



# Infection Prevention and Public Health Update

## OKLAHOMA STATE DEPARTMENT OF HEALTH

2011 1st Quarter

### National Healthcare Safety Network (NHSN)

#### Uploading HAI Data Into NHSN

The NHSN has been enabled to accept electronic infection reports, denominator data, and process of care data from commercial infection surveillance systems. Clinical Document Architecture (CDA) is a Health Level 7 (HL7) standard which provides the framework for formatting of electronic documents.

For those hospital facilities who are currently using a commercial surveillance software, it is possible that you will be able to use your current electronic software to upload your data into the National Healthcare Safety Network using a CDA electronic document. You will need to talk with your current surveillance software vendor in order to determine whether or not they can create a CDA document for your NHSN data reporting.

**To implement CDA for NHSN, please contact your Infection Control Software vendor to inquire about the availability of generating CDA events records for importation into NHSN.**

[http://www.cdc.gov/nhsn/CDA\\_eSurveillance.html](http://www.cdc.gov/nhsn/CDA_eSurveillance.html)

The link provided above will take you to the CDC page where the HL7 Implementation Guide for CDA Release 2 can be found. This guide is designed for all software developers to use who are wanting to enable their software systems to report HAI data to the NHSN.

Having the ability to directly upload data from your facility's electronic database system will prove to be a valuable and time-saving tool. This is especially true when using the Procedure -associated module when reporting surgical denominator data.



#### Summary of November 4, 2010 NHSN Training

The morning session was presented by Mary Andrus BA,RN,ICI, who is the president and owner of Surveillance Solutions Worldwide, Inc. Mrs. Andrus covered the background and purposes of healthcare-associated infection (HAI) surveillance and identified some of the barriers to collecting HAI data. She described not only the impact public reporting has had on HAI surveillance and reporting, but proposed potential solutions to the challenges of HAI surveillance and reporting. Examples of the financial impact of HAIs on individual healthcare facilities were given and examples of how individual facilities could calculate the estimated cost to their facility for one HAI.

*"If you can't measure it, you can't  
manage it"  
- Mary Andrus*

The afternoon session was presented by Gloria Morrell RN,MS,MSN,CIC, Nurse Consultant with the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC). The majority of Ms. Morrell's presentation focused on case studies and applying the surveillance definitions and the infection-specific criteria for reporting HAIs in the acute care setting outlined by CDC/NHSN.

Based on the feedback from the training evaluations, most of the participants in attendance would have liked for Ms. Morrell's lecture to have been one full day instead of the 4 hours given. The table below represents the specifics regarding the numbers registered for the training, the number who attended the training, and the response when asked if the overall conference and individual presentation objectives had been met.

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Is it an A or B?

Is it a 1 or a 2?

### SUTI OR ABUTI?

**Scenario:** 67 y/o patient comes to the ER with suspected infection. They can find no other signs of infection and believe the infection is related to a UTI. The patient does not currently have a foley and has not had one in the last 48 hours. The patient is not complaining of any S/S of UTI. The doctor orders a UA with C/S and blood cultures. ( Do we have a SUTI or an ABUTI?)

Criterion	Urinary Tract Infection
	Symptomatic Urinary Tract Infection (SUTI) Must meet at least 1 of the following criteria
<b>SUTI 1a</b>	<p>Patient had a urinary catheter in place at the time of the infection <i>And</i> At least 1 of the following signs or symptoms with no other recognized cause: Fever &gt; ( 38 C), suprapubic tenderness, or costovertebral angle pain or tenderness <i>And</i> A positive urine culture of <math>\geq 10^5</math> colony-forming units (CFU)/ml with no more than 2 species of microorganisms.</p> <p style="text-align: center;">OR</p> <p>Patient had indwelling urinary catheter removed within the 48 hours prior to specimen collection <i>and</i> at least 1 of the following signs or symptoms with no other recognized cause: fever (&gt;38°C), urgency, frequency, dysuria, suprapubic tenderness, or costovertebral angle pain or tenderness <i>and</i> a positive urine culture of <math>\geq 10^5</math> colony-forming units (CFU)/ml with no more than 2 species of microorganisms.</p>
<b>SUTI 1b</b>	<p><b>Patient did not have an indwelling urinary catheter in place at the time of specimen collection nor within 48 hours prior to specimen collection</b> <i>And</i> has at least 1 of the following signs or symptoms with no other recognized cause: fever (&gt;38°C) in a patient that is <math>\leq 65</math> years of age, urgency, frequency, dysuria, suprapubic tenderness, or costovertebral angle pain or tenderness <i>and</i> a positive urine culture of <math>\geq 10^5</math> CFU/ml with no more than 2 species of microorganisms.</p>
<b>SUTI 2a</b>	<p>Patient had an indwelling urinary catheter in place at the time of specimen collection <i>and</i> at least 1 of the following signs or symptoms with no other recognized cause: fever (&gt;38°C), suprapubic tenderness, or costovertebral angle pain or tenderness <i>and</i> a positive urinalysis demonstrated by at least 1 of the following findings: a. positive dipstick for leukocyte esterase and/or nitrite; b. pyuria (urine specimen with <math>\geq 10</math> white blood cells [WBC]/mm<sup>3</sup>; c. microorganisms seen on Gram stain of unspun urine or <math>\geq 3</math> WBC/high power field of unspun urine <i>and</i> a positive urine culture of <math>\geq 10^3</math> and <math>&lt; 10^5</math> CFU/ml with no more than 2 species of microorganisms.</p>
Criterion	Asymptomatic Bacteremic Urinary Tract Infection (ABUTI)
<b>ABUTI</b>	<p><b>Patient with or without an indwelling urinary catheter has no signs or symptoms</b> (i.e., for any age patient, no fever (&gt;38°C), urgency, frequency, dysuria, suprapubic tenderness, or costovertebral angle pain or tenderness, or for a patient <math>\leq 1</math> year of age, <i>and</i> fever (&gt;38°C core), hypothermia (&lt;36°C core), apnea, bradycardia, dysuria, lethargy, or vomiting) <b>a positive urine culture of <math>&gt; 10^5</math> CFU/ml with no more than 2 species of uropathogen microorganisms* and a positive blood culture with at least 1 matching uropathogen microorganism to the urine culture, or at least 2 matching blood cultures drawn on separate occasions if the matching pathogen is a common skin contaminant.</b> * Fever is not diagnostic for UTI in the elderly (&gt; 65 years of age) and therefore fever in this age group does not disqualify from meeting the criteria of an ABUTI. * <b>For ABUTI, report only isolate (s) in both blood and urine specimens.</b> * Uropathogen microorganisms are: Gram-negative bacilli, <i>Staphylococcus</i> spp., yeasts, beta-hemolytic <i>Streptococcus</i> spp., <i>Enterococcus</i> spp., <i>G. vaginalis</i>, <i>Aerococcus urinae</i>, and <i>Corynebacterium</i> (urease positive).</p>



