



Surgical Site Infection (SSI) Event

Introduction: In 2002, in the United States, an estimated 14 million NHSN operative procedures were performed (CDC unpublished data). SSIs were the second most common healthcare-associated infection, accounting for 17% of all HAIs among hospitalized patients¹. A similar rate was obtained from NHSN hospitals reporting data in 2006-2008 (16,147 SSI following 849,659 operative procedures) with an overall rate of 1.9%.²

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 and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases.³

Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk.^{4,5,6,7} 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.^{5,6} Recommendations are outlined in the CDC's *Guideline for Prevention of Surgical Site Infection, 1999*.⁷

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

Requirements: Select at least one NHSN operative procedure category (Table 1) and indicate this on the *Patient Safety Monthly Reporting Plan* (CDC 57.106). Collect numerator and denominator data on all procedures included in the selected procedure categories for at least one month.

The *International Classification of Diseases, 9th Revision Clinical Modifications* (ICD-9-CM) codes, which are defined by the ICD-9 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. The preciseness of the data, as well as their wide use, allows their use in grouping surgery types for the purpose of determining SSI rates. ICD-9-CM codes are updated annually in October and NHSN operative procedure categories are subsequently updated and changes shared with NHSN users. Table 1: NHSN Operative Procedure Category Mappings to ICD-9-CM Codes below outlines operative procedures and their grouping into NHSN operative procedure categories according to ICD-9-CM codes. In addition, for certain NHSN operative procedure categories, Current Procedural Terminology (CPT) code mapping is provided. A general description of the types of operations contained in the NHSN operative procedure categories is also provided.



Table 1. NHSN Operative Procedure Category Mappings to ICD-9-CM Codes and CPT Codes

Legacy Code	Operative Procedure	Description	ICD-9-CM Codes / CPT Codes
AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement	38.34, 38.44, 38.64
AMP	Limb amputation	Total or partial amputation or disarticulation of the upper or lower limbs, including digits	84.00-84.19, 84.91
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)	47.01, 47.09, 47.2, 47.91, 47.92, 47.99
AVSD	Shunt for dialysis	Arteriovenostomy for renal dialysis	39.27, 39.42
BILI	Bile duct, liver or pancreatic surgery	Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)	50.0, 50.12, 50.14, 50.21-50.23, 50.25, 50.26, 50.29, 50.3, 50.4, 50.61, 50.69, 51.31-51.37, 51.39, 51.41-51.43, 51.49, 51.51, 51.59, 51.61-51.63, 51.69, 51.71, 51.72, 51.79, 51.81-51.83, 51.89, 51.91-51.95, 51.99, 52.09, 52.12, 52.22, 52.3, 52.4, 52.51-52.53, 52.59-52.6, 52.7, 52.92, 52.95, 52.96, 52.99
BRST	Breast surgery	Excision of lesion or tissue of breast including radical, modified, or quadrant resection, lumpectomy, incisional biopsy, or mammoplasty	85.12, 85.20-85.23, 85.31-85.36, 85.41-85.48, 85.50, 85.53-85.55, 85.6, 85.70-85.76, 85.79, 85.93-85.96 19101, 19112, 19120, 19125, 19126, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380



Legacy Code	Operative Procedure	Description	ICD-9-CM Codes / CPT Codes
CARD	Cardiac surgery	Procedures on the heart; includes valves or septum; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation	35.00-35.04, 35.06, 35.08, 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.42, 35.50, 35.51, 35.53, 35.54, 35.60-35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 37.10-37.12, 37.31-37.33, 37.35-37.37, 37.41, 37.49, 37.60*
CEA	Carotid endarterectomy	Enderterectomy on vessels of head and neck (includes carotid artery and jugular vein)	38.12
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularization of the heart; includes obtaining suitable vein from donor site for grafting	36.10-36.14, 36.19
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example the internal mammary (thoracic) artery	36.15-36.17, 36.2
CHOL	Gallbladder surgery	Cholecystectomy and cholecystotomy	51.03, 51.04, 51.13, 51.21-51.24 47480, 47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620,
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations	17.31-17.36, 17.39, 45.03, 45.26, 45.41, 45.49, 45.52, 45.71-45.76, 45.79, 45.81-45.83, 45.92-45.95, 46.03, 46.04, 46.10, 46.11, 46.13, 46.14, 46.43, 46.52, 46.75, 46.76, 46.94 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44160, 44204, 44205, 44206, 44207, 44208, 44210
CRAN	Craniotomy	Excision repair, or exploration of the brain or meninges; does not include taps or punctures	01.12, 01.14, 01.20-01.25, 01.28, 01.29, 01.31, 01.32, 01.39, 01.41, 01.42, 01.51-01.53, 01.59, 02.11-02.14, 02.91-02.93, 07.51-07.54, 07.59, 07.61-07.65, 07.68, 07.69, 07.71, 07.72, 07.79, 38.01, 38.11, 38.31, 38.41, 38.51, 38.61, 38.81, 39.28



