Definitions and Surveillance for Healthcare Associated Infections (HAIs) in Long-term Care

Infection Control in Long Term Care Facilities

April 1st, 2026

Evelyn Cook, RN, CIC

1

- No Disclosures

2

How confident are you that your facility has a strong infection prevention program that includes all the necessary elements?

A. Completely confident

B. Somewhat confident

C. Not confident

D. Have NO idea

SPICE

3

If you wanted to compare your IP surveillance data to another NH in your community that cared for a similar resident population, how confident are you that events will be tracked the same way?

A. Very confident

B. Slightly confident

C. Not confident at all

D. Not sure if I can compare my own data from one year to the next

SPICE

4

What standardized definition(s) does your facility use for surveillance?

A. National Healthcare Safety Network (NHSN)
B. Revised McGeer Definitions
C. Loeb Criteria
D. When the physician documents an infection
E. No standardized criteria
F. A and B

5

"The IP role is essential to developing and maintaining an effective, evidence-based IPCP. The main goal of both the IP and the IPCP is to reduce infection risk by protecting residents, staff, and visitors from exposure to disease-causing pathogens"

Long-Term Care

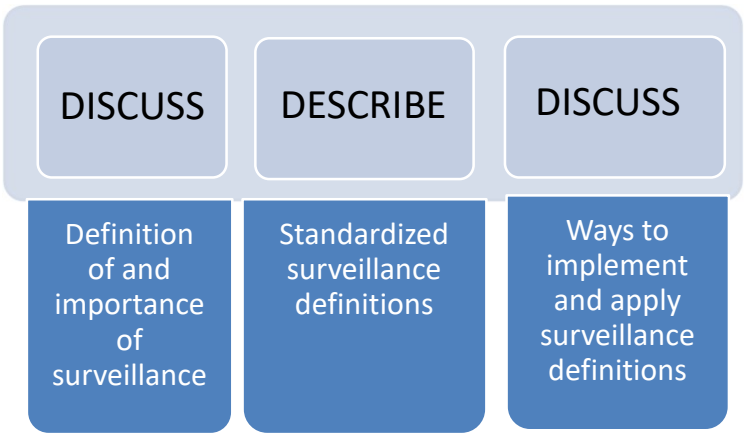
Author(s):
Deb Patterson Burdsall PhD, RN-BC, CIC, LTC-CIP, FAPIC Infection Preventionist, Manager Baldwin Hill Solutions LLC Grantee Illinois Department of Public Health Hektoen Institute of Medicine Chicago, IL
Linda Behan, BSN, RN, CIC Infection Preventionist, President: Long Term Care Infection Prevention, LLC
Evelyn Cook, RN, CIC Associate Director NC Statewide Program for Infection Control and Epidemiology University of North Carolina at Chapel Hill Chapel Hill, NC
Karen Trimberger, RN, MPH, NE-BC, CIC, LTC-CIP Infection Preventionist Owner: Trimberger Consulting Services, LLC Grantee Illinois Department of Public Health Hektoen Institute of Medicine Chicago, IL

Original Publication:
July 23, 2025

Store - Association for Professionals in Infection Control & Epidemiology

6

OBJECTIVES



SPICE

7

- "Surveillance is a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare team to assist in improving those outcomes and processes (APIC Text)
- "Surveillance system must include "**routine, ongoing**, and **systematic collection**, **analysis,** interpretation, and **dissemination** of surveillance data to identify infections (i.e., HAI and communicable-acquired), infection risks, communicable disease outbreaks and to maintain or improve resident health status:" (CMS §483.80 Infection Control 8/24)

SPICE

8

Rationale for Conducting Surveillance

- One of the most important aspects of an IP's responsibilities
- Should cover residents, staff, contractors (in the facility) and visitors
- Include process and outcome measures

1. Establish Baseline Data
2. Reduce Infection Rates
3. Detection of Outbreaks
4. Monitor Effectiveness of Interventions
5. Education of HCP

Required as a component of your plan

SPICE

9

- The National Academies of Sciences, Engineering, and Medicine(NASEM) have recommended that the IP ***have sufficient time to perform required duties***
- One survey found approximately ***25% of IP time is spent on infection surveillance.***[1]
- Submitting surveillance data to a network, which allowed for comparing infection rates across facilities and tracking performance improvement, has been associated with a ***decreased rate of healthcare-associated infections (HAIs),*** including influenza-like illness, urinary tract infections (UTIs), and pneumonia over time.

