

NOTES FROM MONTHLY SHARP NHSN USERS' CONFERENCE CALL

January 25, 2012

Thank you to those who were able to join our monthly NHSN users' conference call. If you were unable to participate on this call, we hope that you will be able to participate next month. Any healthcare facility is welcome to participate in these calls, whether they are sharing NHSN data with us or not. These conference calls are voluntary. Registration and name/facility identification are **not** required to participate.

Our monthly conference calls will be held on the 4th Wednesday each month at 10:00 a.m.

Call-in number: 877-336-1831

Passcode: 9103755

Webinar: <http://breeze.mdch.train.org/mdchsharp/>

Suggestions for agenda items and discussion during the conference calls are always welcome! Please contact Judy at weberj4@michigan.gov to add items to the agenda.

HIGHLIGHTS OF JANUARY 2012 CONFERENCE CALL

Welcome and Previous Meeting Notes

Judy welcomed those on the conference call and reminded participants that notes from previous conference calls will be posted on the MDCH SHARP website at www.michigan.gov/hai, under the box entitled "NHSN Information & SHARP Trainings and Conferences". Notes from the most recent call will be posted on the home page.

Aggregated & Individual Hospital Reports

Allison finished and emailed out the Semi-Annual Individual Reports. She has received a couple of questions, but not much feedback yet. She is also working on the 2011 Third Quarter Report which will be posted to www.michigan.gov/hai soon. After all of the facilities have agreed to the revised Conferred Rights template, she said that she can begin the 2010-2011 Annual report.

Conferred Rights Acceptance – New Template

In December 2011, the SHARP Unit became aware of the need to revise our template of Conferred Rights in order to see missing denominator data for the MDRO/CDI module. Most hospitals sharing data with us have re-accepted our new template, but there are still a couple of hospitals who have not yet accepted it. If you have not already done so and you are one of our participating hospitals, please go under "Group" on the navigation bar of the NHSN home page, click on "Confer Rights", then highlight "MDCH-SHARP", and hit the "Confer Rights" box. This will bring up the new template. You can simply

click the “Accept” button at the bottom of the page and this will give us rights to the data that we need. Thank you to those hospitals that have already done this! (Note: as of 2/8/12, all of our participating hospitals have now accepted the new template.)

Hospital Validation Studies by CMS

We mentioned last month that we had become aware that CMS would be conducting validation studies within 800 acute care hospitals across the U.S. this year. I talked with staff at MPRO and they indicated that they have not yet received approval from QIOSC to release this information. Donna Modras from MPRO re-confirmed this on this conference call. Hopefully, we will hear more about this in the near future.

February CDC Training on CAUTIs and SSIs

CDC will be conducting another 2-day training for hospitals and other interested parties on the CAUTI and SSI modules in early February (Feb 9 and 10). This is the same training that Allison and Judy attended on December 5 and 6, 2011 in Atlanta. The February training has already filled up but we anticipate that CDC will hold additional trainings so be on the look-out for these email notices if you are interested in attending an onsite training at CDC.

SSI Module – Definition of Implant

Please remember to look at the definition of “implant” when you are using the SSI module to report infections. Included in the definition are things that you may not think about including: mesh, internal staples, hemoclips, as well as other more obvious things like heart valves, metal rods, screws, cements, etc. Remember also that implants must be monitored for a SSI for a period of one year, according to NHSN requirements.

SSI Module – ICD-9 Codes

Please remember that there are multiple ICD-9 codes included under the operative procedures for abdominal hysterectomy and for colon surgery. These ICD-9 codes can be found in the SSI protocol found on the NHSN website (www.cdc.gov/nhsn).

Proper Wound Specimen Collection

In the January 2012 NHSN E-News, CDC had a reminder about properly collecting specimens and transporting them to the laboratory. Improperly collected and/or transported specimens can result in the failure to isolate the causative organism. CDC encourages IPs to review these practices with their nursing and lab colleagues to assure that aseptic technique is being used to obtain appropriate specimens.

Help Links on NHSN

Reminder that there are help links when hospitals are working within NHSN. The NHSN “Help” button is located in the dark blue area of the top right corner, next to the “Log out” button. Here you can get help with definitions, reporting instructions, etc. Don’t forget to use this if you need help while you are working in NHSN.

Guidance regarding NHSN Alerts

These alerts should come up when you first log into NHSN and will let you know if you have missing or incomplete data reported within NHSN. There is a document in the Resource Library of NHSN, entitled “NHSN Alerts” that can help you interpret what these alerts mean and how to correct missing or incomplete data. Included in this document is also information about how to report “No Events” within NHSN.

