>**(Available for use in outpatient ambulatory hemodialysis facilities only)** | | | |
| Outpatient Hemodialysis Clinic | 1153-6 | OUT:NONACUTE:CLINIC: DIAL | An outpatient setting for maintenance hemodialysis patients where they are evaluated and dialyzed in-center. |
| Home Hemodialysis | 1262-1 | COMM:NONACUTE: HOME:DIAL | Hemodialysis performed by a patient (and the patient's caregiver) and at home. |
| **MISCELLANEOUS AREAS**<br>**(Mainly used for Healthcare Personnel Safety component)** | | | |
| Float | 1206-2 | IN:ACUTE:FLOAT | For HCWs who do not work at least 75% of the time at a single location, the work location code for 'float' should be entered. (This location is available only for Healthcare Personnel Safety Component use only.) |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Morgue/Autopsy Room | 1189-0 | NONPTC:NA:LAB: PATH_MORG | An area within a facility that is used for the storage and/or postmortem examination of deceased persons. |
| Sleep Studies (for in and out patients) | 1020-7 | IN:NONACUTE:CLINIC: SLEEP | Area where patients stay overnight and are evaluated for sleep disorders. |
| Treatment Room | 1209-6 | IN:ACUTE:SUPPORT: TREAT | A room in a patient care unit, in which various treatments or procedures requiring special equipment are performed, such as removing sutures, draining a hematoma, packing a wound, or performing an examination. |
| **FACILITY-WIDE LOCATIONS**<br>**(Available only for Laboratory Identified Event Reporting [LABID] and Antimicrobial Use and Resistance [AUR] Module)** | | | |
| Facility-wide Inpatient FacWideIN | 1250-0 | FACWIDEIN | This location represents all inpatient locations for the facility, where appropriate numerator and denominator counts can be collected. All of the facility's inpatient locations with an overnight stay must be represented for full inpatient facility coverage, where denominators can be accurately collected and there is the possibility of the MDRO to present, transmitted, and identified in that specific location. Currently, it is available for use in the MDRO/CDI Module for LabID Event reporting and in the AUR Module. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Facility-wide Outpatient FacWideOUT | 1251-8 | FACWIDEOUT | This location represents all outpatient locations for the facility, where appropriate numerator and accurate denominator counts can be collected. All of the facility's outpatient locations must be represented for full outpatient facility coverage, where denominators can be accurately collected and there is the possibility of the MDRO to be present, transmitted, and identified in that specific location. Currently, it is available for use in the MDRO/CDI Module for LabID Event reporting. |
| **COMMUNITY LOCATIONS** | | | |
| Blood Collection (Blood Drive Campaign) | 1195-7 | COMM:NONACUTE:CLINIC: BLOOD | A location not designated or equipped to perform healthcare functions (e.g., school gym or shopping mall) that have been set up specifically to collect donations of blood and blood products from the public. |
| Home Care | 1192-4 | COMM:NONACUTE: HOME | A patient's home location where medical services including routine noninvasive and other noninvasive procedures (e.g., insertion of indwelling urinary catheter, insertion of IV line) are performed by healthcare workers and family members under the supervision of a licensed independent practitioner (e.g., MD, CNP, PA). |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Home-based Hospice | 1194-0 | COMM:NONACUTE:HOME:HSP | A patient's home location where end-of-life services are performed by healthcare workers, family members, and volunteers. |
| Location outside facility | 1204-7 | COMM:NOTFAC | A location outside this facility, including unknown outside location. |
| Specimen Collection Area (Community) | 1196-5 | COMM:NA:LAB:SPEC | A location not designated or equipped to perform healthcare functions (e.g., school gym or shopping mall) that have been set up specifically to collect body fluids for healthcare testing. Examples would be blood sugar or cholesterol screening clinics. |
| **NON-PATIENT CARE LOCATIONS**<br>**(Non-Patient Care Areas available for use in Biovigilance or Healthcare Personnel Safety Components only)** | | | |
| Administrative Areas | 1184-1 | NONPTC:NA:SUPPORT:ADMIN | Areas within a healthcare facility where administrative functions take place. No patient care takes place in these areas. |
| Assisted Living Area | 1106-4 | NONPTC:NA:HOME | A location where persons live and have available to them housekeeping, meal preparation, transportation, and other non-medical services. Patient care is not done in this area. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Blood Bank | 1185-8 | NONPTC:NA:LAB:BLOOD | An area within a healthcare facility that may collect, store, and distribute blood and blood products, and performs diagnostic tests on blood/components to determine compatibilities. |
| Central Sterile Supply | 1186-6 | NONPTC:NA:SUPPORT: CSS | An area within a healthcare facility where durable medical equipment is cleaned/decontaminated, wrapped, sterilized, and stored in preparation for transport to a landfill or incineration. |
| Central Trash Area | 1187-4 | NONPTC:NA:SUPPORT: SOILED | An area adjacent to a healthcare facility where bio-hazardous and non-bio-hazardous wastes are collected in preparation for transport to a landfill or incineration. |
| Centralized Transfusion Service | 1261-7 | NONPTC:NA:LAB:CTS | A location outside the facility that stores, manipulates, issues, and/or performs compatibility testing on blood and blood products (e.g., a contracted transfusion service or a separate hospital that provides transfusion services for your facility). |
| Clinical Chemistry Laboratory | 1011-6 | NONPTC:NA:LAB:CHEM | An area within a diagnostic laboratory that performs general clinical chemistry analysis (clinical biochemistry), endocrinology, therapeutic substance |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| | | | monitoring, toxicology, blood pH and blood gas analysis, urinalysis and urine pregnancy testing. |
| Facility Grounds | 118-2 | NONPTC:NA:SUPPORT: GRNDS | Any outdoor area adjacent to a healthcare facility that belongs to the facility (e.g., sidewalks, parking ramps, lawns). |
| General Laboratory | 1010-8 | NONPTC:NA:LAB | An area that encompasses all clinical divisions within a diagnostic laboratory. |
| Hematology Laboratory | 1012-4 | NONPTC:NA:LAB:H | An area within a diagnostic laboratory that determines the specific properties of blood (e.g., CBC, white blood count). |
| Histology/Surgical Pathology Laboratory | 1013-2 | NONPTC:NA:LAB: HIST_PATH | An area within a diagnostic laboratory that uses high-power microscopy to evaluate cells and tissues for the presence or absence of disease. |
| Housekeeping/Environmental Services | 1182-5 | NONPTC:NA:SUPPORT: HSKP | An area within a healthcare facility where the activities of housekeeping/environmental services staff are coordinated and supplies are stored. |
| Laundry Room | 1183-3 | NONPTC:NA:SUPPORT: LAUN | An area within a healthcare facility where laundry is sorted, washed, dried, and prepared for transport and use. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Microbiology Laboratory | 1014-0 | NONPTC:NA:LAB:MICRO | An area within a laboratory that performs diagnostic tests to determine the presence or absence of bacteria and their related properties. |
| Pharmacy | 1179-1 | NONPTC:NA:SUPPORT: PHARM | An area within a healthcare facility where medications are prepared and labeled for patient use. |
| Physical Plant Operations Center | 1181-7 | NONPTC:NA:SUPPORT: ENG | An area within a healthcare facility where construction, renovation, and maintenance staff activities and supplies are coordinated. They may also include areas of machinery and equipment. |
| Public Area in Facility | 1180-9 | NONPTC:NA:SUPPORT: PUB | Any indoor area within a healthcare facility that is not used for patient care and that is available to the public (e.g., waiting rooms, cafeterias, hallways). |
| Serology Laboratory | 1015-7 | NONPTC:NA:LAB:SER | An area within a diagnostic laboratory that performs blood tests to determine the presence or absence of certain diseases or the levels of immunity. |
| Soiled Utility Area | 1190-8 | IN:NA:SUPPORT:TRASH | Area where used and/or soiled disposable or durable medical equipment is stored and/or cleaned in preparation for disposal or reprocessing/reuse. |

| CDC Location Label | NHSN Healthcare Service Location Code | CDC Location Code | Location Description |
|---|---|---|---|
| Virology Laboratory | 1016-5 | NONPTC:NA:LAB:VIR | An area within a diagnostic laboratory that performs tests and/or culturing to determine the presence or absence of specific viruses. |

