



NHSN Announces Updates to the Hemovigilance Module

NHSN Version 6.6.1, scheduled for release in April 2012, includes several very important updates to the Adverse Reaction and Incident data collection forms. The updated forms and instructions will be available on the [NHSN website](#). These changes are summarized below.

Adverse Reaction form

- “Facility location where *reaction occurred*” will be changed to “Facility location where *patient was transfused*”
- The form will be rearranged so that the ‘Investigation Results’ section is completed before the ‘Component Details’ section
- New business rules will allow only CDC-defined case definition and imputability criteria classification for the selected adverse reaction
- The ‘Component Details’ section will accept entry of both ISBT-128 and Codabar-labeled units for a single reaction
- New business rules will require the user to designate an implicated unit when only a single unit is entered in an adverse reaction record, except when reporting TACO

Incident form

- The language for ‘Incident result’ will be changed for clarity, while preserving the original meaning

Old ‘incident results’	New ‘incident results’
1 – No recovery, harm	1 – Product transfused; reaction
2 – No recovery, no harm	2 – Product transfused; no reaction
3 – Near miss, unplanned recovery	3 – No product transfused; unplanned recovery
4 – Near miss, planned recovery	4 – No product transfused; planned recovery

- Under ‘Product Action,’ when ‘Product destroyed’ is selected, the form will accept entry of both ISBT-128 and Codabar-labeled units

Reminders and Tips for Participants in CMS’s Hospital Inpatient Quality (IQR) Reporting Program

For hospitals that participate in CMS’s Hospital Inpatient Quality (IQR) Reporting Program, reporting of CAUTI data from all adult and pediatric ICU locations and SSI data for inpatient abdominal hysterectomy and colon procedures is required as of January 1, 2012. This is in addition to the ongoing CLABSI data reporting from adult, pediatric, and neonatal ICU locations that started in January of 2011. Operational guidance documents for CLABSI, CAUTI, and SSI reporting to NHSN as part of the Hospital IQR Program can be found at <http://www.cdc.gov/nhsn/cms-welcome.html>.

Don’t wait until the due date to enter your data! CDC/NHSN strongly encourages healthcare facilities to enter each month’s data within 30 days of the end of the month in which it was collected (e.g., all March data should be entered by April 30) so it has the greatest impact on infection prevention activities.

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However, for the purposes of fulfilling CMS quality measurement reporting requirements, each facility's data must be entered into NHSN no later than 4½ months after the end of the reporting quarter. Therefore, Q1 data must be entered by August 15, Q2 data by November 15, Q3 data by February 15, and Q4 data by May 15.

Quick tips to help make sure your data are entered on time and shared with CMS:

- Keep your digital certificate up-to-date. Digital certificates have to be renewed on a yearly basis and renewal notices are e-mailed to users about one month before their old certificate expires.
- Make sure your hospital's CCN is correctly entered on the Facility Info screen within NHSN. The CCN is used to submit your facility's NHSN data to CMS on your behalf. (See article below)
- Be sure to update your monthly reporting plans for 2012 to include CAUTI surveillance for all adult and pediatric ICU locations and SSI surveillance for inpatient abdominal hysterectomy and colon procedures. Your monthly reporting plans should continue to include CLABSI surveillance for all adult, pediatric, and neonatal ICU locations.

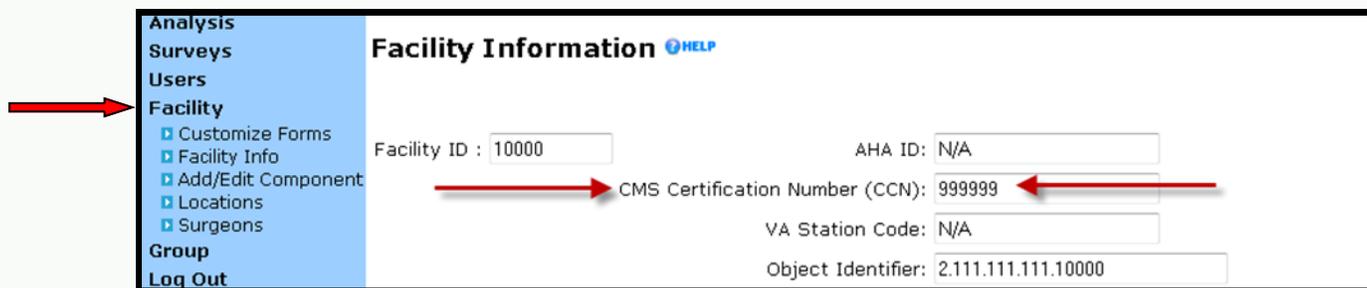
Ensure Your Facility's CCN is Valid in NHSN