Use of “Zero Events” or “No Event” Reporting

Reminder: “No Event” reporting is now a requirement of CMS, effective January 1, 2012. If you have **no** CLABSIs, CAUTIs, VAPs, dialysis events, and/or MDRO/CDI events, there are now boxes to report **no events** for these categories under “Summary Data” on the NHSN navigation bar.

LTAC/LTCH Reporting to NHSN

Just a reminder that long term acute care or long term care hospitals will be required to begin reporting CLABSIs and CAUTIs beginning October 1 of this year (2012). LTACs/LTCHs will need to enroll in NHSN but it is recommended that they wait until after the next release of NHSN which is expected at the end of this month (January 2012). In the new release, new location types that are specific to LTACs and LTCHs will be added so these facilities should wait until the new release becomes available. (Note NHSN version 6.6. was released on 2/6/12).

New NHSN Release

As previously mentioned, a new release of NHSN is expected at the end of January or early February 2012. Watch your emails for this announcement. (Note: NHSN version 6.6. was released on 2/6/12).

Updates to Facility Data/E-Mail Addresses

Just a reminder to everyone to keep your “**facility information**” updated on NHSN. If your NHSN Facility Administrator leaves, if that person changes their email address, or the hospital address changes, the replacement NHSN Facility Administrator must make those changes under “Facility” on the NHSN navigation bar. This is the information that CDC uses to send emails or other information to your facility, and you may miss out on important information if this is not updated. Remember too that the Facility Administrator can give administrative rights to other persons within your hospital. This can be done under “Users” on the NHSN navigation bar. CDC recommends that more than one person at each hospital should be given administrative rights within NHSN.

Still Accepting Hospitals to join MDCH_SHARP Group

If you are a hospital that has not yet joined the MDCH_SHARP Group in NHSN, you can still do this. There is no limit to the number of hospitals who can join our group. Contact Judy and she can send you our Data Use Agreement and walk you through the steps to join our Group and confer rights to us. You will need the SHARP “joining password” to join our Group which Judy will be able to give to you.

Data Use Agreements and Addendums

Jennie Finks explained that the MHA Keystone Center for Patient Safety and the Vermont Oxford Network have asked the SHARP Unit to share specific NHSN data from our participating hospitals. In order to do this, MDCH SHARP developed a Master Data Use Agreement **addendum**. This addendum was recently sent to Michigan hospitals by the MHA Keystone Center for Patient Safety in a mailing announcing their Hospital Engagement Network (HEN) project funded through CMS's Partnership for Patients. Hospitals who have signed the MDCH SHARP Master Data Use Agreement, conferred rights to SHARP within NHSN, and sign the addendum, grant permission for the SHARP Unit to share hospital-identified NHSN data with the MHA Keystone Center for Patient Safety and/or the Vermont Oxford Group. The letter of commitment included in this packet from MHA (if signed and returned) was to indicate that the hospital is agreeing to participate in the HEN project with MHA. If there questions regarding these agreements and addendums, feel free to contact Judy in the SHARP Unit.

SSI and CAUTI Case Studies

Joe Coyle and Allison Gibson went through several SSI and CAUTI case studies with conference call participants in order to provide a better understanding of how to interpret NHSN's definitions for these infections. Correct answers to the case studies, as well as discussion regarding the answers, are posted on the www.michigan.gov/hai website as a power point presentation.

Suggested Topics for Discussion

The SHARP Unit again requested that hospitals should contact SHARP staff with any suggestions for future topics or trainings to be conducted during these monthly conference calls.

Next Conference Call

The next monthly conference call is scheduled for Wednesday, February 22 at 10:00 a.m. Details regarding phoning in are listed at the top of these minutes and also posted on the www.michigan.gov/hai home page.

NHSN User Group Case Studies



**PROVIDED BY CDC NHSN TRAINING
PRESENTED DURING 1/25/12 CALL**

Please Note:



- These questions and answers were provided by the Centers for Disease Control and Prevention. The explanations were provided by the MDCH SHARP unit to help explain the justification behind the answers. If you have comments, concerns, or questions about the questions, answers, or explanations below please feel free to contact Joe Coyle at CoyleJ@michigan.gov
- As always, if you have any questions or suggestions regarding our monthly calls, please contact Allison Gibson at gibsona4@michigan.gov or Judy Weber at weberj4@michigan.gov

Question 2



- **A 45 year old male had a colon resection (COLO) on 6/18. On 6/22 the patient's abdominal incision had purulent drainage and slight erythema and induration; the incision is intact. The wound culture specimen was sent to the lab (Enterobacter spp and E. coli). The patient was started on antibiotics. What should be reported to NHSN?**

Question 2 Answer



- **SSI-SIP**
- **Explanation:** This meets the definition for superficial SSI according to the NHSN surveillance definitions. Purulent drainage plus a positive wound culture within 30 days post-op is evidence of an SSI. Since the wound is intact and there is no additional evidence suggesting a deeper infection, the SSI is considered superficial.