This important and time-intensive responsibility is one of numerous responsibilities, including the IP's engagement in continuing education and need to train and educate nursing home personnel in IPC

[1]*SHEA Expert Guidance Multisociety guidance for infection prevention and control in nursing homes; Infection Control & Hospital Epidemiology (2025), 1–28 doi:10.1017/ice.2025.10252*

SPICE

10

Types of Surveillance

- Total (or Whole) House Surveillance
- Targeted Surveillance
- Combination Surveillance Strategy

SPICE

11

Total (Whole House)

- Monitor:
  - All infections
  - Entire population
  - All units

Pros	Cons
Monitor all infections	Overall rate not sensitive or risk-adjusted
Include entire population	No trends or comparison
	Labor intense and inefficient use of resources
	Not based on risk assessment

SPICE

12

Priority Directed (Targeted)

- Focus on:
  - Care units
  - Infections related to devices
  - Invasive procedures
  - Significant organisms – epidemiologically important
  - High-risk, high-volume procedures
  - Infections having known risk reduction methods

SPICE

13

Targeted Surveillance

Pros	Cons
Risk-adjusted rates	May miss some infections
Can measure trends and make comparisons	Limited information on endemic rates
More efficient use of resources	
Can target potential problems	
Identify performance improvement opportunities	
Can evaluate effectiveness of prevention activities	

SPICE

14

Combination

- Monitor:
  - Targeted events in defined populations and
  - Selected whole-house events
- Pros:
  - Rates are risk-adjusted
  - Measure trends
  - Target potential problems
  - Track selected events house-wide
- Cons:
  - May miss some infections

SPICE

15

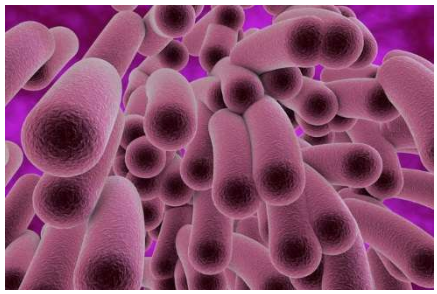
Selection of Processes and Outcomes

Processes-areas you might want to consider (CMS 8/24):

- Hand hygiene
- Appropriate use of PPE
- Point-of-care testing
- Urinary Catheter insertion/maintenance
- Cleaning and disinfection products/procedures

Outcomes

- Acute respiratory infections
- Urinary tract infections
- Skin/Soft Tissue Infections
- Gastroenteritis



SPICE

16

Establish Priorities for Routine Surveillance

- Mandatory/required-Cat 1C
- *Frequency (incidence) of the infection
- *Communicability
- *System/resident cost (↑mortality, hospitalization)
- *Early Detection

Based on the Infection Prevention risk assessment

SPICE

17

Should be included in routine surveillance

Points to Consider	Infections	Comments
Evidence of transmissibility in a healthcare setting	Viral respiratory tract infections, viral GE, and viral conjunctivitis	Associated with outbreaks among residents and HCP in LTCFs
Processes available to prevent acquisition of infection, i.e., HH compliance		
Clinically significant cause of morbidity or mortality	Pneumonia, UTI, GI tract infections, (including C. *difficile)* and SSTI	Associated with hospitalization and functional decline in LTCF residents
Specific pathogens causing serious outbreaks	Any invasive group A *Streptococcus* infection, acute viral hepatitis, norovirus, scabies, influenza-**COVID-19, *C auris***	A single laboratory-confirmed case should prompt further investigation

table 1. Considerations for Inclusion of Infections in Long-Term Care Facilities (LTCFs) into Facility Infection Surveillance Programs-Revisiting McGeer Definitions

SPICE

18

Infections that could be included in routine surveillance

Points to Consider	Infections	Comments
Infections with limited transmissibility in a healthcare settings	Ear and sinus infections, fungal oral and skin infections and herpetic skin infections	Associated with underlying comorbid conditions and reactivation of endogenous infection
Infections with limited preventability		

SPICE

19

Infections for which other accepted definitions should be applied in LTCF surveillance

Points to Consider	Infections	Comments
Infections with other accepted definitions (may apply to only specific at-risk residents)	Surgical site infections, central-line- associated bloodstream infections and ventilator-associated pneumonia (Could add LabID *C. difficile* or MRSA)	LTCF-specific definitions were not developed. Refer to the National Healthcare Safety Network's criteria

SPICE

20

Surveillance

- ***The facility's surveillance system must include a data collection tool and the use of nationally-recognized surveillance criteria such as but not limited to, the CDC's National Healthcare Safety Network (NHSN) Long Term Care Criteria to define infections or revised McGeer criteria***

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents
(Rev. 08-2024)

SPICE

21

Minimum Criteria for Initiation of Antibiotics in Long-Term Care Residents

Suspected Urinary Tract Infection

Loeb et al. Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term Care Facilities: Results of a Consensus Conference.
Inf Control Hosp Epi. 2001

SPICE

22

Tracking Infections in Long-term Care Facilities

Eliminating infections, many of which are preventable, is a significant way to improve care and decrease costs. CDC's National Healthcare Safety Network provides long-term care facilities with a customized system to track infections in a streamlined and systematic way. When facilities track infections, they can identify problems and track progress toward stopping infections. On the national level, data entered into NHSN will gauge progress toward national healthcare-associated infection goals.

