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Diving Deep Into SSI Surveillance

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Objectives

- Attendees will learn to navigate the resources required for Surgical Site Infection (SSI) surveillance and navigate the NHSN application to enter SSI Denominator for Procedure data and SSI Events.
- Attendees will understand the foundational elements necessary to perform SSI surveillance.
- Comprehensive case studies will be used to build the skills necessary to conduct SSI surveillance.

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Background, Settings, Requirements, and other important information to consider with SSI surveillance

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SSI Surveillance

Today's presentation will focus on inpatient facilities and/or hospital outpatient procedure departments (HOPD) where the selected NHSN operative procedures are performed.

Note: Ambulatory Surgery Centers (ASCs) that report to NHSN must use the Outpatient Procedure Component (OPC) to perform SSI surveillance.

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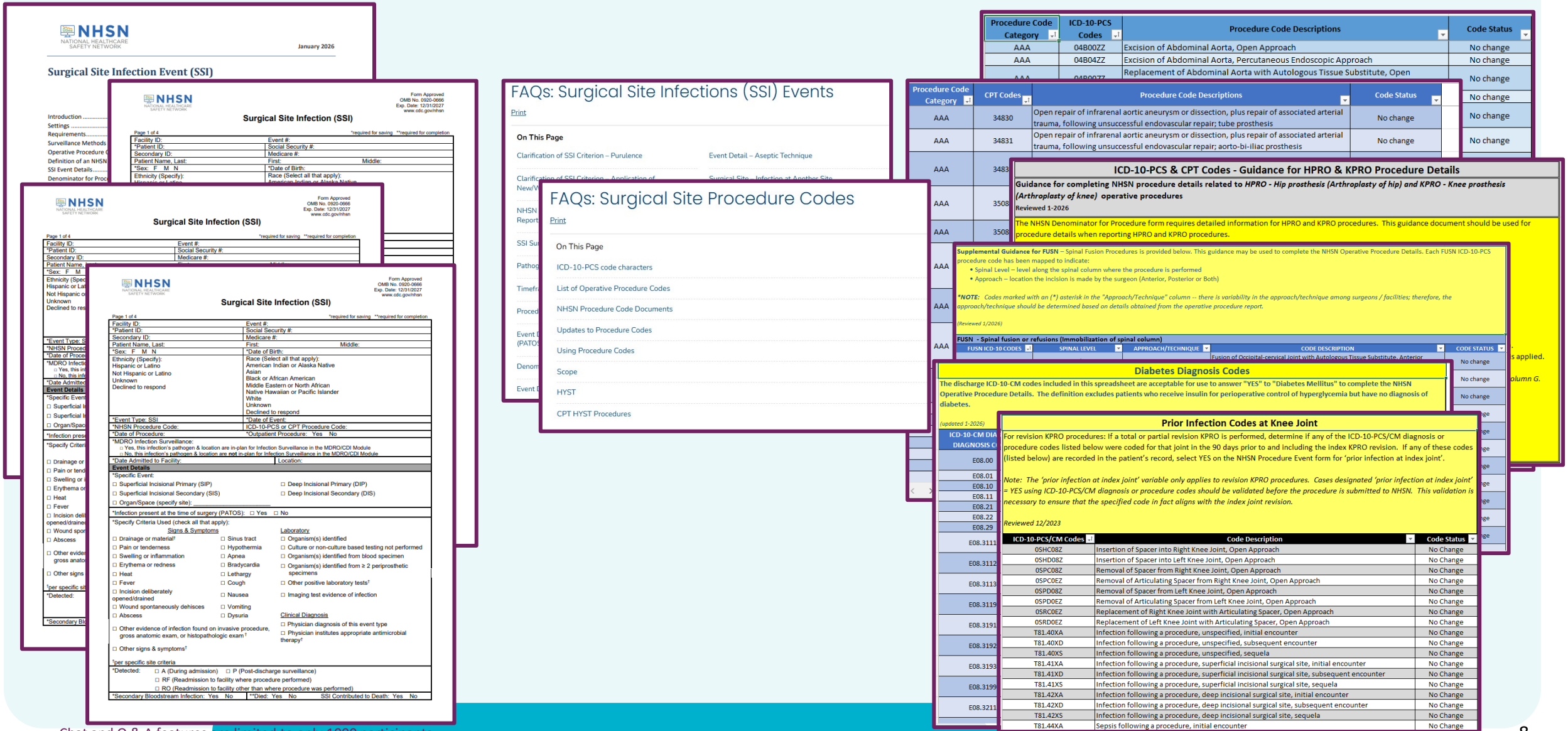
There is much to consider with SSI surveillance....Where do I start?



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What is required for reporting?

- Indicate on the Patient Safety Monthly Reporting Plan (MRP) that surveillance will be conducted for at least one NHSN operative procedure category (based on the operative procedure codes assigned and the guidance provided on the previous slide indicating what constitutes an NHSN operative procedure).
- Perform surveillance for SSI events for all operative procedure categories noted on the MRP.
- Collect and report SSI event (numerator) and operative procedure (denominator) data on all procedures included in the selected operative procedure categories indicated on the MRP.

Note: The MRP is form CDC 57.106 and is found on the NHSN SSI webpage: https://www.cdc.gov/nhsn/psc/ssi/index.html

What am I required to report?

- NHSN does not mandate reporting.
- NHSN would expect to receive data (both numerator and denominator) for each operative procedure category selected on the facility Monthly Reporting Plan (MRP).

How do I determine what to select on the Monthly Reporting Plan (MRP)?

As noted on the previous slide, NHSN does not mandate reporting. What you select on MRP may include (but is not limited to):

- Federal requirements
  - CMS: https://www.cdc.gov/nhsn/cms/index.html
- State requirements
  - Contact your state HAI coordinator for more details
- Internal facility risk assessment
- Other requirements

Important Point for SSI Surveillance - 1

1

- Only the facility that performs the NHSN operative procedure can report the procedure (denominator data) and subsequent SSI event that would be attributed to the operative procedure (numerator data).
- A facility that identifies an SSI event for an operative procedure performed at another facility should report the information necessary to the facility that performed the procedure.

Important Point for SSI Surveillance - 2

2

- The date of the procedure determines the protocol year to use with SSI surveillance.

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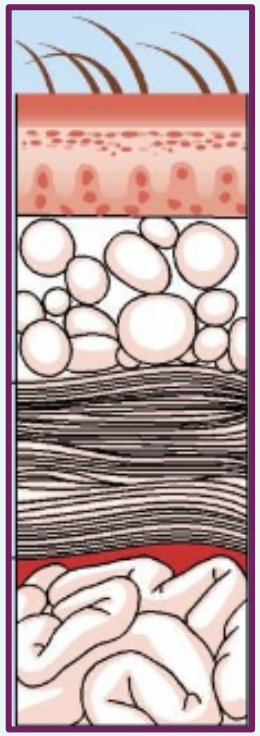
Important Point for SSI Surveillance - 3

3

- When monitoring for SSI events, all three tissue levels will be monitored for each operative procedure category selected on the Monthly Reporting Plan.



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Navigation of SSI Resources

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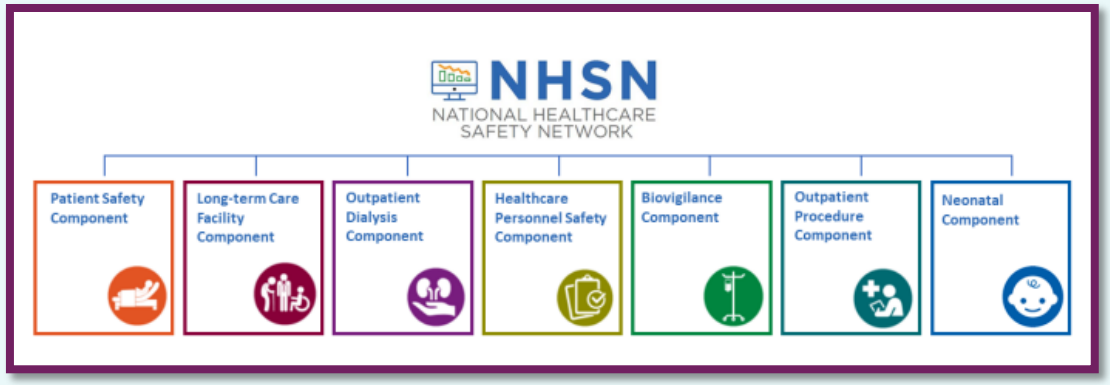
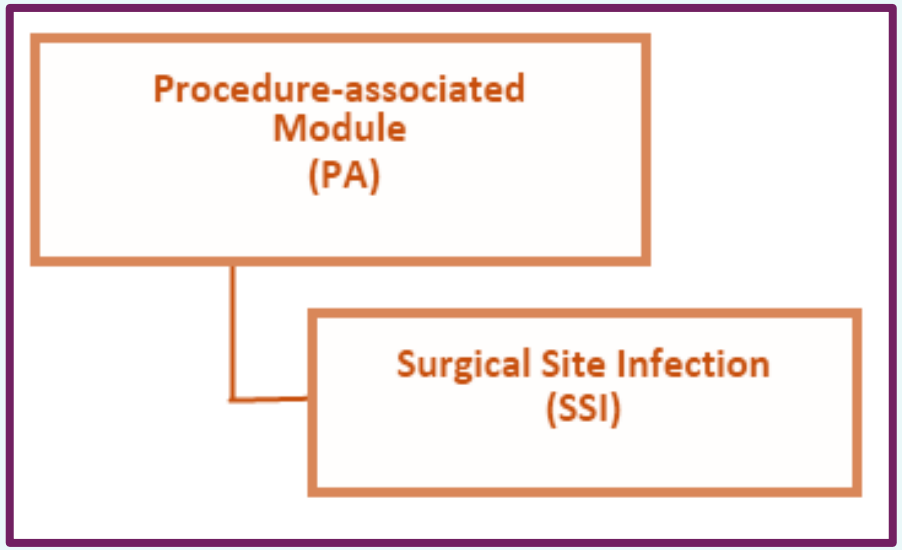
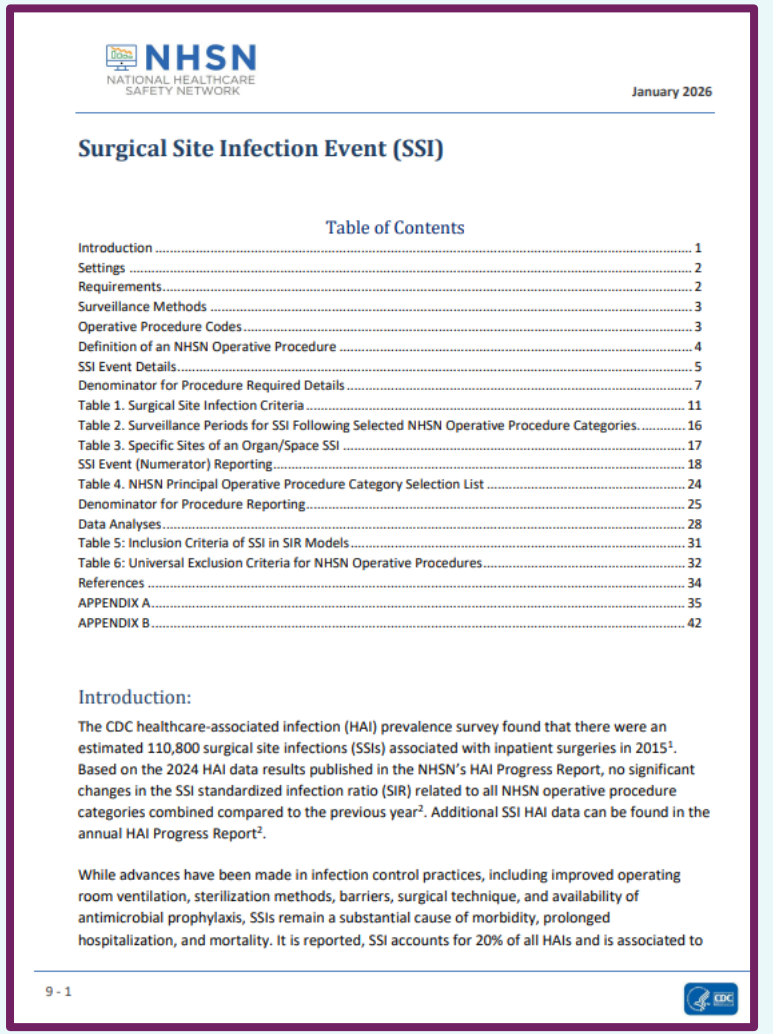
Where does SSI Surveillance Reside Within the NHSN Patient Safety Component (PSC)?







NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2026

Surgical Site Infection Event (SSI)

Table of Contents

Introduction:

The CDC healthcare-associated infection (HAI) prevalence survey found that there were an estimated 110,800 surgical site infections (SSIs) associated with inpatient surgeries in 2015[1]. Based on the 2024 HAI data results published in the NHSN's HAI Progress Report, no significant changes in the SSI standardized infection ratio (SIR) related to all NHSN operative procedure categories combined compared to the previous year[2]. Additional SSI HAI data can be found in the annual HAI Progress Report[2].

While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, prolonged hospitalization, and mortality. It is reported, SSI accounts for 20% of all HAIs and is associated to

9 - 1

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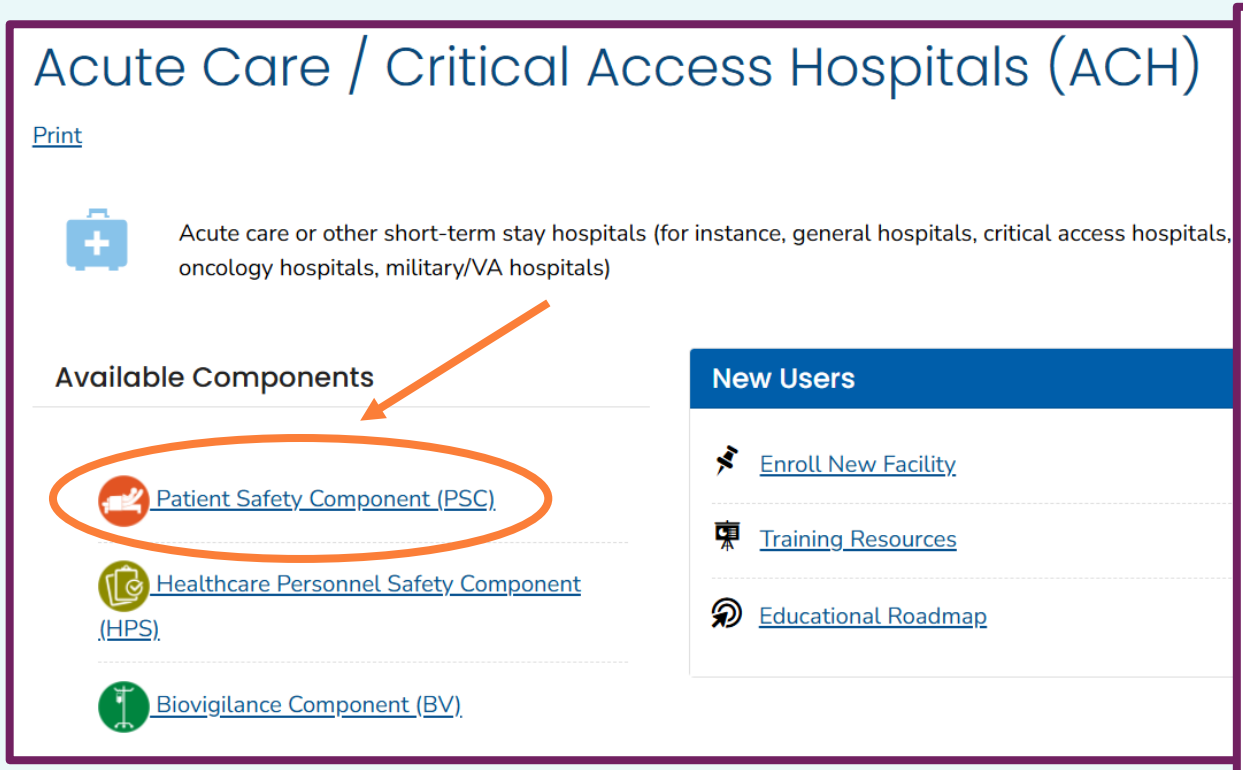
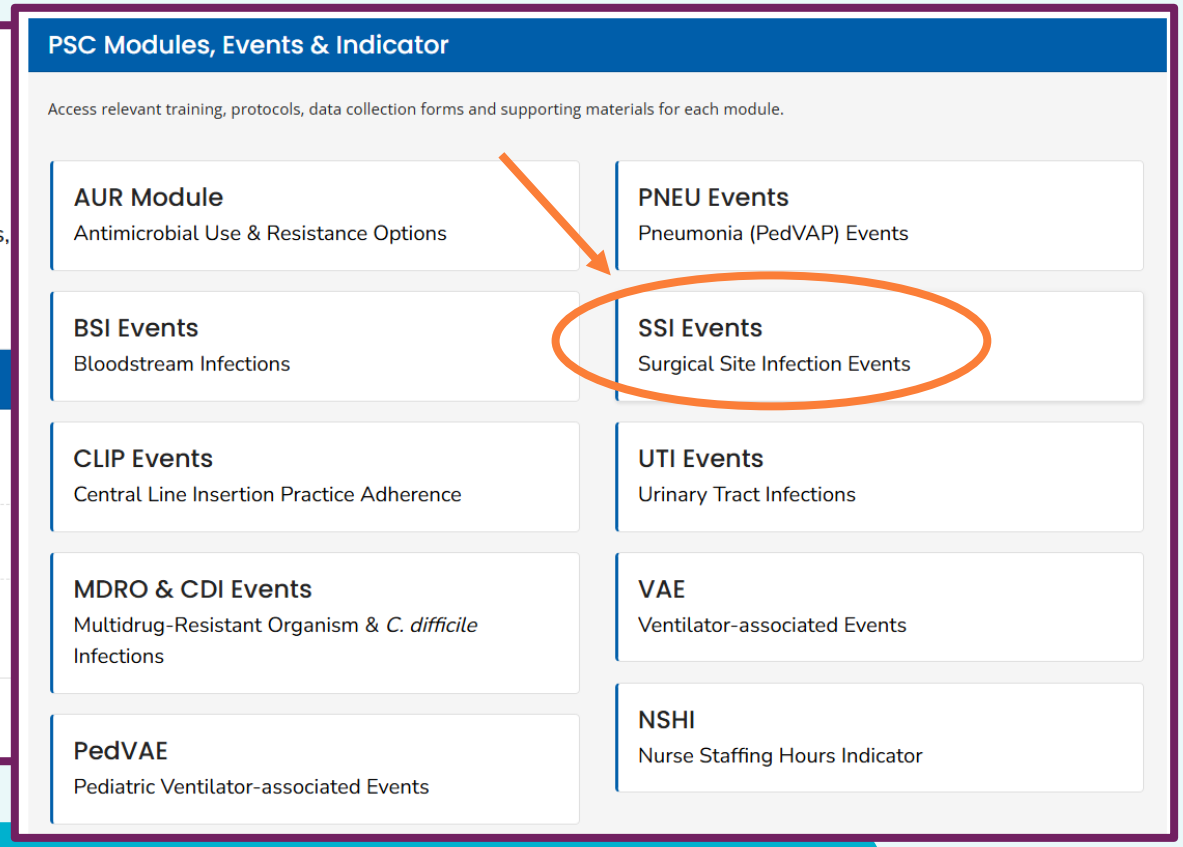
Where do I find SSI Surveillance Guidance?

- https://www.cdc.gov/nhsn/acute-care-hospital/index.html





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Where do I find SSI Surveillance Guidance? Cont.

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Where do I find SSI Surveillance Guidance? Cont'd.

- https://www.cdc.gov/nhsn/faqs/faq-ssi.html

FAQs: Surgical Site Infections (SSI) Events

Print

On This Page

Clarification of SSI Criterion – Purulence

Clarification of SSI Criterion – Application of New/Worsening Pain

NHSN Denominator for Procedure and SSI Event Reporting Instructions

SSI Surveillance Period and SSI attribution

Pathogen Assignment

Timeframe for SSI Elements

Procedure – Contaminated Procedure

Event Detail – Infection present at time of surgery (PATOS)

Denominator – Wound Class and ASA

Event Detail – Gross Anatomical Exam

Event Detail – Aseptic Technique

Surgical Site – Infection at Another Site

Surgical Site – Invasive Manipulation

Denominator – Height & Weight

Surgical Site – Post op Complications

Surgical Site – Hematomas and Seromas

Denominator – Trauma

NHSN Procedure and SSI Event Reporting

Event Detail – Level of SSI and Application of Site-Specific Definition

NHSN SSI Case Review

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Where do I find SSI Surveillance Guidance? (Continued)

- https://www.cdc.gov/nhsn/psc/ssi/index.html

Data Collection Forms & Instructions

All Data Collection Forms are Print-only

SSI Event

Surgical Site Infection (SSI) form (57.120) [PDF – 180 KB]

- Customizable form [DOCX – 80 KB]

Table of Instructions [PDF – 6 pages]

Denominator Form

Denominator for Procedure (57.121) [PDF – 100 KB]

- Customizable form [DOCX – 60 KB]

Table of Instructions [PDF – 8 pages]

Operative Procedure Code Documents

2026 Operative Procedure Code Documents

The documents listed below should be used for procedures performed January 1, 2026 through December 2026.

List of NHSN Procedure Code Updates – January 2026 [XLS – 19 KB]

ICD-10-PCS Procedure Code Mapping to NHSN Operative Procedure Codes – January 2026 [XLS – 787 KB]

Current Procedural Terminology (CPT) Procedure Code Mapping to NHSN Operative Procedure Codes – January 2026 [XLS – 346 KB]

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Navigation of the NHSN Application for SSI

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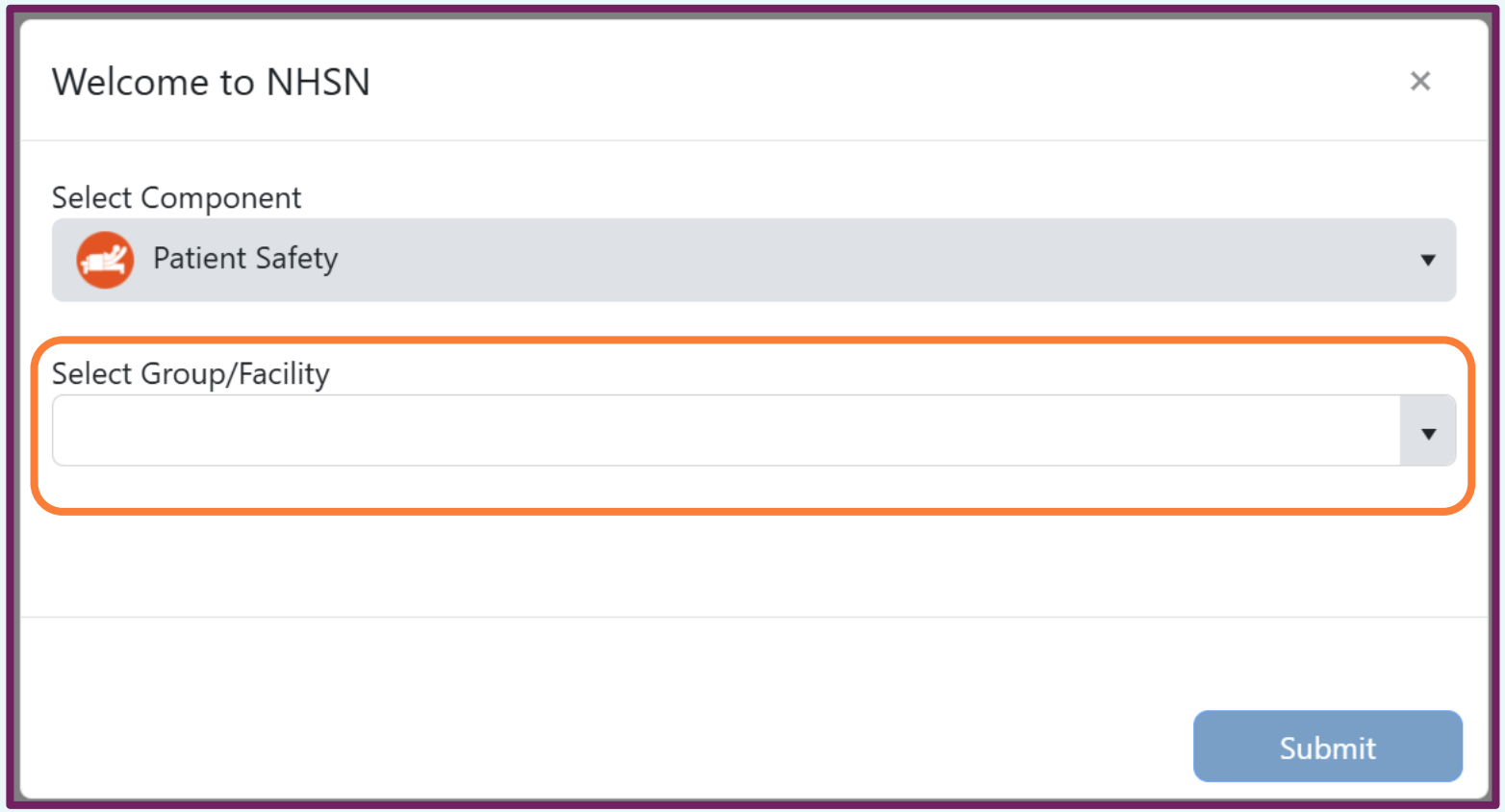
Log into NHSN Application

- Select your facility from the drop-down.
- Click ‘Submit’.