Question 3



- **Day 1: HPRO performed. Patient screened for MRSA upon admission to ICU per protocol. Day 2: Patient is very confused. Temperature normal. Wound condition good. Day 3: Results of the admission screening cultures of the nose and groin are positive for MRSA. The following entry is found in the chart: "Patient removed the dressing several times. Recurrent confused condition. Wound edges very red and taut." Day 5: Entry in the chart: "Wound abscess lanced by the attending surgeon". A wound specimen sent to lab for culture. Antibiotics begun. Day 7: Wound culture: MRSA. Day 9: Improvement in wound condition. Discharged to Rehabilitation Center. Does this patient have an SSI? If so, what type?**

Question 3 Answer



- **Yes, Superficial SSI**
- **Explanation:** This case also meets the definition for a superficial SSI. There is a positive wound culture for MRSA within 30 days post-op and there is no evidence of a deeper infection. Despite the patient having a positive nasal screen for MRSA and picking at his surgical dressing this still meets the surveillance definition for an SSI even though the positive wound may not be a direct result of the surgery itself.

Question 4



- **A female patient underwent a KPRO operation on December 22, 2010. She returned to her surgeon on January 31, 2011 with purulent drainage from the superficial incision, which had started 2 days prior. How should this infection be reported?**

Question 4 Answer



- **Not reported, does not meet criteria for SSI**
- **Explanation:** This case does not meet the definition criteria for an SSI. Indeed, the patient does have purulent drainage from the superficial wound suggesting a superficial SSI, but since the drainage started >30 days post-op this case does not meet the SSI definition. Implant procedures are followed for one year, but superficial infections are required to occur within 30 days of the surgery to meet the definition.

Question 5



- **A spinal fusion (FUSN) patient was seen in the ER 11 days post op with a large cellulitis, a pain level 10/10, swelling, tenderness, and redness. He was admitted for treatment with antibiotics. He had leukocytosis and an elevated CRP (199). Serous drainage from the incision was no growth. Is this superficial incisional or deep incisional SSI?**

Question 5 Answer



- **Neither, the surveillance criteria for SSI are not met**
- **Explanation:** This case also does not meet the SSI criteria. The patient does have cellulitis, pain, swelling, tenderness, and erythema, but the absence of purulence and a negative culture rules out a SSI.

Question 6



- **POD 3: 66 y.o. patient in the ICU with a Foley catheter s/p exploratory lap; patient noted to be febrile (38.9°C) and complained of diffuse abdominal pain. WBC increased to 19,000. He had cloudy, foul-smelling urine and urinalysis showed 2+protein, + nitrite, 2+ leukocyte esterase, WBC-TNTC, and 3+ bacteria. Culture was 10,000 CFU/ml E. coli. The abdominal pain seemed localized to surgical area. Is this a UTI? If so, what type?**

Question 6 Answer



- **Yes, SUTI Criterion 2a**
- **Explanation:** Firstly, we recognize that the patient is an adult with catheter in place. Next we look for signs and symptoms of a UTI. In this case the patient has a fever $>38^{\circ}\text{C}$ and has abdominal pain (though this is possibly related to the patient's recent surgery). Urinalysis shows positive leukocyte esterase and nitrite, with white blood cells too numerous to count. Finally, with a urine culture of 10^4 *E. coli*, this meets the criteria 2a for a SUTI.

Question 7



- **84 year old patient is hospitalized with GI bleed. Day 3: Patient has indwelling catheter in place and no signs or symptoms of infection. Day 9: Patient becomes unresponsive, is intubated and CBC shows WBC of 15,000. Temp 38.0°C. Patient is pancultured. Blood culture and urine both grow Streptococcus pyogenes - urine $>10^5$ CFU/ml. Is this a UTI? If so, what type?**

Question 7 Answer



- **Yes, ABUTI**
- **Explanation:** This is another adult patient presenting with a catheter in place. This patient does not have signs and symptoms of a UTI (*note the patient's fever is 38°C, but not >38°C*). The patient has a positive urine culture of *streptococcus pyogenes* of $>10^5$. There is also a blood culture with matching organism. This meets the ABUTI definition.

