MISCELLANEOUS		
Topic	**Question**	**Answer**
Definition of HAI	What is the definition of a healthcare-associated infection (HAI)?	An infection is considered an HAI if all elements of a CDC/NHSN site-specific infection criterion were first present together on or after the 3rd hospital day (day of hospital admission is day 1). For an HAI, an element of the infection criterion may be present during the first 2 hospital days as long as it is also present on or after day 3. All elements used to meet the infection criterion must occur within a timeframe that does not exceed a gap of 1 calendar day between elements.
Gap day	Does "...criterion were first present together on or after the 3rd hospital day…" mean that all elements of an HAI criterion have to be present on the same day to meet criteria?	No. There can be a gap of up to one day between elements. However, to determine if a patient meets HAI criterion, do not utilize elements that were present on day 1 or 2 but not present on or after day 3.
Surveillance vs. clinical	What is the difference between a surveillance definition of an infection and a clinical diagnosis? i.e., My physician states that a patient is not infected although the patient clearly meets the NHSN HAI criteria. How do I respond?	Surveillance definitions are designed to study and identify trends in a population. The application of their standardized criteria, and only these criteria, in a consistent manner allows, confidence in aggregation and analysis of data. Alternatively, clinical diagnoses are patient specific. Unlike surveillance definitions, ALL available diagnostic data are considered in a clinical diagnosis, including additional clinical, epidemiological and laboratory data. Therefore a clinical diagnosis may be made even when a surveillance definition may not be met. Failure to meet a surveillance definition should never impede or override clinical judgment during diagnosis, management or treatment of patents.
Positive surveillance screening and HAI	If a patient is admitted to a facility and is methicillin-resistant Staphylococcus aureus (MRSA) positive by admission screening and then develops an infection with MRSA, is that infection a healthcare-associated infection (HAI)?	Yes. A positive screening culture at admission does not mean that any subsequent infection with that organism is not a healthcare-associated infection (HAI). Many HAIs are caused by organisms from endogenous patient sources and prevention efforts may be employed to prevent these organisms from causing an HAI. A positive screening culture without evidence of infection usually represents colonization NOT incubation. See also, definition of HAI, above.

MISCELLANEOUS		
Topic	**Question**	**Answer**
Temperature measurement	Is there a standard or recommendation regarding the use of, or the conversion of, axillary temperature readings to an oral or core equivalent?	The issue of the route of temperature measurement was considered here at NHSN and a decision was made to forego requiring a certain route of measurement, since our aim is not to direct care, but rather to measure the effect of care on outcomes. A detailed literature search was performed and subject matter experts consulted regarding the many routes of measurement and what they may mean when compared to others. The final determination was that there are no research-based guidelines concerning converting temperatures based on route of measurement. Therefore, NHSN's guidance on this issue, is that users should follow their facilities' policies and utilize temperatures which they deem to be accurate and upon which clinical decisions are based.
Patient Identification	Which Patient ID should be used when reporting data to NHSN: the visit/account number or the medical record number?	The patient ID is the key identifier in NHSN for each facility. Therefore, the patient ID should be an identifier that remains constant for the patient on any subsequent visits; oftentimes, this is the medical record number. The use of an identifier that changes with each visit to the facility, for example, would result in the inability to link an SSI to a procedure, as well as inappropriate assignment and calculation of LabID event rates.
Definition of inpatient	How is “inpatient” defined for NHSN reporting purposes?	NHSN defines an inpatient as a patient whose admission date and discharge date are different calendar days. The facility's label as "inpatient" is not necessary to meet the NHSN inpatient definition.

MISCELLANEOUS		
Topic	**Question**	**Answer**
Step-down units	Our critical care unit is actually both a medical critical care and step-down unit because we don't have a step-down unit in our hospital. So would the location designation for this type of unit be "Mixed Acuity" ward and if yes, would CLABSIs need to be reported for participation in the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Quality Reporting Program?	The designation of Mixed Acuity Ward should be utilized only when both of the following are true: 1. Less than 80% of the patients are of the same acuity level, e.g., critical care, step down or ward level; and 2. "Virtual" locations cannot be set up within NHSN to identify groups of patients of the same acuity levels. This requires the ability to identify separate patient days and device days for these groups of patients. For CMS IPPS reporting, CLABSI reporting is currently only required for critical care locations for acute care facilities. However, Long-Term Acute Care facilities are required to report CLABSIs for all inpatient locations. Correct mapping of facility locations is vital for appropriate comparison and CLABSI Standardized Infection Ratio (SIR) calculation. More detailed and important guidance can be found at: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf

MISCELLANEOUS		
Topic	**Question**	**Answer**
Fever	If present, must a fever be applied to criteria of more than one type of HAI, or can it be determined that the fever is due to one type of infection but not another, for instance due to a pneumonia (PNEU) but not a coincident urinary tract infection (UTI)?	Because a fever is a non-specific sign of infection, it is possible that an individual may run a fever due to more than one infection at a time. It would be impossible to determine which infection (if not both) was the cause of the fever. Therefore, in this example, if all other criteria besides fever are met, both the PNEU and the UTI would be reported if surveillance for both of these events was being performed.
Location codes	How do I know if I have my location codes set-up correctly?	Please refer to the guidance that is provided in the CDC Locations and Descriptions Chapter that can be found at this location http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf . The beginning of this chapter offers a guide which will help you set up your locations properly.

MISCELLANEOUS		
Topic	**Question**	**Answer**
HAI definition for 2013	Why did the NHSN definition of an HAI change for 2013?	Several studies have demonstrated there is subjective application of the NHSN HAI surveillance definitions by different IPs and facilities, and in the era of public reporting this subjective application of the definitions results in unfair inter-facility comparison of HAI rates. One of the areas repeatedly identified to be of particular concern is the determination of whether an infection was present/incubating at the time of admission or a healthcare-associated infection. With this in mind, CDC and HICPAC surveillance working group, a group made up of infectious disease professionals, healthcare epidemiologist, infection Preventionists, and state public health representatives, developed a set of objective surveillance criteria to be implemented into NHSN in Jan 2013 (this includes the >2 calendar day rule for determining if an infection is an HAI, that you referenced) and used by all reporting facilities. Through use of the same set of objective criteria it is expected that data reported to the system will be comparable. The use of the > 2 calendar day rule will correctly identify HAIs most of the time, but there are occasions where an infection thought to be present/incubating at the time of admission will still be classified as a HAI. It was felt that patients clearly showing signs and symptoms of infection at the time of presentation to the facility would undergo sufficient clinical workup within 2 calendar days, to correctly classify the infection. It is acknowledged that this surveillance criteria will not always match the clinical opinion of whether an infection was present/incubating at the time of admission to the facility. However, the need for objective and reliable surveillance definition and criteria is paramount in when data are being used for public reporting purposes.

MISCELLANEOUS		
Topic	**Question**	**Answer**
Physician diagnosis	Can physician diagnosis be used to identify an infection that is present on admission to the facility?	If physician diagnosis is used to meet any part of the NHSN criteria, then it can continue to be used as one of the elements of a CDC/NHSN site-specific infection criterion to identify an infection that was present on admission. However, if physician diagnosis is not included as part of the CDC/NHSN site-specific criteria, then only documentation of signs or symptoms (e.g., fever) that were assessed by a healthcare provider and that are part of the CDC/NHSN site-specific criteria can be used as an element to identify an infection as present on admission. For example, since the BSI criteria do not include physician diagnosis as part of the criteria, a physician documented BSI cannot be used as an element to meet CDC/NHSN criteria for a BSI. This includes a present on admission BSI as well as healthcare associated BSI. As a reminder, a patient must meet all elements of a CDC/NHSN site-specific infection criterion within the first two days of admission to be considered present on admission. This is regardless of admitting diagnosis or treatments the patient may be receiving upon admission (e.g., antibiotics).
Counting device days	How are partial device days, or single day vacations from events handled when determining if a device has been in place for the minimum > 2 calendar days for an infection to be associated with that device?	If a device is present for any part of a calendar day, then that day contributes to the minimum days requirement for the device-associated infection. If a full calendar day passes without the device then the day count begins again for device days, once the device is reinserted.
Swing beds	Should swing bed patients be included in our HAI and inpatient LabID event surveillance efforts?	Yes. All patients residing in an inpatient unit should be included in the surveillance efforts for that unit, including swing bed patients.