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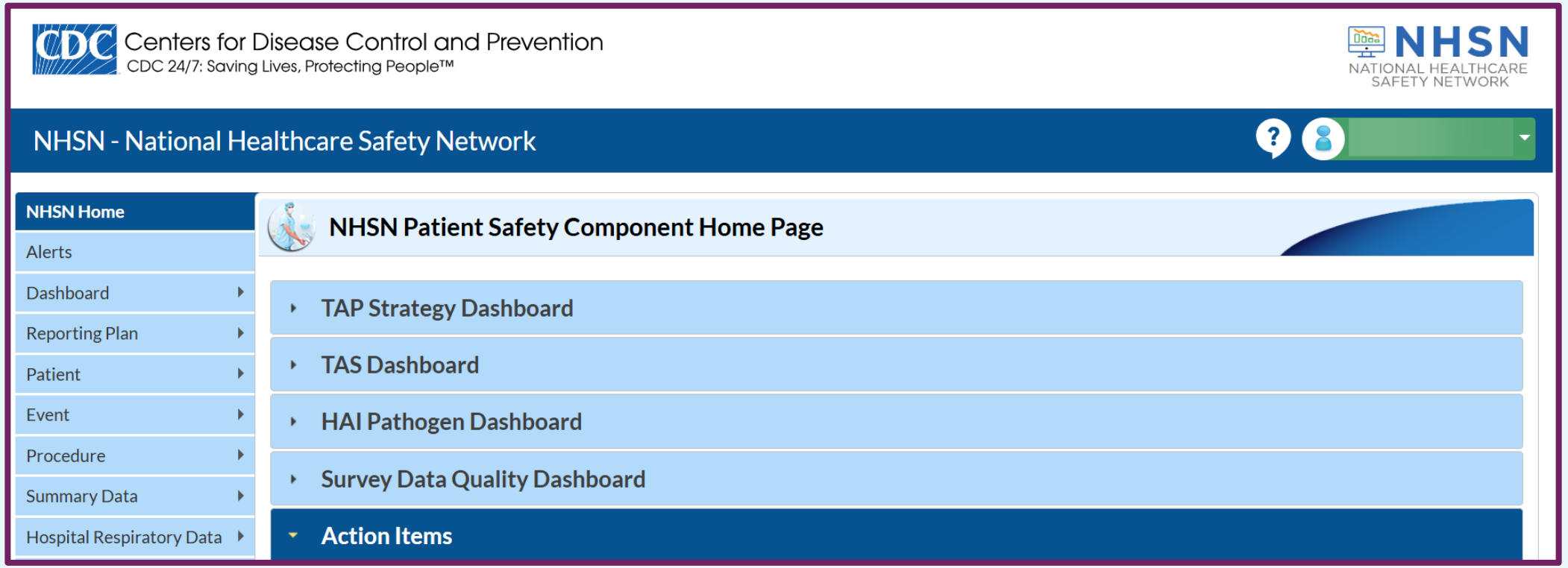
NHSN Home Page



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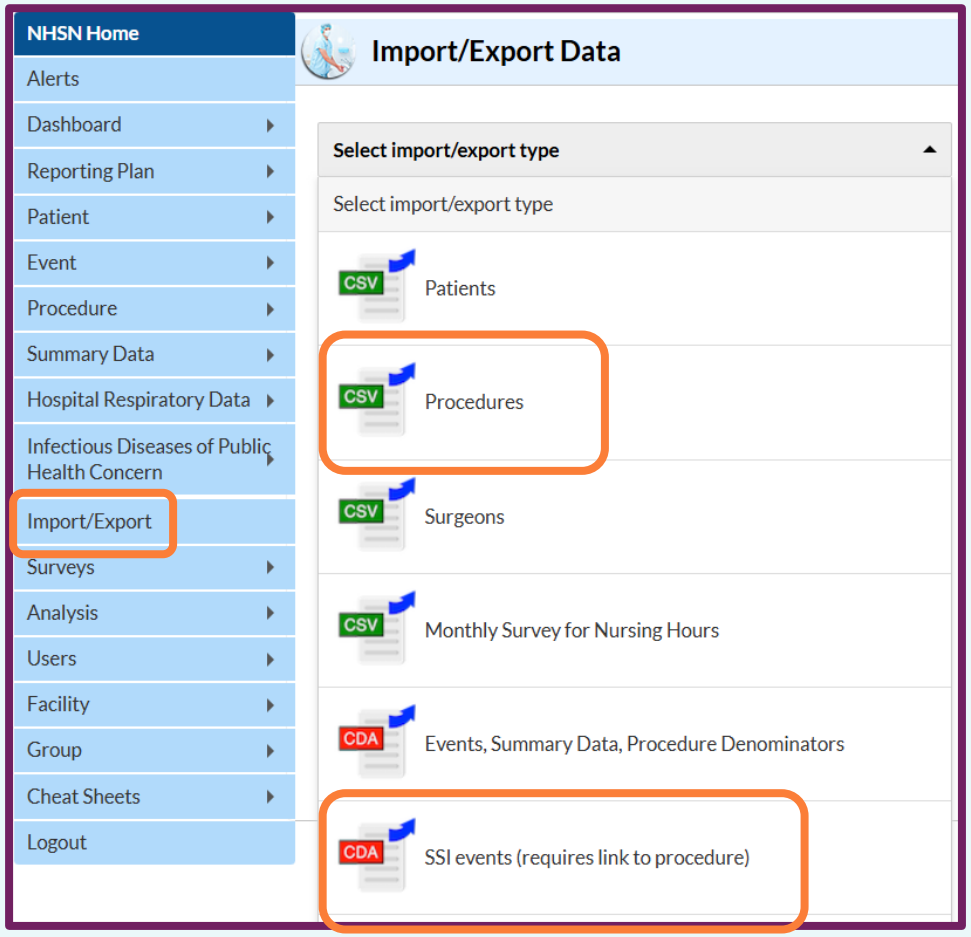
Import Procedure Denominators & SSI Events

- Click the 'Import/Export' tab on the left-hand menu to import CSV/CDA (Comma-Separated Value/Clinical Document Architecture) files for your facility's procedure denominators and/or SSI event data.



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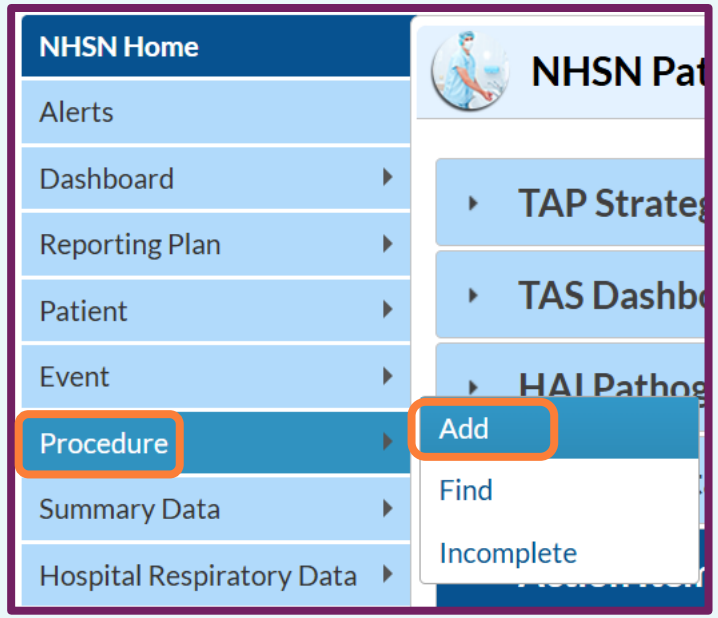
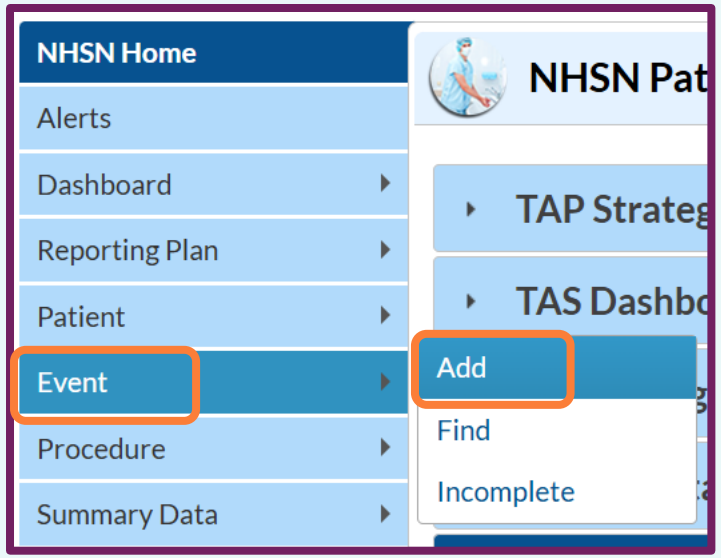
Manual Entry of Procedures & SSI Events

- To manually enter a procedure into the application, select the ‘Procedure’ tab on the left-hand menu on the NHSN home page, then click **Add**.
- To manually enter an SSI event into the application, select the ‘Event’ tab on the left-hand menu on the NHSN home page, then click **Add.**





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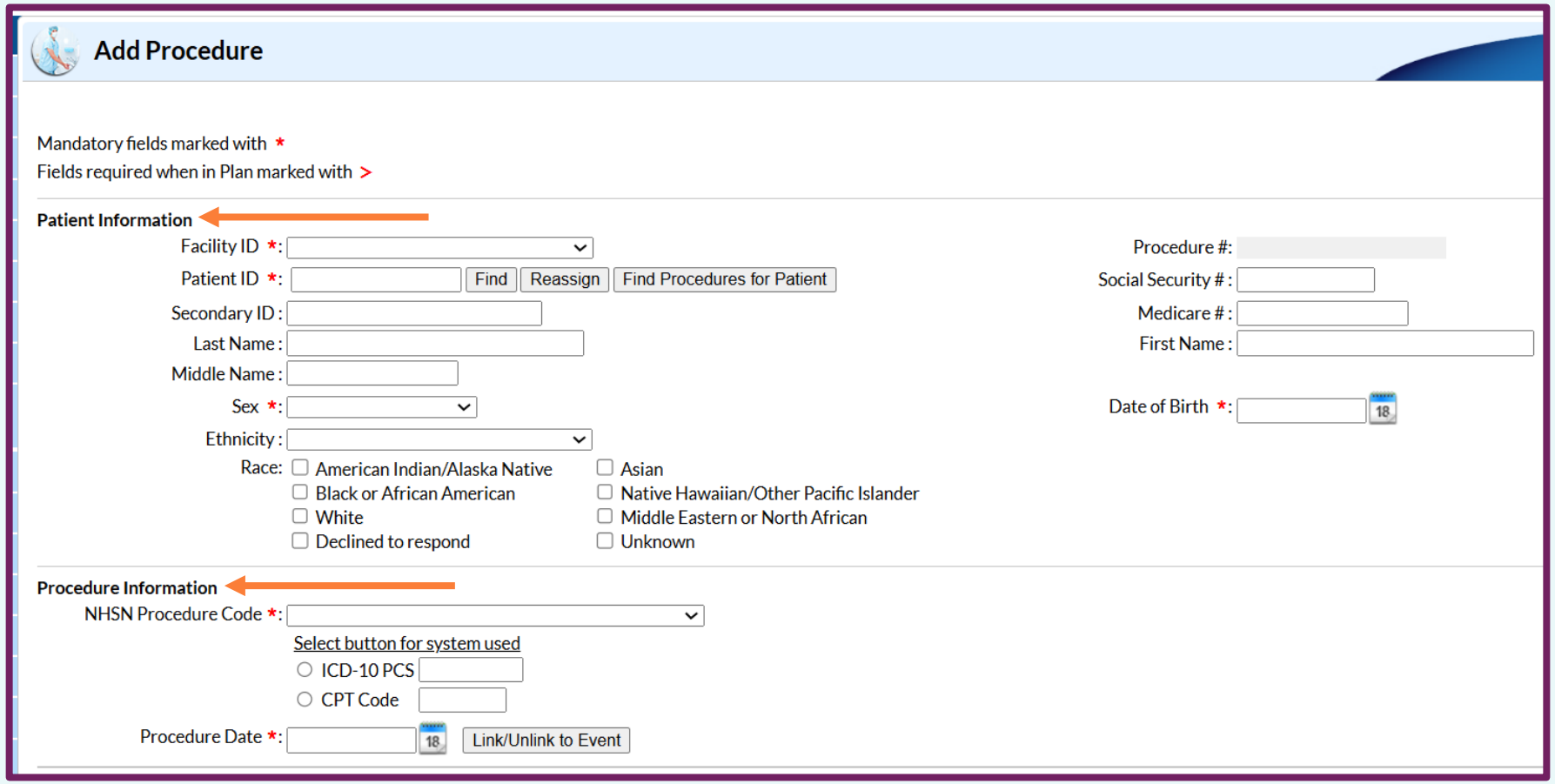
Denominator for Procedure Form



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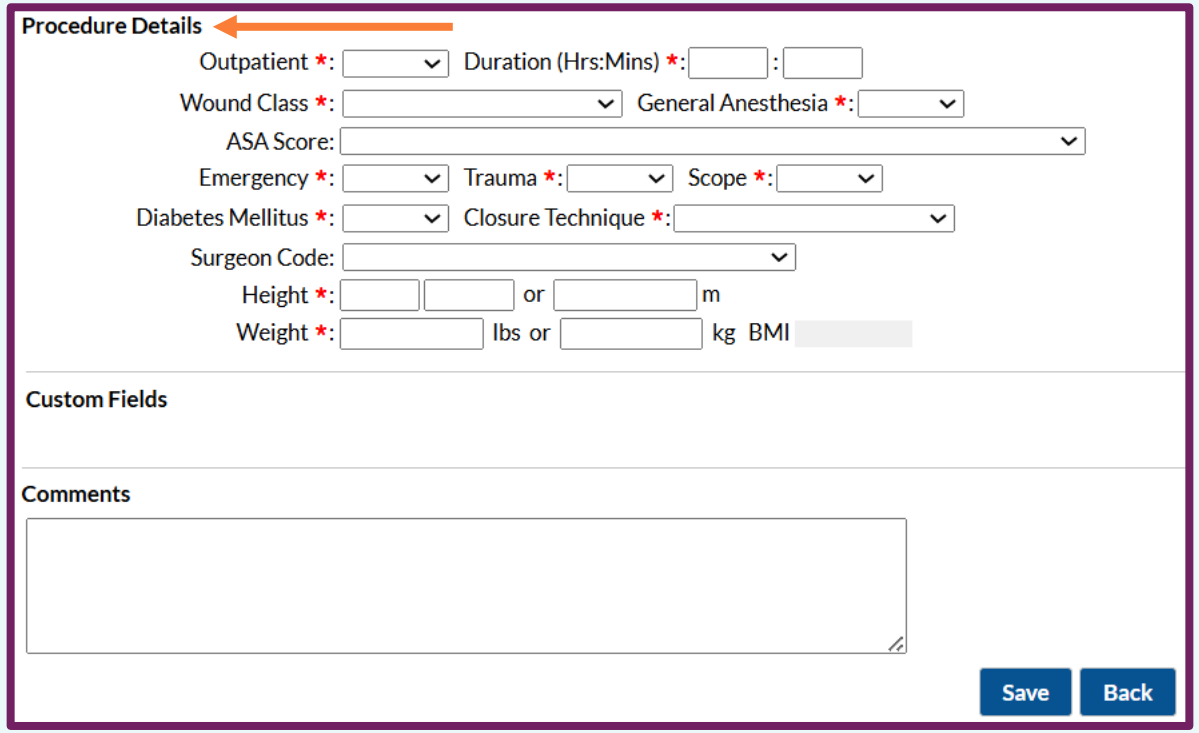
Denominator for Procedure Form – cont.



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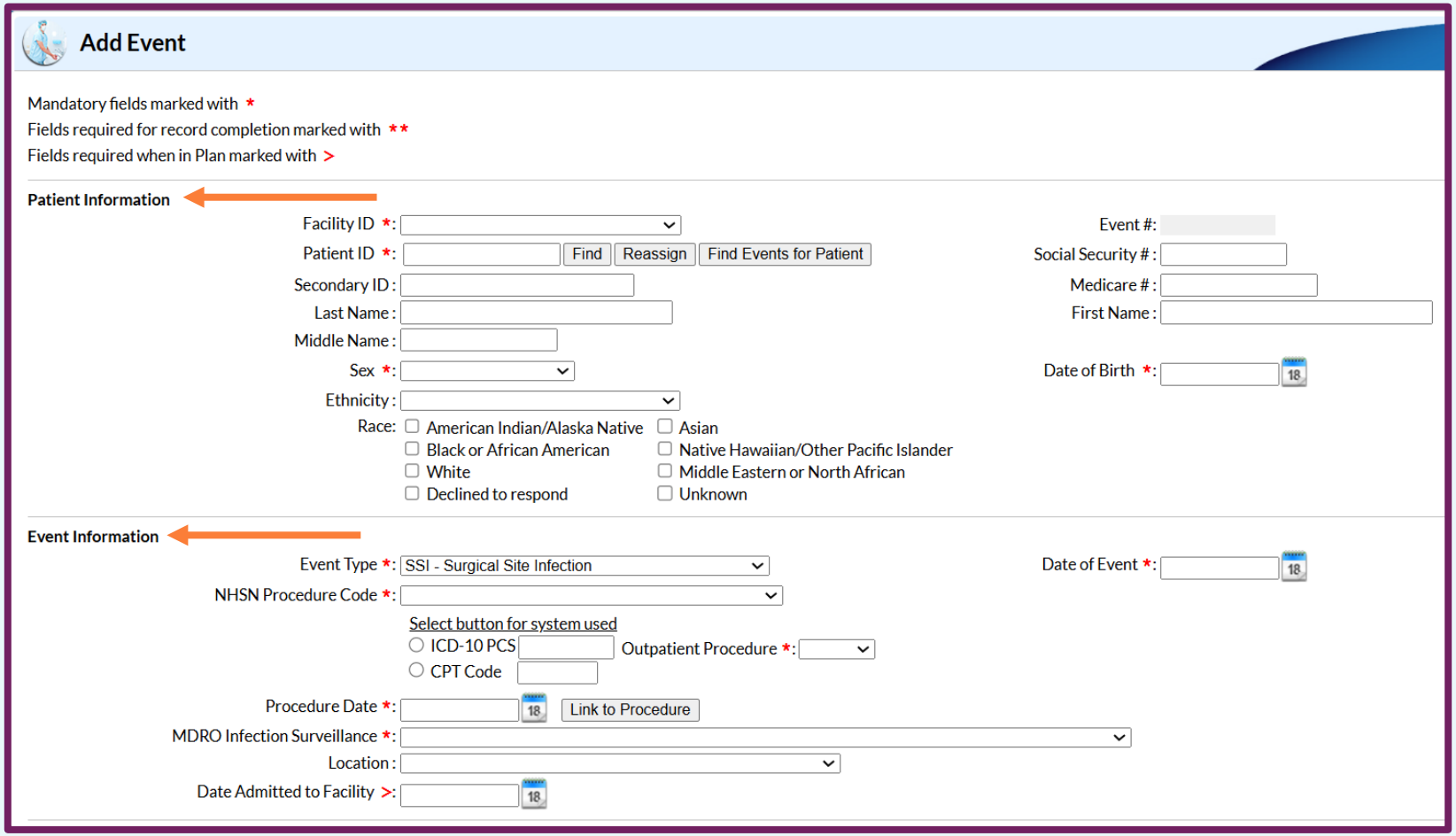
SSI Event Form



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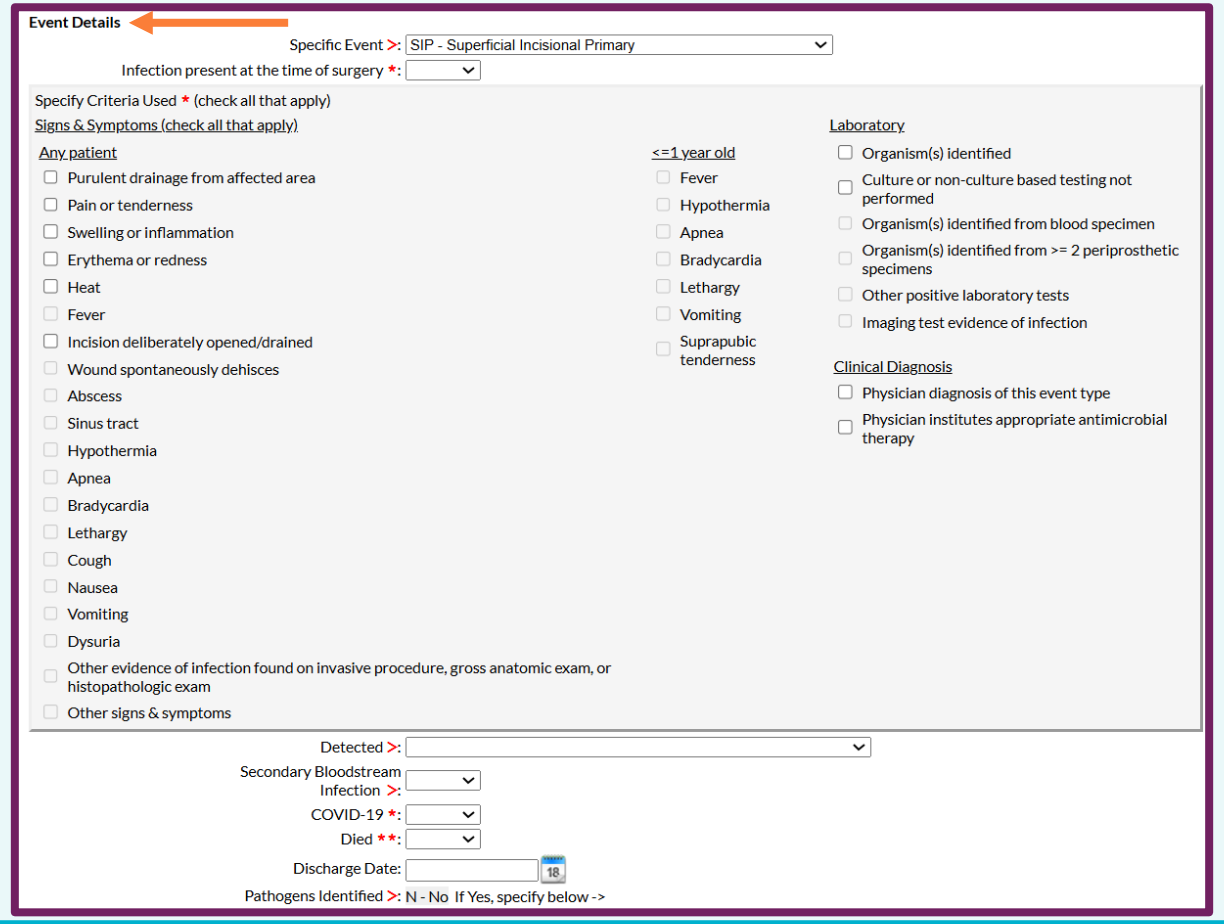
NHSN APPLICATION NAVIGATION

SSI Event Form – Superficial Incisional



Event Details

Specific Event >: SIP - Superficial Incisional Primary

Infection present at the time of surgery *:

Specify Criteria Used * (check all that apply)

Signs & Symptoms (check all that apply)

Any patient

- Purulent drainage from affected area
- Pain or tenderness
- Swelling or inflammation
- Erythema or redness
- Heat
- Fever
- Incision deliberately opened/drained
- Wound spontaneously dehisces
- Abscess
- Sinus tract
- Hypothermia
- Apnea
- Bradycardia
- Lethargy
- Cough
- Nausea
- Vomiting
- Dysuria
- Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam
- Other signs & symptoms

<=1 year old

- Fever
- Hypothermia
- Apnea
- Bradycardia
- Lethargy
- Vomiting
- Suprapubic tenderness

Laboratory

- Organism(s) identified
- Culture or non-culture based testing not performed
- Organism(s) identified from blood specimen
- Organism(s) identified from >= 2 periprosthetic specimens
- Other positive laboratory tests
- Imaging test evidence of infection

Clinical Diagnosis

- Physician diagnosis of this event type
- Physician institutes appropriate antimicrobial therapy

Detected >:

Secondary Bloodstream Infection >:

COVID-19 *:

Died **:

Discharge Date:

Pathogens Identified >: N - No If Yes, specify below ->

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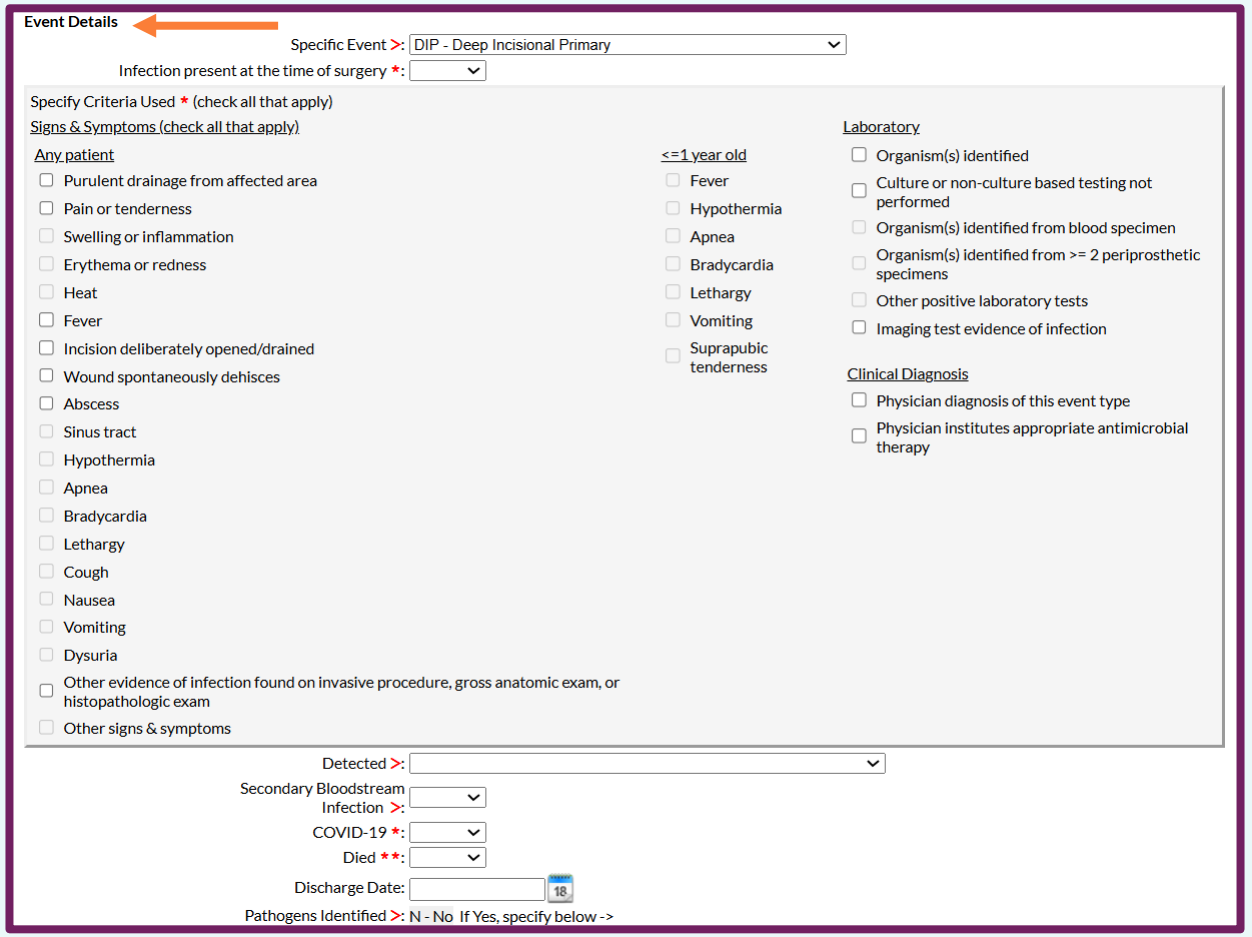
NHSN APPLICATION NAVIGATION