Legacy Code	Operative Procedure	Description	ICD-9-CM Codes / CPT Codes
CSEC	Cesarean section	Obstetrical delivery by Cesarean section	74.0, 74.1, 74.2, 74.4, 74.91, 74.99
FUSN	Spinal fusion	Immobilization of spinal column	81.00-81.08
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones with or without internal or external fixation; does not include placement of joint prosthesis	79.21, 79.22, 79.25, 79.26, 79.31, 79.32, 79.35, 79.36, 79.51, 79.52, 79.55, 79.56 <hr/> 23615, 23616, 23630, 23670, 23680, 24515, 24516, 24538, 24545, 24546, 24575, 24579, 24586, 24587, 24635, 24665, 24666, 24685, 25337, 25515, 25525, 25526, 25545, 25574, 25575, 25607, 25608, 25609, 25652, 27236, 27244, 27245, 27248, 27254, 27269, 27283, 27506, 27507, 27511, 27513, 27514, 27535, 27536, 27540, 27758, 27759, 27766, 27769, 27784, 27792, 27814, 27822, 27826, 27827, 27828
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication	43.0, 43.42, 43.49, 43.5, 43.6, 43.7, 43.81, 43.82, 43.89, 43.91, 43.99, 44.15, 44.21, 44.29, 44.31, 44.38-44.42, 44.49, 44.5, 44.61-44.65, 44.68-44.69, 44.95-44.98
HER	Herniorrhaphy	Repair of inguinal, femoral, umbilical, or anterior abdominal wall hernia; does not include repair of diaphragmatic or hiatal hernia or hernias at other body sites	17.11-17.13, 17.21-17.24, 53.00-53.05, 53.10-53.17, 53.21, 53.29, 53.31, 53.39, 53.41-53.43, 53.49, 53.51, 53.59, 53.61-53.63, 53.69 <hr/> 49491, 49492, 49495, 49496, 49500, 49501, 49505, 49507, 49520, 49521, 49525, , 49550, 49553, 49555, 49557, 49560, 49561, 49565, 49566, 49568, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49650, 49651, 49652, 49653, 49654, 49655, 49656, 49657, 49659, 55540
HPRO	Hip prosthesis	Arthroplasty of hip	00.70-00.73, 00.85-00.87, 81.51-81.53 <hr/> 27125, 27130, 27132, 27134, 27137, 27138, 27236, 27299



Legacy Code	Operative Procedure	Description	ICD-9-CM Codes / CPT Codes
HTP	Heart transplant	Transplantation of heart	37.51-37.55
HYST	Abdominal hysterectomy; Includes that by laparoscope	Removal of uterus through abdominal wall; includes that by laparoscope	68.31, 68.39, 68.41, 68.49, 68.61, 68.69 <hr/> 58150, 58152, 58180, 58200, 58210, 58541, 58542, 58543, 58544, 58548, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956
KPRO	Knee prosthesis	Arthroplasty of knee	00.80-00.84, 81.54, 81.55 <hr/> 27438, 27440, 27441, 27442, 27443, 27486, 27487
KTP	Kidney transplant	Transplantation of kidney	55.61, 55.69
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures	03.01, 03.02, 03.09, 80.50, 80.51, 80.53, 80.54†, 80.59, 84.60-84.69, 84.80-84.85
LTP	Liver transplant	Transplantation of liver	50.51, 50.59
NECK	Neck surgery	Major excision or incision of the larynx and radical neck dissection; does not include thyroid and parathyroid operations	30.1, 30.21, 30.22, 30.29, 30.3, 30.4, 31.45, 40.40-40.42
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures	55.01, 55.02, 55.11, 55.12, 55.24, 55.31, 55.32, 55.34, 55.35, 55.39, 55.4, 55.51, 55.52, 55.54, 55.91
OVRY	Ovarian surgery	Operations on ovary and related structures	65.01, 65.09, 65.12, 65.13, 65.21-65.25, 65.29, 65.31, 65.39, 65.41, 65.49, 65.51-65.54, 65.61-65.64, 65.71-65.76, 65.79, 65.81, 65.89, 65.92-65.95, 65.99
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker	00.50-00.54, 17.51, 17.52, 37.70-37.77, 37.79-37.83, 37.85-37.87, 37.89, 37.94-37.99
PRST	Prostate surgery	Suprapubic, retropubic, radical, or perineal excision of the prostate; does not include transurethral resection of the prostate	60.12, 60.3, 60.4, 60.5, 60.61, 60.62, 60.69