MISCELLANEOUS		
Topic	**Question**	**Answer**
Yellow Triangle at bottom of page	The rows on my monthly reporting plan are not populating. I have a yellow exclamation mark in a triangle at the bottom of my screen.	If you have a yellow triangle error message at the bottom of the screen, it may be an indication that you are having a JAVA issue. The drop down box is populated by an Ajax call so it could be an ActiveX setting. 1. Open Internet Explorer. 2. Click on Tools then Internet Options. 3. Choose Security Tab. 4. Click on Custom Level. 5. Check the radio button against Enable, under ActiveX controls and Plug-ins. 6. Click OK. 7. In warning window asking Are you sure you want to change the security settings at this zone?, Click Yes. 8. Click Apply and then Click OK. If the Active X controls are already enabled then you need to add *.cdc.gov to your trusted sites. To do this do the following: 1. Open Internet Explorer. 2. Click on Tools then Internet Options. 3. Choose Security Tab. 4. Click sites next to Trusted Sites. 5. Add *.cdc.gov to the trusted sites.

MISCELLANEOUS		
Topic	**Question**	**Answer**
APRV	What does the new field “Number on APRV” found on the Summary Data Report refer to?	Airway Pressure Release Ventilation (APRV) is a type of mechanical ventilation referenced in the VAE Surveillance Protocol and it is now included on the denominator data collection forms (ICU and SCA) and is also a field in the summary data report. **Complete “Number on APRV” only if you have chosen VAE as an event to follow in your Plan for the month**. The Number of patients on a ventilator is a conditionally required field. Complete "Number of patients on a ventilator" if you have chosen ventilator-associated event (VAE—for adults) or pediatric ventilator-associated pneumonia (PedVAP) as an event to follow in your Plan for the month. Please refer to the links below for further directions. Instructions for Completion of the Denominators for Specialty Care Area (SCA)/Oncology (ONC) (CDC 57.117) http://www.cdc.gov/nhsn/forms/57.117_DenominatorSCA_BLANK.pdf Instructions for the Completion of Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or SCA) (CDC 57.118) http://www.cdc.gov/nhsn/forms/57.118_DenominatorICU_BLANK.pdf Ventilator Associated Event (VAE) http://www.cdc.gov/nhsn/acute-care-hospital/vae/index.html

Surgical Site Infections

Topic	Question	Answer
SSI and CMS IPPS	What must be reported to NHSN for SSI surveillance as part of the IPPS program? Why can't I report only deep and organ space (complex) SSIs for a period of 30 days?	Although The Centers for Medicaid and Medicare Services are utilizing NHSN as a tool to collect a subset of SSI data for colon and abdominal hysterectomy surgeries (specifically deep incisional and organ/space SSIs identified within 30 days of procedure), to be a participant in NHSN a facility must follow the SSI protocol completely. This means they must adhere to the definition and reporting requirements for SSI as specified in the NHSN Patient Safety Component Protocol Manual. Superficial incisional SSIs as well as those that occur within secondary incisions and those that occur within the 90 day surveillance period, where applicable, must be reported as a part of this module. These additional data are analyzed by NHSN but not provided to CMS.
Hysterectomy and CMS IPPS	Which types of hysterectomy procedures and approaches are included in the CMS IPPS program?	The CMS IPPS program requires that all abdominal hysterectomies which are included in the NHSN operative procedure category HYST be included in SSI surveillance. The list of ICD-9-CM categories for HYST can be found in Table 1 Surgical Site Infection of the NHSN manual's SSI Event Chapter found at this location: http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf. Note that some laparoscopic procedures are included in this category.
Scope	When reporting procedure data for laparoscopic assisted supracervical hysterectomies , should the data field "Scope" be completed as "Yes"?	Check Y (Yes) if the entire NHSN operative procedure was performed using a laparoscope/robotic assist. Check N (No) if the incision was extended to allow hand assistance or was fully converted to an open approach.
SSI and infection at another site	If a post-operative patient develops an infection which meets criteria for an SSI, but an infection was present in another site also, does this have to be reported as an SSI? An example is a patient status/post HPRO who has a UTI and develops a deep incisional SSI with the same organism causing the UTI.	Yes, patients can have more than one infection at a time i.e. an SSI and a CAUTI. The exception is a bloodstream infection (BSI). When a positive blood culture is found at the same time there is another infection present, be sure to confirm that the blood is not secondary to the other infection. Only primary BSIs are reported as BSIs to NHSN. Appendix 1 Secondary BSI Guide, found in the CLABSI Event chapter of the NHSN manual provides directions on distinguishing between primary and secondary BSIs. http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf. In the case of an SSI with a secondary BSI, the SSI is reported and the BSI is noted as secondary when reporting the SSI.
Wicks, drains, and skin closure	If wicks or drains are left in place between the skin staples of a surgical incision, should this case be included in NHSN SSI surveillance? If the patient develops a superficial incisional SSI must I report it?	Yes, as long as the edges of the incision are approximated without gaps, with the exception of the drains and wicks. As of 2013, primary closure of a surgical incision is defined as *closure of all tissue levels, regardless of the presence of wires, wicks, drains, or other devices or objects extruding through the incision. However, regardless of whether anything is extruding from the incision, if the skin edges are not fully reapproximated for the entire length of the incision (e.g., are loosely closed with gaps between suture/staple points), the incision is not considered primarily closed and therefore the procedure would not be considered an NHSN operative procedure. In such cases, any subsequent infection would not be considered an SSI, although it may be an HAI if it meets criteria for another specific infection site (e.g., skin or soft tissue infection).*

Surgical Site Infections

Topic	Question	Answer
Dirty/infected surgical procedures	Can a patient develop a surgical site infection per NHSN definitions following a dirty/infected surgical procedure or would such an infection be considered present or incubating on admission or at the time of surgery? If so, must such an SSI be reported to NHSN for participation in the CMS Inpatient Prospective Payment System (IPPS) program?	Yes, if the wound was closed primarily, a patient can develop an SSI following a dirty/infected procedure and the SSI must be reported to NHSN. A wound classification of dirty/infected assigned to such a case is the marker that an infection was incubating or present at the time of the operation, and this factor is taken into account through risk adjustment techniques. Essentially, more SSIs are expected to occur in such situations and this is taken into account. Further, because NHSN only includes operations which are closed primarily, and because there are surgical options other than primary closure available when infection or gross contamination of the operative wound is encountered (e.g., leave incision open, use a wound vac, etc.), subsequent infection of the operative incision or organ/space is counted as an HAI SSI when SSI criteria are met. The rationale is that if the surgeon elects to close the wound before the patient leaves the OR, he/she considers the subsequent risk of continuing or new infection to be minimal. Should one occur, including it in the SSI count will help bring attention to it so that prevention strategies for future patients may be explored. We realize that in today's climate of pay-for-reporting and soon to be pay-for-performance, that this way of handling these situations has become challenging. Therefore, we have worked with our HICPAC surveillance working group to address this issue and will be presenting additional variables in 2014.
	If a postoperative patient develops an infection after the surgical site is accessed (e.g., breast implants are infused/enlarged; postoperative joint is aspirated, etc.) is this considered an SSI?	If no symptoms of infection were present at the time of accession, an infection that develops after this accession would not be considered an SSI. Once a surgical site has been accessed in the postoperative period (i.e., the area of surgery underneath the skin is entered),a subsequent infection may be related to this accession, rather than the surgical procedure, and therefore no SSI would be reported. If however, symptoms of infection were present at the time of accession, a subsequent infection may simply be extension of the already present SSI. Such cases may require case by case consideration.
CPT codes	Can my facility choose to use either ICD-9-CM codes or CPT codes to identify our surgical procedures?	Only ICD-9-CM codes may be utilized at this time for SSI surveillance of inpatient procedures. CPT codes or ICD-9-CM codes can be utilized for outpatient SSI surveillance but whichever method is chosen must be used consistently.
Robotic surgeries	Are robotic surgeries included in NHSN operative procedure categories?	Yes, robotic surgeries are included in NHSN operative procedure categories. The procedure codes identified in Table 1 NHSN Operative Procedure Category Mapping to ICD-9-CM and CPT codes are the most current final determination of the inclusion of a surgical procedure. http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf
Fall after operative procedure	If a patient falls upon a postoperative incision, which then opens and ultimately becomes infected within the SSI surveillance time period, is this reported as an SSI?	There are several scenarios which may apply here: Please see page 9-16 of the NHSN Patient Safety Component Manual for specific guidance and examples. http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf

Surgical Site Infections

Topic	Question	Answer
COLO procedures and CMS requirements	How do I know what types of procedures need to be followed in COLO to be compliant with CMS reporting requirements?	Table 1 NHSN Operative Procedure Category Mappings to ICD-9-CM Codes which is found in Chapter 9, SSI Events of the NHSN Patient Safety Component Manual, provides a complete listing of all codes included in each of the NHSN Operative Procedure Categories. http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf
Multiple incisions	How do I report separate NHSN operative procedures with 2 separate incisions?	If a patient has 2 procedures with separate incisions a Denominator for Procedure form will be completed for each and data entered into NHSN. Should an SSI develop, it would be entered for the appropriate procedure.
Broth only cultures	How do I interpret 'broth only' for the final culture report when reporting infection events in NHSN?	Positive cultures from broth only are considered a positive culture result and treated as such for surveillance purposes. Such media can be enriched to identify organisms that might otherwise be missed.
ASA codes	What if my facility does not report ASA codes for surgical procedures I would like to follow in NHSN?	ASA codes are a required element for NHSN SSI surveillance for inpatient procedures only. As such, participation requires the collection of this data element. SSI surveillance for outpatient procedures does not require the reporting of ASA scores so your facility could participate in SSI surveillance in outpatients without collecting ASA data.
Non-NHSN operative procedures	Can I follow operative procedures if the ICD-9 codes are not listed in Table 1, Operative Procedures Category Mappings to ICD-9-CM Codes and CPT Codes in the SSI Chapter? http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf	Other surgical procedures may be monitored for SSI utilizing NHSN, however, this surveillance will need to be completed "off plan". This means that the procedure will not appear in the facility's NHSN monthly reporting plan and that the data reported will not be utilized by NHSN for analysis purposes. Performing surveillance for these procedures will require the facility to create a custom procedure within NHSN. Guidance on how to do this is provided by clicking on the Help icon within NHSN and typing "custom procedure" in the search box.
Location field	What if I don't know the location where the patient was after surgery in order to attribute the SSI?	SSIs are attributed to procedures and not to locations. Therefore you are not required to complete the location field on the Denominator for Procedure form. The location field may optionally be used internally for trending data.
Pediatric operative procedures	What kinds of pediatric surgeries are followed in NHSN?	NHSN Operative Procedure categories include procedures performed on patients of all ages. If a facility is monitoring SSI "in plan", it will need to monitor and report SSIs in ALL patients undergoing the NHSN Operative Procedure Category, not just the pediatric patients. By stratifying by date of birth in the analysis features of NHSN, it is possible to analyze SSI trends in pediatric patients only.
Pin-site infections	Are pin-site infections considered SSIs?	No. Pin-site infections are not considered NHSN SSIs. However, depending on the symptoms present, they may meet the criteria for a Skin or Soft Tissue Infection (SST) if a facility monitors for these types of infection.

Surgical Site Infections

Topic	Question	Answer
Anastomotic leak	Is an intraabdominal infection that develops secondary to an anastomotic leak a complication of surgery, or a Surgical Site Infection (SSI)?	Both. An anastomotic leak may contribute to the development of an infection, but without surgery, there would not have been an anastomotic leak. If the patient meets SSI criteria it must be reported as such.
Hematoma	Is an "infected hematoma" in a postoperative wound an SSI?	The fact that wounds can be labeled in various ways by different physicians is the reason that criteria rather than labels or diagnoses are used for determination of healthcare-associated infections in NHSN. If a wound described as an infected hematoma meets an SSI criterion, it must be so reported, even if the physician disagrees. Please check the criteria.
Percutaneous procedures	The NHSN operative procedure category CARD includes ICD-9-CM code 37.25, cardiac biopsy. Should cardiac biopsies that are performed percutaneously be included in surveillance of SSIs in the NHSN operative procedures category of CARD?	ICD-9-CM codes are developed by the ICD-9-CM Coordination and Maintenance Committee of the Centers for Medicare and Medicaid Services. Some include more than one specific surgical technique. Such is true for 37.25. Even though this ICD-9-CM code includes both open and percutaneously performed cardiac biopsies, procedures performed percutaneously do not meet the definition of an NHSN operative procedure because there is no incision. Therefore such procedures should not be included in the denominators for CARD SSI rates, and any associated postoperative infections should not be reported as SSIs. Note: Such an infection may be a healthcare-associated infection (HAI), but it cannot be an SSI. Cardiac biopsies coded as ICD-9-CM code 37.25 but performed through an open incision should continue to be included in the surveillance of CARD SSIs.
C-section	Is a C-section a clean-contaminated wound class if the amniotic membranes were ruptured prior to surgery?	Because C-sections involve entry into the genital tract, even uneventful C-sections are considered clean-contaminated operations. Uneventful C-section in the case of prolonged membrane rupture but without evidence of chorioamnionitis would be a clean-contaminated surgical wound. If chorioamnionitis was encountered during a C-Section, such a case would be classified as a dirty/infected surgical wound. There are no parameters associated with length of membrane rupture before delivery to determine the wound class.
Trauma	Is a fall considered "trauma" when completing the Denominator for Procedure form for surgical site infection surveillance?	Yes, trauma is defined in NHSN as "blunt or penetrating traumatic injury." Therefore, if the surgery was performed because of a fall, e.g., a hip arthroplasty following a fall, then indicate "yes" for the trauma field.
Laminectomy procedure	Could you please clarify whether laminectomies must be included in LAMI SSI surveillance if they are performed as "prep" for the spinal fusion?	When a laminectomy is used solely as the approach for a spinal fusion procedure, a separate Denominator for Procedure record for the laminectomy should NOT be entered/imported into NHSN. This is true even when laminectomy is being monitored in the Monthly Reporting Plan for that month. This reflects a medical coding rule, not an NHSN protocol rule.

Surgical Site Infections

Topic	Question	Answer
Joint replacement procedures	What is the difference between total and partial joint replacement?	A total joint replacement involves replacing both articulating surfaces of the joint. A partial includes replacing only one.
Primary vs. revision	What is the difference between primary and revision joint arthroplasties?	A primary joint replacement is the initial replacement of any of the articulating surfaces in a joint. A revision joint replacement is any replacement of articulating surfaces after the primary replacement.
SSI changes for 2013	What is the reasoning behind changing the definitions for surgical site infections…specifically the 365 day review being dropped to 90 days?	Beginning in 2013, the NHSN SSI Surveillance Period was changed to either 30 or 90 days for deep incisional and organ/space (i.e., Complex) SSI, depending on the procedure type. The surveillance period remains 30 days for all Superficial SSI. While historically the NHSN SSI protocol required follow up for Complex SSI for 30 days or 1-year after the procedure, based on absence or presence of an implant, both the burden and usefulness the data collected during the 1-year follow up period was evaluated. Descriptive analysis of SSI data reported to NHSN identified that the large majority (>85% for most procedure types) of SSIs are detected within either 30 or 90 days post-procedure depending on the type of surgery. Consequently, it was concluded that the small amount of additional data collected during the 1-year surveillance period did not offset the additional burden of continuing to require surveillance for the 1-year time period. Additionally, it is unclear if the later onset SSIs (i.e., those that occur greater than 3-6 months or more after surgery) are a true indicator of surgical quality, so their value to informing SSI prevention efforts is likely less than those SSIs that occur relatively soon (i.e., 30 to 90 days) postoperatively. Finally, the 30-day period being used for most surgical procedures (including COLO and HYST) is consistent with current federal reporting mandates, which are limited to a 30-day surveillance period.
Attending physician	How does NHSN define *Attending Physician* ?	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).
Wound class	I am trying to enter a COLO procedure and clean is not listed on the drop down menu, why is it not listed as a choice?	There are a few Operative procedures that should never be entered as "CLEAN" cases. In our recent update we have removed the choice of clean from the drop down menu for a few procedure categories. You stated are trying to enter a COLO as clean and this is one of the procedures that is not allowed to be entered as clean. This is also true for APPY, BILI, CHOL, COLO, REC, SB, and VHYS procedure categories. This information is found under the wound classification section of the NHSN SSI protocol on page 8 and 9.