SSI Event Form – Deep Incisional



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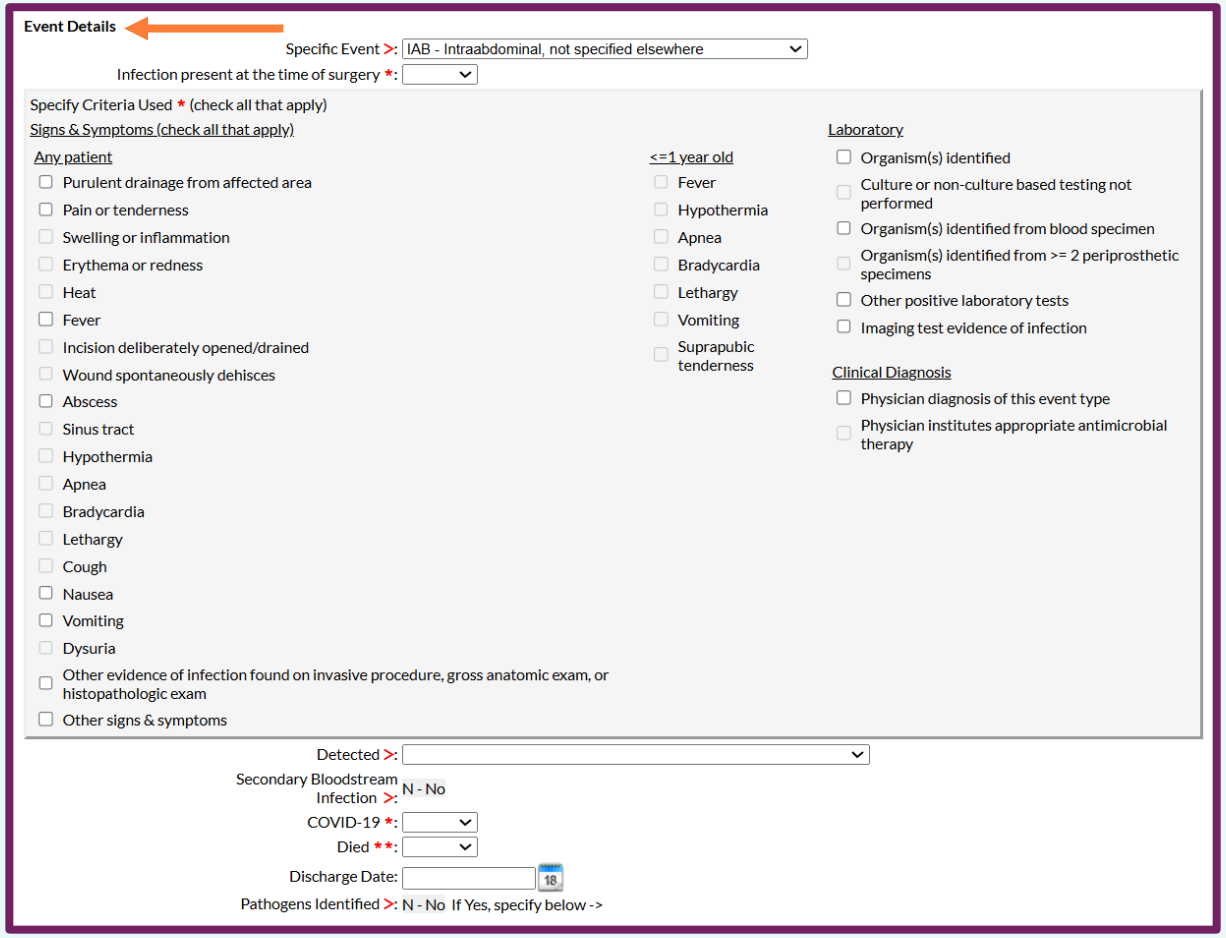
NHSN APPLICATION NAVIGATION

SSI Event Form – Organ/Space



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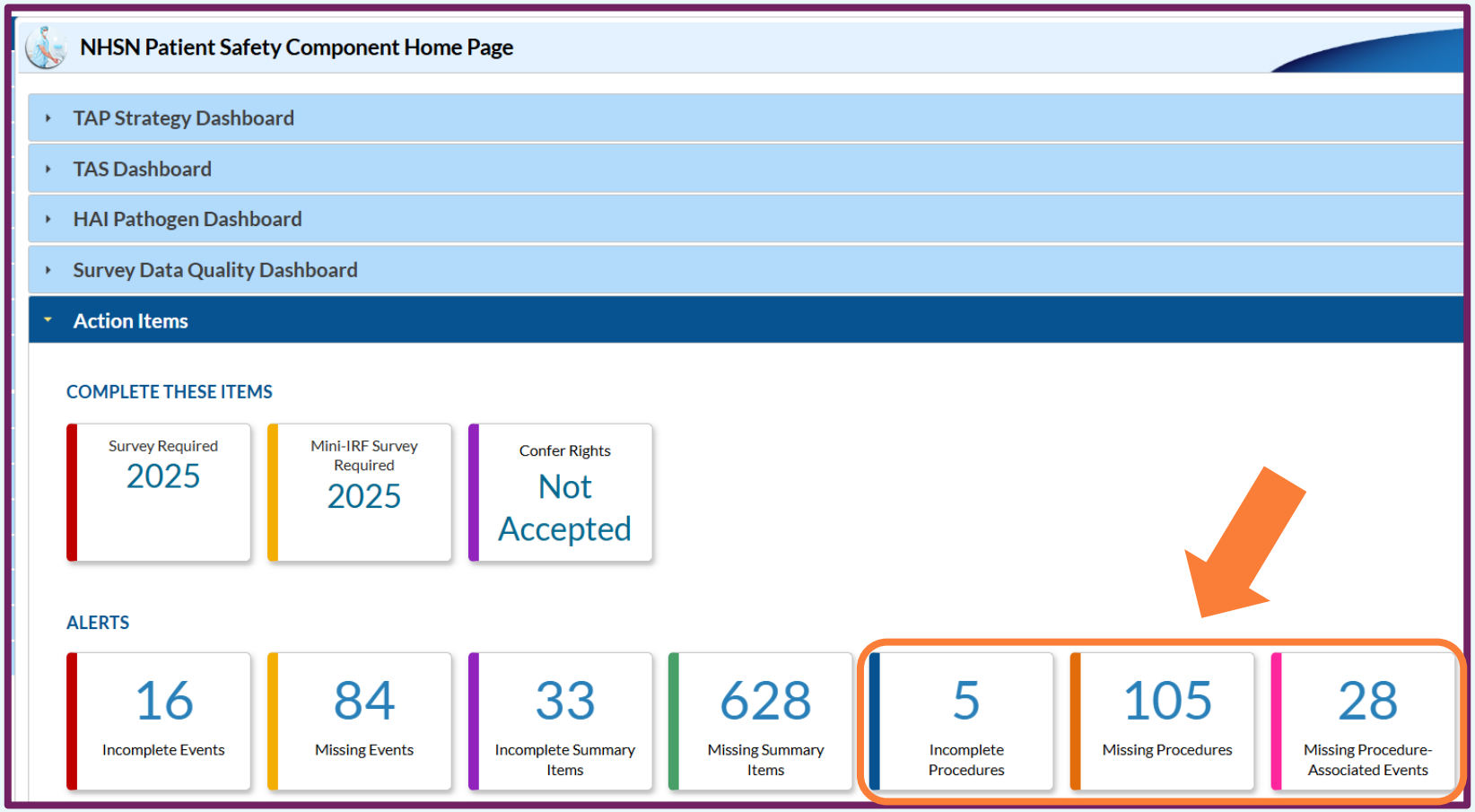
NHSN Home Page - Alerts



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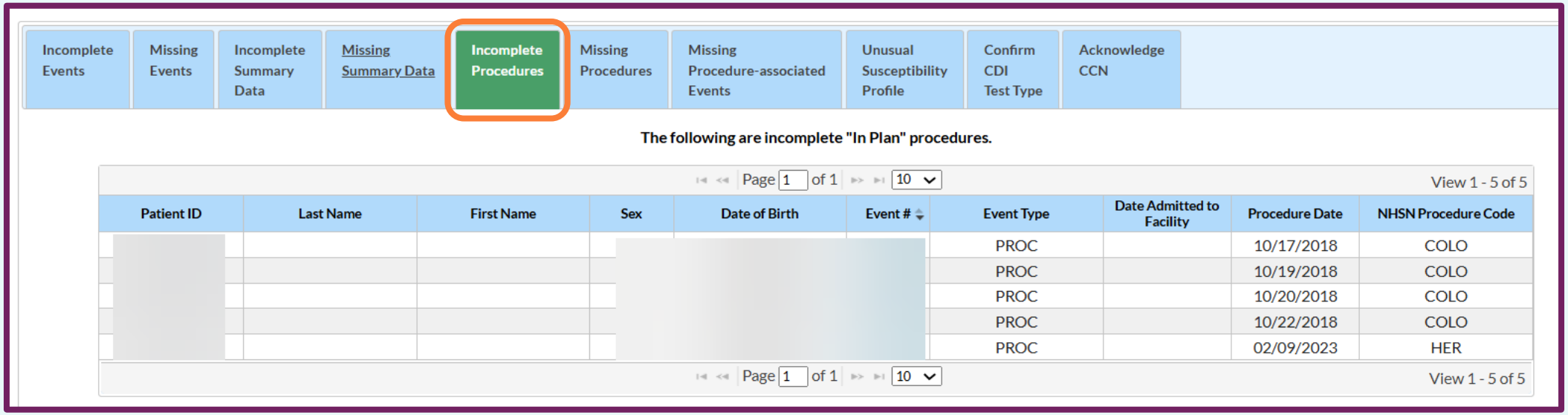
NHSN Alerts – Incomplete Procedures

- Procedures that are missing any of the required fields will populate this list.
- To rectify, click the hyperlink for the 'Event #' – this will take you to the Denominator for Procedure form where you can edit and save the form after the required information has been entered.



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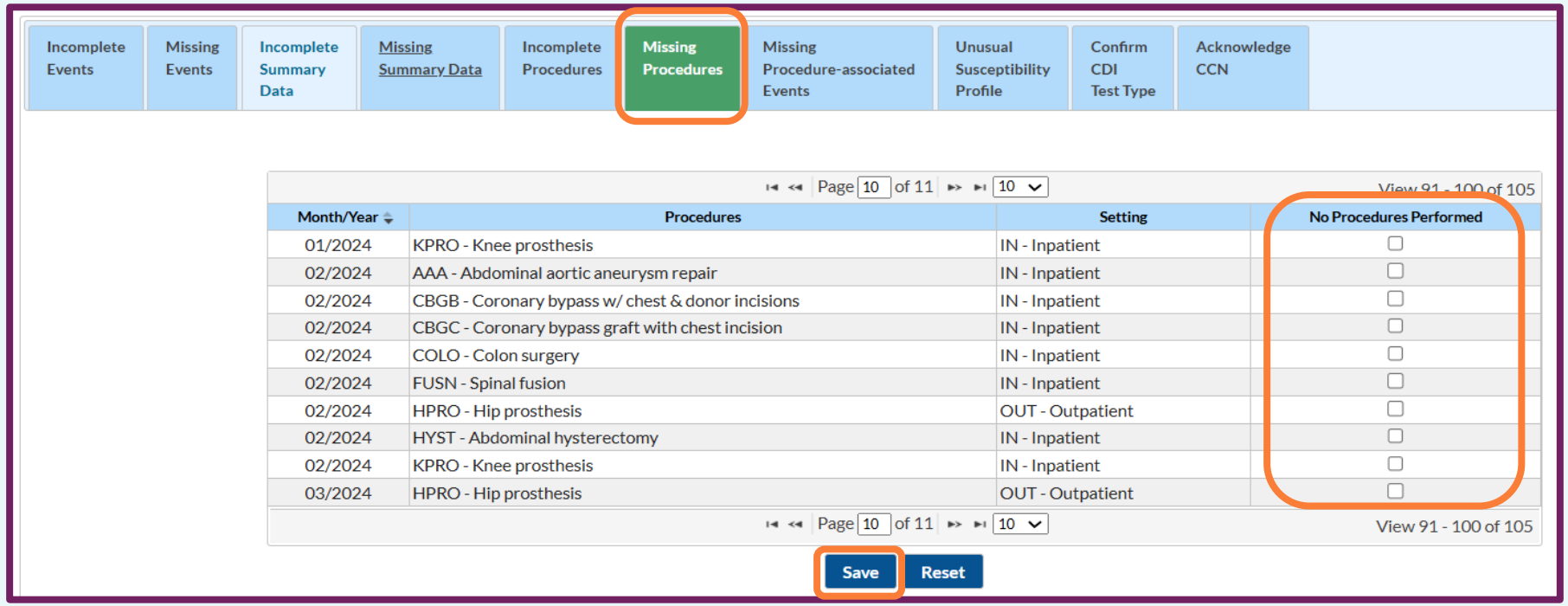
NHSN Alerts – Missing Procedures

- If no procedures in your facility's Monthly Reporting Plan were performed over the course of a month(s), select the 'No Procedures Performed' checkbox, then save.



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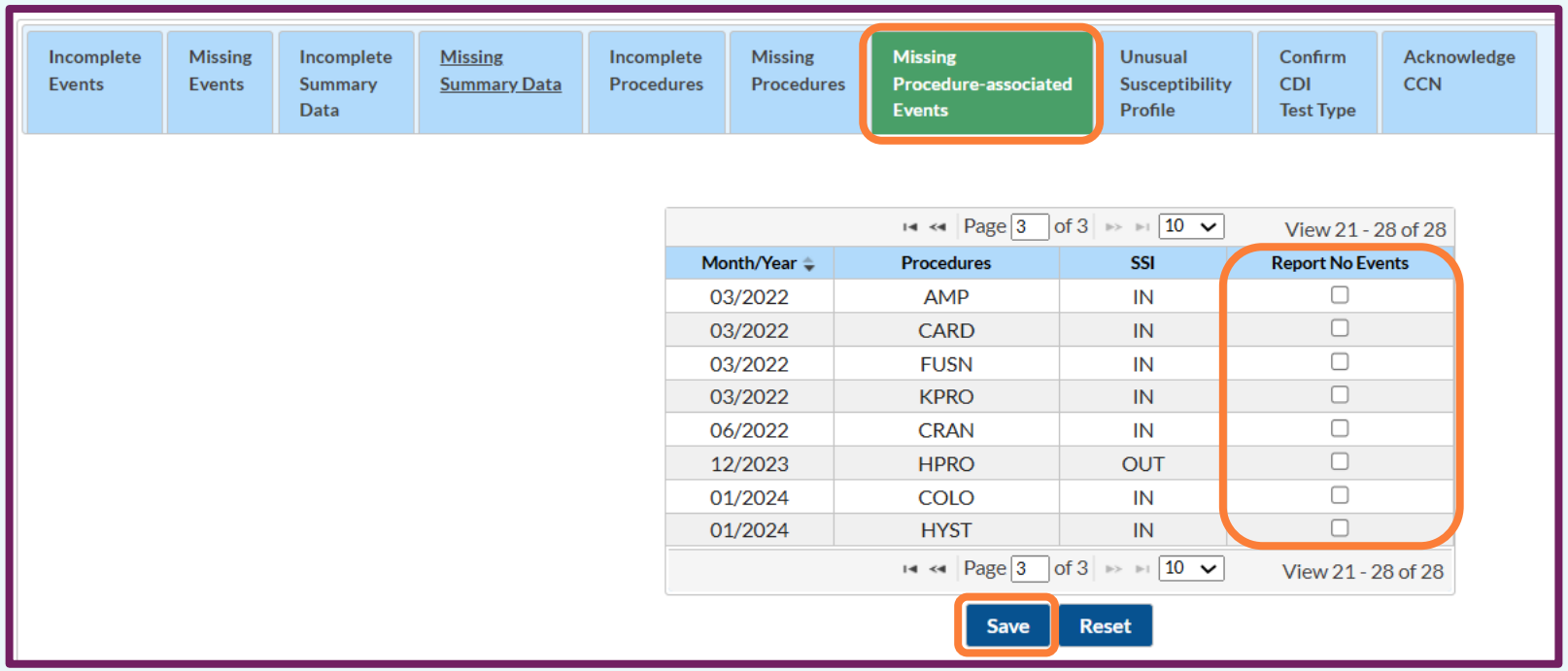
NHSN Alerts – Missing Procedure-associated Events

- If there are no SSI events attributed to an NHSN operative procedure category for a given month, select the 'Report No Events' checkbox, then click **Save**.



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NHSN Operative Procedure

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What is an NHSN Operative Procedure?

- An NHSN Operative Procedure is a procedure that is included in the ICD-10 PCS AND/OR CPT (International Classification of Diseases, 10th Revision, Procedure Coding System AND/OR Current Procedural Terminology) NHSN Operative Procedure Code Mapping

AND

- Takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or entry is through an existing incision (such as an incision from a prior operative procedure)

AND

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

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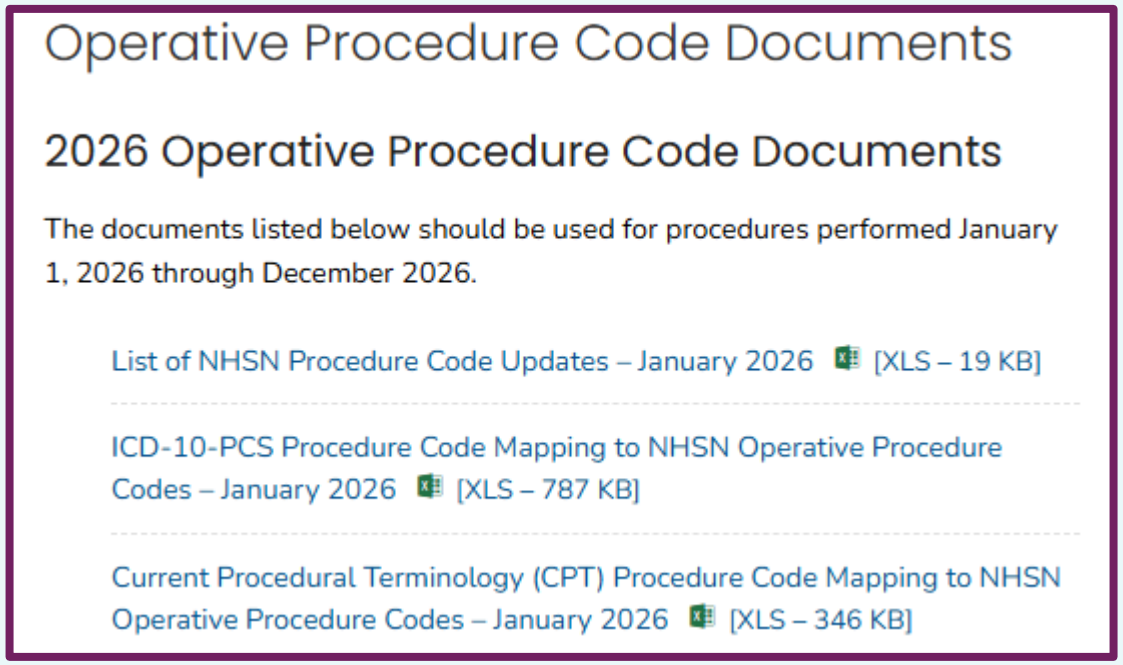
How do I know if the operative procedure is included in NHSN code mapping?

- NHSN Code Mapping Guidance Documents can be found on the NHSN SSI webpage under the 'Operative Procedure Code Documents' section:

https://www.cdc.gov/nhsn/psc/ssi/index.html



Operative Procedure Code Documents

2026 Operative Procedure Code Documents

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Current Procedural Terminology (CPT) Procedure Code Mapping to NHSN Operative Procedure Codes – January 2026 [XLS – 346 KB]

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How do I know if the operative procedure is included in NHSN code mapping?

- Upon opening the NHSN code mapping documents, you will review the spreadsheet to determine if the code assigned by your facility medical coder matches a qualifying code in the mapping document.

Procedure Code Category	ICD-10-PCS Codes	Procedure Code Descriptions	Code Status
AAA	04B00ZZ	Excision of Abdominal Aorta, Open Approach	No change
AAA	04B04ZZ	Excision of Abdominal Aorta, Percutaneous Endoscopic Approach	No change
AAA	04R007Z	Replacement of Abdominal Aorta with Autologous Tissue Substitute, Open Approach	No change
AAA	04R00JZ	Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach	No change
AAA	04R00KZ	Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach	No change
AAA	04R047Z	Replacement of Abdominal Aorta with Autologous Tissue Substitute, Percutaneous Endoscopic Approach	No change
AAA	04R04JZ	Replacement of Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach	No change
AAA	04R04KZ	Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	No change
AMP	0X600ZZ	Detachment at Right Forequarter, Open Approach	No change
AMP	0X610ZZ	Detachment at Left Forequarter, Open Approach	No change
AMP	0X620ZZ	Detachment at Right Shoulder Region, Open Approach	No change
AMP	0X630ZZ	Detachment at Left Shoulder Region, Open Approach	No change
AMP	0X680Z1	Detachment at Right Upper Arm, High, Open Approach	No change
AMP	0X680Z2	Detachment at Right Upper Arm, Mid, Open Approach	No change
AMP	0X680Z3	Detachment at Right Upper Arm, Low, Open Approach	No change
AMP	0X690Z1	Detachment at Left Upper Arm, High, Open Approach	No change
AMP	0X690Z2	Detachment at Left Upper Arm, Mid, Open Approach	No change
AMP	0X690Z3	Detachment at Left Upper Arm, Low, Open Approach	No change

Procedure Code Category	CPT Codes	Procedure Code Descriptions	Code Status
AAA	34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	No change
AAA	34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	No change
AAA	34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	No change
AAA	35081	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta	No change
AAA	35082	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	No change
AAA	35091	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	No change
AAA	35092	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	No change
AAA	35102	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	No change

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NHSN Operative Procedure Categories

- The code mapping guidance documents will note the operative procedure category based on the operative procedure code(s) assigned.
- Table 2, Page 9-16 in the NHSN Patient Safety Component Manual identifies the 39 NHSN operative procedure categories eligible for SSI surveillance.

Table 2. Surveillance Periods for SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

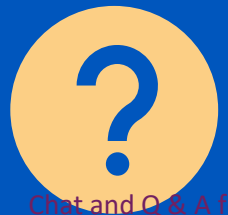
30-day Surveillance			
Category	**Operative Procedure**	**Category**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THYR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory laparotomy

90-day Surveillance	
Category	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Knowledge Check #1

Where can you find the NHSN Code Mapping Guidance Documents?

1. In Appendix 'C' of Chapter 9 (SSI Event Surveillance) of the NHSN Patient Safety Manual
2. In the SSI Event FAQs
3. There are no NHSN Code Mapping Guidance Documents
4. On the NHSN SSI webpage under 'Operative Procedure Code Guidance Documents'



Diving Deep Into SSI Surveillance

Knowledge Check #1– Answer and Rationale

Where can you find the NHSN Code Mapping Guidance Documents?

1. In Appendix 'C' of Chapter 9 (SSI Event Surveillance) of the NHSN Patient Safety Manual
2. In the SSI Event FAQs (Frequently Asked Questions)
3. There are no NHSN Code Mapping Guidance Documents
4. **On the NHSN SSI webpage under 'Operative Procedure Code Guidance Documents'**

Code Mapping Guidance Documents for both ICD-10 PCS and CPT coding can be found here [NHSN SSI webpage]: https://www.cdc.gov/nhsn/psc/ssi/index.html

Denominator for Procedure Details

Required Procedure Details:

- Outpatient Status
- Wound Class
- Trauma Status
- Duration
- General Anesthesia
- Diabetes Status
- Closure Technique
- Height
- Weight

In addition, there are some conditionally required fields:

- CSEC (C-section): Duration of Labor
- FUSN (Fusion): Spinal Level and Approach
- HPRO (Hip Prosthesis)and KPRO (Knee Prosthesis): Additional Procedure Details

NHSN Inpatient Operative Procedure vs. NHSN Outpatient Operative Procedure

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

- NHSN Outpatient Operative Procedure: An NHSN operative procedure performed on a patient whose date of admission to the healthcare facility and the date of discharge are the same calendar day

Denominator for Procedure Reporting Instruction #1

1. **Different operative procedure categories performed during same trip to the OR:** When procedures in more than one NHSN operative procedure category are performed during the same trip to the operating room through the same or different incisions, a *Denominator for Procedure* form is completed for each NHSN operative procedure category being monitored in the Monthly Reporting Plan.
   For example:
   - If a CARD and CBGC are performed through the same incision during the same trip to the operating room, and both procedures are monitored in the Monthly Reporting Plan, complete a *Denominator for Procedure* form for each procedure.
   - If following a motor vehicle accident, a patient has an FX and SPLE performed during the same trip to the operating room, and both procedures are monitored in the Monthly Reporting Plan, complete a *Denominator for Procedure* form for each procedure.

   EXCEPTION: If a patient has both a CBGC and CBGB during the same trip to the operating room, report only as a CBGB. Only report as a CBGC if there is only a chest incision. CBGB and CBGC are never reported for the same patient for the same trip to the operating room.

Knowledge Check #2

Mr. Cal Culator presents to the emergency department on March 1 after motor vehicle accident. He has an NHSN qualifying XLAP, SB and COLO procedure on March 1 at 1640. The procedure end time is 1802. Your facility reports all 39 NHSN operative procedure categories inyour Monthly Reporting Plan. Which operative procedure categories are reported in your facility denominator for procedure data?

1. XLAP only
2. COLO only
3. XLAP, SB and COLO
4. No Operative Procedures are reported

Knowledge Check #2– Answer and Rationale

Mr. Cal Culator presents to the emergency department on March 1 after motor vehicle accident. He has an NHSN qualifying XLAP, SB and COLO procedure on March 1 at 1640. The procedure end time is 1802. Your facility reports all 39 NHSN operative procedure categories inyour Monthly Reporting Plan. Which operative procedure categories are reported in your facility denominator for procedure data?

1. XLAP only
2. COLO only
3. **XLAP, SB and COLO** 
4. No Operative Procedures are reported

Per Denominator for Procedure reporting instruction #7 because the operative episodes occur with 24 hours of each other, only the XLAP is reported.

Denominator for Procedure Reporting Instruction #2

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

Denominator for Procedure Reporting Instruction #3

3. **Duration of operative procedures if patient has two different NHSN operative procedures performed via separate incisions on the same trip to the OR:** Try to determine the correct duration for each separate procedure (if this is documented); otherwise, take the time for both procedures and split it evenly between the two. For example, if an AMP and SPLE are performed during the same trip to the OR.