NHSN's long-term care component is ideal for use by: nursing homes, skilled nursing facilities, chronic care facilities, and assisted living and residential care facilities

C. difficile & MRSA Infections

Surveillance for C. difficile, MRSA, and other Drug-resistant Infections

Urinary Tract Infections (UTI)

Surveillance for Urinary Tract Infections (UTI)

Prevention Process Measures

Surveillance for Prevention Process Measures – Hand Hygiene, Gloves and Gown Adherence

SPICE

23

INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY OCTOBER 2012, VOL. 33, NO. 10

SHEA/CDC POSITION PAPER

Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria

Nimalie D. Stone, MD;[1] Muhammad S. Ashraf, MD;[2] Jennifer Calder, PhD;[3] Christopher J. Crnich, MD;[4] Kent Crossley, MD;[5] Paul J. Drinka, MD;[6] Carolyn V. Gould, MD;[1] Manisha Juthani-Mehta, MD;[7] Ebbing Lautenbach, MD;[8] Mark Loeb, MD;[9] Taranisia MacCannell, PhD;[1] Preeti N. Malani, MD;[10,11] Lona Mody, MD;[10,11] Joseph M. Mylotte, MD;[12] Lindsay E. Nicolle, MD;[13] Mary-Claire Roghmann, MD;[14] Steven J. Schweon, MSN;[15] Andrew E. Simor, MD;[16] Philip W. Smith, MD;[17] Kurt B. Stevenson, MD;[18] Suzanne F. Bradley, MD[10,11] for the Society for Healthcare Epidemiology Long-Term Care Special Interest Group*

These definitions were intended exclusively for long-term care facilities that housed patients for 24-hour care under professional nursing supervision. As the number of patients in LTC facilities grew, surveillance criteria were needed to identify infections in this specialized setting consistently.

SPICE

24

Clinical Disagreement?

	Surveillance Definitions	Clinical Diagnosis
Purpose	Identify trends within a population for prevention	Identify disease in, and treatment for, individual patients
Components	Limited predetermined data elements	All diagnostic information available
Clinical Judgment	Excluded if possible	Valued

It is important to remember that infection surveillance definitions are intended to ***standardize what health care facilities deem "infections."***
They are different from clinical decision-making criteria at the bedside.
Presentations of infection in older residents of LTC facilities may be atypical, so failure to meet surveillance definitions may not entirely exclude the presence of infection.

SPICE

25

- Although all CMS-certified nursing homes have been required to track a resident' admission, and on a quarter basis information about UTI pneumonias, C. difficile, and antibiotic-resistant bacteria using the Minimum Data Se Minimum Data Set definitio ***are not the same as those used for HAI surveillance a should not be substituted f infection surveillance purposes***

SPICE

26

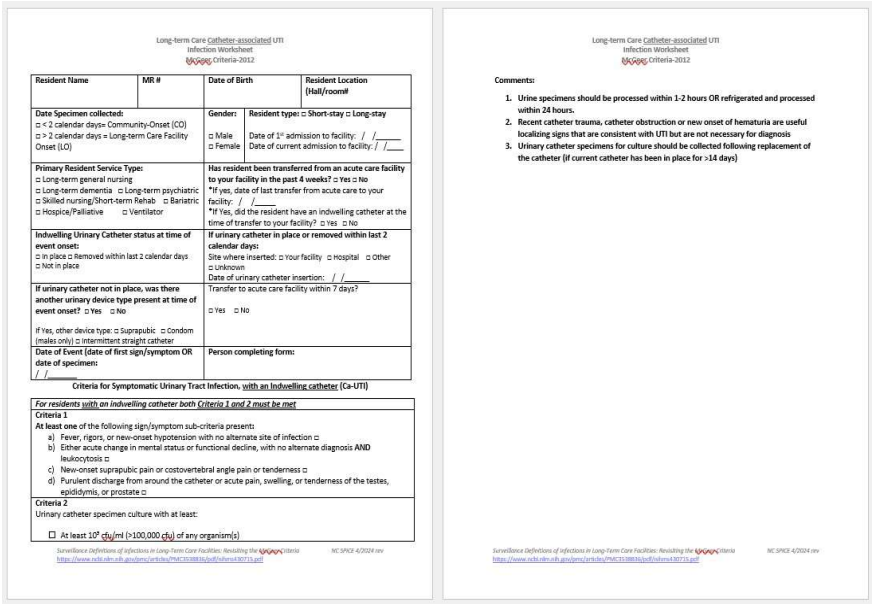
Surveillance Tools

- IPs need several critical tools to perform effective surveillance[1]
  - Line List
  - Device Use
  - Access to microbiology cultures
  - Standardized infection criterion