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### NHSN Training Summary Continued from page 1

All speaker handouts were provided to attendees in a spiral bound book along with a NHSN Hints & Tips sheet. Currently we have a few extra copies and would like to make those available to those who were unable to attend the training. If you would like a copy of the NHSN training handouts, please contact Lloyd Richardson at [lloyd\\_r@health.ok.gov](mailto:lloyd_r@health.ok.gov)

Total number registered for the training: 143	Total number of attendees: 129
Total number of completed evaluations: 89  87 of the 89 responses either agreed or strongly agreed that the objectives listed were met.	Of the 89 evaluations, 2 marked strongly disagree on the each objective for each speaker and the overall conference. It is unclear if they just misread the scoring instructions or if their intent was to strongly disagree that they received nothing from the training. Neither of the 2 offered additional comments.



By Vonnie Meritt

As we approach January 1, 2011, we take a look to the future and the changes it will bring. All hospitals participating in the Hospital Inpatient Quality Reporting Program (Reporting Program), formerly known as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program will begin reporting Central Line Associated Blood Stream Infections (CLABSI). This measure was finalized for Fiscal Year (FY) 2013 payment determination for events on or after **January 1, 2011**.

Since 2008, Oklahoma has had a state mandate requiring hospitals to report incidents of CLABSI using the NHSN. Under the advisement of the Hospital Advisory Council, the reporting of CLABSI events were limited to those involving adult patients in intensive care units. With the new IPPS Reporting Program, the definition for the CLABSI Healthcare Associated Infection (HAI) measure has been expanded to include not only adults, but also pediatric and neonatal intensive care unit (ICU) patients. Therefore, the **state manda-**

**tory monthly reporting will now include adult, pediatric and neonatal patients in intensive care units effective January 1, 2011.** The additional units should be added to your monthly reporting plan and the viewing rights to that data conferred to OSDH for the new locations. The OSDH HAI Prevention staff is available to assist you in the process of updating NHSN. If you need assistance or have further questions, please contact Janice Mouser or Lloyd Richardson @ (405) 271-6576.

### Questions & Answers

CLIP Module -

Q- When entering data for CLIP, the physician or inserter is unsuccessful on their first attempt of placing the central line catheter. Is it necessary to document that unsuccessful attempt, and if so, how do you document the attempt?

A—Currently, NHSN requests that all attempts are entered. Participation in NHSN CLIP surveillance enables participating facilities and CDC to: 1) Monitor central line insertion practices in individual patient care units and facilities and to provide aggregate adherence data for all participating facilities; and 2.) Facilitate quality improvement by identifying specific gaps in adherence to recommended prevention practices, and target intervention strategies for reducing central line-associated bloodstream infections. You should document all attempts at placing a central line using : The *Central Line Insertion Practices Adherence Monitoring Form* (CDC 57.125) which is used to collect and report central line insertion practices for every central line insertion or attempt at insertion occurring during the month in the unit (s) selected for surveillance. Elements of this data will be used to calculate adherence to recommended insertion practices.

*Answer to : SUTI or ABUTI Pg 2*

If the patient did not have symptoms of UTI but the UA indicates growth of 10<sup>5</sup> of no more than two species of microorganisms and a positive blood culture which matches at least one of the uropathogens identified in the UA, they have an ABUTI.