Denominator for Procedure Reporting Instruction #4

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

Denominator for Procedure Reporting Instruction #5

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

Denominator for Procedure Reporting Instruction #6

6. **Same NHSN operative procedure category via separate incisions:** For operative procedures that can be performed via separate incisions during same trip to the operating room (specifically the following, AMP, BRST, CEA, FUSN, FX, HER, HPRO, KPRO, LAM, NEPH, OVRY, PVBY), separate *Denominator for Procedure* forms are completed. To document the duration of the procedures, indicate the procedure/surgery start time to procedure/surgery finish time for each procedure separately or, alternatively, take the total time for the procedures and split it evenly between procedures. Appendix B provides guidance for the 12 NHSN operative procedure categories that can have multiple procedures reported per category per patient per calendar day.

   Notes:

   - A COLO procedure with a colostomy formation is considered one COLO procedure with multiple primary incision sites.
   - Laparoscopic hernia repairs are considered one HER procedure, regardless of the number of hernias repaired in a trip to the OR. In most cases there will be only one incision time documented for this procedure. If more than one time is documented, total the durations. Open (specifically, non-laparoscopic) hernia repairs are reported as one HER procedure for each hernia repaired via a separate incision, (specifically, if two incisions are made to repair two defects, then two HER procedures are reported). It is anticipated that separate incision times will be recorded for these procedures. If not, take the total time for both procedures and split it evenly between the two.

Denominator for Procedure Reporting Instruction #7

7. **More than one operative procedure through same incision/surgical space within 24 hours:** When a patient has more than one operative procedure via the same incision or into the same surgical space and the second procedure start time is within 24 hours of the first procedure finish time, report one *Denominator for Procedure* form for the original procedure, combining the durations for both procedures based on the procedure start times and finish times for both procedures.
    - For example, a patient has a CBGB lasting 4 hours and returns to the OR six hours later for another operative procedure via the same incision (for example, CARD). The second operation has duration of 1.5 hours. Record the operative procedure as one CBGB and the duration of operation as 5 hour 30 minutes. If the wound class has changed, report the higher wound class. Do not report the CARD procedure in your denominator data.

Notes:

- If the first procedure is **not** an NHSN operative procedure, this guidance does not apply.
- If the second procedure is **not** an NHSN operative procedure, this guidance does still apply
- When the patient returns to the OR within 24 hours of the end of the first procedure assign the surgical wound closure technique that applies when the patient leaves the OR from the first operative procedure.
- If the ASA class has changed in the second procedure, report the higher ASA class.
- The surveillance period for the procedure reported begins at the completion of the second procedure.

Denominator for Procedure Reporting Instruction #8

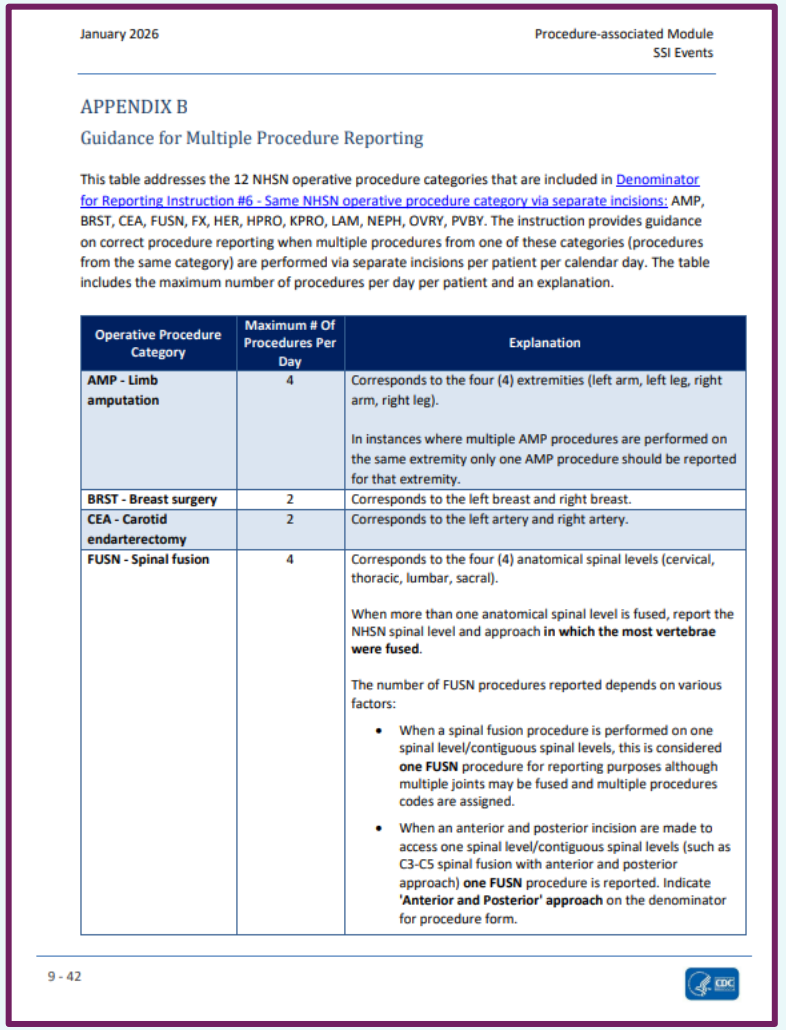
8. **Patient expires in the OR:** If a patient expires in the operating room, do not complete a *Denominator for Procedure* form. This operative procedure is excluded from the denominator.

Denominator for Procedure Reporting Instruction #9

9. **HYST or VHYS:** For the purpose of NHSN SSI reporting, hysterectomy procedure codes that involve an incision made into the abdomen, including trocar insertion, are listed in the abdominal hysterectomy (HYST) category. The correct CPT hysterectomy procedure codes should be assigned by a medical record coder using current guidelines and conventions. Hysterectomy procedures should be designated as a HYST or VHYS, based on the approach of the procedure (5th character of the ICD-10 operative procedure code) the facility's medical coder assigns to the hysterectomy procedure.

Appendix B: Guidance for Multiple Procedure Reporting

- Addresses the 12 NHSN operative procedure categories that are included in Denominator for Procedure Reporting Instruction #6: When the same operative procedure category is performed via the same NHSN operative procedure category via separate incisions: AMP, BRST, CEA, FUSN, FX, HER, HPRO, KPRO, LAM, NEPH, OVRY PVBY.
- This table includes the maximum number of procedures that can be reported per patient per day with an explanation.



APPENDIX B

Guidance for Multiple Procedure Reporting

This table addresses the 12 NHSN operative procedure categories that are included in Denominator for Reporting Instruction #6 - Same NHSN operative procedure category via separate incisions: AMP, BRST, CEA, FUSN, FX, HER, HPRO, KPRO, LAM, NEPH, OVRY, PVBY. The instruction provides guidance on correct procedure reporting when multiple procedures from one of these categories (procedures from the same category) are performed via separate incisions per patient per calendar day. The table includes the maximum number of procedures per day per patient and an explanation.

Operative Procedure Category	Maximum # Of Procedures Per Day	Explanation
AMP - Limb amputation	4	Corresponds to the four (4) extremities (left arm, left leg, right arm, right leg). In instances where multiple AMP procedures are performed on the same extremity only one AMP procedure should be reported for that extremity.
BRST - Breast surgery	2	Corresponds to the left breast and right breast.
CEA - Carotid endarterectomy	2	Corresponds to the left artery and right artery.
FUSN - Spinal fusion	4	Corresponds to the four (4) anatomical spinal levels (cervical, thoracic, lumbar, sacral). When more than one anatomical spinal level is fused, report the NHSN spinal level and approach **in which the most vertebrae were fused**. The number of FUSN procedures reported depends on various factors: • When a spinal fusion procedure is performed on one spinal level/contiguous spinal levels, this is considered **one FUSN** procedure for reporting purposes although multiple joints may be fused and multiple procedures codes are assigned. • When an anterior and posterior incision are made to access one spinal level/contiguous spinal levels (such as C3-C5 spinal fusion with anterior and posterior approach) **one FUSN** procedure is reported. Indicate **'Anterior and Posterior' approach** on the denominator for procedure form.

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Knowledge Check #3

Ms. Dee Nominator is admitted on January 25 for acute abdominal pain. She has an NHSN qualifying APPY on January 25 start time 1000 end time 1100. On January 26 at 0900 she returns to the operating room (OR) for an NHSN qualifying XLAP due to a suspected bleed. All 39 operative procedure categories are included on your facility Monthly Reporting Plan. What procedures are reported in your facility denominator data?

1. APPY and XLAP
2. XLAP
3. APPY
4. No Operative Procedures are reported

Diving Deep Into SSI Surveillance

Knowledge Check #3– Answer and Rationale

Ms. Dee Nominator is admitted on January 25 for acute abdominal pain. She has an NHSN qualifying APPY on January 25 start time 1000 end time 1100. On January 26 at 0900 she returns to the operating room (OR) for an NHSN qualifying XLAP due to a suspected bleed. All 39 operative procedure categories on included on your facility Monthly Reporting Plan. What procedures are reported in your facility denominator data?

1. APPY and XLAP
2. XLAP
3. **APPY** 
4. No Operative Procedures are reported

Denominator for Procedure Reporting Instruction #7 is applied and ONLY the first operative procedure is reported.

Diving Deep Into SSI Surveillance

Knowledge Check #4

Ms. Dee Nominator is admitted on January 25 for acute abdominal pain. She has an NHSN qualifying APPY on January 25 start time 1000 end time 1100. On January 26 at 0900 she returns to the operating room (OR) for an NHSN qualifying XLAP due to a suspected bleed. The procedure end time is 1030. All 39 operative procedure categories on included on your facility Monthly Reporting Plan. BONUS QUESTION: What is the duration reported?

1. 2 hours 30 minutes
2. 1 hour
3. 1 hour 30 minutes
4. No Operative Procedures are reported and therefore no duration

Knowledge Check #4 – Answer and Rationale

Ms. Dee Nominator is admitted on January 25 for acute abdominal pain. She has an NHSN qualifying APPY on January 25 start time 1000 end time 1100. On January 26 at 0900 she returns to the operating room (OR) for an NHSN qualifying XLAP due to a suspected bleed. The procedure end time is 1030. All 39 operative procedure categories on included on your facility Monthly Reporting Plan. BONUS QUESTION: What is the duration reported?

1. **2 hours 30 minutes** 
2. 1 hour
3. The duration of the operative procedure is not reported because the procedures are 'combined'.
4. No Operative Procedures are reported and therefore no duration.

Per Denominator for Procedure Reporting Instruction #7 the duration for the two procedures is combined.

Diving Deep Into SSI Surveillance

The SSI Surveillance Period

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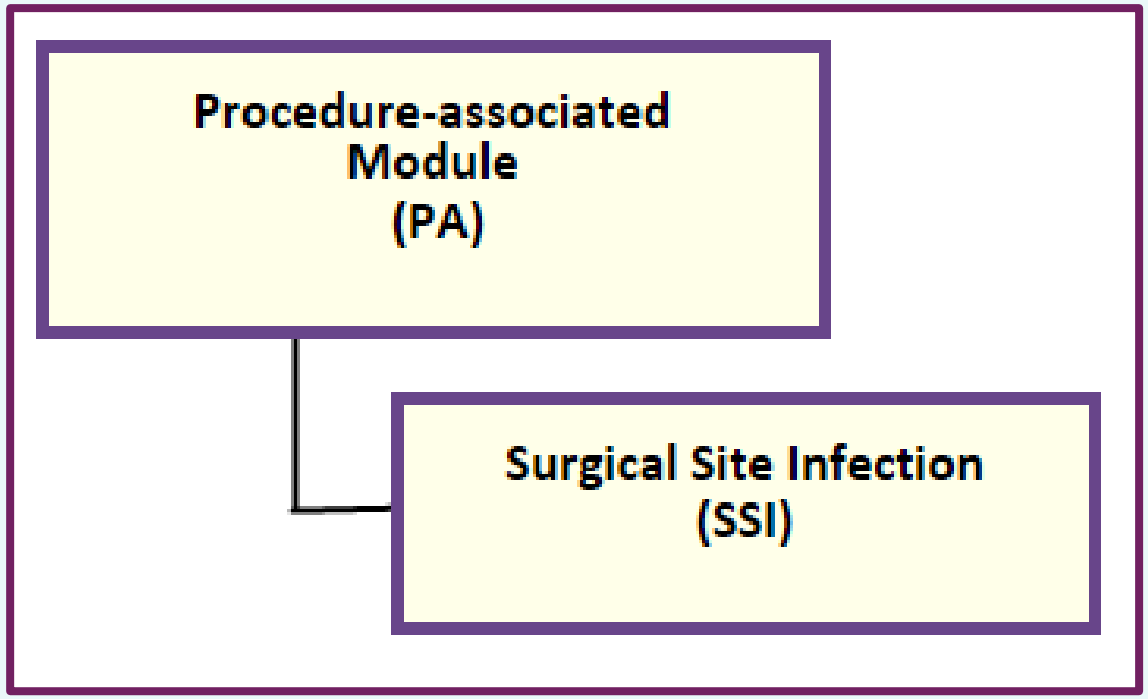
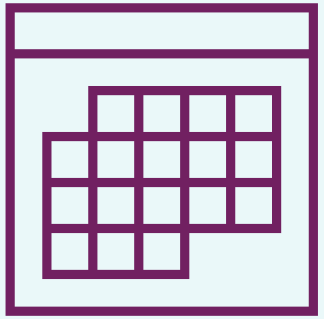
SSI – Procedure-Associated Module





Concept	SSI
Infection Window Period	Not Applicable
Present on Admission	
Healthcare-Associated Infection	
Repeat Infection Timeframe	

SSI Surveillance Period

Each trip to the operating room (OR) for an NHSN operative procedure sets an SSI surveillance period for the surgical site. The length of the surveillance period is based on the operative procedure category.

Table 2. Surveillance Periods for SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

30-day Surveillance			
Category	**Operative Procedure**	**Category**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THYR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory laparotomy

90-day Surveillance	
Category	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Notes:

- Superficial incisional SSIs are monitored for a 30-day period for all procedure categories.
- Secondary incisional SSIs are monitored for a 30-day period regardless of the surveillance period for the primary incision site.

What if the Patient Returns to the operating room (OR)?

- ✓ If a patient returns to the OR for an **NHSN operative procedure** AND **the same surgical space** is entered, the surveillance period for the prior NHSN operative procedure ends and a new SSI surveillance period begins at the conclusion of the procedure.

- ✓ If within the surveillance period following an NHSN operative procedure a **non-NHSN operative procedure** is performed AND **all three tissue levels of the same surgical space** are entered, the SSI surveillance period for the NHSN operative procedure ends at the conclusion of the non-NHSN operative procedure.
  - The SSI surveillance period continues for the tissue levels not entered during the non-NHSN operative procedure.
  - No new surveillance period is set following a non-NHSN operative procedure.

Knowledge Check #5

How long is the SSI surveillance period for a superficial incisional SSI following an NHSN qualifying FUSN?

1. FUSN procedures do not set an SSI surveillance period
2. 90 days
3. 30 days
4. 60 days

Diving Deep Into SSI Surveillance

Knowledge Check #5 – Answer and Rationale

How long is the SSI surveillance period for a superficial incisional SSI following an NHSN qualifying FUSN?

1. FUSN procedures do not set an SSI surveillance period
2. 90 days
3. **30 days** ☑
4. 60 days

Per the NOTES for Table 2 superficial incisional SSIs are monitored for a 30-day period for ALL procedure categories.

90-day Surveillance	
Category	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Notes:

- Superficial incisional SSIs are monitored for a 30-day period for all procedure categories.

Diving Deep Into SSI Surveillance

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SSI Event Surveillance

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How Do I Know What to Monitor For SSI Surveillance?

All procedures included in the NHSN Monthly Reporting Plan are monitored for superficial incisional, deep incisional, and organ/space SSI events and the type of SSI reported must reflect the deepest tissue level where SSI criteria are met during the surveillance period.

SSI events and the procedures to which they are linked are reported to NHSN regardless of noted evidence of infection at time of surgery.

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SSI: Three Tissue Levels

Superficial Incisional (SI)

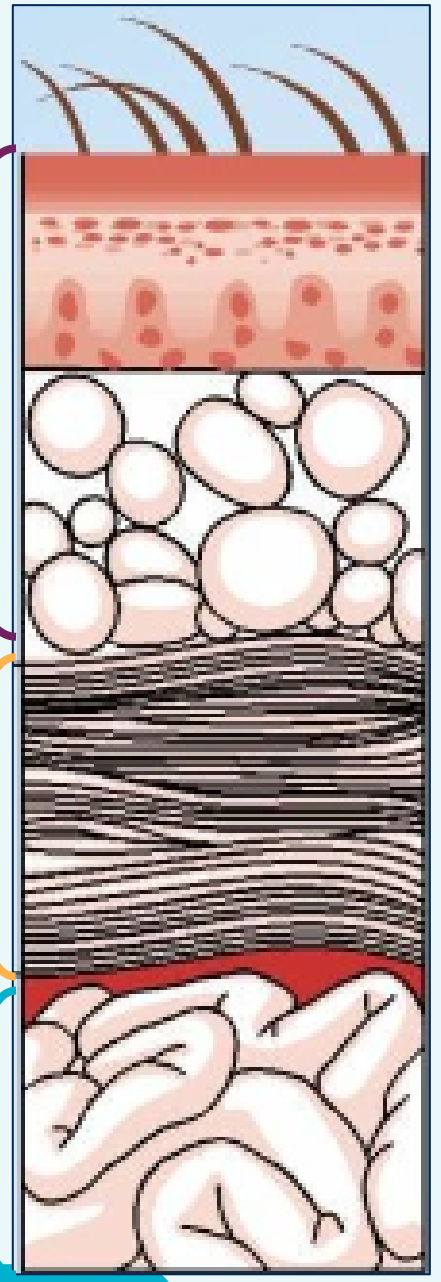
Skin and subcutaneous tissues of the incision

Deep Incisional (DI)

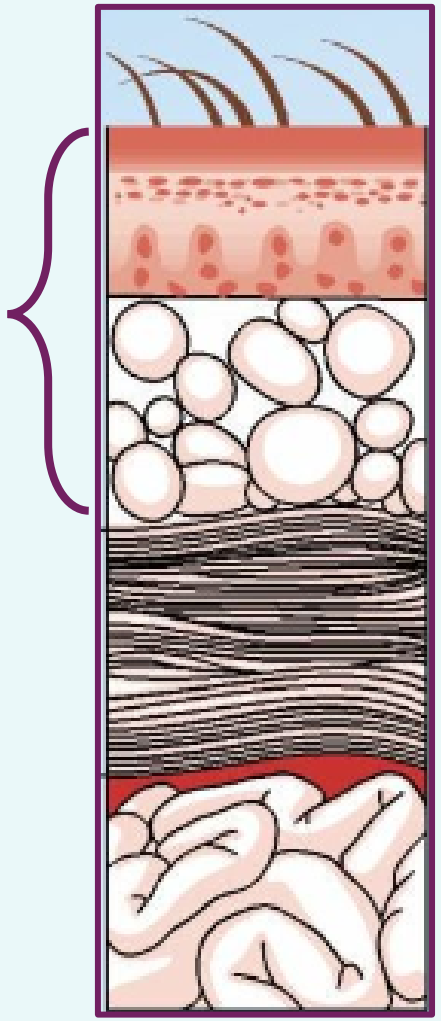
Deep soft tissues of the incision (fascial / muscle layers)

Organ/Space (O/S)

Any part of the body deeper than the fascial / muscle layers



Superficial Incisional SSI



Date of event occurs within 30 days following the NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

patient has at least ***one*** of the following:

a. purulent drainage from the superficial incision.

b. organism(s) identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])

c. a superficial incision that is deliberately opened, re-accessed or aspirated by a surgeon, physician* or physician designee

   AND

   the surgeon, physician*, or physician designee initiates or continues antibiotic or antifungal therapy **on or in the two calendar days following the date of deliberate opening, re-access, aspiration** with a duration of two calendar days or longer

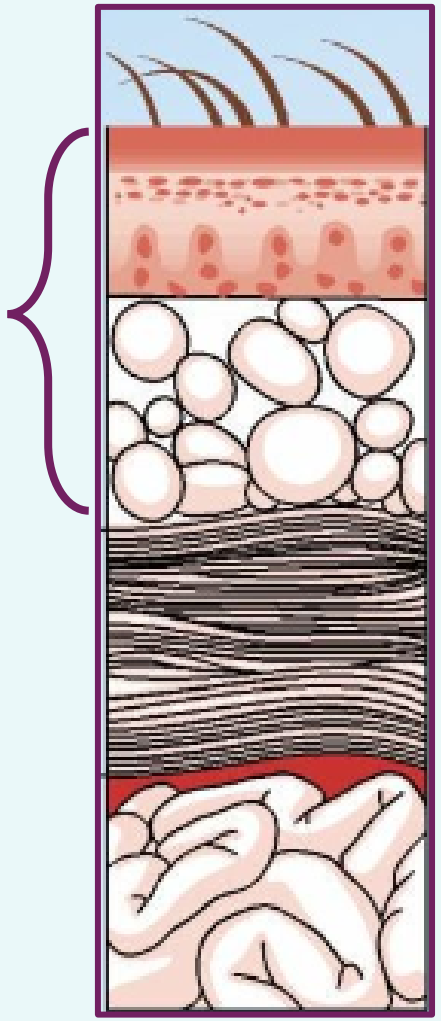
   AND

   patient has at least one of the following signs or symptoms: new or worsening localized pain or tenderness; localized swelling; erythema; or heat

d. diagnosis of a superficial incisional SSI by a physician* or physician designee

* The term physician for the purpose of application of the NHSN SSI criteria may be interpreted to mean a surgeon, infectious disease physician, emergency physician, other physician on the case, or physician's designee (Advanced Practice Nurse [APN], Physician's Assistant [PA]).

Superficial Incisional SSI – cont.



	Superficial incisional SSI
Comments	There are two specific types of superficial incisional SSIs: 1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (for example, C-section incision or chest incision for CBGB) 2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB) **Note:** Refer to SSI Event Reporting Instruction #7 for NHSN operative procedure categories with secondary incision sites available for SSI attribution.
Reporting Instructions for Superficial incisional SSI	**The following do not qualify as criteria for meeting the NHSN definition of superficial incisional SSI:** • Diagnosis/treatment of cellulitis ALONE does not meet superficial incisional SSI criterion 'd'. • A stitch abscess ALONE (minimal inflammation and discharge confined to the points of suture penetration/staple penetration site). • A localized stab wound or pin site infection; depending on the depth, these infections might be considered either an HAI skin (SKIN) or soft tissue (ST) infection. **Notes**: • For the purpose of NHSN surveillance, the term "incision" refers to the incision made for the primary surgical procedure and the term "stab wound" refers to an incision made at another site, generally to accommodate a drain. For an NHSN operative procedure, a laparoscopic trocar site is considered a surgical incision and not a stab wound. If a surgeon uses a laparoscopic trocar site to place a drain at the end of a procedure this is considered a surgical incision.

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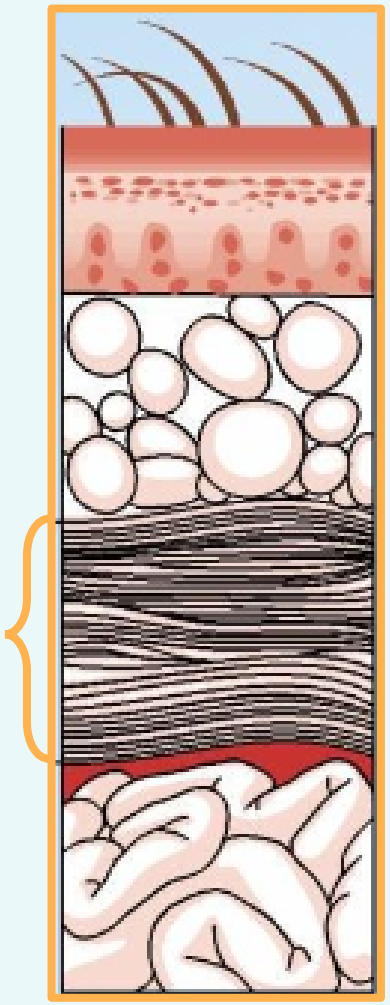
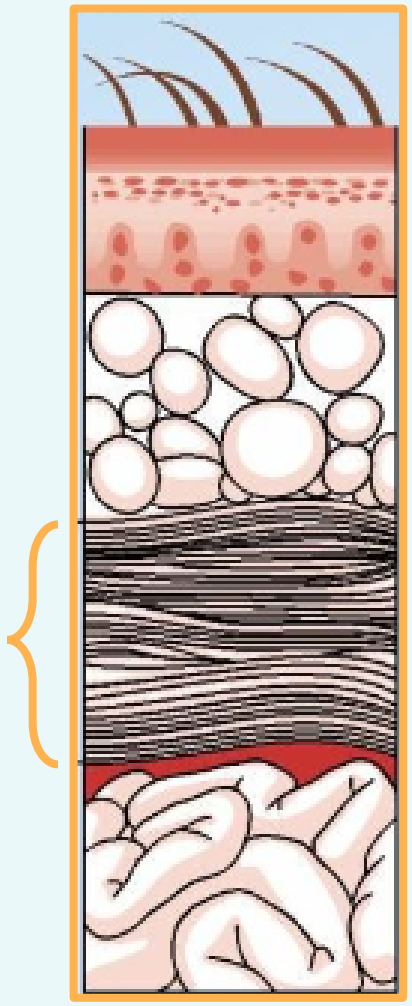
Deep Incisional SSI



	Deep incisional SSI Must meet the following criteria:
	Date of event occurs within 30 or 90 days following the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 **AND** involves deep soft tissues of the incision (for example, fascial and muscle layers) **AND** patient has at least ***one*** of the following: a. purulent drainage from the deep incision b. organism(s) identified from the deep soft tissues of the incision by a culture- or nonculture- based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST]) c. a deep incision that is deliberately opened†, re-accessed, or aspirated by a surgeon, physician‡ or physician designee or spontaneously dehisces¶ **AND** the surgeon, physician‡, or physician designee initiates or continues antibiotic or antifungal therapy **on or in the two calendar days following the date of deliberate opening, re-access, aspiration or spontaneous dehiscence¶** with a duration of two calendar days or longer **AND** patient has at least ***one*** of the following signs or symptoms: fever (>38°C); new or worsening localized pain or tenderness d. an abscess, or other evidence of infection involving the deep incision detected on gross anatomical exam, histopathologic exam, or imaging test †*Excludes any known multi-part/multi-phase procedures that occur over more than one operative episode [during the same admission] that is documented in the medical record by a surgeon prior to or during the first operative procedure [for example, a plan to return to OR that is documented in the operative narrative of the first procedure would be eligible for use].* ‡The term physician for the purpose of application of the NHSN SSI criteria may be interpreted to mean a surgeon, infectious disease physician, emergency physician, other physician on the case, or physician's designee (Advanced Practice Nurse [APN], Physician's Assistant [PA]).
	¶ Spontaneous dehiscence is defined as a re-opening of a surgical incision that is not due to external factors such as direct trauma.