All facilities reporting to NHSN to satisfy CMS requirements under the Hospital Inpatient Quality Reporting (IQR) Program, the Dialysis Quality Improvement (QIP) Program, the Long Term Care Hospital Prospective Payment System (LTCH PPS) Program, or the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Program should ensure that a valid CCN (CMS Certification Number) is listed in NHSN. If your facility enrolled using a CDC Enrollment Number or another identifier, the Facility Administrator must update your facility's information with a valid CCN so that its data can be shared with CMS.

NHSN has had a major influx of new facilities enrolling, particularly outpatient dialysis clinics, long term acute care hospitals, and inpatient rehabilitation facilities, due to new CMS requirements in 2012. It is imperative that Facility Administrators enter their CCNs correctly.

To update your facility's CCN:

Go to the "Facility Info" screen and enter the CCN in the field near the top of the page that says "CMS Certification Number (CCN)" then scroll to the bottom of the page and click "Update".



The screenshot shows the NHSN Facility Information interface. On the left is a navigation menu with options: Analysis, Surveys, Users, Facility (highlighted with a red arrow), Group, and Log Out. Under 'Facility', there are sub-options: Customize Forms, Facility Info, Add/Edit Component, Locations, and Surgeons. The main content area is titled 'Facility Information' with a 'HELP' icon. It contains several input fields: 'Facility ID : 10000', 'AHA ID: N/A', 'CMS Certification Number (CCN): 999999' (with a red arrow pointing to it), 'VA Station Code: N/A', and 'Object Identifier: 2.111.111.111.10000'.

Calling All Facility Administrators



NHSN Facility Administrators are asked to perform an audit of users in their facility to make sure that contact information is up-to-date and to deactivate users who are no longer employed by the facility. Ensuring that user contact information is current is important so that our users receive communications from NHSN, such as this newsletter. If a user no longer needs access to NHSN, the user profile should be set to "Inactive" to terminate access to the facility's data.

While you are auditing your users, please also confirm that the individual listed as your facility's Primary Patient Safety Contact is valid. Instructions on how to re-assign this position are provided below. Note that the individual responsible for the infection prevention/control department is a good candidate for both NHSN Facility Administrator and the NHSN Patient Safety Primary Contact Person.

To reassign a contact, click on Facility Info under Facility on the navigation bar, scroll to the "Contact Information" section, and select "PS - Patient Safety Primary Contact" from the Contact drop-down box. Click "Reassign".

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Contact Information HELP

Contact:

User ID: TIFFANYD78

- You will be taken to the Find User screen. Enter the appropriate search criteria and click "Find".
- From the View User screen, click "Submit".
- You will be taken back to the Facility Contact Information screen. Complete the empty required fields and click "Update". The Patient Safety Primary Contact Role has been reassigned.

Determining the Source of Fever in Patients with More Than One Potential HAI

A few of the NHSN healthcare-associated infection (HAI) definitions contain the phrase "no other recognized cause", or a similar phrase in relation to the identification of symptoms. For example, the NHSN Urinary Tract Infection (UTI) criteria state:

"Patient had an indwelling urinary catheter in place at the time of specimen collection or onset of signs or symptoms and at least 1 of the following signs or symptoms *with no other recognized cause*: fever (>38 °C), suprapubic tenderness, or costovertebral angle pain or tenderness..."