Central Line-Associated Bloodstream Infection (CLABSI)

Topic	Question	Answer
Secondary BSI	What is the meaning of the statement "not related to infection at another site" included in the Laboratory Confirmed Bloodstream Infection criteria?	Please see Appendix 1 Secondary BSI Guide found in Chapter 4, CLABSI Event of the NHSN Patient Safety Component Manual for guidance in determining the primary source of an infection for NHSN CLABSI surveillance purposes. http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf
Contracted staff	How should CLABSIs be reported when they develop in patients whose only central line is accessed solely by contracted dialysis staff?	Facilities are responsible for all of the care which is provided in their facilities. This includes care provided by employed staff and contracted staff alike. Therefore such a CLABSI would be reported for the facility in which the patient is housed.
Dialysis patients	What if patients are provided dialysis by dialysis staff members, either this staff coming to the patient or the patient going to the dialysis unit. Our unit nursing staff does not access the dialysis catheter. If these patients develop CLABSI are they attributable to our location/facility?	If the dialysis unit is one to which patients are transported for dialysis and then escorted back to their inpatient unit for the rest of their care, the CLABSI must be attributed to the inpatient location where the patient is housed overnight. Because in this scenario the dialysis unit does not have overnight patients, there can be no patient day counts nor central line counts and there is no way within NHSN to perform CLABSI surveillance in this location. This is an issue that we are discussing and plan to add a hemodialysis variable to the BSI form in 2014. In the meantime, a facility may create a custom field on the LCBI form and label it something like "Dialysis line care only". Data can be analyzed based on this field and the results utilized for the facility's internal quality work. For more information on how to do this, enter the NHSN application, choose the help icon from the upper right hand corner and type "Custom Fields" in the search box. Remember, the CLABSI will still need to be reported to NHSN for the unit in which the patient is housed.
Blood culture collection methods	If two blood cultures are drawn, one through a central line, and one from a venipuncture and the venipuncture culture is negative for growth but the line culture grows an NHSN pathogen, does this meet the CLABSI criteria?	Yes. Blood cultures collected by any means, either through venipuncture or collected through existing vascular catheters must be considered in your surveillance of BSI. Therefore, a blood culture which is collected through a vascular catheter and that is positive for an organism, is considered a positive blood culture for CLABSI surveillance.
Patient manipulation of central line	If an inpatient is suspected of accessing their own vascular catheter ,e.g., injecting illicit drugs, and a BSI develops, is this BSI attributed to the facility?	Yes, if the patient meets the definition of a BSI this is attributable to your facility. A facility must protect the line as best they can. Prevention efforts may include providing a patient sitter and/or removal of the catheter as soon as clinically possible.
Midline catheter	Does a midline catheter qualify as a central line?	Midline catheters by description are not intended to end in one of the great vessels. However, the location of the tip of the catheter is the determining factor and a recent chest x-ray report may indicate the true location. Also, consider what the line is being used for. To qualify as a central line, is must be used for infusion, withdrawal of blood, or hemodynamic monitoring.

Central Line-Associated Bloodstream Infection (CLABSI)

Topic	Question	Answer
Catheter tips	Are central line catheter tips used to meet the NHSN LCBI criteria? Why?	No. Catheter tip cultures are not utilized for NHSN CLABSI surveillance for several reasons. Catheter tip cultures have been shown to have higher rates of contamination than blood cultures. Furthermore, not all laboratories are able to perform quantified catheter tip cultures. Catheter tips are a part of some other types of non-NHSN surveillance such as catheter-related BSI (CRBSI) which is generally thought of as a clinical definition, used when diagnosing and treating patients. The Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011 address CRBSI and may be helpful when addressing a physician: http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf
Multiple central lines	If a patient has two central lines in at the same time, how do I determine to which line to attribute the positive blood culture?	You will not be required to attribute a CLABSI to a specific central line. Instead you will simply be required to answer whether or not a central line was in place greater than 2 calendar days on the date of the BSI event and also in place on the day of the event or the day before the event?
Purulent drainage from IV site	If a patient has purulent drainage from an old IV site, but a negative blood culture how do I report this to NHSN?	Consult the criteria for VASC-Arterial or Venous Infection available at http://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf. Such a patient would meet criterion 4. If your facility is monitoring for these types of infection, enter this into NHSN as a VASC event.
Intraaortic balloon pumps (IABP)	Are intraaortic balloon pumps (IABP) considered central lines?	No. Because IABPs are not generally used for infusion, blood withdrawal or for hemodynamic monitoring, they are not considered central lines.
Femoral arterial lines	Are femoral arterial lines considered central lines in NHSN?	No. Because the femoral artery is not among the list of great vessels defined for CLABSI surveillance in NHSN, a catheter in this vessel is not considered a central line. Do not include femoral artery catheter days in your count of central line days.
Pre-existing central lines	When patients are admitted to an inpatient unit with a permanent (tunneled) pre-existing central line in place, which is not accessed during the hospitalization, are those days included in the central line-day count?	No. Permanent central lines should be included in the central line-day count beginning on the first day that they are accessed (insertion of the line is considered an accession) and continuing until the patient is discharged or the line is discontinued, whichever comes first. Therefore, if a patient is admitted with a permanent central line which is not accessed until hospital day 4, the line should not be included in the central line-days count until day 4 and then included every day until the patient is discharged or the line is discontinued. If the line is never accessed, it is never counted in the central line day counts.

Central Line-Associated Bloodstream Infection (CLABSI)

Topic	Question	Answer
Chronic dialysis patients	When performing central line-associated bloodstream infection (CLABSI) surveillance in an inpatient dialysis location, should chronic dialysis inpatients be included?	Yes. If CLABSI surveillance in an inpatient dialysis location is part of your monthly reporting plan, all patients in that location must be included in CLABSI surveillance. (Note: inpatient dialysis locations that are not bedded locations, i.e., patients do not spend the night in these locations, but instead are transported there for dialysis and return to another bedded location for the remainder of their care, cannot participate in the NHSN CLABSI protocol at this time.)
MBI-LCBI-organisms list	How was the list of organisms included in the Mucosal Barrier Injury-Laboratory Confirmed Bloodstream Infection (MBI-LCBI) criteria, developed?	The list of organisms included in the MBI-LCBI was developed by consensus of the HICPAC surveillance working group, made up of infectious disease professionals, healthcare epidemiologist, infection preventionists, and state public health representatives. The list of organisms included in the definition is intended to represent those that are most likely to be attributed to mucosal barrier injury. We recognize that not all mucosal barrier injury related bloodstream infections will be categorized as MBI-LCBI. CDC staff will be evaluating the list of MBI-LCBI organisms on an ongoing basis to determine if changes are needed.
Patient reported fever	Can I use patient reported fever to meet CDC/NHSN LCBI criterion 2 for present on admission?	Patient reported signs and symptoms (e.g., fever) cannot be used as an element to meet CDC/NHSN site-specific criteria unless also observed and documented by a healthcare provider. For example, a patient is transferred from a nursing home and is afebrile upon admission to the hospital. The nursing home documentation indicates that the patient had a fever the morning of admission. If the nursing home documented or reported fever is included as part of the patient's admission/facility record, then it can be used as one of the elements to meet CDC/NHSN LCBI criterion 2.
Hypotension	What is the definition of hypotension when evaluating common commensal for CLABSI?	NHSN does not provide a specific value for this vital sign. Instead, each facility should use the vital sign parameters as stated in its policies and procedures for clinical documentation.
Distinguishing serial reportable infections from single, unresolved infection	Is there a time period following the identification of an infection during which another of the same type of infection cannot be reported?	No. At present time NHSN does not have a set time period during which only 1 infection of the same event type may be reported for the same patient (with the exception of VAE and LabID Event reporting for which there is a 14-day window [see individual protocols for VAE and LabID Events]) following an infection which is present on admission (POA) or a healthcare-associated infection (HAI). Discussions are underway regarding creating such a rule, however no final decisions have been made and no changes would be made before 2014. In the meantime, use the clinical information you have available to determine if the original infection has resolved before reporting a second.

Central Line-Associated Bloodstream Infection (CLABSI)

Topic	Question	Answer
Removal and reinsertion of a central line	How do I count calendar days when a central line is removed and later reinserted?	If a central line is removed and then reinserted on the same calendar day or the following day, this represents continuous central line presence because a central line was in place for some period of time each calendar day. If a central line is removed and the patient has an entire calendar day without a central line in place and a central line is subsequently re-inserted, the day of re-insertion represents Day 1 of that central line.
Secondary BSI and time-frame	How closely do the criteria for the BSI and the site specific infection have to fall together in order for the BSI to be considered secondary?	Currently, we do not have a set-time period for which a BSI may or may not be considered secondary to another infection. Instead, our guidance is for users to use the clinical information available to determine if the time-period is reasonable. For example, although the patient does not necessarily have to meet all elements of the NHSN criteria for the primary infection on the exact day of the positive blood culture, the patient must have ongoing signs/symptoms related to the primary infection at the time of the positive blood culture. If the documentation support that the primary infection has resolved (e.g., symptoms resolved), then a positive blood culture must not be reported as secondary to a resolved infection. Same guidance applies to blood cultures that are collected prior to the onset of the signs/symptoms of the primary infection. If the patient has a positive blood culture and no other signs of infection on the date the specimen is collected, then it is unlikely that the BSI is attributable to another infection. NOTE: Please review Note #3 page 4-17 of the Patient Safety Component Manual

Catheter-Associated Urinary Tract Infection (CAUTI)