Legacy Code	Operative Procedure	Description	ICD-9-CM Codes / CPT Codes
PVBY	Peripheral vascular bypass surgery	Bypass operations on peripheral arteries	39.29
REC	Rectal surgery	Operations on rectum	48.25, 48.35, 48.40, 48.42, 48.43, 48.49-48.52, 48.59, 48.61-48.65, 48.69, 48.74
RFUSN	Refusion of spine	Refusion of spine	81.30-81.39
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis	45.01, 45.02, 45.15, 45.31-45.34, 45.51, 45.61-45.63, 45.91, 46.01, 46.02, 46.20-46.24, 46.31, 46.39, 46.41, 46.51, 46.71-46.74, 46.93
SPLE	Spleen surgery	Resection or manipulation of spleen	41.2, 41.33, 41.41-41.43, 41.5, 41.93, 41.95, 41.99
THOR	Thoracic surgery	Noncardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach)	32.09, 32.1, 32.20-32.23, 32.25, 32.26, 32.29, 32.30, 32.39, 32.41, 32.49, 32.50, 32.59, 32.6, 32.9, 33.0, 33.1, 33.20, 33.25, 33.28, 33.31-33.34, 33.39, 33.41-33.43, 33.48, 33.49, 33.98, 33.99, 34.01-34.03, 34.06, 34.1, 34.20, 34.26, 34.3, 34.4, 34.51, 34.52, 34.59, 34.6, 34.81-34.84, 34.89, 34.93, 34.99, 53.80-53.84
THYR	Thyroid and/or parathyroid surgery	Resection or manipulation of thyroid and/or parathyroid	06.02, 06.09, 06.12, 06.2, 06.31, 06.39, 06.4, 06.50-06.52, 06.6, 06.7, 06.81, 06.89, 06.91-06.95, 06.98, 06.99
VHYS	Vaginal hysterectomy, includes that by laparoscope	Removal of uterus through vagina; includes that by laparoscope	68.51, 68.59, 68.71, 68.79
VSHN	Ventricular shunt	Ventricular shunt operations, including revision and removal of shunt	02.21*, 02.22, 02.31-02.35, 02.39, 02.42, 02.43, 54.95 [^]
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system; includes diaphragmatic hernia repair through abdominal approach	53.71, 53.72, 53.75, 54.0, 54.11, 54.12, 54.19, 54.3, 54.4, 54.51, 54.59, 54.61, 54.63, 54.64, 54.71-54.75, 54.92, 54.93



*NOTE: The procedure represented by this ICD-9-CM code can be performed in a number of ways. However, as for all surgeries, if, at the end of the procedure, the skin incision edges do not meet because of drains, wires, or other objects extruding through the incision, the incision is not considered primarily closed. Therefore, the procedure is not considered an NHSN operative procedure and any subsequent infection is not considered a procedure-associated infection (i.e., not an SSI or PPP).

†NOTE: If this procedure is performed percutaneously, it is not considered an NHSN operative procedure and should not be included in LAM denominator data.

^NOTE: Include only if this procedure involves ventricular shunt.

