Duration of Surgery and Anesthesia Time

As Massachusetts begins to implement validation of data submitted to NHSN, we are gaining valuable information from states where the process is already underway. New York’s HAI reporting law required hospital infection data to be validated prior to release. They are the first state to validate NHSN HAI data. Results of their audits for surgical site infections related to hip replacement surgery were recently presented at the 37th Annual Meeting of the Association for Professionals in Infection Control and Epidemiology (APIC)¹. Their findings suggest that there is a misunderstanding by hospitals of specific NHSN terms, such as “duration of procedure” which led to inadvertent reporting errors. Duration of the procedure is related to the time of anesthesia administration should not be included. New York found that some hospitals were including time administering anesthesia in the duration of a procedure. Facilities that include anesthesia time are inaccurately reporting duration and also potentially inflating the calculated risk of infection.

We thank our colleagues in New York for identifying this problem and we ask you to please review your data to ensure correct application of duration of surgery.

¹Audit of Infection Data an Essential Component of HAI Public Reporting

Special points of interest:
- CUSP/ Stop BSI
- Dialysis Collaborative
- Duration of Surgery and Anesthesia Time
- Freestanding Ambulatory Surgical Centers
- NHSN User Roles
- One & Only Campaign

Upcoming Events:
- September: NHSN Data Cleaning Reports sent to all acute care hospitals
  - Influenza Vaccination Reporting Requirements

¹http://www.cdc.gov/nhsn/PDFs/pscManual/16pscKeyTerms_current.pdf
Information on Changing NHSN User Roles

It is important to inform the Department of Public Health (DPH) and The Centers for Disease Control and Prevention (CDC) whenever there is a change in personnel for the role of NHSN Facility Administrator. This is necessary since the Facility Administrator is the only person who can enroll a facility and is the person responsible for reassigning the role of Facility Administrator to another user. They are also responsible for adding users, assigning user rights, and entering data into NHSN. When a Facility Administrator leaves and does not inform CDC, the next Facility Administrator will have to go through the lengthy process of enrolling the facility in NHSN again. User information should also be kept up-to-date. The Facility Administrator can add and deactivate a user at their convenience. When adding a new user, simply select the user tab from the left navigation bar in NHSN. Click ‘add user’ and provide all necessary information. An email will be sent to the user confirming that they have been added to a group and providing instructions for the next step. To deactivate a user, select users tab from navigation bar. Select the user who no longer works at the facility and then click the deactivate button.

Please feel free to share any comments, questions, and/or suggestions you may have with Nicole Johnson at:
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E-mail: nicole.johnson@state.ma.us

We’re on the web!!
http://www.mass.gov/dph/dhcq
Or visit the MDPH website at
http://www.mass.gov/dph
Collaborative Approach to Prevention of Bloodstream Infections in Dialysis

In 2009 the Centers for Disease Control and Prevention (CDC), in partnership with the Delmarva Foundation, the Maryland Department of Health and Mental Hygiene and the Mid-Atlantic Renal Coalition, established a prevention collaborative of outpatient dialysis facilities¹. The objective of this collaborative is to work together to prevent bloodstream infections (BSIs) in hemodialysis and encourage a broader awareness in preventing infections among the dialysis community. The prevention collaborative is accessible to freestanding and hospital-based outpatient dialysis facilities across the nation. Facilities who take part will be measuring BSIs using the dialysis event surveillance module in CDC’s National Healthcare Safety Network (NHSN), and are creating and implementing a package of evidence-based practices to prevent these infections¹.

¹The Collaborative Approach to Prevention of Bloodstream Infections in Dialysis

This collaborative offers the chance for facilities to network with other dialysis facilities through in-person meetings and monthly collaborative calls to discuss infection prevention issues and activities. These exchanges will help contribute to the goals and execution of this initiative. Facilities will also get the opportunity to get input on explicit challenges to prevention from dialysis and BSI prevention experts. Those interested in learning more about becoming a member of the prevention collaborative can visit online at:
http://www.delmarvafoundation.org/providers/ambulatory/dialysis/index.html

You can also contact Dr. Priti Patel (PPatel@cdc.gov) or Dr. Alex Kallen (AKallen@cdc.gov) at the Centers for Disease Control and Prevention (CDC) or Barbara Bond via phone: (410) 872-9608 for additional information.

Ambulatory Surgical Centers (ASCs)

Building on statewide prevention, surveillance and reporting activities, DPH has expanded the HAI program beyond acute care hospitals to include freestanding ambulatory surgical centers (ASC). Beginning June 1, 2010, freestanding ASCs that perform herniorrhaphies were required to enroll in the National Healthcare Safety Network (NHSN) and report hernia related surgical site infections to DPH¹. Massachusetts and Colorado are currently the only states mandating the use of NHSN for reporting HAI in the ambulatory setting. To prepare ASCs to meet this new requirement, the HAI Program provided a training focused on NHSN enrollment and conferring rights to the data. Program staff is continuing to provide ongoing assistance and technical support. Congratulations to all who have completed the process!

One & Only Campaign

Since 1999, more than 125,000 patients in the United States have been informed of possible exposure to blood born pathogens such as, hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV due to lapses in basic infection control practices. Many of these lapses involved healthcare providers reusing syringes, resulting in contamination of medication vials or containers which were used then on subsequent patients¹. The goal of the One & Only Campaign is to ensure patients are protected every time they receive a medical injection. The One & Only Campaign is a public health campaign, led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC) to raise awareness about safe injection practices among patients and healthcare providers. The Safe Injection Practices video for healthcare providers is designed to remind healthcare providers to always utilize basic, evidence-based, common sense precautions to protect patients and themselves². Patients and providers must both insist on nothing less than One Needle, One Syringe, Only One Time for each and every injection. This practice will greatly diminish the risk of contracting hepatitis and other infections through medical injection.

¹http://www.oneandonlycampaign.org/about/default.aspx?landing=true

CUSP/ Stop BSI

The Agency for Healthcare Research and Quality (AHRQ) is funding the national implementation of a patient safety initiative designed to replicate Michigan’s success in reducing central line associated blood stream infections in intensive care unit (ICU) project. The program utilizes the Comprehensive Unit Based Safety Program (CUSP) and CLABSI reduction protocols developed by Peter Pronovost, MD, PhD and others at Johns Hopkins. This model nearly eliminated CLABSI in more than 70 Michigan Hospitals and success has been sustained for more than four years. Coordinated by Paula Griswold, Executive Director of the Massachusetts Coalition for the Prevention of Medical Errors and Pat Noga, R.N PhD(c), Senior Director of Clinical Affairs at the Massachusetts Hospital Association, the CUSP initiative now includes 16 ICUs at ten Massachusetts hospitals, since it started in October 2009. The focus of the collaborative is on technical strategies to prevent CLABSI as well as adaptive strategies to improve teamwork and communication among ICU clinicians, facilitating a culture of safety. Participants have the support of national experts and the opportunity to learn from partnering hospitals in other states.

We are urging hospitals to join this national initiative and enhance efforts to eliminate CLABSIs in Massachusetts. Hospitals interested in more information may contact Paula Griswold, at PGriswold@macoalition.org