Question 8



- 48 year old male involved in motorcycle accident. Closed head injury, multiple fractures. Taken to OR for ORIFs and evacuation of subdural hematoma. Foley catheter and left subclavian catheter placed in ED. Patient remains on ventilator placed in OR. Lungs clear bilaterally. 6 days postop, temp 99.8°F, rhonchi in left lung base. CXR shows possibly infiltrate/atelectasis in this area. Urine draining, clear yellow by Foley. Patient remains ventilated, sputum increased, white. Post op day 7, temp 100.3°F vent settings stable. No change to sputum production. Post op day 8, temp 101.9°F, lungs sounds clear, CXR clear. Patient on vent, with foley, and central line. Pan cultures sent. Empiric antibiotic treatment begun. Post op day 9: Urine culture: 100,000 CFU/ml of *P. aeruginosa*. Sputum: *P. aeruginosa*. Blood culture: no growth. Physical assessment normal. No patient response to suprapubic or costovertebral angle palpation. Does this patient have a UTI? If so, what type?**

Question 8 Answer



- **Yes, SUTI 1a**
- **Explanation:** Again, we are looking at an adult patient with a catheter in place and assessing for a possible UTI. The first thing to notice is the temperature of 101.9°F on day 8. The fever is a potential symptom of an UTI. Also there is a urine culture growing 10^5 CFU/mL of *Pseudomonas aeruginosa*. Since this patient has a symptom of a UTI (fever) and a culture of $\geq 10^5$, this meets the definition for a criteria 1a SUTI. One thing that is 'tricky' about this question is the positive *Pseudomonas* culture from sputum. When calling a SUTI it is important to ensure that the signs and symptoms are being caused by the UTI and not another cause (like in this case a possible respiratory infection). However, the fever starts on post op day 8 and on that day the sputum culture results were clear, so we can reasonably conclude that the fever preceded the positive respiratory culture result and thus is truly a symptom of the UTI.

Question 9



- **9/1: 73 year old patient in neurosurgical ICU. Admitted 7 days ago following cerebrovascular accident. Ventilated, subclavian catheter and Foley catheter in place since admission. Patient reacts only to painful stimuli. 9/2: WBCs slightly elevated, at 12,000/mm³, temp 37.4°C, urine cloudy. Lungs clear to auscultation. 9/3: WBC 15,800/mm³. Temperature: 37.6°C. Breath sounds slightly coarse, minimal clear sputum. Urine unchanged. Blood, endotracheal and urine cultures collected. No suprapubic or CVA pain noted. 9/4: Blood and endotracheal cultures no growth. Urine with 100,000 CFU/ml E. faecium. Does this patient have a UTI? If so, what type?**

Question 9 Answer



- **No UTI**
- **Explanation:** The patient in this question also an adult patient with a catheter in place. The patient does not have any signs or symptoms of an UTI (no fever, costovertebral pain or tenderness, or suprapubic tenderness). So we can safely rule out a SUTI. But does the patient have an ABUTI? To meet the criteria for an ABUTI the patient must have blood and urine cultures with a matching organism. This patient does not have that, therefore the patient does not meet the criteria for an UTI.

Question 10



- **9/1: 68 y.o. female admitted to 6E from OR, status post left KPRO. Foley draining pink urine, PACU nurse reports difficulty with Foley placement. Bulb suction to left knee via stab wound draining small amount blood drainage. IV in left forearm, site without redness and dressing dry. Patient controlled analgesia via pump. 9/2: Drain removed. Patient up to bathroom with help of physical therapist. Foley removed. IV continues. Taking full liquids for lunch. Afebrile. 9/3: Patient to physical therapy. Complains of burning with urination and urgency. Suprapubic pain upon palpation. Temp 37.8°C. Urine collected and sent for culture and U/A; + for 10+ WBCs by HPF of unspun urine, + leukocyte esterase. Empiric antibiotics begun. 9/4: Urine culture with >100,000 CFU/ml *S. epidermidis*. Does this patient have a UTI attributable to 6E?**

Question 10 Answer



- **Yes, patient has a SUTI 1a attributable to 6E**
- **Explanation:** In this example we have an adult patient who has had her catheter removed within the last 48 hours. The patient has numerous symptoms of an UTI including fever, dysuria, urgency, and suprapubic pain. She also has a urine culture result of $\geq 10^5$. So this case meets criteria 1a for a SUTI. Since the patient was transferred from a non-inpatient location (the OR) the NHSN surveillance definition protocol indicates that the UTI event should be assigned to the location where the patient was admitted on the date of the event (when symptoms started or the specimen was collected, whichever came first). So this case is attributed to 6E. (*Note: There is a 48 hour rule when a patient is transferred from one inpatient unit to another, but since this patient transferred from a non-inpatient location, the 48 hour rule does not apply.*)