Topic	Question	Answer
Irrigation	Should we include Foley catheters that are irrigated in our CAUTI surveillance?	Yes. Irrigating indwelling catheters may increase the risk of UTI. These catheters are included in CAUTI surveillance.
Leg bags	My facility changes Foley catheters from bed bags to leg bags so that our patients can attend physical therapy. Or: My ICU opens catheter systems to replace catheter bags with urometers. Should these be included in CAUTI surveillance since the system is not "closed"?	Yes. Both of these practices may increase the risk of UTI. Neither excludes the patient from CAUTI surveillance.
U/A on admission	My facility routinely performs urinalysis (U/A) on patients admitted to identify urinary tract infections present or incubating on admission. When these are positive can subsequent infections be excluded from reporting to NHSN?	Not entirely. NHSN no longer utilizes the term "present or incubating" in its determination of healthcare-association infection. Instead facilities must utilize the new definition of HAI (see below) to make this determination. Unless all elements of the criterion are present together in the 2 days before admission, the day of admission, and/or the day after admission, a subsequent infection is considered healthcare-associated. *HAI: An infection is considered an HAI if all elements of a CDC/NHSN site-specific infection criterion were first present together on or after the 3rd hospital day (day of hospital admission is day 1). For an HAI, an element of the infection criterion may be present during the first 2 hospital days as long as it is also present on or after day 3. All elements used to meet the infection criterion must occur within a timeframe that does not exceed a gap of 1 calendar day between any two elements.*
Spinal cord injury, heavily sedated, or ventilated patients	My location cares for patients who may not be able to verbalize or sense suprapubic tenderness or costovertebral angle pain or tenderness, e.g., patients with spinal cord injury, heavily sedated or ventilated patients. How can I report CAUTI in these patients?	Surveillance criteria may not be equally sensitive for all patient populations. The UTI criteria may not be as sensitive in patient populations such as spinal cord injury patients, those with brain injuries or the heavily sedated patient. As you are probably aware, NHSN definitions, as surveillance definitions, are aimed at the larger in-patient population as a whole and developed to gather information that can be used broadly. They also need to be constructed in such a way to balance sensitivity and specificity along with feasibility. A set of criteria that covered every subpopulation with high specificity and sensitivity would be so complicated that it would be very difficult to employ and next to impossible to do so consistently across different facilities. However, NHSN recognizes that some of the populations mentioned above, may be at high risk of CAUTI and therefore has begun a targeted discussion of the CAUTI criteria and its application to various patient populations. There may be future changes to the criteria as a result, but it would be 2014 at the earliest, before any changes may be operationalized. If you have suggestions and/or are aware of research about valid indicators of UTI in certain populations, please feel free to forward it to NHSN@cdc.gov for our consideration.

Catheter-Associated Urinary Tract Infection (CAUTI)

Topic	Question	Answer
Mixed flora	If a urine culture is positive for 1 organism >100,000 CFU/ml and also for mixed flora, does this meet one of the urine culture results required for UTI?	No. Because "mixed flora" means that at least 2 organisms are present in addition to the identified organism, such a urine culture does not meet the criteria for a positive urine culture with 2 organisms or less. Such a urine culture cannot be utilized to meet the UTI criterion.
Funguria	Why does NHSN consider patients with funguria in the urine as CAUTIs?	Candiduria is a recognized cause of CAUTI. Therefore, there is no exclusion of these organisms from the UTI criteria. However, a targeted discussion of the CAUTI criteria and its application to various patient populations has recently been implemented. There may be future changes to the criteria as a result, but it would be 2014 at the earliest, before any changes may be operationalized.
UrC on NICU reporting summary	What does the UrC column mean on my NICU monthly reporting summary? Is this a required field?	This column is used by facilities performing off-plan monitoring for catheter-associated urinary tract infections in the neonatal intensive care unit. It is used to capture the number of indwelling urinary catheter days in the unit for the month. NOTE: Monthly reporting plans cannot include CAUTI surveillance in NICUs.
ABUTI and CMS	Are asymptomatic bacteremic urinary tract infections (ABUTIs) in patients in adult and pediatric intensive care units (ICUs) included in the reporting requirements for CMS's Hospital Inpatient Quality Reporting Program beginning January 2012?	Yes. Keep in mind that ABUTI may occur in patients with or without an indwelling urinary catheter. Therefore, if a patient in an adult or pediatric ICU has an indwelling urinary catheter within the timeframe to meet the device-associated rule, this infection is a CAUTI and is reportable to CMS. Remember that the date of event is defined as the date when the last element used to meet the CDC/NHSN site specific criterion occurred. Only catheter-associated UTI data (both ABUTI and SUTI) are shared with CMS.
Gram stain	Do microorganisms seen as part of a urinalysis (UA) meet the component of symptomatic urinary tract infection (SUTI) criteria 1a and 2a, which states: "c. microorganisms seen on Gram stain of unspun urine"?	No. Since the UA workup does not include Gram staining of the specimen, this component of the criteria is not met.
Patient reported fever	Can I use patient reported fever to meet CDC/NHSN UTI criteria for present on admission?	Patient reported signs and symptoms (e.g., fever) cannot be used as an element to meet CDC/NHSN site-specific criteria unless also observed and documented by a healthcare provider. For example, a patient is transferred from a nursing home and is afebrile upon admission to the hospital. The nursing home documentation indicates that the patient had a fever the morning of admission. If the nursing home documented or reported fever is included as part of the patient's admission/facility record, then it can be used as one of the elements to meet CDC/NHSN UTI criteria.

Catheter-Associated Urinary Tract Infection (CAUTI)

Topic	Question	Answer
Gap day between elements	Could you please explain what you mean by a gap day between any two elements?	There can be no more than a one calendar day gap between any 2 elements (culture result, symptoms, fever, etc.) See example below: Day 1 - Pt admitted and Foley inserted Day 2 - Foley still in place Day 3 - Fever > 100.4° Day 4 - Afebrile - This is the "gap" day Day 5 - (+) urine culture >100000 CFU of E.coli - Meets criteria for a SUTI 1a here If the Culture had not been sent until Day 6 you could not attribute the fever on day 4 to that culture because there would have been a 2-day gap.
UTI when symptoms on different days	If a patient has a (+) urine culture > 100,000 CFU/ml on day 2 and a fever on day 3 is this an HAI?	No, this would not meet criteria. You can not use any culture results or symptoms from day 1 or 2 to meet an HAI criteria unless they are present again on or after day 3. For Example: Day 1 - Pt admitted and Foley inserted Day 2 - Foley still in place; Fever > 100.4° Day 3 - Afebrile Day 4 - (+) urine culture >100000 CFU of *E.coli* Day 5 and Day 6 - remains afebrile The fever on day 2 cannot be used to meet an HAI criteria. The patient would have to have another fever or symptoms on day 3,4, 5, or 6 for this to be a SUTI 1a.
Distinguishing serial reportable infections from single, unresolved infection	Is there a time period following the identification of an infection during which another of the same type of infection cannot be reported?	No. At present time NHSN does not have a set time period during which only 1 infection of the same event type may be reported for the same patient (with the exception of VAE and LabID Event reporting for which there is a 14-day window [see individual protocols for VAE and LabID Events]) following an infection which is present on admission (POA) or a healthcare-associated infection (HAI). Discussions are underway regarding creating such a rule, however no final decisions have been made and no changes would be made before 2014. In the meantime, use the clinical information you have available to determine if the original infection has resolved before reporting a second.
Removal and reinsertion of Foley catheter	How do I count calendar days when a Foley is removed and later reinserted?	If a Foley is removed and then reinserted on the same calendar day or the following day, this represents continuous Foley presence because a Foley was in place for some period of time each calendar day. If a Foley is removed and the patient has an entire calendar day without a Foley in place and a Foley is subsequently reinserted, the day of reinsertion represents Day 1 of that Foley.

Ventilator-Associated Pneumonia

Topic	Question	Answer
New or progressive and persistent infiltrate	Please offer a specific definition of "new or progressive and persistent infiltrate."	This phrase is meant to ensure that there has been a change in the chest x-ray and that it is not a change that is due to some acute reason such as fluid overload. A true pneumonia would not be seen on a single CXR and then resolve the next day.
Tracheostomy ventilation	I just recently ran into two cases of people that were on a vent and vent documentation was done. Sometime later they were put on a T-piece with an ET tube documented, but no vent documentation. Documentation was done this way for multiple days. How should these patients be addressed and should they be included in the vent days?	These patients are similar to patients with tracheostomies that are undergoing weaning from the ventilator. They may have periods of "rest" on the ventilator, and also periods where they are not ventilated during the same calendar day. In short, if the patient is off vent at the time the vent day count is being done, they are not included in the vent day count. But they would still remain very much eligible for a VAP since they are experiencing some period of mechanical ventilation every day.
Patients on ventilator for a portion of the day	Some of our patients are on the ventilator only at night. We count our ventilator days at noon. Are these patients eligible for VAP? If so, we are not getting an accurate number of ventilator days to account for the risk of VAP in this unit.	We recognize certain patient populations will use the ventilator only for a portion of the day. We recommend you count ventilator days in this unit at night, perhaps 12 midnight to include this patient population in the your denominator for the unit.
Distinguishing serial reportable infections from single, unresolved infection	Is there a time period following the identification of an infection during which another of the same type of infection cannot be reported?	No. At present time NHSN does not have a set time period during which only 1 infection of the same event type may be reported for the same patient (with the exception of VAE and LabID Event reporting for which there is a 14-day window [see individual protocols for VAE and LabID Events]) following an infection which is present on admission (POA) or a healthcare-associated infection (HAI). Discussions are underway regarding creating such a rule, however no final decisions have been made and no changes would be made before 2014. In the meantime, use the clinical information you have available to determine if the original infection has resolved before reporting a second.