Deep Incisional SSI – cont.



Comments	Deep incisional SSI
	There are two specific types of deep incisional SSIs: 1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (for example, C-section incision or chest incision for CBGB) 2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB) **Note:** Refer to SSI Event Reporting Instruction #7 for NHSN operative procedure categories with secondary incision sites available for SSI attribution.

Deep Incisional SSI ‘c’

- The exclusion from consideration from deliberate opening for Deep Incisional SSI 'c' still applies, with clarifying language added:

☑ Excludes any known multi-part/multi-phase procedures that occur over more than one operative episode [during the same admission] that is documented in the medical record by a surgeon prior to **or during** the first operative procedure **[for example, a plan to return to OR that is documented in the operative narrative of the first procedure would be eligible for use]**

Deep Incisional SSI ‘c’ - Antibiotic/Antifungal Guidance

- ☑ There is no 'indication' component of the Deep Incisional SSI 'c' antibiotic/antifungal element of this criterion. Therefore, if an antibiotic/antifungal meets the specified timeframe and duration, this element would be met regardless of the indication that is prescribed/administered for.

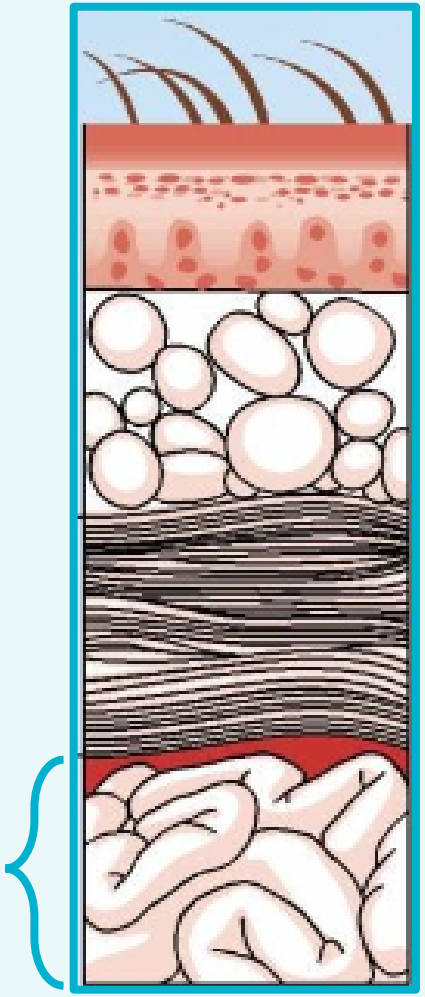
What is New / Worsening Pain?

- Superficial Incisional SSI 'c' and Deep Incisional SSI 'c' both include **New / Worsening Pain** as an element.
- Per a newly added FAQ (#3) for 2026:
  - The intent of ‘new / worsening’ pain is to capture pain that is outside of what may be ‘typical’ post-operative pain within the SSI surveillance period. Documentation used to determine new or worsening pain is **based on facility policy** and may include documentation of pain level, change in type and/or character of pain, frequency/dose/type of analgesic administration, pain impact on mobility or other life quality indicators, and other healthcare provider and physician documentation.
  - Examples of new / worsening pain include [but are not limited to] the following:
    - New pain is experienced in a patient in which ‘typical’ post-operative pain was resolved/not present/reduced and then resumes or develops.
    - If pain is assessed on a pain scale, an increase in the pain scale [for example, pain that was previously documented at a level of 2 and then is documented at a level of 5].

What is a Spontaneous Dehiscence?

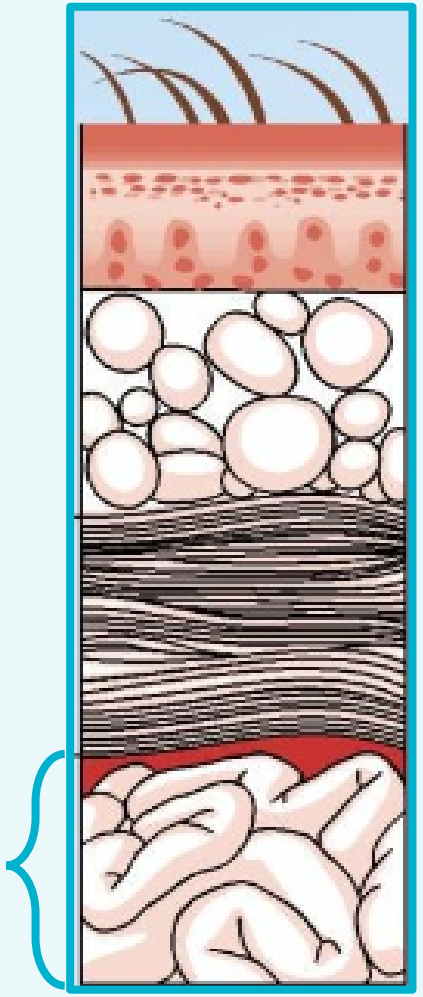
- Per the Deep Incisional SSI 'b' footnote, **Spontaneous Dehiscence** is defined as:
  - a re-opening of a surgical incision that is not due to external factors such as direct trauma.

Organ/Space SSI



	Organ/Space SSI Must meet the following criteria:
	Date of event occurs within 30 or 90 days following the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 **AND** involves the organ/space tissues (deeper than the fascia/muscle) **AND** patient has at least ***one*** of the following: a. purulent drainage from a drain placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT-guided drainage) b. organism(s) identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST]) c. an abscess or other evidence of infection involving the organ/space detected on: • gross anatomical exam or • histopathologic exam or • imaging test evidence definitive or equivocal for infection **AND** meets at least ***one*** eligible [per Appendix A]criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections (Chapter 17).
Comments	Examples of gross anatomic evidence of organ/space infection: • An intraabdominal abscess will require an invasive procedure to actually visualize the abscess. • Visualization of pus or purulent drainage (includes from a drain). • Abdominal, pelvic or uterine pain or tenderness **post Cesarean section (CSEC) or hysterectomy (HYST or VHYS)** is sufficient gross anatomic evidence of infection without an invasive procedure to meet general Organ/Space SSI criterion 'c' **when a Chapter 17 Reproductive Tract Infection criteria is met**. Allowing the documentation of abdominal pain or tenderness as gross anatomic evidence of infection to meet general Organ/Space SSI criterion 'c' enables the user to report an SSI-OREP, SSI-EMET or SSI-VCUF event. Abdominal pain or tenderness cannot be applied as 'other evidence of infection on gross anatomic exam' to meet Deep Incisional SSI criterion 'c' or to meet any Chapter 17 site-specific criterion (for example, OREP '2').

Organ/Space SSI - Cont.



a. purulent drainage from a drain placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT-guided drainage)
b. organism(s) identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])
c. an abscess or other evidence of infection involving the organ/space detected on:
   - gross anatomical exam or
   - histopathologic exam or
   - imaging test evidence definitive or equivocal for infection

NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2026

CDC/NHSN Surveillance Definitions for Specific Types of Infections

Introduction

This chapter contains the CDC/NHSN surveillance definitions and criteria for all specific types of infections. This chapter also provides additional required criteria for the specific infection types that constitute organ space surgical site infections (Refer to Chapter 9 Appendix for specific event types available for organ space SSI attribution for each NHSN operative procedure category). **Comments and reporting instructions that follow the site-specific criteria provide further explanation and are integral to the correct application of the criteria**. Refer to Chapter 2 (Identifying HAIs in NHSN) for specific guidance for making HAI determinations.

Infection criteria contained in this chapter may be necessary for determining whether a positive blood specimen represents a primary bloodstream infection (BSI) or is secondary to a different type of infection (see Appendix B Secondary Bloodstream Infection (BSI) Guide). A BSI that is identified as secondary to another site of infection must meet one of the infection criteria detailed in this chapter or an eligible infection criterion in the Patient Safety manual and meet other requirements. Secondary BSIs are not reported as Laboratory Confirmed Bloodstream Infections in NHSN, nor can they be associated with the use of a central line.

Knowledge Check #6

Ms. Fall Down has an NHSN qualifying KPRO on February 14. On February 18, she has a fall at home, and the surgical wound dehisces including the deep tissues. Upon arrival to the emergency department, she states her post-surgical pain had resolved, but she is now experiencing pain at a level 7/10. She is given intravenous Cefazolin which is continued for the next 4 days. On February 18 she returns to the operating room for wound inspection and closure – all three tissue levels are entered during the return to operating room and no cultures are collected. Which (if any) SSI criterion is met?

1. There is no SSI criterion met as this was a mechanical dehiscence
2. Superficial Incisional SSI 'c' is met
3. There is no SSI criterion met as there were no signs/symptoms of infection identified
4. Deep Incisional SSI 'c' is met

Diving Deep Into SSI Surveillance

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Knowledge Check #6 – Answer

Ms. Fall Down has an NHSN qualifying KPRO on February 14. On February 18, she has a fall at home, and the surgical wound dehisces including the deep tissues. Upon arrival to the emergency department, she states her post-surgical pain had resolved, but she is now experiencing pain at a level 7/10. She is given intravenous Cefazolin which is continued for the next 4 days. On February 18 she return to the operating room (OR) for wound inspection and closure – all three tissue levels are entered during the return to OR and no cultures are collected. Which (if any) SSI criterion is met?

1. There is no SSI criterion met as this was a mechanical dehiscence
2. Superficial Incisional SSI 'c' is met
3. There is no SSI criterion met as there were no signs/symptoms of infection identified
4. **Deep Incisional SSI 'c' is met** 

SEE NEXT SLIDE FOR RATIONALE

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Knowledge Check #6 – Rationale

Ms. Down has a dehiscence with subsequent return to OR where the deep incisional tissues are accessed. In addition, she is given an antibiotic on or in the two calendar days following the date of deliberate opening, re-access, aspiration or spontaneous dehiscence and is experiencing new onset of pain. Therefore, Deep Incisional SSI 'c' is met:

c. a deep incision that is deliberately opened†, re-accessed, or aspirated by a surgeon, physician‡ or physician designee or spontaneously dehisces¶

AND

the surgeon, physician‡, or physician designee initiates or continues antibiotic or antifungal therapy **on or in the two calendar days following the date of deliberate opening, re-access, aspiration or spontaneous dehiscence¶** with a duration of two calendar days or longer

AND

patient has at least ***one*** of the following signs or symptoms: fever (>38°C); new or worsening localized pain or tenderness

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How do I determine which site-specific definitions are eligible?

Table 3. Specific Sites of an Organ/Space SSI

Category	Specific Site	Category	Specific Site
BONE	Osteomyelitis	MED	Mediastinitis
BRST	Breast abscess or mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity infection (mouth, tongue, or gums)
DISC	Disc space infection	OREP	Deep pelvic tissue infection or other infection of the male or female reproductive tract
EAR	Ear, mastoid infection	PJI	Periprosthetic joint infection
EMET	Endometritis	SA	Spinal abscess/infection
ENDO	Endocarditis	SINU	Sinusitis
GIT	Gastrointestinal (GI) tract infection	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
IAB	Intraabdominal infection, not specified elsewhere	USI	Urinary System Infection
IC	Intracranial infection	VASC	Arterial or venous infection
JNT	Joint or bursa infection	VCUF	Vaginal cuff infection
LUNG	Other infection of the lower respiratory tract		

Criteria for these sites can be found in Chapter 17, Surveillance Definitions for Specific Types of Infections.

Appendix A contains a complete list of all NHSN operative procedure categories and the corresponding site-specific SSIs that may be attributable to each category.

APPENDIX A

Specific event types available for SSI attribution by NHSN procedure category

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

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SSI Date of Event (DOE)

- The date when the **first element** used to meet the SSI infection criterion occurs for the **first time** during the SSI surveillance period.
- The **DOE must occur within the SSI surveillance period** to meet SSI criteria.
  - There are some circumstances in which the DOE falls within the surveillance period, but some elements are just outside the surveillance period.
- The type of SSI (superficial incisional, deep incisional, or organ/space) submitted to NHSN and the DOE assigned must reflect the deepest tissue level where SSI criteria are met during the surveillance period.
- Example: HYST performed (date of procedure = day 1 of SSI surveillance period).
  - Superficial Incisional SSI is met with a DOE on day 7 of the surveillance period.
  - Organ/Space SSI – OREP is met with a DOE on day 16 of the surveillance period.
  - The Organ/Space SSI – OREP is the **ONLY** SSI event reported.

Timeframe for SSI elements

- SSI guidelines do not offer a strict timeframe for elements of criteria to occur but historically, all elements used to meet an SSI criterion **generally occur within a 7–10-day timeframe**.
- To ensure that all elements associate to the SSI, the elements must be relational to one another.
- Each case differs based on the individual elements occurring and the type of SSI but the **DOE for an SSI must occur within the appropriate 30- or 90-day SSI surveillance period**.
- Example: An element on day 5 of the surveillance period with another element three weeks later should not be used to cite an SSI.
- Cases differ based on elements that occur and type of SSI under consideration.

Secondary Bloodstream Infection (BSI) Scenarios for SSI

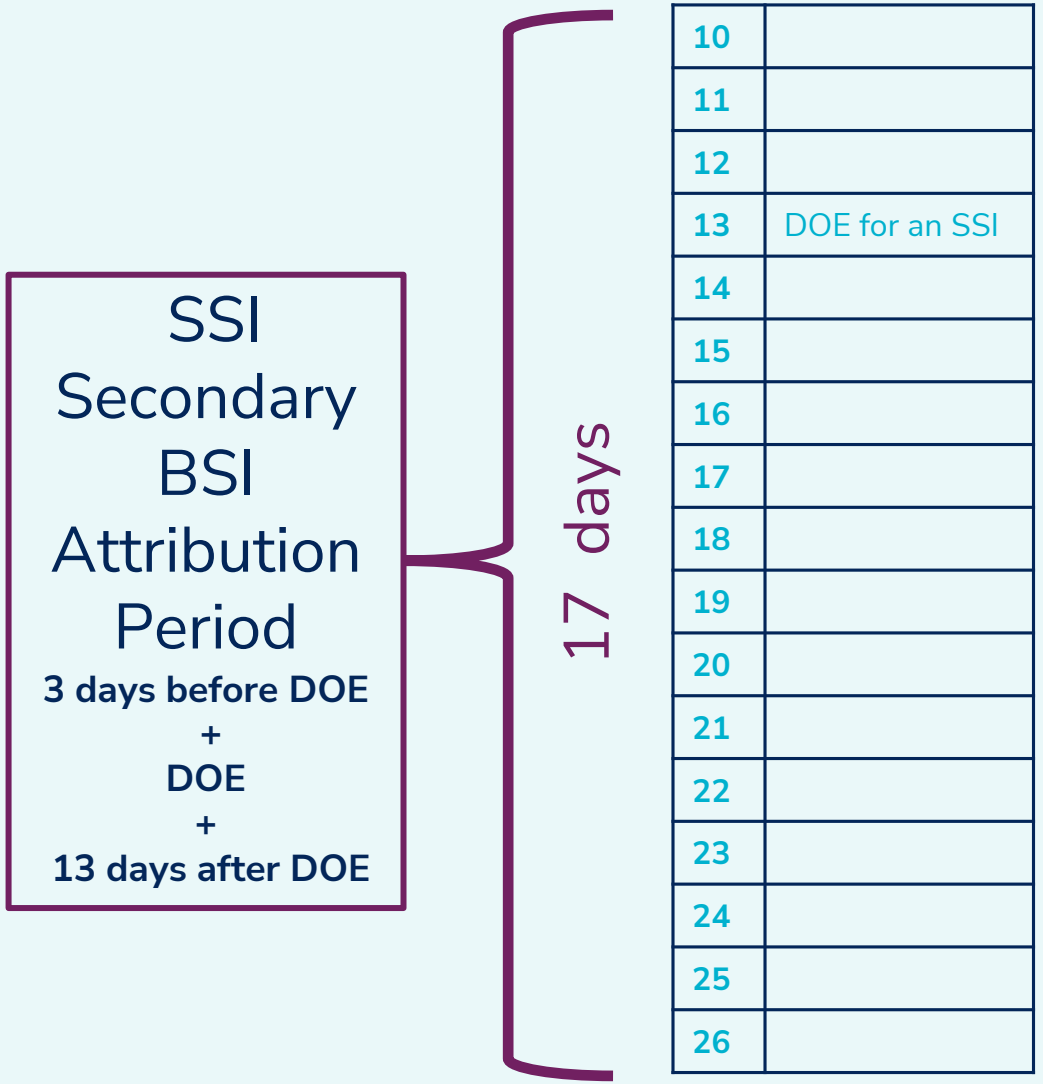
- **Scenario 1 (All levels of SSI):** At least one organism from the blood specimen matches an organism identified from the SSI specimen used as an element to meet the NHSN SSI criterion **AND** the blood specimen is collected during the secondary BSI attribution period. The secondary BSI attribution period for SSI is a 17-day period that includes the SSI DOE, 3 days prior, and 13 days after.

OR

- **Scenario 2 (Organ/Space SSI Only):** An organism identified in the blood specimen is an element that is used to meet the NHSN Organ/Space SSI site-specific infection criterion and is collected during the timeframe for SSI elements.

Scenario 1 – Utilize the Secondary BSI Attribution Period [SBAP]

- **Scenario 1 (All levels of SSI):** At least one organism from the blood specimen matches an organism identified from the SSI specimen used as an element to meet the NHSN SSI criterion **AND** the blood specimen is collected during the secondary BSI attribution period. The secondary BSI attribution period for SSI is a 17-day period that includes the SSI DOE, 3 days prior, and 13 days after.



Scenario 2 Example

- **Scenario 2 (Organ/Space SSI Only):** An organism identified in the blood specimen is an element that is used to meet the NHSN Organ/Space SSI site-specific infection criterion and is collected during the timeframe for SSI elements.

SA-Spinal abscess/infection (spinal abscess, spinal subdural or epidural infection)

Spinal abscess/infection must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from abscess or from purulent material found in the spinal epidural or subdural space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has an abscess or other evidence of spinal infection on gross anatomic or histopathologic exam.
3. Patient has at least ***one*** of the following localized signs or symptoms: fever (>38.0°C), back pain* or tenderness*, radiculitis*, paraparesis*, or paraplegia*

   And at least *one* of the following:

   a. organism(s) identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST)

   AND

   imaging test evidence definitive for spinal abscess/infection, which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for spinal abscess/infection.

   b. imaging test evidence definitive for a spinal abscess/infection (for example, myelography, ultrasound, CT scan, MRI, or other scans [gallium, technetium, etc.]) which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for spinal abscess/infection.

Secondary BSI Guide

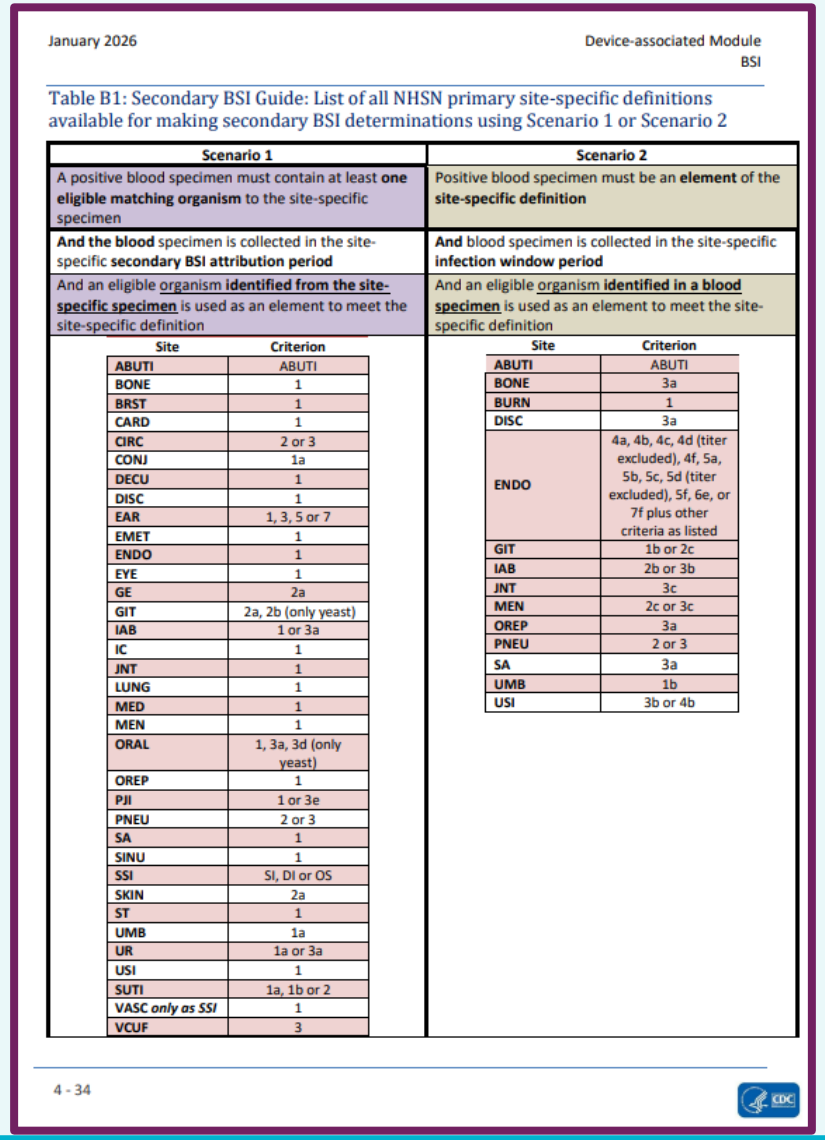


Table B1: Secondary BSI Guide: List of all NHSN primary site-specific definitions available for making secondary BSI determinations using Scenario 1 or Scenario 2

Scenario 1	Scenario 2
A positive blood specimen must contain at least **one eligible matching organism** to the site-specific specimen	Positive blood specimen must be an **element** of the **site-specific definition**
And the blood specimen is collected in the site-specific **secondary BSI attribution period**	**And** blood specimen is collected in the site-specific **infection window period**
And an eligible organism **identified from the site-specific specimen** is used as an element to meet the site-specific definition	And an eligible organism **identified in a blood specimen** is used as an element to meet the site-specific definition

Site	Criterion
ABUTI	ABUTI
BONE	1
BRST	1
CARD	1
CIRC	2 or 3
CONJ	1a
DECU	1
DISC	1
EAR	1, 3, 5 or 7
EMET	1
ENDO	1
EYE	1
GE	2a
GIT	2a, 2b (only yeast)
IAB	1 or 3a
IC	1
JNT	1
LUNG	1
MED	1
MEN	1
ORAL	1, 3a, 3d (only yeast)
OREP	1
PJI	1 or 3e
PNEU	2 or 3
SA	1
SINU	1
SSI	SI, DI or OS
SKIN	2a
ST	1
UMB	1a
UR	1a or 3a
USI	1
SUTI	1a, 1b or 2
VASC *only as SSI*	1
VCUF	3

Site	Criterion
ABUTI	ABUTI
BONE	3a
BURN	1
DISC	3a
ENDO	4a, 4b, 4c, 4d (titer excluded), 4f, 5a, 5b, 5c, 5d (titer excluded), 5f, 6e, or 7f plus other criteria as listed
GIT	1b or 2c
IAB	2b or 3b
JNT	3c
MEN	2c or 3c
OREP	3a
PNEU	2 or 3
SA	3a
UMB	1b
USI	3b or 4b

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Purulence

- There is no standard, clinically agreed upon definition for purulence.
- Descriptors “pus” or “purulence” are sufficient gross anatomic evidence of infection.
- Documentation that uses a color descriptor **and** a consistency descriptor in combination is acceptable to indicate ‘purulence’.
  - **Color**: Green, yellow
  - **Consistency**: Milky, thick, creamy, opaque, viscous
    - For example, fluid only described as yellow, or only described as thick, is not sufficient. However, if the terms are combined, then they may be more representative of purulence (for example: fluid described as thick and yellow).
- **NOTE:** The following descriptors cannot be used to define purulence/infection:
  - ‘Cloudy,’ ‘turbid,’ ‘murky,’ or the odor of a wound
- Gram stain results such as WBCs (white blood cells) or PMNs (polymorphonuclear leukocyte)cannot be used to define purulence within the SSI protocol.

Knowledge Check #7

Which of the following would be considered purulence for NHSN surveillance and reporting purposes? Select all that apply.

1. Tan, yellow, creamy drainage
2. Green, cloudy drainage
3. Green, opaque drainage
4. Yellow-green drainage

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Knowledge Check #7 – Answer and Rationale

Which of the following would be considered purulence for NHSN surveillance and reporting purposes? Select all that apply.

1. **Tan, yellow, creamy drainage** 
2. Green, cloudy drainage
3. **Green, opaque drainage** 
4. Yellow-green drainage

Documentation that uses a color descriptor and a consistency descriptor from the list below in combination is acceptable to indicate 'purulence'.

- Color: Green, yellow
- Consistency: Milky, thick, creamy, opaque, viscous

Diving Deep Into SSI Surveillance

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SSI Event Reporting Instruction #1

1. **Excluded organisms:** Organisms that primarily cause community-associated infections and are not known to (or rarely) cause healthcare-associated infections or surgical site infections, are excluded and cannot be used to meet any NHSN definition.
    - **Fungi:** *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus, Pneumocystis*
    - **Vector-borne bacteria:** *Anaplasma spp., Ehrlichia spp., Borrelia spp, Rickettsia spp.*

   In addition, organisms associated with latent infections (for example, herpes, shingles, syphilis, or tuberculosis) are excluded from meeting SSI criteria.

SSI Event Reporting Instruction #2

2. **Attributing SSI to an NHSN operative procedure when there is evidence of infection at the time of the primary surgery:** The present on admission (POA) definition does not apply to the SSI protocol. If evidence of infection is present at the time of the procedure and the patient meets SSI criteria within the SSI surveillance period following the procedure, an SSI is attributed to the procedure (for guidance on PATOS determination, see SSI Event Reporting Instruction #3).

SSI Event Reporting Instruction #3

3. **Infection present at time of surgery (PATOS):** PATOS is a YES/NO field found on the SSI event form. PATOS denotes there was evidence of infection visualized (seen) during the surgical procedure to which a subsequent SSI is attributed. The evidence of infection must be noted intraoperatively and documented within the narrative portion of the operative note or report of surgery to be eligible for PATOS (pre/post op diagnoses, 'indication for surgery', and other headings routinely included in an operative note are not eligible with answering PATOS).

   Key points for consideration:

   a) Only select PATOS = YES when it applies to the depth of the SSI that is being attributed to the procedure. Examples:

      - When a patient has documentation of an intraabdominal infection at time of surgery and then later returns with an organ/space SSI, PATOS = YES.