## References

1. American Academy of Pediatrics. Policy Statement Levels of Neonatal Care. Pediatrics 2012; 130 (3): 587-597.

# General Key Terms

**(Key terms specific to protocols are found in the individual protocols)**

| Term | Definition |
|---|---|
| **Aseptically obtained** | Obtained in a manner to prevent introduction of organisms from the surrounding tissues into the specimen being collected. |
| **Birthweight** | Birthweight is the weight of the infant at the time of birth and should not be changed as the infant gains weight. The birthweight categories are as follows: A = ≤750 g; B = 751-1000 g; C = 1001-1500 g; D = 1501-2500 g; E = >2500 g. |
| **CDC location** | A CDC-defined designation given to a patient care area housing patients who have similar disease conditions or who are receiving care for similar medical or surgical specialties. Each facility location that is monitored is "mapped" to one CDC Location. The specific CDC Location code is determined by the type of patients cared for in that area according to the **80% Rule**. That is, if 80% of patients are of a certain type (e.g., pediatric patients with orthopedic problems) then that area is designated as that type of location (in this case, an Inpatient Pediatric Orthopedic Ward). The admission/transfer diagnosis should be used when determining the appropriate location mapping. The admission diagnosis is considered the most accurate depiction of the patient's illness and reason for being admitted to a particular unit. (See also virtual location in the Locations and Descriptions chapter.)<br><br>For detailed instructions on how to map locations, see "Instructions for Mapping Patient Care Locations in NHSN" in the Locations and Descriptions chapter. |
| **Clinical correlation** | Physician documentation of antimicrobial treatment for site-specific infection. |
| **Date of event** | The date of event is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period. Synonyms: infection date, date of infection. In the case of a process of care event, the date the process or intervention was performed (e.g., the day a central line was inserted is the date of CLIP event). This definition does not apply to LabID event, or VAE. See Date of event for VAE and LabID Event in respective protocols. |
| **Device-associated infection** | An infection meeting the HAI definition is considered a device-associated (e.g., associated with the use of a ventilator, central line, or indwelling urinary catheter) HAI if the device was in place for >2 calendar days on the date of event and was also in place on the date of event or the day before. If the device was in place for >2 calendar days and then removed, the date of event must be the day of discontinuation or the next day to be device associated. For a patient who has a central line in place on hospital admission, day of first access is considered device Day 1. |

| Term | Definition |
|---|---|
| **Device days** | A count of the number of patients with a specific device in the patient care location during a time period. This count can be determined electronically or manually by a daily count or weekly sampling. See Denominator Data section within individual protocols. |
| **Died** | The patient died during this facility admission. |
| **Event contributed to death** | The event either directly caused death or exacerbated an existing disease condition which then led to death as evidenced by available documentation (e.g., death/discharge note, autopsy report, etc.). |
| **Event date** | See Date of event. |
| **Fever** | See Vital signs. |
| **Gross Anatomical Exam** | Physical examination with or without invasive procedure. For example, evidence of infection found on gross anatomical exam may refer to: findings elicited or visualized on physical examination or observed during an invasive procedure. |
| **In-plan surveillance** | Facility has indicated in their monthly reporting plan that the NHSN surveillance protocol(s) will be utilized, in its entirety, for that particular event. Only in-plan data are submitted to CMS in accordance with CMS's Quality Reporting Programs. Only data that are entered into NHSN "in-plan" are included in NHSN annual reports or other NHSN publications. |
| **Healthcare-associated Infection (HAI)** | An infection is considered a Healthcare-associated Infection (HAI) if the date of event of the NHSN site-specific infection criterion occurs on or after the 3rd calendar day of admission to an inpatient location where day of admission is calendar day 1. See Identifying HAIs chapter. **Note:** The HAI definition is not to be used in the SSI, VAE, or LabID Event protocols. |
| **Hypotension** | See Vital signs. |
| **Infant** | A patient who is ≤ 1 year (≤ 365 days) of age. |
| **Infection date** | See Date of Event. |
| **Inpatient location** | See location. |
| **Intensive care unit (ICU)** | Also known as a Critical Care Unit, the ICU is a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only. Specialty care areas are also excluded (see definition). The type of ICU is determined by the kind of patients cared for in that unit according to the 80% rule. That is, if 80% of patients are of a certain type (e.g., patients with trauma), then that ICU is designated as that type of unit (in this case, trauma ICU). When an ICU houses roughly equal populations of medical and surgical patients (a 50/50 to 60/40 mix), it is called a medical/surgical ICU. |

| Term | Definition |
|---|---|
| | |
| **Location** | The patient care area to which a patient is assigned while receiving care in the healthcare facility. **Note:** Only mapped inpatient locations where denominator data are collected can be used for reporting infection events via the Device-associated Module. Operating rooms (including cardiac cath labs, C-section rooms, and interventional radiology) and outpatient locations are not valid locations for these types of surveillance. See also CDC location. |
| **Location of attribution** | The inpatient location where the patient was assigned on the date of event. See individual protocols. |
| **Neonate** | A patient who is ≤ 30 days of age. |
| **Off-plan surveillance** | Facility has not indicated in their monthly reporting plan that the NHSN surveillance protocol(s) will be utilized, in its entirety, for that particular event. Off-plan data are not submitted to CMS in accordance with CMS's Quality Reporting Programs. Off-plan data are not included in NHSN annual reports or other NHSN publications. |
| **Patient days** | A count of the number of patients in the patient care location during a time period. This count can be determined electronically or manually by a daily count or weekly sampling. See Denominator Data section within individual protocols. |
| **Present on Admission (POA)** | An infection is considered **Present on Admission (POA)** if the date of event of the NHSN site-specific infection criterion occurs during the POA time period, which is defined as the day of admission to an inpatient location (calendar day 1), the 2 days before admission, and the calendar day after admission. See Identifying HAIs chapter. **Note:** Rules for POA should not be applied to SSI, VAE, or LabID Events. |
| **Repeat Infection Timeframe (RIT)** | The RIT is a 14-day timeframe during which no new infections of the same type are reported. The date of event is Day 1 of the 14-day RIT. See Identifying HAIs chapter. **Note:** Rules for RIT should not be applied to SSI, VAE, or LabID Events. |
| **Secondary BSI Attribution Period** | The Secondary BSI Attribution Period is the period in which a positive blood culture must be collected to be considered as a secondary bloodstream infection to a primary site infection. This period includes the Infection Window Period combined with the Repeat Infection Timeframe (RIT). It is 14-17 days in length depending upon the date of event. **Note:** The Secondary BSI attribution period does not apply to SSI, VAE, LabID, or primary BSI events. Specific guidance can be found in the respective VAE and SSI protocols for secondary BSI attribution. |