Because fever is so often used in the identification of catheter-associated urinary tract infection (CAUTI), and because this may be the only symptom present or documented, NHSN users have questioned the correct method to use when this sign exists and other possible infectious processes are present. For instance, an Infection Preventionist may identify a patient who has either a pneumonia (PNU) or a UTI, based on how the fever is applied. The inclusion or exclusion of the fever may be the determining factor as to which type of infection is identified. In a catheterized patient who has a positive urine culture of >100,000 CFU/ml of *E. coli* and a fever of 38.4 °C but no other documented UTI symptoms, inclusion of the fever as a sign is event determining. The same can be true of PNU and other HAIs.

The intention of the phrase "no other recognized cause" is to relate to infection-specific symptoms, i.e., in the case of UTI, dysuria, urgency, suprapubic pain and costovertebral angle tenderness. For instance, a patient who is s/p abdominal hysterectomy may have postoperative pain, possibly low in the pelvis, which is not indicative of a UTI.

Fever is a non-specific sign and as such may be due to more than one infection occurring at the same time. In other words, a patient may have a fever due to both a PNU and a CAUTI at the same time. It would be impossible to determine which infection, or both, may be causing the fever. For this reason, in this example, fever must be attributed to more than one cause at the same time. To allow facilities to determine which infection to attribute the infection to, would allow "gaming" of the system such that the infection could be selectively attributed to a type of HAI that is not included in public reporting.

NHSN recognizes a need to improve some phrasing that exists within some NHSN HAI definitions. The HAI definitions are undergoing thorough review and will be updated as quickly as possible. In the meantime this information has been previously shared in the Q and A section of the NHSN newsletter and now again in this format. Please share with others who may need to know.

Methods and Sources of Data for Surgical Site Infection Surveillance

Once you have determined the surgical patient population you will monitor, identification and review of a variety of data sources will be required to adequately identify cases of SSI. Appraisal of admission and surgery logs, and most importantly, review of patient charts for signs and symptoms of SSI and other risk factors is required. In addition, laboratory results, pathology reports, radiology tests and other diagnostic test data and reports are very helpful in case finding. If you are fortunate enough to have an electronic medical record, utilize this means to obtain patient clinical and demographic data. Looking for cases prospectively—monitoring patients in house for events and procedures—is required. Frequent rounds on the surgical unit with review of vital signs, nurses' notes, and physicians' progress notes are excellent ways to identify needed information. Speaking with the primary care staff, including physicians, nurses, other caregivers, social workers, and ward secretaries are great ways to case find. Communicating in this manner allows you to train others to identify and share important information with you. Employing a team approach also allows you to be more productive in your case finding and may save you valuable time. Being present on the unit allows you to observe patient care practices and intervene as "teachable moments" to prevent infection arise.

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In addition to prospective surveillance, looking back or retrospective methods can be used as a secondary approach to supplement the findings obtained while making rounds or to obtain final test results for your SSI surveillance and reporting.

You will also need to set up ways to track patients who are readmitted by, for example, monitoring the admission diagnosis or surgeon, and emergency room admissions. Communication with fellow IPs at other hospitals and related facilities is a key method to keep up with case finding for every facility.

Post-discharge SSI surveillance methods include surgeon and/or patient surveys by mail or phone. Your facility can develop a tool that includes NHSN SSI criteria information and the most common specific infection site criteria for the operative procedures being monitored. Training for the surgeons and office staff is important to enable accurate communication of information. Providing SSI surveys to the office staff and surgeons in a simple-to-use manner will aid in a more successful case ascertainment and enhance response rate. If patient surveys are used, it is important to develop methods to interview patients using common language phrases to help them accurately recall whether they had any signs or symptoms of SSI. Use of the above techniques will help ensure accurate case finding for surgical site infections.

Prostatectomy ICD-9-CM Code Change

Please note that the code 60.62 will be removed from the NHSN operative procedure category, Prostatectomy (PRST). This procedure involves cryoablation and therefore no incision. This change should be instituted at this time. Please make note of it in Table 1 of Chapter 9, (p.9-5) of the NHSN Patient Safety Component Manual.

