Answers to Frequently Asked Questions on Reporting in NHSN

1. **With multiple infection sites, if you are unsure of the primary site of the infection, what should you do?**
   - If more than one NHSN operative procedure was done through a single incision, attempt to determine 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 a superficial incisional SSI), or if the infection site being reported is not an SSI, use the NHSN Principal Operative Procedure Selection Lists (Table 3) to select which operative procedure to report.
   - If a patient has several NHSN operative procedures 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 is associated with a different operation.
   - If a patient has a CLABSI in addition to another infection and cultures of both sites show the same organism present reference the NHSN CLABSI Protocol Manual (Determining the Sameness of Organisms). Look at antibiotic sensitivity. If both organisms are not sensitive to the same antibiotics, then they are not the same organism despite the same genus. One infection would not be secondary to the other.

2. **Should CAUTIs be counted on an OB-GYN floor?**
   - Not unless the floor fits the 80/20 rule. In other words, 80 percent of the patients on the unit must fit into either an adult medical, surgical, or med/surg location as described by NHSN. If not, the floor does not fit the criteria for Alabama NHSN reporting of CAUTIs. See the NHSN Protocol Manual – "CDC Location Labels and Location Descriptions."

3. **If an abdominal hysterectomy is performed but the uterus is removed through the vagina, is this still reported as an abdominal hysterectomy (HYST) for surgical site infection (SSI) reporting in the NHSN, or should it be recorded as a vaginal hysterectomy (VHYS)?**

   - This procedure should be recorded as a VHYS. Medical record coders are trained to assign ICD-9-CM hysterectomy codes based on the manner in which the uterus is removed. Therefore procedures where the uterus is removed via the abdomen are coded abdominal hysterectomies and fall within the NHSN operative procedure category HYST. When the uterus is removed via the vagina, the procedure is coded as a vaginal hysterectomy and is included in the NHSN operative procedure category VHYS. In keeping with this, laparoscopic hysterectomies where the uterus is removed via the vagina are included in the category VHYS.

   - ICD-9-CM codes for laparoscopic hysterectomy procedures are included within the NHSN operative procedure categories of HYST (abdominal hysterectomy) and VHYS (vaginal hysterectomy) (see also Q and A on the next page). If the hysterectomy procedure was performed using a laparoscope and the uterus was removed either through the small incision or through the vagina, be sure to indicate "Yes" for the Endoscope field response. Check "No", if the laparoscopic incision was extended to allow for the

insertion of the surgeon's hand. (Reference: CDC NHSN Newsletter, vol. 6 issue 2, June 2011)

3. **How close together can or should blood cultures be drawn?**
   - Ideally, blood specimens for cultures should be obtained from two to four blood draws from separate venipuncture sites (e.g., right and left antecubital veins), not through a vascular catheter. These blood draws should be **performed** simultaneously or over a short period of time (i.e., within a few hours). The phrase "two or more blood cultures drawn on separate occasions" means that blood from at least two blood draws were collected within two days of each other. For example, blood draws on Monday and Tuesday or Monday and Wednesday would be acceptable for blood cultures drawn on separate occasions, but blood draws on Monday and Thursday would be too far apart in time to meet this criterion. (Reference: NHSN CLABSI Protocol)

4. **If you start a procedure as a laparoscopic procedure but convert to an open procedure, how is the procedure classified?**
   - **If the entire operative procedure was not performed using an endoscope/laparoscope,** select "No" for endoscope/laparoscope. Check "Yes" for endoscope/laparoscope only if the entire operative procedure was performed using an endoscope/laparoscope. (Reference: NHSN Protocol Manual Chapter 14 Instructions for the completion of Denominator for Procedure Form).

5. **What is the NHSN definition of an open procedure? Is it only if the skin is broken, or does the MD have to insert his hands as well?**
   - NHSN does not provide a direct definition for an open procedure and does not require that the IP label a procedure as an open procedure when completing the Denominator for Procedure form (CDC 57.121).
   - When completing the Denominator for Procedure form(CDC 57.121) you are required to indicate if the procedure was performed using an endoscope/laparoscope.
   - The June 2011 NHSN newsletter includes a section describing endoscopic/laparoscopic procedures as a minimal access type surgical approach. Also, included in this section is a statement that an endoscopic/laparoscopic procedure extended to allow for the insertion of the surgeon's hand is NOT considered a laparoscopic procedure.
   - Therefore, if a procedure includes an incision that is extended to ALLOW for the insertion of the hand, it is not an endoscopic/laparoscopic procedure, but may still meet the criteria required for an operative procedure in NHSN.
   - Remember, NHSN clearly defines an operative procedure as 1) one that is performed on a patient who is an NHSN inpatient or an NHSN outpatient; 2) one that takes place during an operation (defined as a single trip to the operating room (OR) one where a surgeon makes at least one incision through the skin or mucous membrane, including laparoscopic approach, and closes the incision before the patient leaves the OR; and 3) one that is included in Table 1 (NHSN Operative Procedure Category Mappings to ICD-9-CM Codes.)

6. **If we only have to report SSIs from inpatient procedures, and you get your procedure denominator numbers from OR reports which don't specify whether the patient is an inpatient or an outpatient, how do you reconcile this?**

- The best solution is to require/encourage staff doing data collection for each location to document whether inpatient or outpatient setting. However, if a surgery is done by the hospital (whether in the hospital OR or in the hospital's outpatient surgery suite), if the patient is admitted and the date of the admission is different than the date of discharge, that meets the CDC's definition of inpatient. Only those patients who meet the CDC definition of inpatient would be added to your denominator data.