[1]*Long term care Chronicles: Robbie Hilliard, MSN, RN, CIC; January 8, 2025*

SPICE

27



Long-term Care Catheter-associated UTI
Infection Worksheet
NHSN Criteria-2012

Resident Name	MR #	Date of Birth	Resident Location (Hall/room#
Date Specimen collected: □ < 2 calendar days= Community-Onset (CO) □ > 2 calendar days = Long-term Care Facility Onset (LO)		**Gender:** □ Male □ Female	**Resident type:** □ **Short-stay** □ **Long-stay** Date of 1st admission to facility: / /____ Date of current admission to facility: / /___
Primary Resident Service Type: □ Long-term general nursing □ Long-term dementia □ Long-term psychiatric □ Skilled nursing/Short-term Rehab □ Bariatric □ Hospice/Palliative □ Ventilator		**Has resident been transferred from an acute care facility to your facility in the past 4 weeks? □ Yes □ No** *If yes, date of last transfer from acute care to your facility: / /____ *If Yes, did the resident have an indwelling catheter at the time of transfer to your facility? □ Yes □ No	
Indwelling Urinary Catheter status at time of event onset: □ In place □ Removed within last 2 calendar days □ Not in place		**If urinary catheter in place or removed within last 2 calendar days:** Site where inserted: □ Your facility □ Hospital □ Other □ Unknown Date of urinary catheter insertion: / /____	
If urinary catheter not in place, was there another urinary device type present at time of event onset? □ Yes □ No If Yes, other device type: □ Suprapubic □ Condom (males only) □ Intermittent straight catheter		Transfer to acute care facility within 7 days? □ Yes □ No	
Date of Event [date of first sign/symptom OR date of specimen: / /____		**Person completing form:**	

Criteria for Symptomatic Urinary Tract Infection, with an Indwelling catheter (Ca-UTI)

For residents with an indwelling catheter both Criteria 1 and 2 must be met
Criteria 1 **At least one** of the following sign/symptom sub-criteria present: a) Fever, rigors, or new-onset hypotension with no alternate site of infection □ b) Either acute change in mental status or functional decline, with no alternate diagnosis **AND** leukocytosis □ c) New-onset suprapubic pain or costovertebral angle pain or tenderness □ d) Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate □
Criteria 2 Urinary catheter specimen culture with at least: ☐ At least 10^3 cfu/ml (>100,000 cfu) of any organism(s)

Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria NC SPICE 4/2024 rev
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/pdf/nihms430715.pdf

Long-term Care Catheter-associated UTI
Infection Worksheet
NHSN Criteria-2012

Comments:

1. **Urine specimens should be processed within 1-2 hours OR refrigerated and processed within 24 hours.**
2. **Recent catheter trauma, catheter obstruction or new onset of hematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis**
3. **Urinary catheter specimens for culture should be collected following replacement of the catheter (if current catheter has been in place for >14 days)**

Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria NC SPICE 4/2024 rev
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/pdf/nihms430715.pdf

SPICE

28

29

Attribution of infection to LTCF

- No evidence of an incubating infection at the time of admission to the facility
  - Basis of clinical documentation of appropriate signs and symptoms and not solely on screening microbiologic data
- Onset of clinical manifestation occurs > 2 calendar days after admission.

SPICE

30

Attribution of infection to LTCF

- All symptoms must be new or acutely worse
- Non-infectious causes of signs and symptoms should always be considered prior to diagnosis
- Identification of an infection should not be based on a single piece of evidence
  - Clinical, microbiologic, radiologic
- Diagnosis by physician insufficient (based on definition)

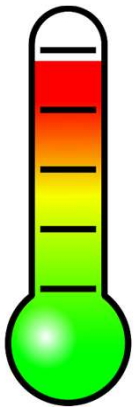
SPICE

31

Constitutional Requirements

Fever:

- A single oral temperature >37.8°C [100°F], OR
- Repeated oral temperatures >37.2°C [99°F]; rectal temperature >37.5° (99.5°F) OR
- >1.1°C [2°F] over baseline from a temperature taken at any site



SPICE

32

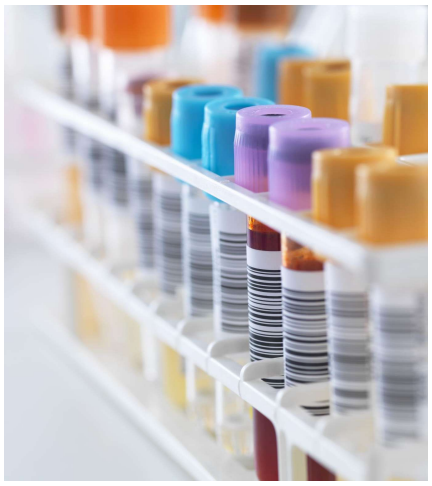
Constitutional Requirements

Leukocytosis

- Neutrophilia > 14000 WBC/mm^3

OR

- Left shift (>6% bands or ≥1500 bands/mm^3)



SPICE

33

Constitutional Requirements

Acute Change in Mental Status from Baseline

- Based on Confusion Assessment Method (CAM) criteria available in MDS

Change	Criteria	
Acute Onset	Evidence of acute change in mental status from resident baseline	
Fluctuating	Behavior fluctuating (e.g., coming and going or changing in severity during assessment)	
Inattention	Resident has difficulty focusing attention (e.g., unable to keep track of discussion or easily distracted	
Disorganized Thinking	Resident's thinking is incoherent (e.g., rambling conversation, unclear flow of ideas)	Either /or
Altered level of consciousness	Resident's level of consciousness is described as different from baseline (e.g., hyperalert, sleepy, drowsy, difficult arouse, nonresponsive)	