MDRO/CDI		
Topic	**Question**	**Response**
LabID Event reporting verses Infection Surveillance reporting	What is the difference between Laboratory-identified (LabID) Event and Infection Surveillance in the MDRO and CDI Module?	Infection Surveillance occurs in inpatient locations only (where denominator data can be collected) and involves reporting true infections which are caused by one of the listed MDROs or *C. difficile* and that are deemed healthcare-associated. The infection must meet one of the CDC/NHSN-defined healthcare-associated infection (HAI) criteria found at http://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf. Alternatively, LabID Event reporting allows laboratory testing data to be used without clinical evaluation of the patient. These provide proxy infection measures for healthcare acquisition, exposure burden, and infection burden based almost exclusively on laboratory data and limited admission date data. The NHSN system will categorize the event as healthcare-onset or community-onset based solely on admission and specimen collection dates. LabID Events can be performed either overall facility-wide inpatient (FacWideIN), overall facility-wide outpatient (FacWideOUT), or for specific locations.
Transfer Rule	Does the Transfer Rule apply to LabID Event Reporting?	The Transfer Rule does NOT apply to LabID Event reporting. LabID Events are based solely on the location of the patient at the time of specimen collection.
Specimens collected from outside facilities	Can specimens collected from outside hospitals (e.g., satellite hospitals) on the same day as admission be used as the first isolate for LabID Event reporting?	In order for an outpatient specimen (e.g., collected from ED), collected on the same calendar day as inpatient admission, to be considered a LabID Event for the admitting facility, the specimen must have been collected by the facility's own location (ED or other affiliated outpatient clinic). Since facilities have different levels of access to lab data beyond that from their own facility, this is the best way to standardize data collection and reporting.
Specimens collected in the ED	Can specimens collected in the facility's emergency department are other facility affiliated outpatient location be used for facility-wide inpatient (FacWideIN) LabID Event reporting?	Specimens collected in the facility's emergency department or other outpatient location can be used for FacWideIN LabID Event reporting only if the specimen was collected on the same calendar day as patient admission to an inpatient location. In this case, the LabID Event can be entered into the NHSN application and the "Location" field should be entered as the inpatient admitting location.
Prior evidence of infection	Why will the system not let me answer "Yes" to the question *"documented prior evidence of infection or colonization with the specific organism type from a previously reported LabID event?"*	This is a non-editable data field and will be auto-filled by the system only depending on whether there is a prior LabID Event entered for the same organism and same patient. If there is a previous LabID event for this organism type entered into NHSN in a prior month, the system will auto-populate with a "YES." The auto-filled response to this question is used in the calculation of the MDRO Infection/Colonization Incidence Rate when a facility is reporting all specimens (not just blood) and, therefore, may likely represent colonization events. What this means is that hospitals are not being penalized when it comes to the overall (all specimen) infection/colonization incidence rate, as all "YES" previous positive events are excluded. Furthermore, this data field is NOT used in *C. difficile* analysis.

MDRO/CDI		
Topic	**Question**	**Response**
Classification of healthcare onset (HO)	NHSN categorized a patient with *C. difficile* as healthcare onset (HO), even though the "*documented prior evidence of infection or colonization with this specific organism type from a previously reported LabID Event* " data field is auto-populated as "YES."	This particular auto-filled data field does not have anything to do with the application categorizing an Event as healthcare onset (HO) or community onset (CO), as this categorization is based almost exclusively on laboratory data and limited admission date data for the current admission. A LabID Event will be categorized as HO if specimen collection is >3 days after admission to the facility irrespective of the patient having a prior history of *C. difficile* . However, NHSN will further categorize the Event as incident or recurrent based on any previous LabID Events for CDI entered into NHSN. Any CDI LabID Event from a specimen that was obtain >2 weeks and ≤ 8 weeks after the most recent CDI LabID Event for that patient will be categorized as recurrent.
Previous admissions and classification of LabID Events	If participating in facility-wide inpatient LabID Event Reporting for CDI, and a patient is discharged from the hospital without signs or symptoms of diarrhea, and readmitted two weeks later with CDI, how is the infection categorized in NHSN? What if the patient had spent time in another healthcare facility (e.g., rehabilitation center, different hospital, etc.) between the previous discharge and the readmission?	LabID Events are categorized as healthcare onset (HO) or community onset (CO) based almost exclusively on laboratory data and limited admission date data, this is irrespective of the patient having a prior history of C. difficile. Although the patient could have also spent time at another facility in the time between previous discharge and the new admission, this extra information is not asked because of burden for searching outside of one's own facility. And, custom fields can be used, if a facility wants to track such information.
Recurrent and Incidence CDI	What is the categorization of recurrent and incident C. difficile based on?	These categorizations are based on the length of time between LabID Events for the same patient. Specifically: Incident CDI Assay= Any CDI LabID Event from a specimen obtained >8 weeks after the most CDI recent 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.
FacWideOUT CDI reporting	Can I choose specific outpatient locations if I am participating in C. difficile LabID Event Reporting facility-wide outpatient (FacWideOUT)?	If the facility's monthly reporting plan indicates facility-wide outpatient (FacWideOUT) reporting, then all affiliated outpatient locations must be included in LabID reporting. Facility's do have the option to select specific outpatient locations rather than FacWideOUT.
Specimens included in FacWideOUT	Does FacWideOUT include all specimens received in our lab? Why?	Facility-wide outpatient (FacWideOUT) reporting includes affiliated outpatient locations which are affiliated with the reporting facility and in which patients receive some type of care, this excludes outpatient laboratory facilities.

MDRO/CDI

Topic	Question	Response
MRSA blood and non-blood isolates	If a MRSA blood isolate is entered as the first specimen of the month, can a second MRSA non-blood specimen (e.g. urine) be entered that month for the same patient and same location?	NO. If monitoring all MRSA specimens, any MRSA isolate from the same patient and location after an initial isolation MRSA during a calendar month is considered a duplicate MRSA isolate and should not be entered, regardless of the specimen source, except unique blood source. This means that if the first MRSA isolate for the month is from a blood source, no other non-blood MRSA isolates should be reported for the calendar month for that patient and location. If there is another positive MRSA blood isolate from same patient and location, there should be a full 14 days with no positive blood MRSA isolates for the patient and location before another MRSA Blood LabID Event is entered into NHSN for the patient. See Figure 1 in MDRO and CDI Module (Chapter 12) for algorithm for ALL SPECIMENS.
Denominator for LabID Event reporting	How is the denominator calculated for LabID Event Reporting for outpatient locations?	Patient encounters are used to calculate the LabID denominator for affiliated outpatient locations. An encounter is defined as a patient visit to an outpatient location for care.
Discharge in past 3 months	Should a facility look back 3 calendar months or 90 days to answer the question "has the patient been discharged from your facility in the last 3 months?"	The application is validating that the date of last discharge must be at most 3 months prior to Date Specimen Collected. Also, it is using 3 calendar months (not 90 days) for this validation. For example, if the Date Specimen Collected is 08/01/2012, then the date of last discharge cannot be prior to 05/01/2012. In the event that the months are less than 31 days in the month, the application compares the day portion of the dates as well. For example, if the Date Specimen Collected is 05/31/2012, then the date of last discharge cannot be before 03/01/2012. (Anything < 02/31/2012 is not allowed, but since 02/31/2012 is not a valid date, the earliest date possible is 03/01/2012.). Similarly, if the Date Specimen Collected is 12/31/2011, then the date of last discharge cannot be < 10/01/2011.
Discharge in past 3 months and affiliated facility	If a patient was recently discharged from a sister hospital , do I answer "YES" to the question, "*has the patient been discharged from your facility in the past 3 months* ?"	NO. If the patient was not discharged from that exact facility, then this question must be answered as NO. The user should not look at two different campuses as the same.
Inter-facility transfer and LabID Events	If a patient changes locations within the hospital (transfers to another unit), and has a duplicate culture within the same month, is this a new LabID Event?	Yes. A new LabID Event from a new location within the facility should be reported. This allows users to follow and track patients that carry potential exposure and transmission burden to new locations in the facility, which can be particularly helpful for facilities that may have problems with CDI outbreaks or are tracking the success of their CDI control measures. The NHSN system is designed when calculating events at the facility-wide inpatient level to remove the duplicates.
CMS reporting	Where can I find information regarding CMS reporting requirements for LabID Events	Beginning January 2013, CMS will require that acute care hospitals report C. difficile LabID Events and MRSA bacteremia LabID Events at the facility-wide inpatient (FacWideIN) level. Operational Guidance for Acute Care Hospitals are available on the NHSN Resource Library page: http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html