The Difference between CRBSI and CLABSI

NHSN criteria to define healthcare-associated infections are designed for surveillance purposes and not for clinical management. Conversely, the Infectious Diseases Society of America (IDSA) has published a clinical practice guideline for the diagnosis and management of intravascular catheter-related bloodstream infections (CRBSI). Because the purpose of these two definitions differ, CLABSI to identify an association between a central line and a bloodstream infection (BSI) and CRBSI to identify a causal relationship between the central line and BSI, the components of the definitions differ. For example, the CRBSI definition includes both the use of catheter tip cultures and recommends the use of blood cultures drawn through the vascular catheter. The NHSN BSI definition does not utilize catheter-tip cultures nor recommend collecting blood cultures through vascular catheters since not all patients with BSI have catheters. In short, what constitutes a CRBSI for patient diagnosis and treatment purposes is not the same as what constitutes a CLABSI, as defined in NHSN, for surveillance purposes.

Resources:

The NHSN CLABSI surveillance protocol is available at: http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABSCurrent.pdf

The Infectious Diseases Society of America. (2009). Clinical practice guidelines for the diagnosis and management of intravascular catheter-related infection. Available at http://www.idsociety.org/Other_Guidelines/

Double Check Your Surveys

While performing internal analyses at CDC, we've identified some inaccuracies in the Patient Safety Annual Facility Survey data. These include (but are not limited to): more patient days than would be expected based on the total number of beds, exactly the same number of patient days and admissions from year to year, and a lower total bedsize than has been reported for active, individual locations.

Note that these data are used for determining risk adjustment for current and future national aggregate data and should be reported as accurately as possible.

Most, if not all, facilities should have completed a 2011 survey by now; if not, please do so. We kindly ask that you review your completed survey in its entirety and resolve any inaccuracies that were previously reported.

Surveys can be modified by following these steps:

1. Go to Surveys > Find.
2. Select "Facility Survey Data" as the Survey Type and "2011" as the Year.
3. Click Find.
4. Review the Survey; if changes are necessary, click Edit at the bottom of the screen.
5. Make any appropriate changes and then click Save.

CDA Corner

- In the next release of NHSN, scheduled for late summer 2012, the system will be updated to allow for reporting of dialysis event and denominator data and summary data for the MDRO/CDI module. Please contact your vendor if you have questions about the vendor's system's ability to produce these CDA files.
- An important reminder: Currently, the "Report No Events" boxes for the Device-Associated, Procedure-Associated, and MDRO modules are NOT automatically checked after data are imported via CDA. Facilities must manually check the relevant boxes to confirm that they have no infections to report for the month.
- The NHSN CDA website will be updated during the next several months. Current materials on the website include a link to a list of vendors whose software products are able to create CDA files that can be imported to NHSN, information about getting started with CDA, and a training slideset describing how facility users can manually import their CDA zip files. The NHSN CDA website can be found at http://www.cdc.gov/nhsn/CDA_eSurveillance.html.

NHSN Questions & Answers

Q: Could you please clarify whether Laminectomies are NOT supposed to be counted if they are performed as "prep" for the Fusion?

A: 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.

Q: If a drain is left postoperatively in the incision used for a laparoscopic procedure, is the wound considered primarily closed?

A: Yes. Because the incision used for a laparoscope is very small, similar to stab wounds made for surgical drains, such procedures would be considered to have primarily closed incisions.

Q: For a patient who has both a mastectomy and a reconstructive procedure (DIEP or TRAM) on the same breast during the same trip to the OR, how can I enter an infection in the abdominal incision made as a part of the reconstructive procedure?

A: In this situation since these are both procedures included in the NHSN operative procedure category BRST, enter/import only a single Denominator for Operative Procedure form for BRST, combining the duration of both procedures. Unfortunately, currently it is not possible to enter a superficial or deep incisional **secondary** SSI to identify infection in the abdominal incision for BRST procedures. We are making the necessary changes to allow this data entry. For now, a temporary workaround is to enter these SSIs as primary SSIs and include a note in the comments section about the incision (abdomen vs breast) or ICD-9-CM code involved.

The National Healthcare Safety Network (NHSN) is a voluntary, secure, Internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC.

During 2008, enrollment in NHSN was opened to all types of healthcare facilities in the United States, including acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities.

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