      - When a patient has documentation of an intraabdominal infection at time of surgery and then later returns with a superficial or deep incisional SSI, PATOS = NO.

   b) Examples of verbiage that is considered evidence of infection include but are not limited to: abscess, infection, purulence/pus, phlegmon, osteomyelitis, "feculent peritonitis", or a sinus tract [for HPRO/KPRO procedures ONLY]. A ruptured appendix is evidence of infection at the organ/space level.

   c) Examples of verbiage that is **not** considered evidence of infection include but are not limited to: colon perforation, contamination, necrosis, gangrene, fecal spillage, nicked bowel during procedure, murky fluid, or documentation of inflammation.

   d) The use of the ending "itis" in an operative note/report of surgery does not automatically meet PATOS, as it may only reflect inflammation which is not infectious in nature (for example, diverticulitis, peritonitis, and appendicitis).

   e) Pathology report findings and imaging test findings cannot be used for PATOS determination.

   f) Identification of an organism using culture or non-culture based microbiologic testing method or on a pathology report from a surgical specimen cannot be used for PATOS determination.

   g) Wound class assignment cannot be used for PATOS determination.

   h) Trauma resulting in a contaminated case does not automatically meet the PATOS requirement. For example, a fresh gunshot wound to the abdomen may be a trauma with a high wound class but there would not be time for infection to develop.

   i) For C-Section [CSEC] procedures ONLY: chorioamnionitis [including suspected chorioamnionitis] documented in the operative narrative is eligible for use for PATOS at the organ/space tissue level.

PATOS (Present At Time of Surgery)

- A **YES/NO** field found on the SSI event form that denotes there was evidence of infection visualized (seen) during the surgical procedure to which a subsequent SSI is attributed.
  - An SSI must be identified within the surveillance period following an NHSN operative procedure to review for PATOS.

- Evidence of infection must be noted intraoperatively and documented within the narrative portion of the operative note/report of surgery (commonly labeled 'procedure in detail'/'description of procedure' section)
  - NOT surgical narrative: Pre/post op diagnoses, 'indication for surgery' sections.
  - A 'Findings' section, if a reflection of what the surgeon 'sees' present at time of surgery, can be considered surgical narrative.

- PATOS is tissue level specific: documented infection must be at the same tissue level as subsequent SSI for PATOS = YES.

- Pathology reports, culture results, wound classification, trauma status, imaging test findings cannot be used with answering the PATOS question.

Chorioamnionitis

i) For C-Section [CSEC] procedures ONLY: chorioamnionitis [including suspected chorioamnionitis] documented in the operative narrative is eligible for use for PATOS at the organ/space tissue level.

Knowledge Check #8

Ms. See Section presents to triage in active labor and is running a fever of 101.6°F. Complete blood count shows a white blood cell count of 16,000 cells/mm^3 . During labor, the nurse notices fetal and maternal tachycardia. The decision is made to take Ms. See for a C-section. In the operative narrative there is documentation of suspected intra-amniotic infection, but no gross anatomic evidence of infection was seen. 3 weeks after the C-section an Organ/Space SSI – EMET is identified and reported. How would the PATOS question on the SSI Event form be answered?

1. PATOS = NO, there was no gross anatomic evidence of infection
2. This question does not apply to C-section procedures
3. PATOS = YES, documentation of suspected intraamniotic infection meets for PATOS at the Organ/Space tissue level

Diving Deep Into SSI Surveillance

Knowledge Check #8 – Answer and Rationale

Ms. See Section presents to triage in active labor and is running a fever of 101.6°F. Complete blood count shows a white blood cell count of 16,000 cells/mm^3 . During labor, the nurse notices fetal and maternal tachycardia. The decision is made to take Ms. See for a C-section. In the operative narrative there is documentation of suspected intraamniotic infection, but no gross anatomic evidence of infection was seen. 3 weeks after the C-section an Organ/Space SSI – EMET is identified and reported. How would the PATOS question on the SSI Event form be answered?

1. PATOS = NO, there was no gross anatomic evidence of infection
2. This question does not apply to C-section procedures
3. **PATOS = YES, documentation of suspected intraamniotic infection meets for PATOS at the organ/space tissue level**

Documentation of intra-amniotic infection [also known as chorioamnionitis] is eligible for use for PATOS for a subsequent SSI event of the organ/space tissue level.

Diving Deep Into SSI Surveillance

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SSI Event Reporting Instruction #4

4. **Multiple tissue levels are involved in the infection:** The type of SSI (superficial incisional, deep incisional, or organ/space) reported must reflect the deepest tissue level where SSI criteria are met during the surveillance period. The DOE assigned is the date of the first element used to meet the SSI criteria at the deepest tissue level that is met.
    - Report infection that meets criteria for organ/space SSI as an organ/space SSI, regardless of superficial or deep tissue involvement.
    - Report infection that meets criteria for deep incisional SSI as a deep incisional SSI, regardless of superficial tissue involvement.
    - If a patient meets criteria for a deep incisional SSI on day 10 of the SSI surveillance period and a week later (day 17 of the SSI surveillance period) the patient meets criteria for an organ/space SSI, the DOE assigned is the date of the organ/space SSI.

SSI Event Reporting Instruction #5

5. **Attributing SSI to a NHSN procedure when several are performed on different dates:** Each trip to the OR for an NHSN operative procedure sets an SSI surveillance period. When a patient has several NHSN operative procedures performed on different dates, attribute the SSI to the most recently performed NHSN operative procedure [for which the patient is in an SSI surveillance period for]

   Note: For multiple NHSN operative procedures performed within a 24-hour period, see Denominator Reporting Instruction #7.

SSI Event Reporting Instruction #6

6. **Attributing SSI to NHSN procedures that involve multiple primary incision sites:** When multiple primary incision sites of the same NHSN operative procedure become infected, report as a single SSI, and assign the type of SSI (superficial incisional, deep incisional, or organ/space) that represents the deepest tissue level where SSI criteria are met at any of the involved primary incision sites during the surveillance period. Examples:

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

SSI Event Reporting Instruction #7

7. **Attributing SSI to NHSN operative procedures that have secondary incision sites**: Certain procedures can involve secondary incisions (specifically, BRST, CBGB, CEA, FUSN, PVBY, REC, and VSHN). Secondary incision sites are monitored for Superficial Incisional Secondary (SIS) SSI and Deep Incisional Secondary (DIS) SSI. The surveillance period for all secondary incision sites is 30 days, regardless of the required deep incisional or organ/space SSI surveillance period for the primary incision site(s) (Table 2). Procedures meeting this designation are reported as one operative procedure, although up to two SSI events can be reported linked to the procedure (a primary incision site SSI and a secondary incision site SSI). For example:

   - A saphenous vein harvest incision site in a CBGB procedure is considered the secondary incision site. One CBGB procedure is reported, the saphenous vein harvest site is monitored for 30 days following surgery for SSI, and the chest incision is monitored for 90 days following surgery for SSI. If the patient meets criteria for an SSI at the saphenous vein harvest site (such as a superficial incisional SSI) and meets criteria for an SSI at the chest site (such as a deep incisional SSI) two SSIs are reported and linked to the CBGB procedure.
   - A tissue harvest site (for example, Transverse Rectus Abdominis Myocutaneous [TRAM] flap) in a BRST procedure is considered the secondary incision site. One BRST procedure is reported, and if the secondary incision site becomes infected, report as either SIS or DIS as appropriate.

SSI Event Reporting Instruction #8

8. **SSI detected at another facility:** An SSI event is reported by the facility where the NHSN operative procedure was performed. When a potential SSI is detected at a facility other than the one where the procedure was performed, enough detail is provided to the reporting facility in the event an SSI should be reported to NHSN. If an SSI is determined, the reporting facility should indicate **Detected = RO** (patient readmission to a facility other than where procedure was performed) on the SSI event form when reporting the SSI.

SSI Event Reporting Instruction #9

9. **SSI attribution after multiple categories of NHSN procedures are performed during a single trip to the OR**: When more than one NHSN operative procedure category is performed through a single incision/laparoscopic site(s) during a single trip to the operating room, attribute the SSI to the procedure associated to the infection. When attribution is not clear, use the NHSN Principal Operative Procedure Category Selection Lists (Table 4) to select the operative procedure to which the SSI should be attributed. For example, when a patient meets criteria for an SSI after a single trip to the OR in which both a COLO and SB were performed, and the source of the SSI is not apparent, assign the SSI to the COLO procedure per Table 4.

   The final decision for **SSI attribution lies with the local facility based on the full details of the case as documented in the medical record**. It is critical that documentation is included which supports the SSI attribution.

SSI Event Reporting Instruction #10

10. **SSI following invasive manipulation or accession of the operative site:** An SSI will **NOT** be attributed when the following 3 criteria are ALL met:

- during the post-operative period there is no suspicion or evidence of infection related to the surgical site/space.

  And
- an invasive manipulation or accession of the site/space is performed for diagnostic or therapeutic purposes (for example, needle aspiration, accession of ventricular shunts, accession of breast expanders).

  And
- an infection subsequently develops in a tissue level which was entered during the manipulation/accession.

Notes:

- Suspicion or evidence of infection may include signs and symptoms of infection (for example, fever or pain) depending on the site of the procedure.
- Tissue levels not manipulated/accessed are still eligible for SSI. For example, a superficial debridement following a COLO procedure, where the muscle/fascia and organ/space is not entered, a subsequent deep incisional or organ/space SSI following the debridement may be an SSI attributable to the COLO procedure.
- This reporting instruction does NOT apply to closed manipulation (for example, closed reduction of a dislocated hip after an orthopedic procedure).
- Invasive manipulation does not include wound packing or changing of wound packing materials as part of postoperative care.
- Routine flushing of catheters as part of the facility's standard care and maintenance is not considered invasive manipulation.
- Each trip to the OR for an NHSN operative procedure sets an SSI surveillance period for the surgical site.

SSI Event Reporting Instruction #11

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

SSI Attribution – Table 4

- SSI Event Reporting Instruction #9 Table 4, page 9-23 of the SSI protocol is used to determine SSI attribution since source of attribution is not clear.

9. **SSI attribution after multiple categories of NHSN procedures are performed during a single trip to the OR:** When more than one NHSN operative procedure category is performed through a single incision/laparoscopic site(s) during a single trip to the operating room, attribute the SSI to the procedure associated to the infection. When attribution is not clear, as is often the case when the infection is an incisional SSI, use the NHSN Principal Operative Procedure Category Selection Lists (Table 4) to select the operative procedure to which the SSI should be attributed. For example, when a patient meets criteria for an SSI after a single trip to the OR in which both a COLO and SB were performed, and the source of the SSI is not apparent, assign the SSI to the COLO procedure per Table 4. The final decision for SSI attribution lies with the local facility based on the full details of the case.

Table 4. NHSN Principal Operative Procedure Category Selection List

(The categories with the highest risk of SSI are listed before those with lower risks.)

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

Case Studies

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CASE STUDY 1

Ms. Ima Starr presents to Enterprise Medical Center on 1/5/26 for an elective small bowel procedure. Intraoperatively, a colon perforation occurs, immediately recognized and repaired. The surgeon's op note indicates only a small amount of purulence escaped at the site of perforation. The surgical episode codes into SB and COLO procedure categories. The monthly reporting plan for this facility includes small bowel and colon procedure SSI surveillance.

Question 1: Is there language for PATOS (infection present at time of surgery)?

1. Yes - a perforation automatically qualifies as infection
2. No – a perforation is a complication of surgery not an infection
3. No – there is no language in the op note consistent with infection
4. Yes – the purulence documented in the op-note is gross anatomic evidence of infection

Question 1-1: Is there language for PATOS (infection present at time of surgery) in the op-note?

1. Yes, a perforation automatically qualifies as infection
2. No – a perforation is a complication of surgery not an infection
3. No – there is no language in the op note consistent with infection.
4. **Yes – the purulence documented in the op-note is gross anatomic evidence of infection.** 

Rationale: SSI Reporting Instruction # 3 - Infection present at time of surgery (PATOS): PATOS is a YES/NO field found on the SSI event form. PATOS denotes there was evidence of infection visualized (seen) during the surgical procedure to which a subsequent SSI is attributed. The evidence of infection must be noted intraoperatively and documented within the narrative portion of the operative note or report of surgery to be eligible for PATOS (SSI protocol pg. 9-18).
Key point for consideration: Only select PATOS = YES when it applies to the depth of the SSI that is being attributed to the procedure.

CASE STUDY 1

Ms. Ima Starr presents to Enterprise Medical Center on 1/5/26 for an elective small bowel procedure. The patient is discharged home 1/7. Office follow-up on 1/20 where surgeon documents a slight opening in the midline surgical incision with serous drainage. There's redness at the incision site, but the patient denies pain stating, 'my abdomen is just more tender since I've been home." The surgeon extends the opening in the midline incision for a better look at superficial tissues, decides all is well but prescribes a short 3-day course of antibiotics at the patient's insistence. This information is available through a common patient record system.

- 1/5: SB and COLO procedure
- 1/7: discharge home
- 1/20: Office visit – slight opening midline incision, serous drainage, redness, no pain, new worsening abdominal tenderness
- 1/20: Office visit – MD extends midline incision opening, antibiotics x 3 days

CASE STUDY 1

Ms. Ima Starr presents to Enterprise Medical Center on 1/5/26 for an elective small bowel procedure. The patient is discharged home 1/7. Office follow-up on 1/20 where surgeon documents a slight opening in the midline surgical incision with serous drainage. There's redness at the incision site, but the patient denies pain stating, 'my abdomen is just more tender since I've been home." The surgeon extends the opening in the midline incision for a better look at superficial tissues, decides all is well but prescribes a short 3-day course of antibiotics at the patient's insistence. This information is available through a common patient record system.

Question 1-2: Is an SSI criterion met 1/20 during the follow-up office visit?

1. Yes –superficial incisional SSI criteria 'a' is met
2. Yes – superficial incisional SSI criteria 'b' is met
3. Yes – superficial incisional SSI criteria 'c' is met
4. Yes – superficial incisional SSI criteria 'd' is met

Question 1-2: Is an SSI Criteria met on 1/20 office visit?

RATIONALE:

1. Yes – Superficial incisional SSI 'a' is met
2. Yes – superficial incisional SSI criteria 'b' is met
3. **Yes – superficial incisional SSI criteria 'c' is met**
4. Yes – superficial incisional SSI criteria 'd' is met

Rationale: SI-SSI criteria: Patient has at least one of the following:
c. a superficial incision that is **deliberately opened, re-accessed** or aspirated by surgeon, physician*, or physician designee **AND** the **physician initiates or continues antibiotic** or antifungal therapy on or in the **two calendar days following** the date of deliberate opening, re-access, aspiration with a **duration of two calendar days or longer AND** patient has at least one of the following signs or symptoms: new or **worsening localized** pain or **tenderness,** localized swelling, erythema, or heat

CASE STUDY 1

Ms. Ima Starr presents to Enterprise Medical Center Hospital on 1/5/26 for an elective small bowel procedure. Intraoperatively, a colon perforation occurs, it's immediately recognized and repaired. The surgical episode is coded as an SB and COLO procedure. The monthly reporting plan for the facility includes small bowel and colon procedure SSI surveillance. A Superficial Incisional SSI is identified on 1/20/26.

Question 1-3: When reported into NHSN, which denominator procedure receives attribution?

1. The SB procedure because it was the planned procedure
2. The COLO procedure
3. We can't tell, attribute the SSI to both procedures.

Question 1-3: Which procedure receives attribution of this SIP?

1. The SB procedure because it was the planned procedure
2. **The COLO procedure** 
3. We can't tell, attribute the SSI to both procedures

Rationale: SSI Reporting Instruction #9. **SSI attribution after multiple categories of NHSN procedures are performed during a single trip to the OR**: When more than one NHSN operative procedure category is performed through a single incision/laparoscopic site(s) during a single trip to the operating room, attribute the SSI to the procedure associated to the infection. When **attribution is not clear,** use the NHSN Principal Operative Procedure Category Selection Lists **(Table 4)** to select the operative procedure to which the SSI should be attributed. (SSI protocol pg. 9-22; Table 4 pg. 9-24)

CASE STUDY 1

Ms. Ima Starr presents to Enterprise Medical Center Hospital on 1/5/26 for an elective small bowel procedure. Intraoperatively, a colon perforation occurs, it's immediately recognized and repaired. The surgical episode is coded as an SB and COLO procedure. The monthly reporting plan for the facility includes small bowel and colon procedure SSI surveillance. A Superficial Incisional SSI is identified on 1/20/26. The facility sends surgeon letters as part of their post-discharge surveillance. The surgeon letter is returned with no SSI identified.

Question 1-4: Does the surgeon opinion of no SSI change the SSI citation?

1. Yes – the surgeon opinion is highest priority in SSI surveillance
2. Yes – it's inappropriate to submit an SSI to NHSN if the MD doesn't agree
3. No – when an SSI criteria is met in the appropriate surveillance period following an NHSN operative procedure, an SSI is reported to NHSN

Question 1-4: Does the MD opinion of no SSI change the SSI citation?

1. Yes – the surgeon opinion is highest priority in SSI surveillance
2. Yes – it's inappropriate to submit an SSI to NHSN if the surgeon doesn't agree
3. **No – when an SSI criteria is met in the appropriate surveillance period following an NHSN operative procedure, an SSI is reported to NHSN** 

Rationale: SSI Reporting Instruction #11: Reporting instructions for post-operative infection scenarios: An SSI should be reported to NHSN without regard to …. other occurrences that may or may not be attributable to postoperative actions (extends to include surgeon opinion of an event). This instruction concerning various postoperative circumstances is necessary to reduce subjectivity and data collection burden. (SSI protocol, pg. 9-23).

- Surveillance definitions are intentionally standardized to minimize subjectivity and ensure consistency in reporting across all NHSN-participating facilities. While NHSN recognizes surveillance definitions may not always align with clinical judgment or perceived preventability, their purpose is to enable uniform data collection and meaningful comparison across institutions. These definitions are designed to capture the broadest scope of events within defined parameters and support consistent application across time and facilities.

CASE STUDY 2 – QUESTION 1

Mr. Scoobi Diver had a KPRO (Knee Prosthesis) NHSN operative procedure performed on 1/20/2026 and is then discharged 1/21/2026. On 2/1/2026 he presents to the provider's office with knee pain and swelling. No fever. Incision is healing well. Synovial fluid aspirate culture shows few MRSA (Methicillin-resistant Staphylococcus aureus) in enrichment broth only. CRP (C-reactive protein) 10 mg/dl, ESR (erythrocyte sedimentation rate) 10 mm/hr.

On 2/3/2026 the patient is taken to the OR for revision. Two periprosthetic cultures are collected, culture #1 showing MRSA, culture #2 showing no growth. No sinus tract is noted, no purulence. Synovial fluid alpha-defensin is positive. No other laboratory values are available.

Question 1: Does the patient have an SSI on 2/1/2026?

a. Yes. Scenario meets Superficial SSI definitions.
b. No. The MRSA in enrichment broth can't be used to meet SSI definitions.
c. Organ/space SSI b definitions are met, but PJI (Periprosthetic Joint Infection)definitions are not met.
d. Organ/space SSI definitions are not met, but PJI 3. definitions are met

Diver Q1: Does the patient have an SSI on 2/1/2026?

Mr. Scoobi Diver had a KPRO (Knee Prosthesis) NHSN operative procedure performed on 1/20/2026 and is then discharged 1/21/2026. On 2/1/2026 he presents to the provider's office with knee pain and swelling. No fever. Incision is healing well. Synovial fluid aspirate culture shows few MRSA in enrichment broth only. CRP 10 mg/dl, ESR 10 mm/hr.

On 2/3/2026 the patient is taken to the OR for revision. Two periprosthetic cultures are collected, culture #1 showing MRSA, culture #2 showing no growth. No sinus tract is noted, no purulence. Synovial fluid alpha-defensin is positive. No other laboratory values are available.

Question 1: Does the patient have an SSI on 2/1/2026?

a. Yes. Scenario meets Superficial SSI definitions.
b. No. The MRSA in enrichment broth can't be used to meet SSI definitions.
c. Organ/space SSI b definitions are met, but PJI definitions are not met.
d. Organ/space SSI definitions are not met, but PJI 3. definitions are met.

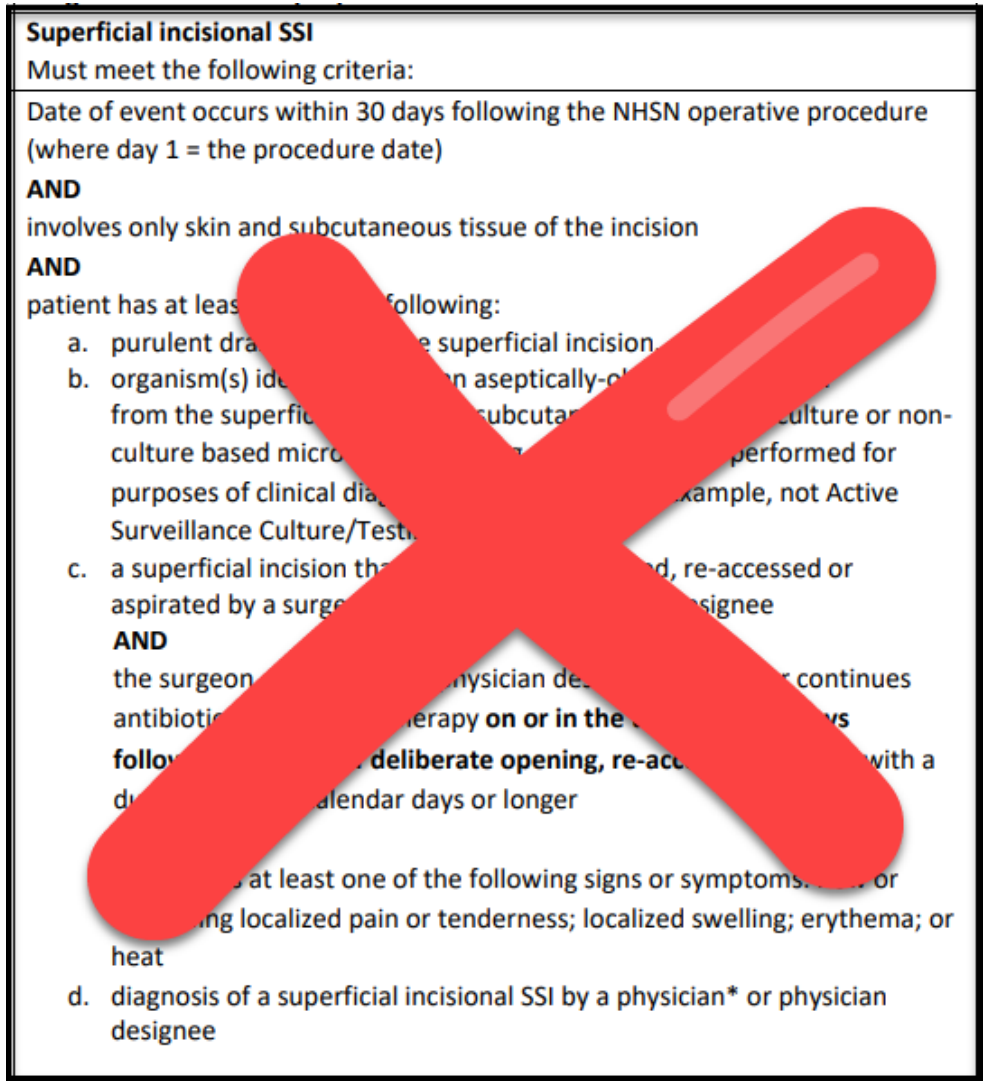
Diver Q1: Does the patient have an SSI on 2/1/2026? (Cont.)

Question 1: Does the patient have an SSI on 2/1/2026?

a. Yes. Scenario meets Superficial SSI definitions.
b. No. The MRSA in enrichment broth can't be used to meet SSI definitions.
c. Organ/space SSI b definitions are met, but PJI definitions are not met.
d. Organ/space SSI definitions are not met, but PJI 3. definitions are met

- Although the scenario describes a symptom which is an element of Superficial SSI definitions, no Superficial SSI definitions are fully met.
- Organisms identified in enrichment broth qualify for use to meet SSI culture definitions.
- The MRSA culture finding meets O/S SSI b definitions, but PJI 1, 2, or 3 are NOT met.

Diver Q 1: Does the patient have an SSI on 2/1/2026?



Superficial incisional SSI

Must meet the following criteria:

Date of event occurs within 30 days following the NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

patient has at leas… following:

a. purulent dra… superficial incision

b. organism(s) ide… n aseptically-o… from the superfi… subcutan… ulture or non-culture based micro… performed for purposes of clinical dia… xample, not Active Surveillance Culture/Testi…

c. a superficial incision th… d, re-accessed or aspirated by a surge… signee

AND

the surgeon… hysician de… continues antibiotic… erapy **on or in the** … **ys follo… deliberate opening, re-acc…** with a d… alendar days or longer

… at least one of the following signs or symptoms: … or …ng localized pain or tenderness; localized swelling; erythema; or heat

d. diagnosis of a superficial incisional SSI by a physician* or physician designee

Organ/Space SSI

Must meet the following criteria:

Date of event occurs within 30 or 90 days following the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

involves the organ/space tissues (deeper than the fascia/muscle)

AND

patient has at least ***one*** of the following:

a. purulent drainage from a drain placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT-guided drainage)

b. organism(s) identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])

c. an abscess or other evidence of infection involving the organ/space detected on:
   - gross anatomical exam or
   - histopathologic exam or
   - imaging test evidence definitive or equivocal for infection

AND

meets at least ***one*** eligible [per Appendix A]criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections (Chapter 17).

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Diver Q1: Does the patient have an SSI on 2/1/2026? (Cont'd)

Organ/Space SSI

Must meet the following criteria:

Date of event occurs within 30 or 90 days following the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

involves the organ/space tissues (deeper than the fascia/muscle)

AND

patient has at least ***one*** of the following:

a. purulent drainage from a drain placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT-guided drainage)

b. organism(s) identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])

c. an abscess or other evidence of infection involving the organ/space detected on:
   - gross anatomical exam or
   - histopathologic exam or
   - imaging test evidence definitive or equivocal for infection

AND

meets at least ***one*** eligible [per Appendix A]criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections (Chapter 17).

PJI – Periprosthetic Joint Infection (for use as Organ/Space SSI following HPRO and KPRO only)

Periprosthetic joint or bursa infections must meet at least ***one*** of the following criteria:

1. ***Two*** positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract* communicating with the joint, purulence, or other gross anatomic evidence of infection.
3. Having ***three*** of the following minor criteria:
   a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
   b. elevated synovial fluid white blood cell (WBC; >10,000 cells/µL) count *OR* "++" *(or greater)* change on leukocyte esterase test strip of synovial fluid.
   c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
   d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).
   e. organism(s) identified from a single positive periprosthetic specimen (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   f. Synovial fluid alpha-defensin positive.
   g. Physician diagnosis of periprosthetic joint infection.