SPICE

34

Constitutional Requirements

Acute Functional Decline

- New 3-point increase in total ADL score (0-28) from baseline based on 7 ADLs {0 = independent; 4 = total dependence}
  1. Bed mobility
  2. Transfer
  3. Locomotion within LTCF
  4. Dressing
  5. Toilet use
  6. Personal hygiene
  7. Eating

SPICE

35

Site Specific Definitions

Knowledge Checks

SPICE

36

Respiratory Tract Infections

Criteria	Comments
A. Common cold syndrome/pharyngitis At least **two** criteria present 1. Runny nose or sneezing 2. Stuffy nose (i.e., congestion) 3. Sore throat or hoarseness or difficulty swallowing 4. Dry cough 5. Swollen or tender glands in neck	Fever may or may not be present. Symptoms must be new, and not attributable to allergies

37

Respiratory Tract Infections

Criteria	Comments
B. Influenza-like Illness **Both** criteria 1 and 2 present 1. Fever 2. At least **three** of the following symptom sub-criteria (a-f) present a. Chills b. New headache or eye pain c. Myalgias or body aches d. Malaise or loss of appetite e. Sore throat f. New or increased dry cough	If criteria for influenza-like illness and another upper or lower respiratory tract infection are met at the same time, only the diagnosis of influenza-like illness should be used Due to increasing uncertainty surrounding the timing of the start of influenza season, the peak of influenza activity and the length of the season, 'seasonality' is no longer part of the criteria to define influenza-like illness

38

Respiratory Tract Infections

Criteria	Comments
C. Pneumonia	For both pneumonia and lower respiratory tract infections, presence of underlying conditions which could mimic a respiratory tract infection presentation (congestive heart failure, interstitial lung disease), should be excluded by review of clinical records and an assessment of presenting symptoms and signs
All criteria 1-3 present	
1. Interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrate	
2. At least **one** of the following respiratory sub-criteria (a-f) present	
a. New or increased cough	
b. New or increased sputum production	
c. O_2 saturation <94% on room air or a reduction in O_2 saturation of more than 3% from baseline	
d. New or changed lung exam abnormalities	
e. Pleuritic chest pain	
f. Respiratory rate of ≥ 25/min	
3. At least **one** constitutional criteria	

SPICE

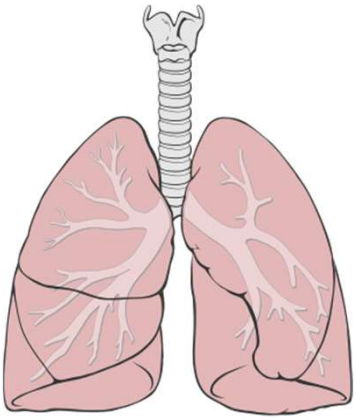
39

Respiratory Tract Infections

Criteria	Comments
D. Lower respiratory tract (Bronchitis or Tracheo-bronchitis	For both pneumonia and lower respiratory tract infections, presence of underlying conditions which could mimic a respiratory tract infection presentation (congestive heart failure, interstitial lung disease), should be excluded by review of clinical records and an assessment of presenting symptoms and signs
All criteria 1-3 present	
1. Chest radiograph not performed or *negative* for pneumonia or new infiltrate.	
2. At least **two** of the following respiratory sub-criteria (a-f) present	
a. New or increased cough	
b. New or increased sputum production	
c. O_2 saturation <94% on room air or a reduction in O_2 saturation of more than 3% from baseline	
d. New or changed lung exam abnormalities	
e. Pleuritic chest pain	
f. Respiratory rate of ≥ 25/min	
3. At least **one** constitutional criteria	

SPICE

40



Knowledge Check

SPICE

41

Knowledge Check #1

Mr. Do Little has multiple co-morbidities including hypertension and acute respiratory failure. Vitals on admission WNL

On day seven after admission, the daughter tells the nurse “dad is not responding like he used to. He can not hold a conversation, tires easily and is not able to brush his teeth, eat or dress without assistance.” **I think he has a UTI. He needs an antibiotic.**

SPICE

42

Clinical Picture

Physical exam:

- Temp 100.7, pulse 107, RR 26 and O2 sat 93%
- Ronchi noted on auscultation of the chest the resident is confused

MD notified and orders urine and chest x-ray

Results:

- Culture + E. coli 10^2 cfu/ml and
- chest x-ray: no new findings

SPICE

43

Does Mr. Do Little have an infection?