| Term | Definition |
|---|---|
| **Standardized Infection Ratio (SIR)** | Summary measure used to track HAIs over time. It compares the number of reported HAIs to the number of predicted HAIs, based on NHSN baseline data. The SIR adjusts for several factors that may impact the risk of acquiring an HAI. See the SIR Newsletter for more information. |
| **Surveillance cultures** | Those cultures reported as part of infection prevention and control surveillance including, but not limited to stool cultures for vancomycin-resistant *Enterococci* (VRE) and/or nasal swabs for methicillin-resistant *Staphylococcus aureus* (MRSA) surveillance, not for use in patient diagnosis. Also called active surveillance cultures or testing (ASC/AST). Positive surveillance cultures do not contribute or preclude a patient from meeting NHSN HAI or LabID event criteria. |
| **Teaching hospital** | There are three types of teaching hospital defined in NHSN:<br>• **Major:** Facility has a program for medical students and post-graduate medical training.<br>• **Graduate:** Facility has a program for post-graduate medical training (i.e., residency and/or fellowships).<br>• **Undergraduate:** Facility has a program for medical students only. |
| **Temperature** | See Vital signs. |
| **Transfer rule** | If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location and admission. Examples are found in UTI, BSI and PNEU modules. |
| **Trauma** | Blunt or penetrating injury that occurs outside of the operating room environment. |
| **Vital signs** | For fever, which NHSN does have as a stated value, use the temperature documented in the patient's medical record (i.e., no conversion of temperature based on route of collection). If a specific value for a vital sign is not stated in a CDC/NHSN HAI definition criterion (e.g., hypotension), the facility should use the vital sign parameters as stated in its policies and procedures for clinical practices. |

# CDC/NHSN Surveillance Definitions for Specific Types of Infections

## INTRODUCTION

This chapter contains the CDC/NHSN surveillance definitions and criteria for all specific types of infections. **Comments and reporting instructions that follow the site-specific criteria provide further explanation and are integral to the correct application of the criteria**. This chapter also provides additional required criteria for the specific infection types that constitute organ space surgical site infections (SSI) (e.g., mediastinitis [MED] that may follow a coronary artery bypass graft, intra-abdominal abscess [IAB] after colon surgery, etc.). Refer to Chapter 2 (Identifying HAIs in NHSN) for specific guidance for making HAI determinations.

Infection criteria contained in this chapter may be necessary for determining whether a positive blood culture represents a primary bloodstream infection (BSI) or is secondary to a different type of infection (see Appendix 1 Secondary Bloodstream Infection (BSI) Guide). A BSI that is identified as secondary to another site of infection must meet one of the infection criteria detailed in this chapter and meet other requirements. Secondary BSIs are not reported as Laboratory Confirmed Bloodstream Infections in NHSN, nor can they be associated with the use of a central line.

**NOTES:**

- Criteria for urinary tract infections (UTI), bloodstream infection (BSI), pneumonia (PNEU) infections, ventilator-associated events (VAE) and surgical site infections (SSI) are no longer included in this chapter. For those criteria, see individual protocol chapters.

- Organisms belonging to the following genera cannot be used to meet any NHSN definition: *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis*. These organisms are typically causes of community-associated infections and are rarely known to cause healthcare-associated infections, and therefore are excluded.

- A **matching organism** is defined as one of the following:

    1. If genus and species are identified in both cultures, they must be the same.
        a. **Example:** A blood culture reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter cloacae* are matching organisms.
        b. **Example:** A blood culture reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter aerogenes* are NOT matching organisms as the species are different.

    2. If the organism is less definitively identified in one culture than the other, the identifications must be complementary.

        a. **Example:** A surgical wound growing *Pseudomonas* spp. and a blood culture growing *Pseudomonas aeruginosa* are considered a match at the genus level and therefore the BSI is reported as secondary to the SSI.

b. **Example:** A blood culture reported as *Candida albicans* and a culture from a decubitus reported as yeast are considered to have matching organisms because the organisms are complementary, i.e. Candida is a type of yeast.

3. Antibiograms of the blood and potential primary site isolates do not have to match.

## CRITERIA FOR SPECIFIC TYPES OF INFECTION

Infection criteria have been grouped into 14 major types with some further categorized into specific infections. For example, there are three specific types of central nervous system infections (intracranial infection, meningitis or ventriculitis, and spinal abscess without meningitis) that are grouped under the major type of CNS–Central Nervous System.

The specific and major types of infection used in NHSN and their abbreviated codes are listed in alphabetical order, by major type code and the criteria for each of the specific types of infection follow it.

## BJ-BONE AND JOINT INFECTION

### BONE-Osteomyelitis

Osteomyelitis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

   **And at least *one* of the following:**
   a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
   b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

** With no other recognized cause*

**Reporting instruction**
Report mediastinitis following cardiac surgery that is accompanied by osteomyelitis as SSI-MED rather than SSI-BONE.

### DISC-Disc space infection

Vertebral disc space infection must meet at least **one** of the following criteria:

1. Patient has organisms identified from vertebral disc space by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of vertebral disc space infection on gross anatomic or histopathologic exam.
3. Patient has at least ***one*** of the following: fever (>38.0°C), pain at the involved vertebral disc space*

   **And at least *one* of the following:**
   a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for vertebral disc space infection).
   b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for vertebral disc space infection).

** With no other recognized cause*

**JNT-Joint or bursa infection (not for use after HPRO or KPRO procedures)**

Joint or bursa infections must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from joint fluid or synovial biopsy by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of joint or bursa infection on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following signs or symptoms with no other recognized cause: swelling, pain or tenderness, heat, evidence of effusion, or limitation of motion.
   **And at least *one* of the following:**
   a. elevated joint fluid white blood cell count (per reporting laboratory's reference range) OR positive leukocyte esterase test strip of joint fluid
   b. organisms and white blood cells seen on Gram stain of joint fluid
   c. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   d. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for joint or bursa infection).

**PJI – Periprosthetic Joint Infection (following HPRO and KPRO only)**

Joint or bursa infections must meet at least ***one*** of the following criteria:

1. Two positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract communicating with the joint.
3. Having ***three*** of the following minor criteria:
   a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
   b. elevated synovial fluid white blood cell (WBC; >10,000 cells/μL) count *OR* ++ (*or greater)* change on leukocyte esterase test strip of synovial fluid
   c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
   d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field)
   e. organisms identified from a single positive periprosthetic (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

**COMMENTS**

- A matching organism is defined on page 17 -1.Organisms identified from hip or knee hardware can be used to meet criterion 1.
- A sinus tract is defined as a narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.
- The NHSN definition of PJI is closely adapted from the Musculoskeletal Infection Society's (MSIS's) definition of PJI (*Proceedings of the International Consensus Meeting on Periprosthetic Joint Infection, 2013*).
- The standard laboratory cutoff values in criteria 3a - 3d are provided by NHSN for HPRO and KPRO SSI surveillance purposes only. The NHSN laboratory cutoffs are not intended to guide clinicians in the actual clinical diagnosis and management of acute or chronic PJI. Clinicians should refer to the MSIS consensus definition for clinical use.