For PJI 3, three of the listed elements are needed to fully meet the definition.

CASE STUDY 2 – QUESTION 2

Mr. Scoobi Diver had a KPRO (Knee Prosthesis) NHSN operative procedure performed on 1/20/2026 and is then discharged 1/21/2026. On 2/1/2026 he presents to the provider's office with knee pain and swelling. No fever. Incision is healing well. Synovial fluid aspirate culture shows few MRSA in enrichment broth only. CRP 10 mg/dl, ESR 10 mm/hr.

On 2/3/2026 the patient is taken to the OR for revision. Two periprosthetic cultures are collected, culture #1 showing MRSA, culture #2 showing no growth. No sinus tract is noted, no purulence. Synovial fluid alpha-defensin is positive. No other laboratory values are available.

Question 2: Does the patient have an SSI on 2/3/2026?

a) No. No matching organisms from two periprosthetic cultures to meet PJI 1.

b) No. PJI 3. e. and f. are met, but the third required element is missing.

c) Yes. Organ/space SSI b, and PJI 1. are met.

d) Organ/space SSI b, and JNT 1 definitions are met.

Diver Q2: Does the patient have an SSI on 2/3/2026?

Mr. Scoobi Diver had a KPRO (Knee Prosthesis) NHSN operative procedure performed on 1/20/2026 and is then discharged 1/21/2026. On 2/1/2026 he presents to the provider's office with knee pain and swelling. No fever. Incision is healing well. Synovial fluid aspirate culture shows few MRSA in enrichment broth only. CRP 10 mg/dl, ESR 10 mm/hr.

On 2/3/2026 the patient is taken to the OR for revision. Two periprosthetic cultures are collected, culture #1 showing MRSA, culture #2 showing no growth. No sinus tract is noted, no purulence. Synovial fluid alpha-defensin is positive. No other laboratory values are available.

Question 2: Does the patient have an SSI on 2/3/2026?

a) No. No matching organisms from two periprosthetic cultures to meet PJI 1.

b) No. PJI 3. e. and f. are met, but the third required element is missing.

c) Yes. Organ/space SSI b, and PJI 1. are met

d) Organ/space SSI b, and JNT 1 definitions are met

Diver Q 2: Does the patient have an SSI on 2/3/2026?

a) No. No matching organisms from two periprosthetic cultures to meet PJI 1.

b) No. PJI 3. e. and f. are met, but the third required element is missing.

c) Yes. Organ/space SSI b, and PJI 1 are met.

d) Organ/space SSI b, and JNT 1 definitions are met.

- The two periprosthetic cultures from 2/1/26 and 2/3/2026 are used to meet PJI 1.
- JNT definitions are not used during the surveillance period for KPRO and HPRO procedures. PJI is used.
- Remember that PJI 3 requires three of the listed elements to fully meet definitions.

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Diver Q 2: Does the patient have an SSI on 02/3/2026?

PJI – Periprosthetic Joint Infection (for use as Organ/Space SSI following HPRO and KPRO only)

Periprosthetic joint or bursa infections must meet at least ***one*** of the following criteria:

1. ***Two*** positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract* communicating with the joint, purulence, or other gross anatomic evidence of infection.
3. Having ***three*** of the following minor criteria:
   a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
   b. elevated synovial fluid white blood cell (WBC; >10,000 cells/µL) count *OR* "++" *(or greater)* change on leukocyte esterase test strip of synovial fluid.
   c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
   d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).

   e. organism(s) identified from a single positive periprosthetic specimen (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   f. Synovial fluid alpha-defensin positive.
   g. Physician diagnosis of periprosthetic joint infection.

JNT-Joint or bursa infection (not for use as Organ/Space SSI after HPRO or KPRO procedures)

Joint or bursa infections must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from joint fluid or synovial biopsy by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of joint or bursa infection on gross anatomic or histopathologic exam.
3. Patient has a suspected joint or bursa infection and at least two of the following signs or symptoms: swelling*, pain* or tenderness*, heat*, evidence of effusion*, or limitation of motion*.
   And at least *one* of the following:
   a. elevated joint fluid white blood cell count (per reporting laboratory's reference range) OR positive leukocyte esterase test strip of joint fluid.
   b. organism(s) and white blood cells seen on Gram stain of joint fluid.
   c. organism(s) identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   d. imaging test evidence definitive for infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for joint or bursa infection.

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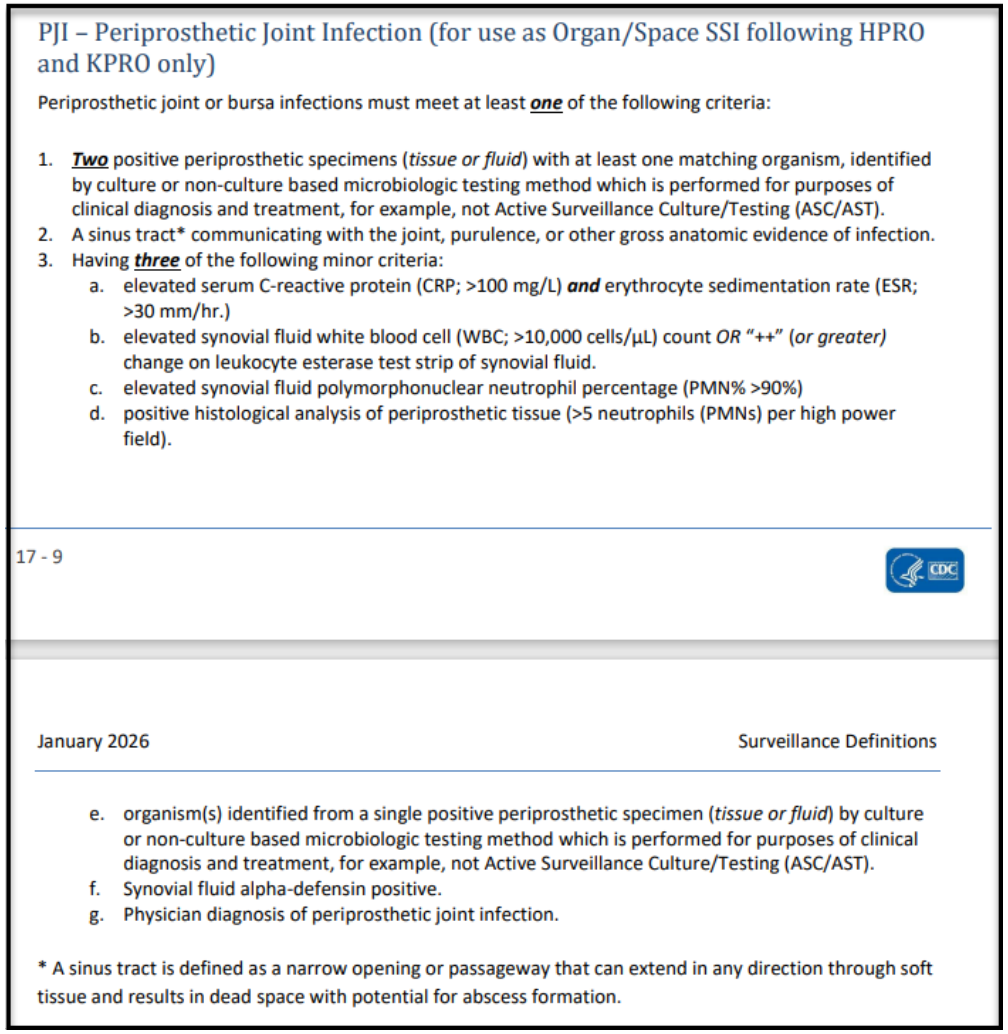
Diver Q 2: Does the patient have an SSI on 02/03/2026?



PJI – Periprosthetic Joint Infection (for use as Organ/Space SSI following HPRO and KPRO only)

Periprosthetic joint or bursa infections must meet at least ***one*** of the following criteria:

1. ***Two*** positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract* communicating with the joint, purulence, or other gross anatomic evidence of infection.
3. Having ***three*** of the following minor criteria:
   a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
   b. elevated synovial fluid white blood cell (WBC; >10,000 cells/µL) count *OR* "++" *(or greater)* change on leukocyte esterase test strip of synovial fluid.
   c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
   d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).

17 - 9

January 2026 Surveillance Definitions

   e. organism(s) identified from a single positive periprosthetic specimen (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   f. Synovial fluid alpha-defensin positive.
   g. Physician diagnosis of periprosthetic joint infection.

* A sinus tract is defined as a narrow opening or passageway that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.

Reminders on PJI definitions:

- Two periprosthetic specimens to meet PJI 1 may be collected on two different dates within the surveillance period.
- Sinus tract may be mentioned in the procedure note or described. The organ/space tissue level must be involved in the communication channel of tissue levels. Exit through the skin is not required to meet sinus tract.
- Purulence or other gross anatomic evidence of infection meets PJI 2.
- Alpha-defensin is added to the definition for 2026.
- Physician diagnosis was added to the definition for 2026.
- JNT definitions are not used in HPRO and KPRO surveillance periods to meet site specific definitions.

CASE STUDY 3

Mr. Will Power presents to a Pittsburgh emergency department (which shall remain unnamed) 2300 on 3/1 with nausea/vomiting (N/V) & acute abdominal pain. The patient relates an uneventful planned appendix removal (APPY) 3/1 start time 0800 in the hospital main operating room (OR), d/c home 1600. Surgeon called/visits and takes the patient directly to OR for a second look (XLAP) procedure, start time 0200 3/2. An existing trocar site is used to open the abdomen where an inflamed pancreas covered with fibrous exudate is identified.

No other significant findings are noted; 0600, patient admitted and moved to the inpatient surgical unit. The surgical unit admission assessment notes the patient is 3 weeks post-op total hip replacement at an ambulatory surgery center (not part of the hospital). Review of hip incision is unremarkable, healing well, no infection suspected. The APPY and XLAP are performed at this same facility where SSI surveillance for all NHSN operative procedures is conducted.

Question 3-1: What type of SSI surveillance is conducted by the hospital?

3/1 0800 APPY – discharge home 1600
3/1 2300 – ED visit with N/V, acute abdominal pain
3/2 0200 XLAP – trocar incision extended, findings: inflamed pancreas with fibrinous exudate
3/2 0600 transfer to inpatient surgical unit
3/2 admission assessment – pt. 3 weeks post-op HPRO with hip incision healing, no s/sx infection

1. SSI surveillance for APPY
2. SSI surveillance for XLAP
3. SSI surveillance for APPY and XLAP
4. SSI surveillance for HPRO
5. No SSI surveillance is conducted

Question 3-1: What type of SSI surveillance is conducted by the hospital?

1. **SSI surveillance for APPY** 
2. SSI surveillance for XLAP
3. SSI surveillance for APPY and XLAP
4. SSI surveillance for HPRO
5. No SSI surveillance is conducted

Rationale: Denominator Reporting Instruction #7 (SSI protocol pg. 9-25): **More than one operative procedure through same incision/surgical space within 24 hours**: When a patient has more than one operative procedure via the same incision or into the same surgical space, and the second procedure start time is within 24 hours of the first procedure finish time, **report one Denominator for Procedure form for the original procedure**, *combining the durations for both procedures* based on the procedure start times and finish times for both procedures.

**SSI surveillance is set by the denominator record submitted to NHSN – in this case, the APPY is the reported denominator and starts a 30-day surveillance period for monitoring of SSI event linked to this denominator.

Question 3-2: Is an SSI criteria met with the information provided?

1. Yes, Superficial Incisional SSI criteria 'c' is met.
2. Yes, Deep Incisional SSI criteria 'c' is met.
3. Yes, Organ/Space SSI criteria 'c' is met.
4. No, SSI criteria is not met given the information provided.

3/1 0800 APPY – discharge home 1600

3/1 2300 – ED visit with N/V, acute abdominal pain

3/2 0200 XLAP – OR findings: inflamed pancreas with fibrinous exudate

3/2 0600 transfer to inpatient surgical unit

3/2 admission assessment – pt. 3 weeks post-op HPRO with hip incision healing, no signs or symptoms of infection

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Question 3-2: Is an SSI criteria met with the information provided? (Cont.)

1. Yes, Superficial Incisional SSI criteria 'c' is met
2. Yes, Deep Incisional SSI criteria 'c' is met
3. Yes, Organ/Space SSI criteria 'c' is met
4. **No, SSI criteria is not met given the information provided** 

Rationale: The XLAP performed 3/2 becomes a part of the 3/1 APPY procedure as these procedures occur within 24 hours of each other. The symptoms noted between APPY and XLAP are not eligible for use in meeting an SSI criteria nor is the re-op itself eligible as an element in meeting criteria (does not qualify as a deliberate re-opening of the surgical space). Additionally, any evidence of infection noted at time of XLAP is not eligible for use in meeting SSI criteria. Evidence of infection noted at time of APPY or at time of XLAP is eligible for a PATOS determination if a subsequent SSI is identified.

Question 3-3: Is the denominator reported as an outpatient or inpatient procedure?

Let's revisit the case details:

3/1 0800 APPY – discharged home 1600

3/1 2300 ED with nausea/vomiting and acute abdominal pain

3/2 0200 XLAP – OR findings inflamed pancreas with fibrinous exudate

3/2 0600 Admit to inpatient unit

1. Report as an outpatient procedure.
2. Report as an inpatient procedure.
3. Report the 3/1 APPY as an outpatient procedure and the 3/2 XLAP as an inpatient procedure.
4. I'm Lost!! Why does it matter????

Question 3-3: Is the denominator reported as an outpatient or inpatient procedure?

1. **Report as an outpatient procedure.** 
2. **Report as an inpatient procedure.**
3. **Report the 3/1 APPY as an outpatient procedure and the 3/2 XLAP as an inpatient procedure.**
4. **I'm Lost!! Why does it matter????**

Rationale: SSI protocol pg. 9-8:

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

NHSN **Outpatient** Operative Procedure: An NHSN operative procedure performed on a patient whose date of admission to the healthcare facility and date of discharge are the same calendar day.

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CASE STUDY 4 – QUESTION 1

31-year-old patient Divey Shipwreck is admitted on 1/1/2026 and delivers a healthy baby boy via CSEC on 1/2/2026. The treating OB/GYN (obstetrician/gynecologist) mentions in the narrative of the operative note suspicion of chorioamnionitis, but no gross anatomic evidence of infection is documented. The patient is discharged after uneventful hospitalization.

On 1/20/2026, patient presents to the emergency department (ED) with severe abdominal pain. OB/GYN consult notes include suspicion of endometritis. Fever of 102.0 degrees Fahrenheit is noted in the ED. Antimicrobials are initiated. No imaging has been ordered. No cultures were collected. No description of purulence. Incision is healing well.

Question 1: Does this scenario meet any Organ/space SSI definitions? If so, which one?

a) No organ/space SSI definitions are met.

b) No imaging, so no need to continue surveillance.

c) Organ/space SSI c is met with abdominal pain, if OREP, EMET, or VCUF are met.

d) Organ/space SSI c) is met with fever (gross anatomic evidence of infection)

Shipwreck Q 1 – Does this scenario meet any Organ/space SSI definitions? If so, which one?

31-year-old patient Divey Shipwreck is admitted on 1/1/2026 and delivers a healthy baby boy via CSEC on 1/2/2026. The treating OB/GYN mentions in the narrative of the operative note suspicion of chorioamnionitis, but no gross anatomic evidence of infection is documented. The patient is discharged after uneventful hospitalization.

On 1/20/2026, patient presents to the emergency department (ED) with severe abdominal pain. OB/GYN consult notes include suspicion of endometritis. Fever of 102.0 degrees Fahrenheit is noted in the ED. Antimicrobials are initiated. No imaging has been ordered. No cultures were collected. No description of purulence. Incision is healing well.

a) No organ/space SSI definitions are met.

b) No imaging, so no need to continue surveillance.

c) Organ/space SSI c is met with abdominal pain, if OREP, EMET, or VCUF are met. ☑

d) Organ/space SSI c) is met with fever (gross anatomic evidence of infection)

CASE STUDY 4 – QUESTION 2

31-year-old patient Divey Shipwreck is admitted on 1/1/2026 and delivers a healthy baby boy via CSEC on 1/2/2026. The treating OB/GYN mentions in the narrative of the operative note suspicion of chorioamnionitis, but no gross anatomic evidence of infection is documented. The patient is discharged after uneventful hospitalization.

On 1/20/2026, patient presents to the emergency department (ED) with severe abdominal pain. OB/GYN consult notes include suspicion of endometritis. Fever of 102.0 degrees Fahrenheit is noted in the ED. Antimicrobials are initiated. No imaging has been ordered. No cultures were collected. No description of purulence. Incision is healing well.

Question 2: Which Chapter 17 site specific infection is applied here and met?

a) OREP

b) EMET

c) IAB

d) VCUF

Shipwreck Q 2 – Which Chapter 17 site specific infection is applied here and met?

Are there any possible answers we can rule out?

a) OREP

b) EMET

c) IAB

d) VCUF

CSEC - Cesarean section	DIP - Deep Incisional Primary EMET - Endometritis GIT - Gastrointestinal tract IAB - Intraabdominal, not specified elsewhere OREP - Deep pelvic tissue infection or other infection of the male or female reproductive tract SIP - Superficial Incisional Primary USI - Urinary System Infection

Abdominal, pelvic or uterine pain or tenderness **post Cesarean section (CSEC) or hysterectomy (HYST or VHYS)** is sufficient gross anatomic evidence of infection without an invasive procedure to meet general Organ/Space SSI criterion 'c' **when a Chapter 17 Reproductive Tract Infection criteria is met**. Allowing the documentation of abdominal pain or tenderness as gross anatomic evidence of infection to meet general Organ/Space SSI criterion 'c' enables the user to report an SSI-OREP, SSI-EMET or SSI-VCUF event.

Shipwreck Q 2 – Which Chapter 17 site specific infection is applied here and met? (Cont.)

OREP- Pelvic tissue/space infection or other infection of the male or female reproductive tract (for example, epididymis, testes, prostate, vagina, ovaries, uterus) including chorioamnionitis, but excluding vaginitis, endometritis or vaginal cuff infections

Other infections of the male or female reproductive tract must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from tissue or fluid from one of the specified OREP sites (excludes urine and vaginal swabs) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

2. Patient has an abscess or other evidence of infection of affected site on gross anatomic or histopathologic exam.
3. Patient has **suspected infection of** one of the listed OREP sites and ***two*** of the following localized signs or symptoms: fever (>38.0°C), nausea*, vomiting*, pain or tenderness*, or dysuria*
   And at least *one* of the following:
   a. organism(s) identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST)
   b. physician or physician designee initiates antimicrobial therapy within ***two*** days of onset or worsening of symptoms.

** With no other recognized cause*

a) OREP
b) EMET ☑

EMET-Endometritis

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

1. Patient has organism(s) identified from endometrial fluid or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has **suspected endometritis** with at least ***two*** of the following signs or symptoms: fever (>38.0°C), pain or tenderness (uterine or abdominal) *, or purulent drainage from uterus.

** With no other recognized cause*

Reporting Instructions

- Do not report an HAI chorioamnionitis as EMET (see OREP).
- Do not report subsequent postpartum endometritis after a vaginal delivery as an HAI if a patient is admitted with POA chorioamnionitis (OREP). (See next bullet for endometritis following a C-section).
- Report as an organ space SSI-EMET if a C-section was performed on a patient with chorioamnionitis and the patient later develops endometritis.

First assess if EMET definitions are met. If they are not met, apply OREP definitions.

CASE STUDY 4– QUESTION 3

31-year-old patient Divey Shipwreck is admitted on 1/1/2026 and delivers a healthy baby boy via CSEC on 1/2/2026. The treating OB/GYN mentions in the narrative of the operative note suspicion of chorioamnionitis, but no gross anatomic evidence of infection is documented. The patient is discharged after uneventful hospitalization.

On 1/20/2026, patient presents to the emergency room with severe abdominal pain. OB/GYN consult notes include suspicion of endometritis. Fever of 102.0 degrees Fahrenheit is noted in the emergency department. Antimicrobials are initiated. No imaging has been ordered. No cultures were collected. No description of purulence. Incision is healing well.

Question 3: Is this SSI, O/S c, EMET 2, reported as PATOS?

a) Yes

b) No

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Shipwreck Q 3 – Is this SSI, O/S c, EMET 2, reported as PATOS?

a) Yes ☑
b) No

Suspected chorioamnionitis was documented in the narrative of the operative note.

See page 9-19 of the SSI protocol.

i) For C-Section [CSEC] procedures ONLY: chorioamnionitis including suspected chorioamnionitis documented in the operative narrative is eligible for use for PATOS at the organ/space tissue level.

CASE STUDY 5 – QUESTION 1

62-year-old patient Coral Reef is admitted for a hysterectomy procedure and tumor debulking (ICD-10 code 0UT94ZL) on 2/1/2026. Hospitalization includes initiation of chemotherapy. Patient is discharged on 2/10/2026.

On 2/18/2026 patient is readmitted with abdominal pain, fever of 102.6 degrees Fahrenheit, generalized weakness. CT of the abdomen shows possible pelvic abscess on 2/18/2026. Antimicrobials are initiated. Patient undergoes CT guided abscess drainage attempt on 2/19/2026, but it is unsuccessful. Return to OR on 2/20/2026 where a pelvic abscess is drained (non-NHSN operative procedure). A culture of the abscess was collected but is lost in transit to the laboratory and is never processed. On 2/22/2026 a deep tissue culture shows *Acinetobacter baumanii*.

Question 1: Is this a VHYS or HYST NHSN operative procedure?

a) VHYS

b) HYST

c) It's not an NHSN operative procedure.

d) How would I know?

Reef Q 1 – Is this a VHYS, or HYST NHSN operative procedure??

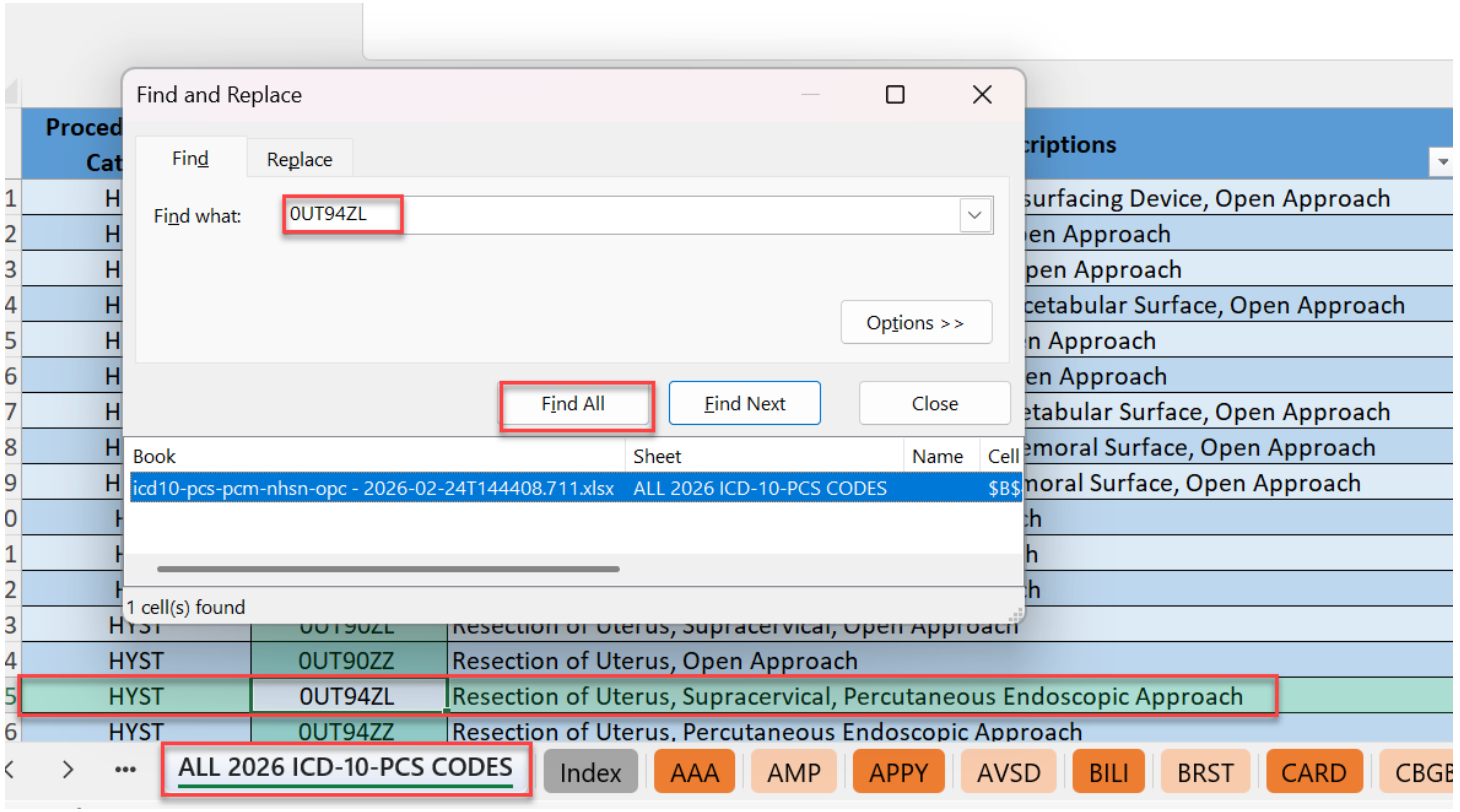
a) VHYS

b) HYST ☑

c) It's not an NHSN operative procedure.

d) How would I know?

- Find the operative procedure code assigned by your coding department
- Enter code in search option of NHSN Excel spreadsheet.
- Code, procedure type, and description will appear.
- If the code is not found, it is not an NHSN operative procedure.



- ICD-10-PCS Procedure Code Mapping to NHSN Operative Procedure Codes – January 2026 [XLS – 787 KB]
- Current Procedural Terminology (CPT) Procedure Code Mapping to NHSN Operative Procedure Codes – January 2026 [XLS – 346 KB]

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Please refer to email Centers for Disease Control and Prevention no-reply@emailupdates.cdc.gov with subject line, "NHSN 2026 Annual Training - Day 1"for additional instructions and links.

CASE STUDY 5 – QUESTION 2

62-year-old patient Coral Reef is admitted for a hysterectomy procedure and tumor debulking (ICD-10 code 0UT94ZL) on 2/1/2026. Hospitalization includes initiation of chemotherapy. Patient is discharged on 2/10/2026.