- Yes
  - What Type of Infection?
    - Pneumonia
    - UTI
    - Lower respiratory Track
- No
- Have no idea

WHY

SPICE

44

Respiratory Tract Infections

Criteria	Comments
D. Lower respiratory tract (Bronchitis or Tracheo-bronchitis	
All criteria 1-3 present 1. Chest radiograph not performed or *negative* for pneumonia or new infiltrate. 2. At least **two** of the following respiratory sub-criteria (a-f) present a. New or increased cough b. New or increased sputum production c. O_2 saturation <94% on room air or a reduction in O_2 saturation of more than 3% from baseline d. New or changed lung exam abnormalities e. Pleuritic chest pain f. Respiratory rate of ≥ 25/min 3. At least **one** constitutional criteria	For both pneumonia and lower respiratory tract infections, presence of underlying conditions which could mimic a respiratory tract infection presentation (congestive heart failure, interstitial lung disease), should be excluded by review of clinical records and an assessment of presenting symptoms and signs

45

Knowledge Check # 2

Mr. U, a resident of LTC facility has a urinary catheter in place for 3 days for acute urinary retention. Later that day he spikes a fever of 101°F and has a cough with shortness of breath.

The physician orders a urine culture, and it comes back positive with >100,000 CFU/ml of Pseudomonas aeruginosa and Candida albicans.

Upon further work, up Mr. U is determined not to have any other symptoms that meet the NHSN CA-SUTI criteria,

A chest X-ray does show infiltrates in the right upper lobe of the lung.

46

Does Mr. U have a Respiratory Track Infection?

A. Yes ★
   A. What type of respiratory track infection

B. No
   A. He does not meet criteria for respiratory track infection because the fever has another alternative source (urinary track infection)

SPICE

47

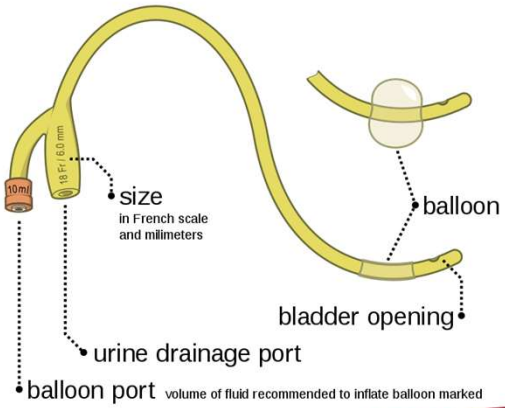
Respiratory Tract Infections

Criteria	Comments
C. *Pneumonia*	
All criteria 1-3 present	
1. Interpretation of chest radiograph as demonstrating **pneumonia or the presence of new infiltrate** ✓	For both pneumonia and lower respiratory tract infections, presence of underlying conditions which could mimic a respiratory tract infection presentation (congestive heart failure, interstitial lung disease), should be excluded by review of clinical records and an assessment of presenting symptoms and signs
2. At least **one** of the following respiratory sub-criteria (a-f) present	
a. **New or increased cough** ✓	
b. New or increased sputum production	
c. O_2 saturation <94% on room air or a reduction in O_2 saturation of more than 3% from baseline	
d. New or changed lung exam abnormalities	
e. Pleuritic chest pain	
f. Respiratory rate of ≥ 25/min	
3. **At least one constitutional criteria** ✓	

SPICE

48

WHAT ABOUT URINARY TRACT INFECTIONS



49

What do the Guidelines Say?

- Insert catheters only for appropriate indications
- Avoid use of urinary catheters in patients and nursing home residents for management of incontinence
- Keep the catheter and collecting tube free from kinking
- Empty the drainage bag regularly using a separate, clean collecting container for each resident (even in semi-private rooms)

- ***Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended.*** It is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system has been compromised

https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html

50

Urinary Specimens: What do the Guidelines Say?

- Specimens collected through the catheter present for more than a few days reflect biofilm microbiology.
- For residents with chronic indwelling catheters **(greater than 14 days)** and symptomatic infection, changing the catheter immediately prior to instituting antimicrobial therapy allows collection of a bladder specimen, which is a more accurate reflection of infecting organisms.
- Urinary catheters coated with antimicrobial materials have the potential to decrease UTIs but have not been studied in the LTCF setting.

SHEA/APIC Guideline: Infection prevention and control in the long-term care facility Philip W. Smith, MD, Gail Bennett, RN, MSN, CICb Suzanne Bradley, MD, Paul Drinka, MD, Ebbing Lautenbach, MD, James Marx, RN, MS, CIC, Lona Mody, MD, Lindsay Nicolle, MD and Kurt Stevenson, MD July 2008

SPICE

51

McGeer Urinary Tract Infections

without catheter

Criteria	Comments
A. For Residents without an indwelling catheter Both criteria 1 and 2 present 1. At **least one** of the following sign/symptom sub-criteria (a-c) present: a) Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate b) Fever or leukocytosis and At least one of the following localizing urinary tract sub-criteria: i. Acute costovertebral angle pain or tenderness ii. Suprapubic pain iii. Gross hematuria iv. New or marked increase in incontinence v. New or marked increase in urgency vi. New or marked increase in frequency c) In the absence of fever of leukocytosis, then at least two or more of the following localizing urinary symptoms i. Suprapubic pain ii. Gross hematuria iii. New or marked increase in incontinence iv. New or marked increase in urgency v. New or marked increase in frequency 2. One of the following microbiologic sub-criteria a) At least 10^5 cfu/ml of no more than 2 species of microorganisms in a voided urine b) At least 10^2 cfu/ml of any number of organisms in a specimen collected by an in and out catheter	UTI should be diagnosed when there are localizing s/s and a positive urinary culture ***A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate of the same organism isolated from the urine and there is no alternate sight of infection*** In the absence of a clear alternate source, fever or rigors with a positive urine culture in a non-catheterized resident will often be treated as a UTI. However, evidence suggest most of these episodes are not from a urinary source Pyuria does not differentiate symptomatic UTI from asymptomatic bacturia Absence of pyuria in diagnostic test excludes symptomatic UTI in residents of LTCF Urine specimens should be processed within 1-2 hours, or refrigerated and processed with in 24 hours.