For a complete mapping of all ICD-9-CM codes to their assignment as an NHSN operative procedure category, a surgical procedure other than an NHSN operative procedure (OTH), or a non-operative procedure (NO), see ICD-9-CM Procedure Code Mapping to NHSN Operative Procedure Categories at <http://www.cdc.gov/nhsn/library.html>.

Definitions:

An NHSN operative procedure is a procedure

1) that is performed on a patient who is an NHSN inpatient or an NHSN outpatient; 2) takes place during an operation (defined as a single trip to the operating room (OR) 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) that is included in Table 1.

*NOTE: 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. Further, any subsequent infection is not considered a procedure-associated infection (i.e., not an SSI or PPP).

NHSN Inpatient: A patient whose date of admission to the healthcare facility and the date of discharge are different calendar days.

NHSN Outpatient: A patient whose date of admission to the healthcare facility and date of discharge are the same calendar day.

Operating Room (OR): 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.⁸ This may include an operating room, C-Section room, interventional radiology room, or a cardiac catheterization lab.

Implant: A nonhuman-derived object, material, or tissue that is placed in a patient during an operative procedure. Examples include: porcine or synthetic heart valves, mechanical heart, metal rods, mesh, sternal wires, screws, cements, internal staples, hemoclips, and other devices. Non-absorbable sutures are excluded because Infection Preventionists may not easily identify and/or differentiate the soluble nature of suture material used.



For surveillance purposes, this object is considered an implant until it or the area/structures contiguous with the implant are manipulated for diagnostic or therapeutic purposes. If infection develops after such manipulation, do not attribute it to the operation in which the implant was inserted; instead attribute it to the latter procedure. If the latter procedure is an NHSN operative procedure, subsequent infection can be considered SSI if it meets criteria. If the latter procedure is not an NHSN operative procedure, subsequent infection cannot be considered an SSI but may meet criteria for other HAI and be reported as such.

REPORTING INSTRUCTIONS:

- Some products are a combination of human- and nonhuman-derived materials, such as demineralized human bone matrix with porcine gel carrier. When placed in a patient during an operative procedure, indicate “Yes” for the Implant field.

A **superficial incisional SSI** must meet one of the following criteria:

Infection occurs within 30 days after the operative procedure and involves only skin and subcutaneous tissue of the incision and

patient has at least one of the following:

- a. purulent drainage from the superficial incision.
- b. organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.
- c. at least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat, and superficial incision is deliberately opened by surgeon, and are culture-positive or not cultured. A culture-negative finding does not meet this criterion.
- d. diagnosis of superficial incisional SSI by the surgeon or attending physician.

NOTE: There are two specific types of superficial incisional SSIs:

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)
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 [leg] incision for CBGB)

REPORTING INSTRUCTIONS:

- Do not report a stitch abscess (minimal inflammation and discharge confined to the points of suture penetration) as an infection.
- Do not report a localized stab wound infection as SSI. 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.
- “Cellulitis”, by itself, does not meet the criteria for Superficial Incisional SSI.



- If the incisional site infection involves or extends into the fascial and muscle layers, report as a deep-incisional SSI.
- Classify infection that involves both superficial and deep incision sites as deep incisional SSI.
- An infected circumcision site in newborns is classified as CIRC. Circumcision is not an NHSN operative procedure. CIRC is not reportable under this module.
- An infected burn wound is classified as BURN and is not reportable under this module.

A **deep incisional SSI** must meet one of the following criteria:

Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision and

patient has at least one of the following:

- a. purulent drainage from the deep incision but not from the organ/space component of the surgical site
- b. a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured and the patient has at least one of the following signs or symptoms: fever ($>38^{\circ}\text{C}$), or localized pain or tenderness. A culture-negative finding does not meet this criterion.
- c. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination
- d. diagnosis of a deep incisional SSI by a surgeon or attending physician.

NOTE: There are two specific types of deep incisional SSIs:

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)
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 [leg] incision for CBGB)

REPORTING INSTRUCTIONS:

- Classify infection that involves both superficial and deep incision sites as deep incisional SSI.

An **organ/space SSI** involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure. Specific sites are assigned to organ/space SSI to further identify the location of the infection. The table below lists the specific sites that must be used to differentiate organ/space SSI. An example is appendectomy with subsequent subdiaphragmatic abscess, which would be reported as an organ/space SSI at the intraabdominal specific site (SSI-IAB). Specific sites of organ/space (Table 2) have specific criteria which must be met in order to qualify as an NHSN event. These criteria are in addition to the general criteria for organ/space SSI and can be found in [Chapter 17](#).