## CNS-CENTRAL NERVOUS SYSTEM INFECTION

### IC-Intracranial infection (brain abscess, subdural or epidural infection, encephalitis)

Intracranial infection must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from brain tissue or dura by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess or evidence of intracranial infection on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following signs or symptoms: headache*, dizziness*, fever (>38.0°C), localizing neurologic signs*, changing level of consciousness*, or confusion*
   **And at least *one* of the following:**
   a. organisms seen on microscopic examination of brain or abscess tissue obtained by needle aspiration or during an invasive procedure or autopsy
   b. imaging test evidence suggestive of infection, (e.g., ultrasound, CT scan MRI, radionuclide brain scan, or arteriogram), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for intracranial infection).
   c. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism
4. Patient ≤1 year of age has at least ***two*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C), apnea*, bradycardia*, localizing neurologic signs*, or changing level of consciousness* (e.g., irritability, poor feeding, lethargy)
   **And at least *one* of the following:**
   a. organisms seen on microscopic examination of brain or abscess tissue obtained by needle aspiration or during an invasive procedure or autopsy
   b. imaging test evidence suggestive of infection, (e.g., ultrasound, CT scan, MRI, radionuclide brain scan, or arteriogram), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for intracranial infection).
   c. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

** With no other recognized cause*

**Reporting instructions**

- Report as MEN if meningitis (MEN) and encephalitis (IC) are present together.
- Report as IC if meningitis (MEN) and a brain abscess (IC) are present together after operation.
- Report as SA if meningitis (MEN) and spinal abscess (SA) are present together after an operation.

**MEN-Meningitis or ventriculitis**

Meningitis or ventriculitis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from cerebrospinal fluid (CSF) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least ***two*** of the following:
   i. fever (>38.0°C) or headache (Note: Elements of "i" alone may not be used to meet the two required elements)
   ii. meningeal sign(s)*
   iii. cranial nerve sign(s)*

   **And at least *one* of the following:**
   a. increased white cells, elevated protein, and decreased glucose in CSF (per reporting laboratory's reference range)
   b. organisms seen on Gram stain of CSF
   c. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)
   d. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism
3. Patient ≤1 year of age has at least ***two*** of the following elements:
   i. Fever (>38.0°C), hypothermia (<36.0°C$^{\pm}$), apnea, bradycardia, or irritability (Note: Elements of "i" alone may not be used to meet the required two elements).
   ii. meningeal signs*
   iii. cranial nerve signs*

   **And at least *one* of the following:**
   a. increased white cells, elevated protein, and decreased glucose in CSF (per reporting laboratory's reference range)
   b. organisms seen on Gram stain of CSF
   c. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)
   d. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

** With no other recognized cause*

**Reporting instructions**

- Report meningitis in the newborn as healthcare associated unless there is compelling evidence indicating the meningitis was acquired transplacentally (i.e., unless it was apparent on the day of birth or the next day).

- Report CSF shunt infection as SSI-MEN if it occurs within 90 days of placement; if later or after manipulation/access, it is considered CNS-MEN and is not reportable under this module.
- Report as MEN if meningitis (MEN) and encephalitis (IC) are present together.
- Report as IC if meningitis (MEN) and a brain abscess (IC) are present together after operation.
- Report as SA if meningitis and spinal abscess (SA) are present together after an operation.

**SA-Spinal abscess without meningitis**

An abscess of the spinal epidural or subdural space, without involvement of the cerebrospinal fluid or adjacent bone structures, must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from abscess in the spinal epidural or subdural space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess in the spinal epidural or subdural space on gross anatomic or histopathologic exam.
3. Patient has at least ***one*** of the following localized signs or symptoms: fever (>38.0°C), back pain* or tenderness*, radiculitis*, paraparesis*, or paraplegia*
   **And at least *one* of the following:**
   a. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence of spinal abscess.
   b. imaging test evidence of a spinal abscess (e.g., myelography, ultrasound, CT scan, MRI, or other scans [gallium, technetium, etc.]).

** With no other recognized cause*

**Reporting instructions**

- Report as IC if meningitis (MEN) and a brain abscess (IC) are present together after operation.
- Report as SA if meningitis (MEN) and spinal abscess (SA) are present together after an operation.

## CVS-CARDIOVASCULAR SYSTEM INFECTION

**CARD-Myocarditis or pericarditis**

Myocarditis or pericarditis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from pericardial tissue or fluid by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), chest pain*, paradoxical pulse*, or increased heart size*
   **And at least *one* of the following:**
   a. abnormal EKG consistent with myocarditis or pericarditis
   b. evidence of myocarditis or pericarditis on histologic exam of heart tissue

c. 4-fold rise in paired sera from IgG antibody titer
d. pericardial effusion identified by echocardiogram, CT scan, MRI, or angiography

3. Patient ≤1 year of age has at least ***two*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C ), apnea*, bradycardia*, paradoxical pulse*, or increased heart size*
   **And at least *one* of the following:**
   a. abnormal EKG consistent with myocarditis or pericarditis
   b. histologic examination of heart tissue shows evidence of myocarditis or pericarditis
   c. 4-fold rise in paired sera from IgG antibody titer
   d. pericardial effusion identified by echocardiogram, CT scan, MRI, or angiography

* *With no other recognized cause*

**Comment:**

- Most cases of post cardiac surgery or post myocardial infarction pericarditis are not infectious.

**ENDO-Endocarditis**

Endocarditis of a natural or prosthetic heart valve must meet at least ***one*** of the following criteria:

1. Organisms identified from cardiac vegetation*, embolized vegetation (e.g., solid organ abscess) documented as originating from cardiac source, or intracardiac abscess by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Organisms seen on histopathologic examination of cardiac vegetation, embolized vegetation (e.g., solid organ abscess) documented as originating from cardiac source, or intracardiac abscess.
3. Endocarditis seen on histopathologic examination of cardiac vegetation or intracardiac abscess.
4. At least ***one*** of the following echocardiographic evidence of endocarditis*:
   i. vegetation on cardiac valve or supporting structures
   ii. intracardiac abscess
   iii. new partial dehiscence of prosthetic valve

   **And at least *one* of the following:**
   a. typical infectious endocarditis organisms † (i.e., Viridans group streptococci, *Streptococcus bovis*, *Haemophilus* spp., *Actinobacillus actinomycetemcomitans*, *Cardiobacterium hominis*, *Eikenella corrodens*, *Kingella* spp., *Staphylococcus aureus*) identified from ≥2 blood collections drawn on separate occasions (on same or consecutive days) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)
   b. *Coxiella burnetii* identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or identified by anti-phase I IgG antibody titer >1:800
5. At least ***three*** of the following:
   i. prior endocarditis, prosthetic valve, uncorrected congenital heart disease, history of rheumatic heart disease, hypertrophic obstructive cardiomyopathy, or known IV drug use
   ii. fever (>38.0°C)
   iii. vascular phenomena: major arterial emboli (i.e., embolic stroke, renal infarct, splenic infarct or abscess, digital ischemic/gangrene from embolic source), septic pulmonary

infarcts, mycotic aneurysm (documented by imaging, seen in surgery, or described in gross pathological specimen), intracranial hemorrhage, conjunctival hemorrhages, or Janeway's lesions documented

iv. immunologic phenomena: glomuleronephritis (documented or chart, or white cell or red blood cell casts on urinalysis), Osler's nodes, Roth's spots, or positive rheumatoid factor.

