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SHEA News

JCAHO Infection Control Indicators

At our SHEA luncheon during the Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), Deborah M. Nadzam, PhD, RN, Associate Director, Outcomes Research and Development, from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), gave an excellent talk on the status of the JCAHO's infection control indicator testing. Dr. Nadzam and Kristina L. Kazlauskas, MHA, Research Associate, Outcomes Research and Development, have provided an article for us on the indicators chosen for beta testing and the results of the alpha testing. A summary of their report follows; a brief summary appeared in the Medical News section of the January 1992 journal, and a longer article by the authors will appear in the quarterly SHEA Newsletter.

-Editor

The Infection Control Indicator Development Task Force met in June 1991 to review results of alpha testing and to select indicators for beta testing. Ten hospitals and one hospital system had tested the infection control indicator set in late spring to assess the field's reaction to each indicator and the feasibility of data collection. Data collection was conducted manually.

The eight infection control indicators were generally recognized as important to patient outcome and worthy of monitoring. The feasibility of data collection was determined to be somewhat difficult for a few reasons. Some of the data elements were unavailable (e.g., time of line insertion, time of unit admission). Some sites also expressed concern about the ongoing collection of data for all eight indicators. Although the Task Force decided to retain all eight indicators for beta testing, changes were made in most of the indicators as a result of the field's comments. The populations of interest were modified, clarified, and refined. Changes regarding each indicator as they enter beta testing are summarized below.

IC-1

Alpha-Selected surgical operations complicated by a wound infection.

Beta-Selected inpatient and outpatient surgical procedures complicated by a wound infection during hospitalization or postdischarge.

Instead of all surgical operations, the denominator was limited to five specific procedures and two more of the hospital's own choosing. Outpatients also were included. Surgical wound surveillance will be continued for 21 postoperative days, necessitating postdischarge surveillance in some instances. Data elements for the two risk indices (NNIS and SENIC) also will continue to be collected. Postdischarge surveillance will be formally evaluated for surgical wound infection in a few test site hospitals during the beta phase. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-2

Alpha-Selected surgical operations complicated by the onset of pneumonia during hospitalization but not beyond ten postoperative days.

Beta-Selected surgical procedures complicated by the onset of pneumonia during hospitalization but not beyond ten

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postoperative days.

The denominator also was limited (same as IC-1) to a total of seven surgical procedures. Only inpatients will be monitored, and no postdischarge surveillance will be necessary. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-3

Alpha-Selected surgical operations on patients who are catheterized during the perioperative period.

Beta-Selected surgical procedures on inpatients who are catheterized during the perioperative period.

The denominator also was limited (same as IC-1) to a total of seven surgical procedures. Again, only inpatients will be monitored, and no postdischarge surveillance will be necessary Deleted data elements included hospital location of catheter insertion, surgical service, whether a urinary tract infection (UTI) was identified, and the date of the identification of the UTI. The hospital may still follow these patients to see if a UTI develops. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-4

Alpha-Ventilated patients who develop pneumonia.

Beta-Ventilated inpatients who develop pneumonia.

The denominator will remain "1,000 ventilator days" of all ventilated inpatients in all special care units (ii no such units, then whole house). Deleted data elements included time of ventilation initiation and time of intensive care unit admission. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-5

Alpha-Patients who develop endometritis within three postoperative days following Cesarean section.

Beta-Inpatients who develop endometritis following Cesarean section, followed until discharge.

Instead of following this population for only three postoperative days, the numerator was changed to follow the patient until discharge. One data element, use of prophylactic antibiotic, was added to allow for further stratification by the hospital. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-6

Alpha-Patients with a central or umbilical line who develop primary bloodstream infection.

Beta-Inpatients with a central or umbilical line who develop primary bloodstream infection.

The denominator will remain "1,000 central or umbilical line days" of all patients with a central or umbilical line in all special care units (ii no such units, then whole house). Two data elements were deleted: time of line insertion and time of intensive care unit admission. Surveillance will be conducted on the denominator population throughout the two-year beta phase.

IC-7

Alpha-Patients with a central or umbilical line and primary bloodstream infection identified through both medical record review and surveillance activities.

Beta-Inpatients with a central or umbilical line and primary bloodstream infection, analyzed by method of identification.

Data element changes and denominator population are identical, as in IC-6. The numerator was revised to highlight that three rates are important to consider: two assessing the specific methods (concurrent surveillance and medical record abstraction) and

SHEA Annual Meeting-April 12 - 14

You still have time to make plans to attend the SHEA Annual Meeting April 12-14, 1992, at the Omni Inner Harbor Hotel in Baltimore, Maryland. The two and one-half day program will be devoted to broad epidemiologic issues relating to adverse clinical outcomes, nosocomial infections, occupational risks for heatlhcare workers, and quality assessment in adult, pediatric, and long-term care settings. The conference will feature symposia, oral andposter presentations, and roundtable discussions with audience participation. If you need more information regarding the conference, contact SHEA, 875 Kings Highway, Suite 200, West Deptford, NJ 08096. Telephone (609) **845-7220.** Fax (609) 853-0411.

Brief items of interest for the SHEA News or Newsletter may be sent to Robert A. Weinstein, MD, SHEA, Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Luke Shore Drive at 31st St., Chicago, IL 60616; FAX (312) 791-3577. Copy must be typed, doublespaced, and may not exceed five pages.

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