On 2/18/2026 patient is readmitted with abdominal pain, fever of 102.6 degrees Fahrenheit, generalized weakness. CT of the abdomen shows possible pelvic abscess on 2/18/2026. Antimicrobials are initiated. Patient undergoes CT guided abscess drainage attempt on 2/19/2026, but it is unsuccessful. Return to OR on 2/20/2026 where a pelvic abscess is drained (non-NHSN operative procedure). A culture of the abscess was collected but is lost in transit to the laboratory and is never processed. On 2/22/2026 a deep tissue culture shows *Acinetobacter baumanii*.

Question 2: Does the unsuccessful attempt to drain the abscess meet Invasive Manipulation definitions to stop the surveillance period?

a) Yes

b) No

c) It was not performed in the OR, so the abscess drainage stops the surveillance period.

Reef Q 2 – Does the unsuccessful attempt to drain the abscess meet Invasive Manipulation definitions to stop the surveillance period?

a) Yes

b) No ☑

c) It was not performed in the OR, so the abscess drainage stops the surveillance period.

There was suspicion of infection present at time of abscess drainage attempt. The 3 criteria of invasive manipulation are not met. Surveillance continues.

SSI Reporting Instruction #10:

10. **SSI following invasive manipulation or accession of the operative site:** An SSI will **NOT** be attributed when the following 3 criteria are ALL met:

- during the post-operative period there is no suspicion or evidence of infection related to the surgical site/space.

And

- an invasive manipulation or accession of the site/space is performed for diagnostic or therapeutic purposes (for example, needle aspiration, accession of ventricular shunts, accession of breast expanders).

And

- an infection subsequently develops in a tissue level which was entered during the manipulation/accession.

CASE STUDY 5 – QUESTION 3

62-year-old patient Coral Reef is admitted for a hysterectomy procedure and tumor debulking (0UT94ZL) on 2/1/2026. Hospitalization includes initiation of chemotherapy. Patient is discharged on 2/10/2026.

On 2/18/2026 patient is readmitted with abdominal pain, fever of 102.6 degrees Fahrenheit, generalized weakness. CT of the abdomen shows possible pelvic abscess on 2/18/2026. Antimicrobials are initiated. Patient undergoes CT guided abscess drainage attempt on 2/19/2026, but it is unsuccessful. Return to OR on 2/20/2026 where a pelvic abscess is drained (non-NHSN operative procedure). A culture of the abscess was collected but is lost in transit to the laboratory and is never processed. On 2/22/2026 a deep tissue culture shows *Acinetobacter baumanii*.

Question 3: Are any SSI definitions met in this scenario?

a) Yes. Deep SSI b) is met with Acinetobacter isolated from the culture on 2/22/2026.

b) No. Patients on chemotherapy are excluded from reporting.

c) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.

d) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026.

Reef Q 3 – Are any SSI definitions met in this scenario?

a) Yes. Deep SSI b) is met with Acinetobacter isolated from the culture on 2/22/2026.

b) No. Patients on chemotherapy are excluded from reporting.

c) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.

d) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026. 

Reef Q 3 – Are any SSI definitions met in this scenario?(Cont'd)

a) Yes. Deep SSI b) is met with Acinetobacter isolated from the culture on 2/22/2026.
b) No. Patients on chemotherapy are excluded from reporting.
c) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.
d) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026.

Each trip to the OR for an NHSN operative procedure sets an SSI surveillance period for the surgical site.

- If a patient returns to the OR for an **NHSN operative procedure** and the same surgical space is entered, the surveillance period for the prior NHSN operative procedure ends and a new SSI surveillance period begins at the conclusion of the procedure.
- If within the surveillance period following an NHSN operative procedure a **non-NHSN operative procedure** is performed, and all three tissue levels are entered, the SSI surveillance period for the NHSN operative procedure ends at the conclusion of the non-NHSN operative procedure. The SSI surveillance period continues for the tissue levels not entered during the non-NHSN operative procedure. No new surveillance period is set following a non-NHSN operative procedure.

a) Is not correct.

The non-NHSN operative procedure on 2/20/2026 where all tissue levels were entered ended the surveillance period for all tissue levels. The surveillance period for the NHSN operative procedure has ended. The culture may be important for clinical and treatment applications, but it is not used to meet SSI surveillance definitions.

Reef Q 3 - Are any SSI definitions met in this scenario? (Cont.)

a) Yes. Deep SSI b) is met with Acinetobacter isolated from the culture on 2/22/2026.

b) No. Patients on chemotherapy are excluded from reporting.

c) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.

d) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026. 

b) Is not correct.

Oncology patients or patients on chemotherapy are not excluded from surveillance.

Reef Q 3– Are any SSI definitions met in this scenario? (Cont'd)

a) Yes. Deep SSI b) is met with Acinetobacter isolated from the culture on 2/22/2026.
b) No. Patients on chemotherapy are excluded from reporting.
c) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.
d) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026.

IAB or OREP?
Either one may be used for attribution to HYST procedures. (See appendix to the SSI protocol)

HYST - Abdominal hysterectomy	DIP - Deep Incisional Primary
	IAB - Intraabdominal, not specified elsewhere
	OREP - Deep pelvic tissue infection or other infection of the male or female reproductive tract
	SIP - Superficial Incisional Primary
	VCUF - Vaginal cuff infection

Reef Q 3 – Are any SSI definitions met in this scenario? (Continued)

d) Organ/space SSI c) is met, and IAB 1., date of event 2/22/2026.
e) Organ/space SSI c) is met, and OREP 3.b) with date of event 2/18/2026. ☑

IAB-Intraabdominal infection, not specified elsewhere including gallbladder, bile ducts, liver (excluding viral hepatitis), spleen, pancreas, peritoneum, retroperitoneal, subphrenic or subdiaphragmatic space, or other intraabdominal tissue or area not specified elsewhere

Intraabdominal infections must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from an abscess or from purulent material from intraabdominal space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has at least one of the following:
   a. abscess or other evidence of intraabdominal infection on gross anatomic or histopathologic exam.
   b. abscess or other evidence of intraabdominal infection on gross anatomic or histopathologic exam. (See Reporting Instructions)
   AND
   organism(s) identified from blood by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). The organism(s) identified in the blood must contain at least one MBI organism from the NHSN Terminology Browser.
3. Patient has at least ***two*** of the following signs or symptoms: fever (>38.0°C), hypotension, nausea*, vomiting*, abdominal pain or tenderness*, elevated transaminase level(s)*, or jaundice*
   And at least *one* of the following:
   a. organism(s) seen on Gram stain and/or identified from intraabdominal fluid or tissue obtained during invasive procedure or from an aseptically-placed drain in the intraabdominal space (for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   b. organism(s) identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). The organism(s) identified in the blood must contain at least one MBI organism from the NHSN Terminology Browser.
   AND
   imaging test evidence definitive for infection (for example, ultrasound, CT scan, MRI, ERCP, radiolabel scans [gallium, technetium, etc.] or on abdominal x-ray), which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for intraabdominal infection.†

OREP- Pelvic tissue/space infection or other infection of the male or female reproductive tract (for example, epididymis, testes, prostate, vagina, ovaries, uterus) including chorioamnionitis, but excluding vaginitis, endometritis or vaginal cuff infections

Other infections of the male or female reproductive tract must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from tissue or fluid from one of the specified OREP sites (excludes urine and vaginal swabs) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

17 - 23

January 2026 Surveillance Definitions

2. Patient has an abscess or other evidence of infection of affected site on gross anatomic or histopathologic exam.
3. Patient has **suspected infection of** one of the listed OREP sites and ***two*** of the following localized signs or symptoms: fever (>38.0°C), nausea*, vomiting*, pain or tenderness*, or dysuria*
   And at least *one* of the following:
   a. organism(s) identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST)
   b. physician or physician designee initiates antimicrobial therapy within ***two*** days of onset or worsening of symptoms.

** With no other recognized cause*

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CASE STUDY 6

2/15/26: Candy Land is admitted to Olympic Hospital with sudden onset chest pain. History includes aortic valve replacement (AVR) 2020 secondary to known IV drug use. Echocardiogram (ECHO) on admit shows valvular stenosis; on 2/16 undergoes CABG with re-do AVR.

The patient has a rocky recovery and on 2/22, fever is recorded at 102.4°F Blood cultures (BCs) are drawn 0600 & 0615. 2/23 Patient oxygen saturation drops, placed on Bi-PAP. Post-op pneumonia is diagnosed, fever noted, new BCs are collected 0800 & 0805 and patient's surgical incision documented as inflamed with purulent drainage. ECHO is performed with moderate valvular regurgitation noted.

The patient is returned to OR 2/26 where the surgical incision is reopened to sternum with thick, green exudate throughout and covering the sternum. BC from 2/22 0600 & 0615 identify *Stenotrophomonas*; the 2/23 0800 BC also identifies *Stenotrophomonas*, 0805 BC is final no growth.

Question 6-1: Is an SSI criteria met in this case?

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use, ECHO = valvular stenosis

2/16/26: CABG/AVR (NHSN operative procedures with 90-day surveillance period)

2/22/26: Pneumonia, Temp 102.4°F, BC (blood culture) x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas* BC x1 no growth, surgical incision inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/26/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum.

1. No – the patient's issues are not related to a surgery.
2. Yes – Superficial Incisional SSI criteria 'a' is met on 2/23.
3. Yes – Deep Incisional SSI criteria 'a' is met on 2/24.
4. Yes – but I'm not sure which one.

Question 6-1: Is an SSI criteria met in this case?

1. **No – the patient's issues are not related to a surgery.**
2. **Yes – Superficial Incisional SSI criteria 'a' is met on 2/23.**
3. **Yes – Deep Incisional SSI criteria 'a' is met on 2/26.**
4. **Yes – but not sure which one.**

Rationale: SSI protocol pg. 9-11/13: Superficial Incisional SSI 'a' purulent drainage from the superficial incision. **Deep Incisional SSI 'd'** an abscess, or other evidence of infection involving the deep incision detected on gross anatomical exam

Rationale: SSI FAQ #1: Purulence is acceptable gross anatomic evidence of infection when documented in the patient record. When the terms 'pus' or 'purulence' are not written in the medical record, NHSN has allowed determinations for purulence based off descriptors. Documentation that uses a color descriptor and a consistency descriptor (from the list below) in combination is acceptable to indicate 'purulence'. **ONLY the following descriptors are eligible for use to meet the definition of purulence: COLOR: Green or Yellow** and **CONSISTENCY**: **Milky, Thick, Creamy, Opaque, Viscous** (SSI FAQ1)

Question 6-1: Is an SSI criteria met in this case?

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/24/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/26/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum.

<u>WAIT!!!</u> - I've established both SI and DI criteria are met. Am I done with SSI surveillance? What about the +BC? Are they part of the SSI determination?

SSI rules for secondary BSI determinations

Secondary BSI Scenarios for SSI: (SSI protocol pg. 9-6)
For a bloodstream infection to be determined secondary to an SSI, one of the following scenarios must be met:

Scenario 1 (All levels of SSI): At least one organism from the blood specimen matches an organism identified from the site-specific specimen that is used as an element to meet the NHSN SSI criterion AND the blood specimen is collected during the secondary BSI attribution period. The secondary BSI attribution period for SSI is a 17-day period that includes the SSI DOE, 3 days prior, and 13 days after.

OR

Scenario 2 (Organ/Space SSI Only): An organism identified in the blood specimen is an element that is used to meet the NHSN Organ/Space SSI site-specific infection criterion and is collected during the timeframe for SSI elements.

Case 6

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage,

ECHO = moderate valvular regurgitation

2/26/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

Rationale: SSI surveillance should continue for the full surveillance period. NHSN recommends reporting an SSI at the deepest tissue level where SSI criterion is met. Even if an SIP or DIP is identified, it's appropriate to continue surveillance for an Organ/Space SSI. IF an O/S SSI criteria can be met, secondary BSI guidance may be applied to determine if the +BC represent a secondary BSI or a primary BSI. **NOTE**: A general O/S SSI criteria AND a specific O/S site infection criteria must be met to fully satisfy O/S SSI criteria. Refer to Appendix A to identify eligible specific O/S site infection criteria to investigate.

Case 6 – (Cont.)

Let's break down the case details:

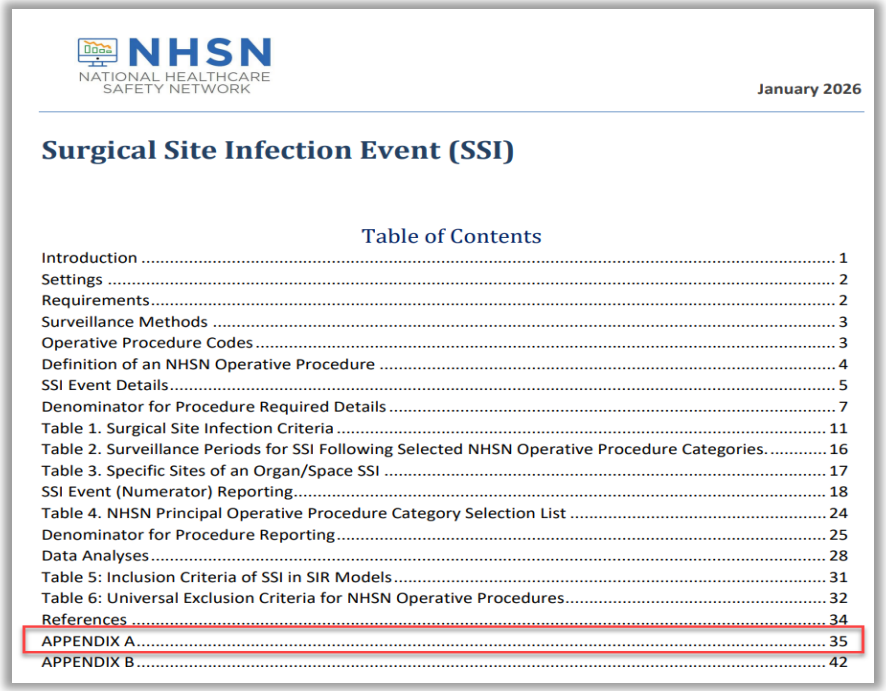
2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4^F, BC x 2 *Stenotrophomonas*

2/23/26: Temp elevated, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/26/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

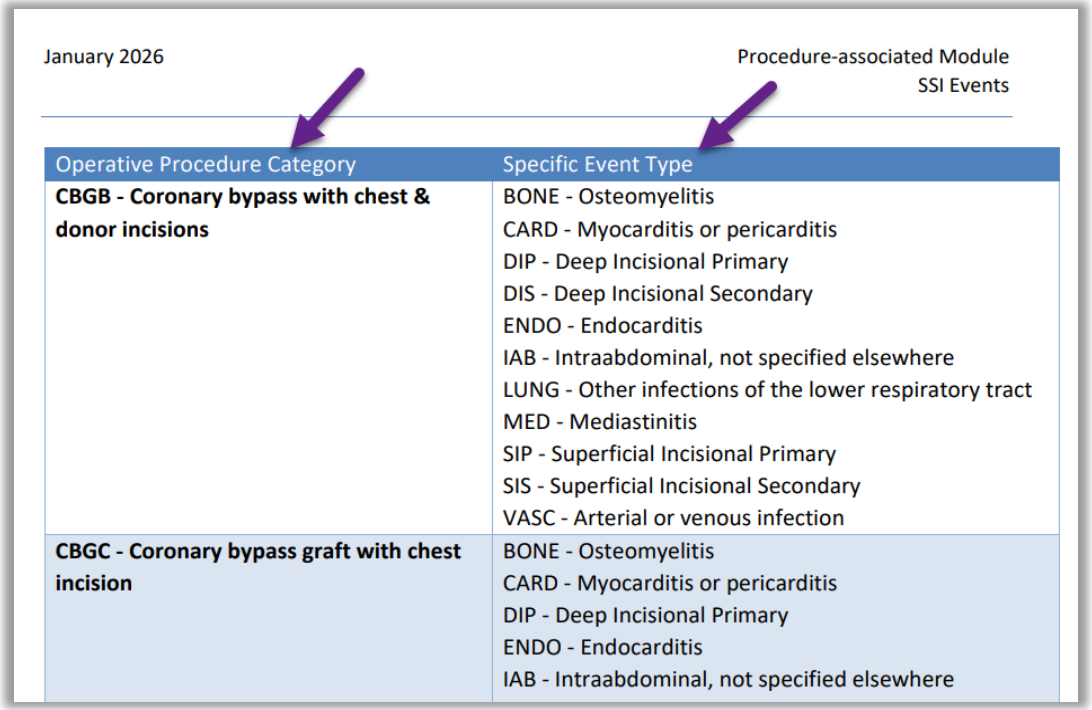


NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2026

Surgical Site Infection Event (SSI)

Table of Contents



January 2026 — Procedure-associated Module SSI Events

Operative Procedure Category	Specific Event Type
CBGB - Coronary bypass with chest & donor incisions	BONE - Osteomyelitis CARD - Myocarditis or pericarditis DIP - Deep Incisional Primary DIS - Deep Incisional Secondary ENDO - Endocarditis IAB - Intraabdominal, not specified elsewhere LUNG - Other infections of the lower respiratory tract MED - Mediastinitis SIP - Superficial Incisional Primary SIS - Superficial Incisional Secondary VASC - Arterial or venous infection
CBGC - Coronary bypass graft with chest incision	BONE - Osteomyelitis CARD - Myocarditis or pericarditis DIP - Deep Incisional Primary ENDO - Endocarditis IAB - Intraabdominal, not specified elsewhere

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Question 6-2: Can a general OS SSI criteria be met?

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/26/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

1. **Yes – General O/S SSI criteria 'a' is met.**
2. **Yes – General O/S SSI criteria 'b' is met.**
3. **Yes – General O/S SSI criteria 'c' is met.**
4. **No – I don't think so – where is this criteria anyway?**

Question 6-2: Can a general OS SSI criteria be met? (Cont.)

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*,

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/24/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

1. **Yes – General O/S SSI criteria 'a' is met.**
2. **Yes – General O/S SSI criteria 'b' is met.**
3. **Yes – General O/S SSI criteria 'c' is met.**
4. **No – I don't think so – where is this criteria anyway? (Hint: SSI protocol, pg. 9-15)**

Question 6-2: Can a general OS SSI criteria be met? (Cont'd)

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/24/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

1. Yes – General O/S SSI criteria 'a' is met.
2. Yes – General O/S SSI criteria 'b' is met.
3. **Yes – General O/S SSI criteria 'c' is met.**
4. No – I don't think so – where is this criteria anyway?

Rationale: General O/S SSI criteria (SSI protocol, pg. 9-18)- c. an abscess or other evidence of infection involving the organ/space detected on: gross anatomical exam (thick, green descriptors = Purulence)

Question 6-3: Can a specific OS site infection criteria be met?

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/24/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

1. Yes - BONE 2
2. Yes - ENDO 4
3. Yes - ENDO 5
4. Yes - ENDO 6
5. Yes - ENDO 7

Question 6-3: Can a specific OS site infection criteria be met? (Cont.)

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/IV drug use; ECHO = valvular stenosis

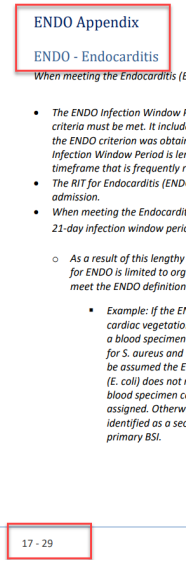
2/16/26: CABG/AVR

2/22/26: Pneumonia, Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Fever, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO = moderate valvular regurgitation

2/24/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum.

1. **BONE 2** = Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam **(pg. 17- 7)**
2. **ENDO 4**
3. **ENDO 5**
4. **ENDO 6**
5. **ENDO 7**



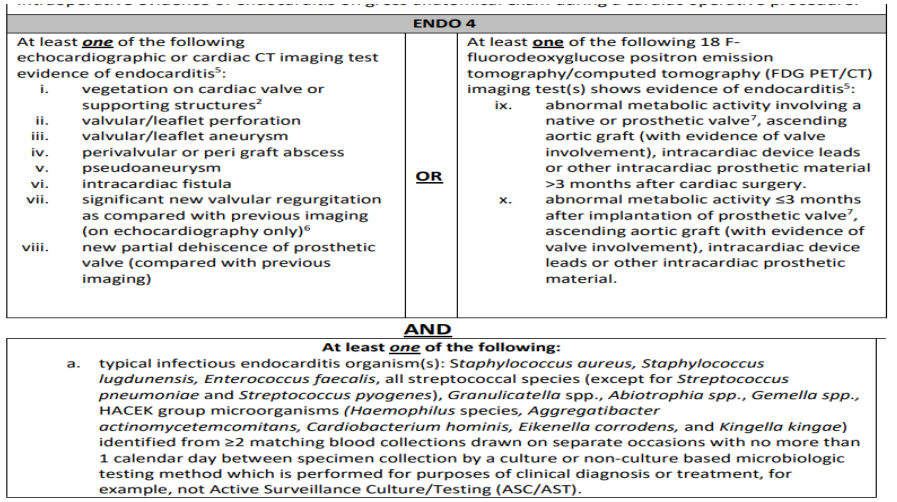
ENDO Appendix

ENDO - Endocarditis

When meeting the Endocarditis (E

- *The ENDO Infection Window P criteria must be met. It includ the ENDO criterion was obtai Infection Window Period is le timeframe that is frequently r*
- *The RIT for Endocarditis (END admission.*
- *When meeting the Endocardi 21-day infection window perio*
  - *As a result of this lengthy for ENDO is limited to org meet the ENDO definition*
    - *Example: If the EI cardiac vegetatio a blood specimen for S. aureus and be assumed the E (E. coli) does not blood specimen c assigned. Otherw identified as a sec primary BSI.*

17 - 29



ENDO 4		
At least ***one*** of the following echocardiographic or cardiac CT imaging test evidence of endocarditis[5]: i. vegetation on cardiac valve or supporting structures[2] ii. valvular/leaflet perforation iii. valvular/leaflet aneurysm iv. perivalvular or peri graft abscess v. pseudoaneurysm vi. intracardiac fistula vii. significant new valvular regurgitation as compared with previous imaging (on echocardiography only)[6] viii. new partial dehiscence of prosthetic valve (compared with previous imaging)	**OR**	At least ***one*** of the following 18 F-fluorodeoxyglucose positron emission tomography/computed tomography (FDG PET/CT) imaging test(s) shows evidence of endocarditis[5]: ix. abnormal metabolic activity involving a native or prosthetic valve[7], ascending aortic graft (with evidence of valve involvement), intracardiac device leads or other intracardiac prosthetic material >3 months after cardiac surgery. x. abnormal metabolic activity ≤3 months after implantation of prosthetic valve[7], ascending aortic graft (with evidence of valve involvement), intracardiac device leads or other intracardiac prosthetic material.

AND

At least *one* of the following:

a. typical infectious endocarditis organism(s): *Staphylococcus aureus, Staphylococcus lugdunensis, Enterococcus faecalis*, all streptococcal species (except for *Streptococcus pneumoniae* and *Streptococcus pyogenes*), *Granulicatella* spp., *Abiotrophia spp., Gemella spp.*, HACEK group microorganisms (*Haemophilus* species, *Aggregatibacter actinomycetemcomitans, Cardiobacterium hominis, Eikenella corrodens,* and *Kingella kingae*) identified from ≥2 matching blood collections drawn on separate occasions with no more than 1 calendar day between specimen collection by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

17 - 30

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Question 6- 3: Can a specific OS site infection criteria be met?

ENDO 4

At least ***one*** of the following echocardiographic or cardiac CT imaging test evidence of endocarditis[5]: i. vegetation on cardiac valve or supporting structures[2] ii. valvular/leaflet perforation iii. valvular/leaflet aneurysm iv. perivalvular or peri graft abscess v. pseudoaneurysm vi. intracardiac fistula vii. significant new valvular regurgitation as compared with previous imaging (on echocardiography only)[6] viii. new partial dehiscence of prosthetic valve (compared with previous imaging)	**OR**	At least **c** fluorode tomogra imaging t ix. x.

AND

At least *one* of the followi

b. typical infectious endocarditis organism(s) in the presence of prosthetic material: *coagulase-negative Staphylococci, Corynebacterium striatum, Corynebacterium jeikeium, Serratia marcescens, Pseudomonas aeruginosa, Cutibacterium acnes,* non-tuberculous mycobacteria, and *Candida* spp. identified from ≥2 matching blood collections drawn on separate occasions with no more than 1 calendar day between specimen collection by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

c. non-typical infectious endocarditis organism(s) identified from ≥3 matching blood collections drawn on separate occasions with no more than 1 calendar day between specimen collection by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

Question 6-3: What specific OS site infection criteria is met?

Let's break down the case details:

2/15/26: Admitted with h/o prosthetic heart valve/ IV drug use; ECHO = valvular stenosis

2/16/26: CABG/AVR

2/22/26: Temp 102.4°F, BC x 2 *Stenotrophomonas*

2/23/26: Temp elevated, BC x1 *Stenotrophomonas*, x1 no growth, sternal wound inflamed w/purulent drainage, ECHO – moderate valvular regurgitation

2/24/26: Return to OR, incision re-opened with thick, green exudate documented to/on the sternum

1. **BONE 2 (no mention of Osteomyelitis in case details)**

2. **ENDO 4 iv (c)**

- **iv. Significant new valvular regurgitation (ENDO footnote 6:** "Significant new valvular regurgitation" is defined as moderate or severe valvular regurgitation. This imaging finding is valve-specific and cannot be pre-existing**)**
- **c -Atypical ENDO organism match in 3 blood cultures drawn on separate occasions no more than 1 calendar day apart (use the NHSN Terminology Browser to define the organism)**
- **Final determination: SSI-ENDO with secondary BSI, *Stenotrophomonas*, DOE 2/22**

Resources

- NHSN Surgical Site Infection (SSI) Events webpage: https://www.cdc.gov/nhsn/psc/ssi/index.html
- Patient Safety Component Manual, Chapter 9 Surgical Site Infection Event (SSI) Protocol: https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- Patient Safety Component Manual Chapter 17: CDC/NHSN Surveillance Definitions for Specific Types of Infections: https://www.cdc.gov/nhsn/pdfs/pscmanual/17pscnosinfdef_current.pdf
- FAQs:
  - Surgical Site Infections (SSI) Events: https://www.cdc.gov/nhsn/faqs/faq-ssi.html
  - Surgical Site Procedure Codes: https://www.cdc.gov/nhsn/faqs/faq-ssi-proc-codes.html

Thank you for joining us today.

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Questions

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Thank you.

For any questions or concerns, contact the NHSN Helpdesk

- **NHSN-ServiceNow** to submit questions to the NHSN Help Desk.
- Access new portal at **https://servicedesk.cdc.gov/nhsncsp**.
- If you do not have a SAMS login, or are unable to access ServiceNow, you can still email the NHSN Help Desk at nhsn@cdc.gov.

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 https://www.cdc.gov/
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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the U. S. Centers for Disease Control and Prevention.

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