7. **A patient makes a single trip to the OR, has five different procedures, but the OR only codes one procedure. Later the patient presents with an infection. How can you reconcile the denominator data?**
   - This is a coding issue that may vary from facility to facility. According to NHSN, if procedures in more than one NHSN operative procedure category (example, COLO and HYST) are performed during the same trip to the OR even if performed through the same incision, a Denominator for Procedure (CDC 57.121) record is reported for each operative procedure being monitored.
   - However, if these procedures only represent different ICD-9-CM codes from the same NHSN Operative Procedure Category (ex. COLO with ICD-9 codes 17.31 and 17.39) that were performed through the same incision, you would record only one procedure for that category.
   - The combined duration of all procedures is recorded if more than one NHSN operative procedure category is performed through the same incision, which is the time from skin incision to primary closure.

8. **If you cannot tell from an OR report whether the incision was left open or closed, how do you reconcile this for denominator data?**
   - If the skin incision edges do not meet because of wires or devices or other objects extruding through the incision, the incision is not considered primarily closed and therefore the procedure is not considered an operation. Look for this information in the operative record. Further, any subsequent infection is not considered a procedure-associated infection (i.e., not an SSI or PPP).(NHSN Procedure Associated Events / SSI)

9. **What is the best way to track SSIs if a patient goes back to his primary physician and you are unaware of this? Those facilities that are checking with MDs and doing post-discharge surveillance may have higher rates because of this.**
   - Currently, Alabama's law does not require facilities to report post-discharge infections; however, it is a question in NHSN, and most IPs feel that if the infection is known to the hospital, it should be reported. In addition, if an IP is made aware of an infection from one of its patients admitted later to another facility, they should still report it.

10. **When reporting patient days, central line days or catheter days, is the total submitted in NHSN for the facility or only the designated location being monitored?**
    - The patient days, central line days or catheter days reported in NHSN are based on the location being monitored. See Chapter 14 of the NHSN Protocol Manual-Table of Instructions for completing forms.

11. Should vascular lines used for dialysis be included in catheter days or CLABSI determination?

- Yes, if it's 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. This includes intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis. (from CDC definitions)

12. Should straight in-and-out catheters be counted in urinary catheter days?

- No, the patient must have an indwelling urinary catheter attached to a closed drainage system. (from CDC definitions)

13. If at birth a blood culture is obtained while inserting an umbilical line, and the culture comes back positive, is this a CLABSI?

- No, the organism has not had time to incubate; it is either a contaminant or an infection acquired in utero.

14. Is a supra-pubic catheter to be counted in CAUTI assessment?

- No, the definition requires the catheter to be an indwelling urethral catheter.

Other information:

- CAUTI criterion 2a should read "spun" as opposed to "unspun". This will be changed in the next NHSN update.
- For CAUTI there must be documentation of signs and symptoms. This is a staff education opportunity.
- Definition of NHSN inpatient: A patient whose date of admission to the healthcare facility and the date of discharge are different calendar days.
- Reference the ADPH algorithm for determining whether an infection is a CLABSI, CAUTI or SSI. It can be found under the "CAUTI, and CLABSI" tabs. There is also a similar flow chart in the NHSN Protocol Manual
- Please complete the hospital survey in NHSN. A notification will appear prompting completion. This is important in ensuring accurate data and location descriptions.
- Ensure that there are multiple people at your facility who are familiar with the NHSN system
- Ensure that NHSN summary data matches your reporting plan and update your reporting plan as needed. Don't just copy it without looking for changes.

Case Examples:

1. An elderly patient has an elevated temperature but it is less than 100.4 degrees. Although this is less than the criteria for a CAUTI, it is still significantly elevated based on the normal core body temperature being lower than 98.6. Would this be classified as a CAUTI?
    - No, fever is not used as a diagnostic tool in patients older than 65 years.

2. A patient is discharged home with an indwelling urinary catheter and comes back to the hospital 4 days later with a positive urinary analysis and a positive blood culture. Is this a reportable hospital-associated CAUTI?
    - No, as the elapsed time since discharge from hospital is greater than 48 hours. However, if signs and symptoms of infection are present within 48 hours of discharge, and the doctor has documented this (either in his office medical record or on the hospital admission record), then this would be classified as a hospital-acquired CAUTI even though the patient is not readmitted until greater than 48 hours after discharge

3. A patient is diagnosed with pneumonia, but doesn't have a sputum culture done. Later a blood culture grows an organism commonly associated with pneumonia. Would this be reported as a primary CLABSI?
    - The BSI would be secondary to pneumonia, since the culture is consistent with an organism commonly associated with pneumonia.

4. A patient is discharged from the ICU. Within 48 hours he becomes symptomatic, is diagnosed with pneumonia and has a positive blood culture. Only one blood culture was done, and it was a recognized pathogen. No sputum culture was collected so connection to pneumonia could not be established. Would this count as a CLABSI?
    - Yes, if the patient had a line, and it's a recognized pathogen, and there is no evidence of infection at another site it would count as a CLABSI.

5. A patient had one positive blood culture showing coag. negative staph. Subsequent blood cultures were negative. The physician, however, diagnosed it as a CLABSI. Should this be reported as a CLABSI?
    - No, per LCBI criteria #2, a <u>common skin contaminant</u> must be cultured from <u>two or more</u> blood cultures drawn on separate occasions, <u>and</u> the patient must also show at least one of the following symptoms of infection (fever greater than 38 °C, chills or hypotension), <u>and</u> these symptoms and positive lab results must not be related to an infection at another site.