**And at least *one* of the following:**

a. typical infectious endocarditis organisms (i.e., Viridans group streptococci, *Streptococcus bovis*, *Haemophilus* spp., *Actinobacillus actinomycetemcomitans*, *Cardiobacterium hominis*, *Eikenella corrodens*, *Kingella* spp., *Staphylococcus aureus*) identified from ≥2 blood collections drawn on separate occasions (on same or consecutive days) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)

b. *Coxiella burnetii* identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)or identified by anti-phase I IgG antibody titer >1:800

6. At least ***one*** of the following†:

i. vegetation on cardiac valve or supporting structures seen on echocardiogram

ii. intracardiac abscess seen on echocardiogram

iii. new partial dehiscence of prosthetic valve seen on echocardiogram

**And at least *three* of the following:**

a. prior endocarditis, prosthetic valve, uncorrected congenital heart disease, history of rheumatic heart disease, hypertrophic obstructive cardiomyopathy, or known IV drug use

b. fever (>38.0°C)

c. vascular phenomena: major arterial emboli (i.e., embolic stroke, renal infarct, splenic infarct or abscess, digital ischemic/gangrene from embolic source), septic pulmonary infarcts, mycotic aneurysm (documented by imaging, seen in surgery, or described in gross pathological specimen), intracranial hemorrhage, conjunctival hemorrhages, or Janeway's lesions documented

d. immunologic phenomena: glomuleronephritis (documented in chart, or white cell or red blood cell casts on urinalysis), Osler's nodes, Roth's spots, or positive rheumatoid factor

e. identification of an organism from the blood by at least ***one*** of the following methods:

- recognized pathogen identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
- same common commensal organism identified from ≥2 blood collections drawn on separate occasions (on same or consecutive days) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)

7. All of the following criteria:

a. prior endocarditis, prosthetic valve, uncorrected congenital heart disease, history of rheumatic heart disease, hypertrophic obstructive cardiomyopathy, or known IV drug use

b. fever (>38.0°C)

c. vascular phenomena: major arterial emboli (i.e., embolic stroke, renal infarct, splenic infarct or abscess, digital ischemic/gangrene from embolic source), septic pulmonary infarcts, mycotic

aneurysm (documented by imaging, seen in surgery, or described in gross pathological specimen), intracranial hemorrhage, conjunctival hemorrhages, or Janeway's lesions documented

d. immunologic phenomena: glomuleronephritis (documented or chart, or white cell or red blood cell casts on urinalysis), Osler's nodes, Roth's spots, or positive rheumatoid factor
e. identification of an organism from the blood by at least ***one*** of the following methods:
   - recognized pathogen identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   - same common commensal organism identified from ≥2 blood collections drawn on separate occasions (on same or consecutive days) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)

*"Cardiac vegetation" includes vegetation on a pacemaker/ defibrillator lead.

† Which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for endocarditis).

**MED-Mediastinitis**

Mediastinitis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from mediastinal tissue or fluid by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of mediastinitis on gross anatomic or histopathologic exam.
3. Patient has at least ***one*** of the following signs or symptoms: fever (>38.0°C), chest pain*, or sternal instability*
   **And at least *one* of the following:**
   a. purulent drainage from mediastinal area
   b. mediastinal widening on imaging test
4. Patient ≤1 year of age has at least ***one*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C ), apnea*, bradycardia*, or sternal instability*
   **And at least *one* of the following:**
   a. purulent drainage from mediastinal area
   b. mediastinal widening on imaging test

** With no other recognized cause*

**Reporting instruction**

- Mediastinal space is the area under the sternum and in front of the vertebral column, containing the heart and its large vessels, trachea, esophagus, thymus, lymph nodes, and other structures and tissues. It is divided into anterior, middle, posterior, and superior regions.
- Report mediastinitis (MED) following cardiac surgery that is accompanied by osteomyelitis as SSI-MED rather than SSI-BONE.

**VASC-Arterial or venous infection**

**Note: If a patient meets the criteria for an LCBI in the presence of an intravascular infection report as an LCBI not as a VASC.**

Arterial or venous infection must meet at least ***one*** of the following criteria:

1. Patient has organisms from extracted arteries or veins identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of arterial or venous infection on gross anatomic or histopathologic exam.
3. Patient has at least ***one*** of the following signs or symptoms: fever (>38.0°C), pain*, erythema*, or heat at involved vascular site*
   ***AND***
   More than 15 colonies cultured from intravascular cannula tip using semiquantitative culture method.
4. Patient has purulent drainage at involved vascular site.
5. Patient ≤1 year of age has at least ***one*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C), apnea*, bradycardia*, lethargy*, pain*, erythema*, or heat at involved vascular site*
   ***AND***
   More than 15 colonies cultured from intravascular cannula tip using semiquantitative culture method.

* *With no other recognized cause*

**Reporting instructions**

- Report infections of an arteriovenous graft, shunt, fistula or intravascular cannulation site without organisms identified from blood as CVS-VASC.
- Report intravascular infections with organisms identified from the blood and meeting the LCBI criteria, as BSI-LCBI. However, if **BOTH** of the following are present at the site of an arteriovenous fistula, arteriovenous shunt, peripheral IV, or non-accessed central line, within the Infection Window Period, mark the data field for risk factor "Central line" as "No":
  - Pus at the site

  AND
  - Positive site culture with at least one matching organism to the positive blood culture
- Report Organ Space VASC infections as an SSI and not an LCBI when you have a SSI with secondary BSI.

**EENT-Eye, ear, nose throat, or mouth infection**

**CONJ-Conjunctivitis**

Conjunctivitis must meet at least ***one*** of the following criteria:

1. Patient has organism(s) or virus identified from conjunctival scraping or purulent exudate obtained from the conjunctiva or contiguous tissues, (e.g., eyelid, cornea, meibomian glands, or lacrimal glands) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has pain or redness of conjunctiva or around eye.
   **And at least *one* of the following:**
   a. WBCs and organisms seen on Gram stain of exudate
   b. purulent exudate
   c. multinucleated giant cells seen on microscopic examination of conjunctival exudate or scrapings
   d. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

**Reporting instructions**

- Report other infections of the eye as EYE.
- Do not report chemical conjunctivitis, caused by silver nitrate ($AgNO_3$), as a healthcare–associated infection.
- Do not report a separate case of conjunctivitis (CONJ) that occurs as a part of another viral illness (e.g., UR).

**EAR-Ear, mastoid infection**

Ear and mastoid infections must meet at least ***one*** of the following criteria:

Otitis externa must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from purulent drainage from ear canal by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least ***one*** of the following localized signs or symptoms: fever (>38.0°C), pain*, erythema*, ***and*** organism(s) seen on Gram stain of purulent drainage from ear canal.

Otitis media must meet at least ***one*** of the following criteria:

3. Patient has organism(s) identified from fluid from middle ear obtained during an invasive procedure (e.g., tympanocentesis) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
4. Patient has at least ***two*** of the following localized signs or symptoms: fever (>38.0°C), pain *, inflammation*, retraction* or decreased mobility of eardrum*, or fluid behind eardrum*.