MDRO/CDI		
Topic	**Question**	**Response**
IRF and LabID Event reporting for FacWideIN	Are inpatient rehabilitation facilities (IRFs) included in FacWideIN LabID Event reporting for the acute care hospital?	The CMS Certification Number (CCN) alone should not determine whether or not a unit's data gets included for LabID Event reporting. Instead, the IRF should be counted in with the acute care facility data whenever and wherever it is appropriate, according to how the particular facility works and views its units. In most cases, we do expect that the IRF location(s) within a facility would be included in that facility's LabID Event reporting, with those patient days and admissions included in the FacWideIN counts. Basically, the decision to include or exclude a location from the inpatient acute care facility counts should be based on whether the location/unit is considered a part of the on-site acute care facility, regardless of the size or type of unit. A helpful rule of thumb to use: If the location is staffed by acute care facility workers, follows the acute care infection control policies, and answers to the acute care administration, then that location should be included as an acute care facility inpatient location.
IRF and admission and discharge for FacWide reporting	How should admissions and discharges between the acute care facility and inpatient IRF be handled when the IRF is considered a "location" within the acute care facility?	If the facility is treating the IRF as a location within the acute care facility for FacWideIN counts, then the movement between the acute care facility and IRF should NOT be counted as a separate discharge and admit. It should be counted as one admission and one discharge from the acute care facility.
LTACs	Should long-term acute care facilities (LTACs) be included in FacWideIN LabID Event reporting for the acute care hospital?	The long-term acute care facilities (LTACs) should all be enrolled as separate HOSP-LTAC facility types in NHSN, and so should never be included in any acute care FacWideIN counts, since they are their own facility and are not part of an acute care facility.
Event categorization on line-listing	Why do LabID Events show as Incident on my line-listing when the patient had a previous LabID for the same organism while housed in another unit during the same admission?	Anything that is reported into the NHSN will show-up on the line-listing to show risk in all of the locations where the patient has been. Although these events may show as "incident" for an individual location (if it is a new event for that particular location), duplicate events will be removed for FacWideIN level reporting.
Discharge in past 3 months and CO-HCFA	Facilities are asked to state whether a patient was discharged from their facility in the past 3 months. Since the NHSN case classification for CDI LabID Events is based on date admitted to facility and date specimen was collected, what is NHSN calculating with the "discharge from facility in the past 3 months" variable?	The question is used to define a case as CO-HCFA, which is based on a LabID Event collected from a patient who was discharged from the facility ≤4 weeks prior to the current date of stool specimen collection. In the future, NHSN may look at the past three months for all MDROs and CDI to determine if recent infection or colonization plays a significant role in additional LabID Events. These data may be relevant to CO cases and for risk adjustment, but is still to be determined.
Discharge in past 3 months	Does the question, "has the patient been discharged from facility in the past 3 months…" refer to both inpatient and outpatient visits?	NO. This question is specific to inpatient status only.

MDRO/CDI		
Topic	**Question**	**Response**
Observation patients	Are observation patients included in facility-wide inpatient (FacWideIN) CDI and/or MDRO LabID Event reporting?	Observation patients housed in an inpatient location must be included in FacWideIN LabID Event reporting (include in both numerator and denominator). Observation patients housed in an outpatient observation location must be excluded from FacWideIN reporting.
Baby locations	Are baby locations included in the hospital admissions and patient days count for MDRO facility-wide inpatient (FacWideIN) LabID Event Reporting? Are baby locations included in the hospital admission and patient days count for *C. difficile* FacWideIN LabID Event Reporting?	While patients from all inpatient locations should be included in FacWideIN counts for MDRO LabID Event reporting, baby locations should be excluded from *C. difficile* LabID Event counts. This includes: neonatal intensive care unit (NICU), specialty care nursery (SCN), well-baby locations, and babies in Labor, Delivery, Recovery, Post-partum (LDRP) locations.
C. difficile LabID Event reporting and age	What age group should be excluded from *C. difficile* LabID Event counts?	Users should not focus on the actual ages of patients, but rather patient locations. NHSN specifically chose not to specify an exact age group because we recognize the increased burden associated with searching and eliminating by a specific age cut point. Therefore, users should only be excluding neonatal intensive care unit [NICU], specialty care nursery (SCN), well-baby locations, and babies in Labor, Delivery, Recovery, Post-partum (LDRP) from numerator and denominator inpatient and well-baby clinics for outpatient encounter counts.
Pediatric locations	For *C. difficile* LabID Event reporting, do I need to exclude infants located in my pediatric locations?	Because of the increased surveillance burden associated with searching for infants located in pediatric and mixed-age locations, users should exclude locations that are known to predominantly house infants (see NHSN 80/20 Rule), which include neonatal intensive care unit (NICU), specialty care nursery (SCN), well-baby locations, and babies in Labor, Delivery, Recovery, Post-partum (LDRP). The intent is to keep this reporting standardized and to eliminate extra burden in removing and identifying infants <12 months of age from units that do not predominantly care for this age group.
Reporting Events for Infection Surveillance and LabID Event	How do I report Events if my facility is participating in both Infection Surveillance Reporting and LabID Event Reporting?	Infection Surveillance and LabID Event reporting are two separate and different reporting pathways and one is not dependent upon the other. If a facility is participating in both reporting options, then they must report each Event separately because HAI Infection Surveillance reporting does not cross over with or cover LabID Event reporting. Please review the MDRO and CDI protocol to understand the difference between MDRO Infection Surveillance reporting and MDRO LabID Event reporting.

MDRO/CDI		
Topic	**Question**	**Response**
MRSA HAIs verses MRSA bacteremia LabID Events	My facility already reports MRSA bloodstream infections as part of state reporting requirements; do I still need to report MRSA bacteremia LabID Events?	For facilities reporting MRSA bloodstream infections (BSI) through the Device-associated module and/or via MDRO Infection Surveillance reporting, keep in mind that MRSA bacteremia LabID Event reporting is a different reporting pathway and, therefore, must be reported separately. Meaning, if you are reporting both HAIs and LabID Events (e.g., MRSA BSI and MRSA LabID Event), you must report each event individually and separately; one as an HAI Event, using the applicable HAI criteria, and another as a LabID Event, using the LabID Event reporting protocol in Chapter 12 of the PSC manual.
Reporting LabID Events on the unit level	When I am entering a CDI LabID Event into NHSN, the drop-down does not give me an option for FacWideIN, why?	LabID Events (e.g., numerator reporting) are based on the location of the patient at the time of specimen collection. When entering a LabID Event, the actual location of the patient during specimen collection should be selected. Facility-wide inpatient (FacWideIN) and/or Facility-wide outpatient (FacWideOUT) are virtual locations that should be selected only when entering denominator summary data for facility-wide reporting.
Denominator for FacWideIN	If we are monitoring FacWideIN can we put in 1 denominator for the entire facility, or must we put in each location data?	For Facility-wide inpatient (FacWideIN) denominator reporting, total inpatient days and total hospital admissions should be reported. These denominator data are reporting separately for MDRO and *C. difficile* since baby locations must be removed from *C. difficile* denominator counts (e.g., neonatal intensive care unit (NICU), specialty care nursery (SCN), well-baby locations, and babies in Labor, Delivery, Recovery, Post-partum (LDRP) locations).
CMS	What is being reported to CMS for LabID Event reporting?	For 2013- A healthcare facility-onset (HO) MRSA bacteremia LabID Event SIR and an HO CDI LabID Event SIR will be reported for each participating acute care facility to CMS.
MICs for LabID Event reporting	Do I enter MICs for LabID Event reporting?	HAI/Infection Surveillance reporting and LabID Event reporting are two separate and different reporting pathways and one is not dependent upon the other. While MICs are required for HAI reporting, this is not a data field in LabID Event reporting. Instead, the MDRO definitions outlined in the MDRO and CDI protocol should be used to define MRSA and other MDROs for LabID Event reporting.
Using LabID Event categories for Infection Surveillance	Can the LabID Event categories (HO, CO, CO-HCFA) be used for Infection Surveillance events?	No, the categorizations apply only to LabID events.
MRSA colonization	If a patient has a history or MRSA colonization, do I still need to enter a MRSA bacteremia LabID Event for that patient?	YES.