52

McGeer Urinary Tract Infections

Criteria	Comments
B. For the resident with an indwelling catheter	
Both criteria 1 and 2 present	Recent catheter trauma, catheter obstruction or new onset hematuria are useful localizing signs consistent with UTI, but not necessary for diagnosis
1. At least **one** of the following sign/symptom sub-criteria (a-d) present: a) Fever, rigors, or new onset hypotension, with no alternate site of infection b) Either acute change in mental status or acute functional decline with no alternate diagnosis and Leukocytosis c) New onset suprapubic pain or costovertebral angle pain or tenderness d) Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate	
2. Urinary catheter culture with at least 10^5 cfu/ml of any organism(s)	Urinary catheter specimens for culture should be collected following the replacement of the catheter (if current catheter has been in place for >14 days)

SPICE

53

54

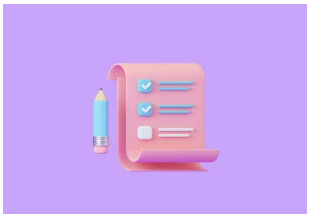
NHSN Notes

- Indwelling urinary catheter should be in place for a minimum of 2 calendar days before infection onset (day 1 = day of insertion)
- Indwelling urinary catheter: a drainage tube that is inserted into the urinary bladder through the urethra, is left in place and is connected to a closed collection system, also called a foley catheter. Indwelling urinary catheters do not include straight in-and-out catheters or suprapubic catheters (these would be captures as SUTIs, not CA-SUTIs)
- *Indwelling catheters which have been in place for > 14 days should be changed prior to specimen collection but failure to change catheter does not exclude a UTI for surveillance purposes*

SPICE

55

NHSN Key Reminders



1. ***"Mixed flora" is not available in the pathogen list within NHSN.*** Therefore, it cannot be reported as a pathogen to meet the NHSN UTI criteria. Additionally, "mixed flora" often represents contamination and likely represents presence of multiple organisms in culture (specifically, at least two organisms).

2. ***Yeast and other microorganisms, which are not bacteria, are not acceptable UTI pathogens***, and therefore, cannot be used to meet NHSN UTI criteria without the presence of a qualifying bacterium.

Not true for McGeers

3. To remove the subjectivity about whether a fever is attributable to a UTI event, ***the presence of a fever, even if due to another cause (for example, pneumonia), must still be counted as a criterion when determining if the NHSN UTI definition is met.***

SPICE

56

NHSN Key Reminders…

- Fever
  - No specific route of measurement is required
  - Use the temperature documented in the resident's medical record (no conversion based on route of collection)
  - Non-specific sign that can be used even in the presence of another possible source
  - Baseline = average of the resident's previous documented temperatures using the same method
- Leukocytosis
  - An elevation in the number of white blood cells (WBC) in the blood (greater than 10,000 cells /mm^3)

14,000 for McGeers

SPICE

57

NHSN Urinary Tract Infections For Residents without an indwelling catheter

Must meet Criteria 1,2 OR 3

Criteria 1

One of the following true:

1. Acute dysuria
2. Acute pain, swelling or tenderness of the testes, epididymis or prostate

AND

A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml

Criteria 2

Either of the following:

1. Fever: (Single temperature >100° F or >99° F on repeated occasions (more than once) OR an increase of >2° F over baseline
2. Leukocytosis: >10,000 cells/mm³ or left shift (6% or 1, 500 bands/mm³

AND

One or more of the following (**New or Marked increase**):

1. Costovertebral angle pain or tenderness
2. Suprapubic tenderness
3. Visible (Gross) hematuria
4. Incontinence
5. Urgency
6. Frequency

AND

A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of $\geq 10^5$ CFU/m

Criteria 3

Two or more of the following **(New and/or marked increase):**

1. Costovertebral angle pain or tenderness
2. Incontinence
3. Urinary urgency
4. Urinary frequency
5. Suprapubic tenderness
6. Visible (gross) hematuria

AND

A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml

Comments: Fever can be used to meet SUTI criteria even if the resident has another possible cause for the fever (for example, pneumonia

58

NHSN Urinary Tract Infections

For the resident with an indwelling catheter-or removed within 2 calendar days prior to the event onset (day of catheter removal is day 1)