Otitis interna must meet at least ***one*** of the following criteria:

5. Patient has organism(s) identified from fluid from inner ear obtained during an invasive procedure by a culture or non-culture based microbiologic testing method which is performed

for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

6. Patient has a physician diagnosis of inner ear infection.

Mastoiditis must meet at least ***one*** of the following criteria:

7. Patient has organism(s) identified from fluid or tissue from mastoid by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
8. Patient has at least ***two*** of the following localized signs or symptoms: fever (>38.0°C), pain or tenderness*, post auricular swelling*, erythema*, headache*, or facial paralysis*

   **And at least *one* of the following:**

   a. organism(s) seen on Gram stain of fluid or tissue from mastoid
   b. imaging test evidence suggestive of infection (e.g., CT scan), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for mastoid infection).

** With no other recognized cause*

**EYE-Eye infection, other than conjunctivitis**

An infection of the eye, other than conjunctivitis, must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from anterior or posterior chamber or vitreous fluid by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least *two* of the following signs or symptoms with no other recognized cause: eye pain, visual disturbance, or hypopyon

   **AND**

   physician initiates antimicrobial therapy within ***two*** days of onset or worsening of symptoms

**ORAL-Oral cavity infection (mouth, tongue, or gums)**

Oral cavity infections must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from abscess or purulent material from tissues of oral cavity by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess or other evidence of oral cavity infection found on invasive procedure, gross anatomic exam, or histopathologic exam.
3. Patient has at least ***one*** of the following signs or symptoms with no other recognized cause: ulceration, raised white patches on inflamed mucosa, or plaques on oral mucosa

   **And at least *one* of the following:**

   a. organisms or virus identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. multinucleated giant cells seen on microscopic examination of mucosal scrapings or exudate
   c. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

d. fungal elements seen on microscopic exam of mucosal scrapings or exudate (e.g., Gram stain, KOH )
e. physician initiates antimicrobial therapy within 2 days of onset or worsening of symptoms

**Reporting instruction**

- Report healthcare–associated primary herpes simplex infections of the oral cavity as ORAL; recurrent herpes infections are not healthcare associated.

**SINU-Sinusitis**

Sinusitis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from fluid or tissue from the sinus cavity obtained during an invasive procedure by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least ***one*** of the following signs or symptoms: fever (>38.0°C), pain or tenderness over the involved sinus*, headache*, purulent exudate*, or nasal obstruction*
   ***AND***
   Imaging test evidence of sinusitis (e.g., x-ray, CT scan)

** With no other recognized cause*

**UR-Upper respiratory tract infection, pharyngitis, laryngitis, epiglottitis**

Upper respiratory tract infections must meet at least ***one*** of the following criteria:

1. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), erythema of pharynx*, sore throat*, cough*, hoarseness*, or purulent exudate in throat*
   **And at least *one* of the following:**
   a. organisms identified from upper respiratory site [i.e. larynx, pharynx, and epiglottis] by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Note: excludes sputum because sputum is not an upper respiratory specimen.
   b. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism
   c. physician diagnosis of an upper respiratory infection
2. Patient has an abscess on gross anatomical or histopathologic exam or imaging test.
3. Patient ≤1 year of age has at least ***two*** of the following signs or symptoms: fever (>38.0°C), hypothermia (<36.0°C ), apnea*, bradycardia*, nasal discharge*, or purulent exudate in throat*
   **And at least *one* of the following:**
   a. organisms identified from upper respiratory site [i.e. larynx, pharynx, and epiglottis] by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Note: excludes sputum because sputum is not an upper respiratory specimen.
   b. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism
   c. physician diagnosis of an upper respiratory infection

** With no other recognized cause*

## GI-GASTROINTESTINAL SYSTEM INFECTION

### CDI-*Clostridium difficile* Infection

Clostridium difficile infection must meet at least ***one*** of the following criteria:

1. Positive test for toxin-producing *C. difficile* on an unformed stool specimen (conforms to the shape of the container). [1,2] (see Reporting instructions)
2. Patient has evidence of pseudomembranous colitis on gross anatomic (includes endoscopic exams) or histopathologic exam.

**Reporting instructions**

- The date of event for CDI criterion 1, will always be the specimen collection date of the unformed stool, i.e., not the date of onset of unformed stool.
- Report the CDI and the GE or GIT if additional enteric organisms are identified and criteria are met for GE or GIT.
- Report each new GI-CDI according to the Repeat Infection Timeframe (RIT) rule for HAIs (see NHSN HAI definitions in Chapter 2 for further details and guidance).
- CDI laboratory-identified event (LabID Event) categorizations (e.g., recurrent CDI assay, incident CDI assay, healthcare facility-onset, community-onset, community-onset healthcare facility-associated) do **not** apply to HAIs; including *C. difficile* associated gastrointestinal infections (GI-CDI).
- Cohen SH, Gerding DN, Johnson S, Kelly CP, Loo VG, McDonald LC, et al. Clinical practice guidelines for Clostridium difficile infection in adults: 2010 update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). *Infection Control and Hospital Epidemiology* 2010; 31:431-455.

### GE-Gastroenteritis (excluding *C. difficile* infections)

Gastroenteritis must meet at least ***one*** of the following criteria:

1. Patient has an acute onset of diarrhea (liquid stools for > 12 hours) and no likely noninfectious cause (e.g., diagnostic tests, therapeutic regimen other than antimicrobial agents, acute exacerbation of a chronic condition, or psychological stress information).
2. Patient has at least ***two*** of the following signs or symptoms: nausea*, vomiting*, abdominal pain*, fever (>38.0°C), or headache*
   **And at least *one* of the following:**
   a. an enteric pathogen is identified from stool or rectal swab by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. an enteric pathogen is detected by microscopy on stool
   c. an enteric pathogen is detected by antigen or antibody assay on blood or feces
   d. evidence of an enteric pathogen is detected by cytopathic changes in tissue culture on stool
   e. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

** With no other recognized cause*

**Reporting instruction**

- The reference to "enteric pathogens" describes pathogens that are not considered to be normal flora of the intestinal tract. Enteric pathogens identified on culture or with the use of other diagnostic laboratory tests include but are not limited to *Salmonella, Shigella, Yersinia, Campylobacter, Giardia.*
- Report only GI-GIT using the event date as that of GI-GIT if the patient meets criteria for both GI-GE and GI-GIT.

**GIT-Gastrointestinal tract infection (esophagus, stomach, small and large bowel, and rectum) excluding gastroenteritis, appendicitis, and *C. difficile* infection**

Gastrointestinal tract infections, excluding, gastroenteritis and appendicitis, must meet at least ***one*** of the following criteria:

1. Patient has an abscess or other evidence of infection on gross anatomic or histopathologic exam of gastrointestinal tract.
2. Patient has at least ***two*** of the following localized signs or symptoms compatible with infection of the organ or tissue involved: fever (>38.0°C), nausea*, vomiting*, pain*or tenderness*, odynophagia*, or dysphagia*

   **And at least *one* of the following:**

   a. organisms identified from drainage or tissue obtained during an invasive procedure or from drainage from an aseptically-placed drain by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. organisms seen on Gram stain or fungal elements seen on KOH stain or multinucleated giant cells seen on microscopic examination of drainage or tissue obtained during an invasive procedure or from drainage from an aseptically-placed drain
   c. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of gastrointestinal infection (e.g., MRI, CT Scan), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for gastrointestinal tract infection).
   d. imaging test evidence suggestive of infection (e.g., MRI, CT scan), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for gastrointestinal tract infection).
   e. evidence of infection on endoscopic examination (e.g., Candida esophagitis, proctitis, etc.)