An **organ/space SSI** must meet one of the following criteria:

Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and

infection involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure and

patient has at least one of the following:

- a. purulent drainage from a drain that is placed through a stab wound into the organ/space
- b. organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space
- c. an abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination
- d. diagnosis of an organ/space SSI by a surgeon or attending physician.

REPORTING INSTRUCTIONS:

- Occasionally an organ/space infection drains through the incision and is considered a complication of the incision. Therefore, classify it as a deep incisional SSI.
- Report mediastinitis following cardiac surgery that is accompanied by osteomyelitis as SSI-MED rather than SSI-BONE.
- If meningitis (MEN) and a brain abscess (IC) are present together after operation, report as SSI-IC.
- Report CSF shunt infection as SSI-MEN if it occurs ≤ 1 year of placement; if later or after manipulation/access, it is considered CNS-MEN and is not reportable under this manual.
- Report spinal abscess with meningitis as SSI-MEN following spinal surgery.
- Episiotomy is not considered an operative procedure in NHSN.

Table 2. Specific sites of an organ/space SSI. Criteria for these sites can be found in the NHSN Help System (must be logged in to NHSN) or [Chapter 17](#).

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



Code	Site	Code	Site
	else-where		
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff

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 (CDC 57.120) 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.

NOTES:

1. 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.
2. If a procedure from more than one NHSN operative procedure category 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 Category Selection Lists (Table 3) to select which operative procedure to report.

Table 3. NHSN Principal Operative Procedure Category Selection Lists

The following lists are derived from Table 1, NHSN Operative Procedure Categories. The operative procedures with the highest risk of surgical site infection are listed before those with a lower risk.

Priority	Code	Abdominal Operations
1	SB	Small bowel surgery
2	KTP	Kidney transplant
3	LTP	Liver transplant
4	BIL	Bile duct, liver or pancreatic surgery
5	REC	Rectal surgery
6	COLO	Colon surgery
7	GAST	Gastric surgery
8	CSEC	Cesarean section
9	SPLE	Spleen surgery
10	APPY	Appendix surgery
11	HYST	Abdominal hysterectomy
12	VHYS	Vaginal Hysterectomy
13	OVRY	Ovarian surgery
14	HER	Herniorrhaphy
15	CHOL	Gall bladder surgery
16	AAA	Abdominal aortic aneurysm repair
17	NEPH	Kidney surgery
18	XLAP	Laparotomy



The following lists are derived from Table 1, NHSN Operative Procedure Categories. The operative procedures with the highest risk of surgical site infection are listed before those with a lower risk.

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 (Spine) Operations
1	RFUSN	Refusion of spine
2	FUSN	Spinal fusion
3	LAM	Laminectomy
Priority	Code	Neurosurgical (Brain) Operations
1	VSHN	Ventricular shunt
2	CRAN	Craniotomy
Priority	Code	Neck Operations
1	NECK	Neck surgery
2	THYR	Thyroid and or parathyroid surgery

The *Instructions for Completion of Surgical Site Infection* form (Tables of Instructions, Tables 12 and 2a) includes 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 the SSI was detected, whether the patient developed a secondary bloodstream infection, whether the patient died, and the organisms isolated from cultures and the organisms' antimicrobial susceptibilities.

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 (CDC 57.121). The data are collected individually for each operative procedure performed during the month specified on the *Patient Safety Monthly Surveillance Plan* (CDC 57.106). The *Instructions for Completion of Denominator for Procedure* form (Tables of Instructions, Table 13) includes brief instructions for collection and entry of each data element on the form.

NOTES:

1. If procedures in more than one NHSN operative procedure category 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 NHSN operative procedure category being monitored.



For example, if a CARD and CBGC are done through the same incision, a *Denominator for Procedure* record is reported for each.

EXCEPTION: If a patient has both a CBGC and CBGB during the same trip to the OR, report only as a CBGB. Only report as a CBGC when there is a chest incision only. CBGB and CBGC are never reported for the same patient for the same trip to the OR. For bilateral operative procedures see #4 below.