MDRO/CDI		
Topic	**Question**	**Response**
Categorization of incident vs. recurrent for Events in different settings	If our facility does C. difficile surveillance for both outpatients as well as inpatients, wouldn't it would be less likely that an infection is called hospital acquired when it is really community acquired?	For FacWide surveillance, CDI Assay (incident vs. recurrent) is assigned based on Events within the same setting only. For example, when performing both FacWideIN and FacWideOUT surveillance, CDI Assay of inpatient CDI LabID Events will be determined by a review of previously-entered CDI LabID Events from inpatient locations only. You could use the optional data fields to track such information if you want.
CO-HCFA categorization for nursing home patients	Why is a CDI LabID Event categorized as CO-HCFA when there is evidence that the patient was in a nursing between admissions to my facility?	CO-HCFA Events are simply an additional level and subset of the categorized CO events. We added this extra level to the CO, to help highlight and flag events for a facility's use, because this subset may be of concern to them and may be events which they could potentially impact and reduce via specific facility prevention efforts. We realize that the patient could have also spent time at another facility in the time between previous discharge and the new admission, and don't ask for this extra info because of burden for searching outside of one's own facility. And, custom fields can be used, if a facility wants to track such info.
Reporting multiple non-blood specimens in same calendar month	Why can't two non-blood specimens in the same calendar month for the same patient with the same pathogen be counted twice? For example, if a patient's first specimen in a calendar month is CSF fluid positive for MRSA, and then 3 weeks later in the same month they have a sputum specimen positive for MRSA, this would only count as one LabID event.	The rationale is that this LabID Event reporting is a proxy measure that, for the MDROs outside of blood, could potentially be infection or colonization, and it is about tracking the specific organism in the patient, and not about identifying separate and unique "infections" (unless just tracking bloods). Therefore, reporting that specific organism once for the patient in the month is representing the exposure burden and potential for transmission that that person brings to that location/facility/environment (e.g., prevalence).
Denominator reporting of discharge data	My organization does not have systems in place that will report admission data. Our financial and clinical systems are based upon discharges, not admissions. Is it possible to utilize discharge data as a proxy measure rather than admission data for use as a denominator?	To maintain consistency in CMS reporting and data analysis, we are unable to accommodate requests to substitute admission data with discharge data. For LabID Event denominator reporting, **admission data** must be used for denominator counts.
CO-HCFA categorization for multiple admissions	My facility participates in LabID Event reporting for C. difficile. If a community-onset (CO) C. difficile patient is re-admitted 3-4 times, will NHSN categorize the patient as having a CO-HCFA each time, even say, in 1 month?	Yes. The system will categorize any CO CDI event as CO-HCFA if the patient was discharged from that facility within the previous 4 weeks. This can be used as a marker for the facility to track cases for transmission prevention efforts.

MDRO/CDI		
Topic	**Question**	**Response**
MRSA bacteremia	MRSA bacteremia is in my plan... do I report all MRSA blood, or just HAI's?	For MRSA bacteremia LabID Event reporting, all non-duplicate MRSA blood isolates should be reported. For each MDRO being monitored, all MDRO test results are evaluated using the algorithms in the MDRO/CDI chapter (Figure 1 [All Specimens] or Figure 2 [Blood Specimens only] to determine reportable LabID events for each calendar month.

Central Line Insertion Practices (CLIP)

Topic	Question	Response
CLIP Bundle	What is included in the “NHSN CLIP Bundle”?	In the analysis options of NHSN, users may opt to determine their facility or unit adherence to the Central Line Insertion Practices (CLIP) bundle. NHSN will analyze facility data and provide rates of adherence for central line insertions that incorporated ALL of the following criteria: • Hand hygiene performed by inserter prior to insertion • Maximum (all 5) sterile barriers used (inserter gown, gloves, mask and cap, and large patient drape) • Skin prepped with chlorhexidene gluconate (CHG), or for infants less than 2 months old, skin prepped with any of the listed agents (CHG, povidone iodine, alcohol, or other) • Skin prep agent is completely dry at time of first skin puncture If just one of those items is N, then CLIP Bundle will be “N”. To determine what items were answered “N”, run a line list of central line insertions and where "Specify Selection Criteria", "CLIP Bundle = N" is chosen. This will provide a snapshot of opportunities for improving Central Line Insertion Practices.
Skin preparation	Why is a CLIP event identified as non-adherent to the CLIP Prevention Bundle if a skin prep other than chlorhexidine gluconate (CHG) is used when there is a documentation of CHG contraindication (CI)?	Clip bundle adherence is defined as an insertion in which all bundle elements were performed. Originally, the inclusion of the contraindication field was made in response to requests from users. Having it included allows facilities to identify for their own purposes the percentage of CLIP events completed in patients purported to have a contraindication to CHG. The incidence of true contraindication to CHG is believed to be very small; conversely, it is frequently applied as a reason for not using chlorhexidine. The contraindication variable allows for facilities with high rates of chlorhexidine intolerance to identify this and potentially intervene to better understand the reasons for high CI in their facilities. This may be a first step in addressing missed opportunities for CHG preparation before central line insertion.
CLIP form for non-successful placement	Does a CLIP form need to be completed for every insertion attempt made?	Yes. Every attempted line insertion represents a potential source of infection for the patient, and each insertion attempt is anticipated to be successful at its inception. Therefore every insertion should be performed according to guidelines, with the anticipation that the line will be successfully placed, and documented for quality improvement purposes.

Central Line Insertion Practices (CLIP)		
Topic	**Question**	**Response**
Non-observed or missing practice	How should non-observed or missing practice information be recorded in CLIP surveillance? For example, if the observer enters the room after the procedure has begun, how should hand washing be recorded, since it was not observed?	Efforts should be made to keep such occurrences to a minimum. If the observer enters the insertion scene after the insertion has begun, the observer should ask the inserted whether each of the insertion elements was performed and record that answer.

Locations		
Topic	**Question**	**Response**
Mixed populations	One of our units is a mix of pediatric and adult patients, however all of the patients are of the same acuity level and service. Should I map this as an adult location or a pediatric location?	This is a good example of when “virtual” locations would be the best option. If there are beds designated for pediatric patients, we recommend that virtual locations are used such that the pediatric beds are considered one location in NHSN and the other beds would be assigned as the most appropriate adult unit. The data collection and reporting for each of these locations would be separate for NHSN. If your facility can operationalize this option, it would be the most appropriate. However, if you’re unable to operationalize this type of data collection in this unit, then the unit should be mapped as the appropriate type for the age group (i.e., pediatric or adult) that holds the majority in that unit.
Bedsize	When adding my locations in NHSN, I'm asked for the location bedsize. Should this represent the number of beds in the unit, or the number that are staffed?	The location bedsize should represent the number of beds that are set up and staffed.
Swing beds	Should the number of beds for my location include swing beds?	Yes. Swing beds should be included in the total location bedsize count. Patients residing in these beds should also be included in your surveillance efforts for this location.
Unit moved to different floor	One of the units in my hospital has moved to a different floor and has a new name. Should I create a new location in NHSN?	If the staff moved with this location, and the type of patients remains the same (i.e., the only difference is the geographical location), then it's recommended to just change “Your Code” and "Your Label" on the existing location record. This will keep all of the data for this location continuous within analysis. Otherwise, it is recommended that your facility inactivates the location and create a new location for the moved unit. Note that deactivating a location will simply prevent you from being able to enter new data for that location; the location and its previously-entered data will still appear in the analysis output options and you will continue to have access to these data.
Inactive locations	If I inactivate one of my locations in NHSN, will I still have access to this location's data?	Yes. Inactivating a location will simply remove the location as an option in the location drop-downs during data entry. All data reported in inactive locations will still be accessible, including through the analysis output options.
Mixed acuity unit and CMS reporting	After further review, we've determined that one of our units should be mapped as a mixed acuity unit. What implications will this have for my hospital's reporting to CMS?	While mixed acuity locations may have ICU beds, they are not considered ICU locations and therefore, are excluded from all reporting that is limited to ICUs. If this is the only unit in your hospital that has ICU beds (i.e., your hospital does not have any ICU locations in NHSN from which to report data), please discuss this situation with your QIO as there is a prescribed process in place to indicate that your facility does not have ICUs.

Locations		
Topic	**Question**	**Response**
Change in patient type	The type of patients that are now housed in one of our units has changed. How do I change the CDC location in NHSN?	Once a location has been used for reporting in NHSN, the CDC Location Description cannot be changed. Instead, you will need to add a new location to represent the new CDC location mapping. Note, however, that when creating this new location, you will need to use a different "Your Code" value. It is also recommend that you inactivate the old location once you've completed all data entry for that location. After the new location has been added and data have been reported under this new location, you will notice that the pooled means to which this location is compared will differ from previous analyses.