** With no other recognized cause*

**Reporting instruction**

- Report only GI-GIT using the event date as that of GI-GIT if the patient meets criteria for both GI-GE and GI-GIT

**HEP-Hepatitis (acute)**

Hepatitis must meet the following criterion:

1. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), anorexia*, nausea*, vomiting*, abdominal pain*, jaundice*, or history of transfusion within the previous three months
   **And at least *one* of the following:**
   a. positive laboratory test for acute hepatitis A, hepatitis B, hepatitis C, or delta hepatitis and duration of hospital stay consistent with healthcare acquisition
   b. cytomegalovirus (CMV) detected in urine or oropharyngeal secretions

** With no other recognized cause*

**Reporting instructions**

- Do not report hepatitis or jaundice of noninfectious origin (alpha-1 antitrypsin deficiency, etc.).
- Do not report hepatitis or jaundice that result from exposure to hepatotoxins (alcoholic or acetaminophen- induced hepatitis, etc.).
- Do not report hepatitis or jaundice that result from biliary obstruction (cholecystitis).

**IAB-Intraabdominal infection, not specified elsewhere including gallbladder, bile ducts, liver (excluding viral hepatitis), spleen, pancreas, peritoneum, subphrenic or subdiaphragmatic space, or other intraabdominal tissue or area not specified elsewhere**

Intraabdominal infections must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from an abscess or from purulent material from intraabdominal space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has:
   a. abscess or other evidence of intraabdominal infection on gross anatomic or histopathologic exam
   b. abscess or other evidence of intraabdominal infection on gross anatomic or histopathologic exam **and** organism(s) identified from blood by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). The organism(s) identified in the blood must contain at least one of the following organisms: *Bacteroides* spp., *Candida* spp., *Clostridium* spp., *Enterococcus* spp., *Fusobacterium* spp., *Peptostreptococcus* spp., *Prevotella* spp., *Veillonella* spp., or Enterobacteriaceae
3. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), nausea*, vomiting*, abdominal pain*, or jaundice*
   **And at least *one* of the following:**
   a. organisms seen on Gram stain or identified from drainage or tissue obtained during invasive procedure or from an aseptically-placed drain (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

b. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) and imaging test evidence suggestive of infection (e.g., ultrasound, CT scan, MRI, radiolabel scans [gallium, technetium, etc.] or on abdominal x-ray), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for intraabdominal infection). The organism(s) identified in the blood must contain at least one of the following organisms: *Bacteroides* spp., *Candida* spp., *Clostridium* spp., *Enterococcus* spp., *Fusobacterium* spp., *Peptostreptococcus* spp., *Prevotella* spp., *Veillonella* spp., or Enterobacteriaceae*

** With no other recognized cause*

**Reporting instruction**

- Use criterion 1 for reporting organisms identified from purulent or abscess material in the intraabdominal space (e.g., JP or CT guided drainage of pus/abscess can be applied to this criteria)
- Use criterion 3a for reporting organisms identified from the intraabdominal space that were not from an abscess or purulent material.
- Do not report pancreatitis (an inflammatory syndrome characterized by abdominal pain, nausea, and vomiting associated with high serum levels of pancreatic enzymes) unless it is determined to be infectious in origin.

**NEC-Necrotizing enterocolitis**

Necrotizing enterocolitis in infants **(**≤1 year of age) must meet one of the following criteria:

1. Infant has at least ***one*** of the clinical and ***one*** of the imaging test findings from the lists below:
   **At least *one* clinical sign:**
   a. bilious aspirate****** (see **Note**)
   b. vomiting
   c. abdominal distention
   d. occult or gross blood in stools (with no rectal fissure)
   **And at least *one* imaging test finding:**
   a. Pneumatosis intestinalis
   b. Portal venous gas (Hepatobiliary gas)
   c. Pneumoperitoneum
   ****Note:** Bilious aspirate as a result of a transpyloric placement of a nasogastric tube should be excluded
2. Surgical NEC: Infant has at least ***one*** of the following surgical findings:
   a. surgical evidence of extensive bowel necrosis (>2 cm of bowel affected)
   b. surgical evidence of pneumatosis intestinalis with or without intestinal perforation

**Reporting instruction**

- Necrotizing enterocolitis (NEC) criteria include neither a site specific specimen nor organism identified from blood specimen, however an **exception** for assigning a BSI secondary to NEC is provided. A BSI is considered secondary to NEC if the patient meets one of the two NEC

criteria **AND** an organism identified from blood specimen collected during the secondary BSI attribution period is an LCBI pathogen, or the same common commensal is identified from two or more blood specimens drawn on separate occasions collected on the same or consecutive days.

## LRI- LOWER RESPIRATORY INFECTION, OTHER THAN PNEUMONIA

### LUNG-Other infection of the lower respiratory tract

Other infections of the lower respiratory tract must meet at least ***one*** of the following criteria:

1. Patient has organisms seen on Gram stain or identified from lung tissue or pleural fluid (when pleural fluid was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). .
2. Patient has a lung abscess or other evidence of infection (e.g., empyema) on gross anatomic or histopathologic exam.
3. Patient has imaging test evidence of abscess or infection.

**Reporting instruction**

- If patient meets LUNG and PNEU report as PNEU only, unless the LUNG is a surgical site organ/space infection, in which case, report both PNEU and SSI-LUNG.

## REPR-REPRODUCTIVE TRACT INFECTION

### EMET-Endometritis

Endometritis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from endometrial fluid or tissue (including amniotic fluid) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), pain or tenderness (uterine or abdominal)*, or purulent drainage from uterus.

** With no other recognized cause*

**Reporting instructions**

- Do not report an HAI chorioamnionitis as EMET (see OREP).
- Do not report subsequent postpartum endometritis after a vaginal delivery as an HAI if a patient is admitted with POA chorioamnionitis (OREP). (See next bullet for endometritis following a C-section).
- Report as an organ space SSI-EMET if a C-section was performed on a patient with chorioamnionitis, and the patient later develops endometritis.

**EPIS-Episiotomy infection**

Episiotomy infections must meet at least ***one*** of the following criteria:

1. Postvaginal delivery patient has purulent drainage from the episiotomy.
2. Postvaginal delivery patient has an episiotomy abscess.

**Comment:**
Episiotomy is not considered an operative procedure in NHSN.

**OREP-Other infection of the male or female reproductive tract (epididymis, testes, prostate, vagina, ovaries, uterus, chorioamnionitis, or other deep pelvic tissues, excluding endometritis or vaginal cuff infections)**

Other infections of the male or female reproductive tract must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from tissue or fluid from affected site (excludes urine) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess or other evidence of infection of affected site on gross anatomic or histopathologic exam.
3. Patient has suspected infection of one of the listed OREP sites and ***two*** of the following localized signs or symptoms: fever (>38.0°C), nausea*, vomiting*, pain or tenderness*, or dysuria*
   **And at least *one* of the following:**
   a. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. physician initiates antimicrobial therapy within ***two*** days of onset or worsening of symptoms

** With no other recognized cause*

**Reporting instructions**

- Report endometritis as EMET.
- Report vaginal cuff infections as VCUF.
- If patient has epididymitis, prostatitis, or orchitis and meets OREP criteria, and they also meet UTI criteria, report UTI only, unless the OREP is a surgical site organ/space infection, in which case, only OREP should be reported.