2. If procedures of different ICD-9-CM codes from the same NHSN Operative Procedure Category are performed through the same incision, record only one procedure for that category. For example, a facility is performing surveillance for both CBGB and CARD procedures. A patient undergoes an aortocoronary bypass of one coronary vessel (36.11, CBGB) and the replacement of both the mitral and tricuspid valves (35.23 and 35.27, both CARD) during the same trip to the OR. You would complete a *Denominator for Procedure* record for the CBGB and another one for the CARD because ICD-9-CM codes 35.23 and 35.27 fall in the same operative procedure category (CARD).
3. If more than one NHSN operative procedure category is performed through the same incision, record the combined duration of all procedures, which is the time from skin incision to primary closure.
4. For bilateral operative procedures (e.g., KPRO), two separate *Denominator for Procedure* (CDC 57.121) records are completed. To document the duration of the procedure, indicate the incision time to closure time for each procedure separately or, alternatively, take the total time for both procedures and split it evenly between the two.
5. 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.
6. Following laparoscopic surgeries, if more than one of the incisions should become infected, only report as a single SSI.
7. If a patient goes to the OR more than once during the same admission and another procedure is performed through the same incision within 24 hours of the original operative incision, report only one procedure on the *Denominator for Procedure* (CDC 57.121) form combining the durations for both procedures. For example, a patient has a CBGB lasting 4 hours. He returns to the OR six hours later to correct a bleeding vessel. The surgeon reopens the initial incision, makes the repairs, and recloses in 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.
8. Do not include in the procedural denominators, procedures during which the patient expired in the operating theatre.



Data Analyses: The SIR is calculated by dividing the number of observed infections by the number of expected infections. The number of expected infections, in the context of statistical prediction, is calculated using SSI probabilities estimated from multivariate logistic regression models constructed from NHSN data during a baseline time period to represent a standard population²

NOTE: The SIR will be calculated only if the number of expected HAIs (numExp) is ≥ 1 .

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.

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. SSI will be included in the numerator of a rate based on the date of procedure, not the date of event. Rate calculations can be performed separately for the different types of operative procedures and stratified by the basic risk index. SSI rate calculation options are available in the advanced analysis feature of the NHSN application.

- Basic SSI Risk Index. The index used in NHSN assigns surgical patients into categories based on the presence of three major risk factors:
 1. Operation lasting more than the duration cut point hours, where the duration cut point is the approximate 75th percentile of the duration of surgery in minutes for the operative procedure.
 2. Contaminated (Class 3) or Dirty/infected (Class 4) wound class.
 3. ASA classification of 3, 4, or 5.

The patient's SSI risk category is simply the number of these factors present at the time of the operation.

¹Klebens RM, Edwards JR, et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Reports 2007;122:160-166.

²Yi M, Edwards JR, et al. Improving risk-adjusted measures of surgical site information for the National Healthcare Safety Network. Infect Control Hosp Epidemiol 2011; 32(10):970-986.

³Emori TG, Gaynes RP. An overview of healthcare-associated infections, including the role of the microbiology laboratory. Clin Microbiol Rev 1993;6(4):428-42.

⁴Condon RE, Schulte WJ, Malangoni MA, Anderson-Teschendorf MJ. Effectiveness of a surgical wound surveillance program. Arch Surg 1983;118:303-7.



⁵ Society for Healthcare Epidemiology of America, Association for Professionals in Infection Control and Epidemiology, Centers for Disease Control and Prevention, Surgical Infection Society. Consensus paper on the surveillance of surgical wound infections. *Infect Control Hosp Epidemiol* 1992;13(10):599-605.

⁶ Haley RW, Culver DH, White JW, Morgan WM, Emori TG, Munn VP. The efficacy of infection surveillance and control programs in preventing healthcare-associated infections in US hospitals. *Am J Epidemiol* 1985;121:182-205.

⁷ Centers for Disease Control and Prevention. Guideline for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol*, 1999;20(4):247-278.

⁸ Facilities Guidelines Institute. Guidelines for design and construction of health care facilities. American Society for Healthcare Engineering; Chicago IL; 2010.

DO NOT USE - NOT CURRENT PROTOCOL