**VCUF-Vaginal cuff infection**

Vaginal cuff infections must meet at least ***one*** of the following criteria:

1. Post hysterectomy patient has purulent drainage from the vaginal cuff on gross anatomic exam.
2. Post hysterectomy patient has an abscess at the vaginal cuff on gross anatomic exam.
3. Post hysterectomy patient has pathogens identified from fluid or tissue obtained from the vaginal cuff by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

**Reporting instruction**

- Report vaginal cuff infections as SSI-VCUF.

**SST-SKIN AND SOFT TISSUE INFECTION**

**BRST-Breast abscess or mastitis**

A breast abscess or mastitis must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from affected breast tissue or fluid obtained by invasive procedure by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has a breast abscess or other evidence of infection on gross anatomic or histopathologic exam.
3. Patient has fever (>38.0°C) and local inflammation of the breast,
   **AND**
   Physician initiates antimicrobial therapy within 2 days of onset or worsening of symptoms.

**Reporting instruction**

- For SSI after a BRST procedure: if the infection is in the subcutaneous region report as a superficial incisional SSI, and if the infection involves the muscle/fascial level report as a deep incisional SSI.

**BURN-Burn infection**

Burn infections must meet the following criteria:

1. Patient has a change in burn wound appearance or character, such as rapid eschar separation, or dark brown, black, or violaceous discoloration of the eschar,
   **AND**
   Organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

**CIRC-Newborn circumcision infection**

Circumcision infection in a newborn (≤30 days old) must meet at least ***one*** of the following criteria:

1. Newborn has purulent drainage from circumcision site.
2. Newborn has at least ***one*** of the following signs or symptoms with no other recognized cause at circumcision site: erythema, swelling, or tenderness,
   **AND**
   Pathogen identified from circumcision site by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
3. Newborn has at least ***one*** of the following signs or symptoms with no other recognized cause at circumcision site: erythema, swelling, or tenderness,
   **AND**
   Common commensal is identified from circumcision site by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). ,
   ***AND***
   Physician initiates antimicrobial therapy within ***two*** days on onset or worsening of symptoms.

**DECU-Decubitus ulcer infection, including both superficial and deep infections**

Decubitus ulcer infections must meet the following criterion:

1. Patient has at least ***two*** of the following signs or symptoms with no other recognized cause: erythema, tenderness, or swelling of decubitus wound edges,
   **AND**
   Organisms identified from needle aspiration of fluid or biopsy of tissue from ulcer margin by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

**SKIN-Skin infection (skin and /or subcutaneous)**

Skin infections must meet at least ***one*** of the following criteria:

1. Patient has at least *one* of the following:
   - purulent drainage
   - pustules
   - vesicles
   - boils (excluding acne)
2. Patient has at least ***two*** of the following localized signs or symptoms with no other recognized cause: pain or tenderness, swelling, erythema, or heat
   **And at least *one* of the following*:***
   a. organisms identified from aspirate or drainage from affected site by a culture or non-culture based testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). If organism is a common commensal (i.e., diphtheroids [*Corynebacterium* spp], *Bacillus* [not *B anthracis*] spp, *Propionibacterium* spp, coagulase-negative staphylococci [including *S epidermidis*], viridans

group streptococci, *Aerococcus* spp, *Micrococcus* spp), it must be the only organism identified.
   b. multinucleated giant cells seen on microscopic examination of affected tissue
   c. diagnostic single antibody titer (IgM) or 4-fold increase in paired sera (IgG) for organism

**Reporting instructions**

- Do not report acne as a skin/soft tissue HAI.
- Report omphalitis in infants as UMB.
- Report infections of the circumcision site in newborns as CIRC.
- For decubitus ulcers, apply the DECU infection criteria only, not SKIN.
- Report infected burns as BURN.
- Report breast abscesses or mastitis as BRST.
- Report localized infection at a vascular access site as a VASC unless there is a positive blood culture meeting LCBI criteria, which should instead be reported as an LCBI (see VASC definition).

**ST-Soft tissue infection (muscle and/or fascia [e.g., necrotizing fasciitis, infectious gangrene, necrotizing cellulitis, infectious myositis, lymphadenitis, or lymphangitis])**

Soft tissue infections must meet at least ***one*** of the following criteria:

1. Patient has organisms identified from tissue or drainage from affected site by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has purulent drainage at affected site.
3. Patient has an abscess or other evidence of infection on gross anatomic or histopathologic exam.

**Reporting instructions**

- Report infected decubitus ulcers as DECU.
- Report infection of deep pelvic tissues as OREP.
- Report localized infection at a vascular access site as a VASC unless there is a positive blood culture then it should be reported as an LCBI (see VASC definition)

**UMB-Omphalitis**

Omphalitis in a newborn (≤30 days old) must meet at least ***one*** of the following criteria:

1. Patient has erythema or drainage from umbilicus
   **And at least *one* of the following:**
   a. organisms identified from drainage or needle aspirate by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
   b. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has erythema and purulence at the umbilicus.

**Reporting instructions**

- Report infection of the umbilical artery or vein related to umbilical catheterization as VASC if there is no accompanying blood culture or a blood culture is negative.
- If the patient meets criteria for LCBI, report as a LCBI (see VASC).

**USI – Urinary System Infection [formerly OUTI] (kidney, ureter, bladder, urethra, or tissue surrounding the retroperitoneal or perinephric space)**

Urinary system infection infections must meet at least ***one*** of the following criteria:

1. Patient has microorganisms identified from fluid (not urine) or tissue from affected site.by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess or other evidence of infection on gross anatomical exam, during invasive procedure, or on histopathologic exam.
3. Patient has ***one*** of the following signs or symptoms:
    - fever (>38.0°C)
    - localized pain or tenderness*

   **And at least *one* of the following:**
    a. purulent drainage from affected site
    b. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) and imaging test evidence suggestive of infection (e.g., ultrasound, CT scan, magnetic resonance imaging [MRI], or radiolabel scan [gallium, technetium]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for urinary system infection).
4. Patient ≤1 year of age has at least ***one*** of the following signs or symptoms:
    - fever (>38.0°C)
    - hypothermia (<36.0°C)
    - apnea*
    - bradycardia*
    - lethargy*
    - vomiting*

   **And at least *one* of the following:**
    a. purulent drainage from affected site
    b. organisms identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) and imaging test evidence suggestive of infection, (e.g., ultrasound, CT scans, magnetic resonance imaging [MRI], or radiolabel scan [gallium, technetium]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for urinary system infection).

** With no other recognized cause*

**Reporting instructions**

- Report infections following circumcision in newborns as SST-CIRC.
- If patient meets USI criteria and they also meet UTI criteria, report UTI only, unless the USI is a surgical site organ/space infection, in which case, only USI should be reported.

## REFERENCES

[1]McDonald LC, Coignard B, Dubberke E, Song, X, Horan T, Kutty PK. Recommendations for surveillance of Clostridium difficile-associated disease. *Infection Control Hospital Epidemiology* 2007; 28: 140-5.

[2]Cohen SH, Gerding DN, Johnson S, Kelly CP, Loo VG, McDonald LC, et al. Clinical practice guidelines for Clostridium difficile infection in adults: 2010 update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). *Infection Control and Hospital Epidemiology* 2010; 31:431-455.