Criteria	Comments
CA-SUTI **One or more** of the following (Signs and Symptoms and Laboratory and diagnostic Testing): a) *Fever (Single temperature >100° F or >99° F on repeated occasions OR an increase of >2° F over baseline) b) Rigors c) New onset hypotension, with no alternate noninfectious cause d) New onset confusion/functional decline **with no alternate diagnosis AND** Leukocytosis (>10,000 cells/mm³ or left shift (6% or 1, 500 bands/mm³) e) New or marked increase in costovertebral angle pain or tenderness f) New or marked increase in suprapubic tenderness g) Acute pain, swelling, or tenderness of the testes, epididymis, or prostate h) Purulent discharge from around the catheter insertion site i) Acute dysuria (used only if catheter removed)	**AND** ↓ A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml **Fever can be used to meet CA-SUTI criteria even if the resident has another possible cause for the fever (for example, pneumonia)*

59

Asymptomatic Bacteremic Urinary Tract Infection (ABUTI)

Resident with or without an indwelling urinary catheter:

1. No qualifying fever or signs or symptoms (specifically no urinary urgency, urinary frequency, acute dysuria, suprapubic tenderness, or costovertebral angle pain or tenderness). If no catheter is in place, fever alone would not exclude ABUTI if other criteria are met

AND

2. A positive urine culture with no more than 2-species of microorganisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml

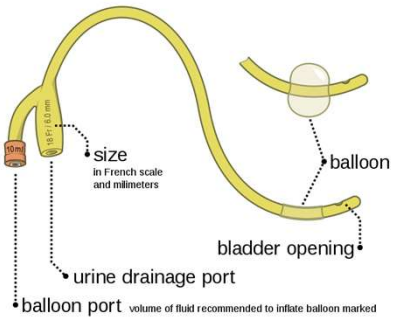
AND

3. A positive blood culture with at least 1 matching bacteria to the urine culture

SPICE

60

Knowledge Check



SPICE

61

Knowledge Check # 1

1 Mar.

Mrs. Ross is a resident in your facility, admitted on February 1st. An indwelling urinary catheter was inserted on March 1st.

5 Mar.

On March 5, the nurse practitioner documented that Mrs. Ross complained of suprapubic pain.

6 Mar.

The following day, on March 6, a specimen collected from the Foley catheter was sent to the lab and subsequently tested positive for greater than 100,000 CFU/ml of E. coli and 100,000 CFU/ml of Candida

SPICE

62

Does Mr. Ross have a CA-UTI?

A. Yes

B. No

SPICE

63

Knowledge Check # 2

Mr. U, a resident of LTC facility has a urinary catheter in place for 3 days for acute urinary retention. Later that day he spikes a fever of 101°F and has a cough with shortness of breath.

The physician orders a urine culture, and it comes back positive with >100,000 CFU/ml of Pseudomonas aeruginosa and Candida albicans.

Upon further work, up Mr. U is determined not to have any other symptoms that meet the NHSN CA-SUTI criteria,

A chest X-ray does show infiltrates in the right upper lobe of the lung.

SPICE

64

Does Mr. U have an CA-SUTI?

A. Yes
   A. He meets criteria for a CA-SUTI
B. No
   A. He does not meet criteria for CA-SUTI because the fever has another alternative source (respiratory infection)

SPICE

65

Knowledge Check # 3

Day 1: Ms. R had an indwelling urinary catheter inserted for a bladder outlet obstruction

Day 2: The indwelling urinary catheter remains in place

Day 3: The resident's indwelling urinary catheter remains in place. The resident had a single oral temp of 100.2°F. A urine culture was collected from the catheter

SPICE

66

Ms. R continued

Day 4: The indwelling urinary catheter remains in place. No symptoms documented

Day 5: The urine culture was positive for Candida glabrata 10^5 CFU/ml

SPICE

67

Does Ms. R have a CA-SUTI?

A. Yes
   A. BUT only meets McGeer definitions

B. No

SPICE

68

Knowledge Check # 4

Mrs. C is an 85-year-old female who is normally ambulatory, independent of ADLs and very social with staff and other residents. She has been a resident of your facility for 10 years

This morning, March 5th, Mrs. C seems confused, refuses breakfast, is incontinent of stool and does not want to get out of bed.

Vital Signs: Temp 99.5, RR 22, O^2Sat 93% on room air and BP is 110/70. Urine is dark yellow and has a strong odor.

Physician orders, UC, BC and chest x-ray

SPICE

69

Knowledge Check # 4

Diagnostic test are completed, and results are as follows:

UC positive for >10^5 cfu/ml of *klebsiella pneumonia and* > 10^2 *candida albicans*

Chest x-ray negative for infiltrate

BC + for *Klebsiella pneumonia*

What Surveillance Definition Does Mrs. C meet?

1. Lower respiratory tract
2. Gastroenteritis
3. Urinary tract infection
4. Bloodstream infection
5. Asymptomatic Bacteremic Urinary Tract Infection

SPICE

70

Skin, Soft Tissue and Mucosal Infections

SPICE

71

Skin, Soft Tissue and Mucosal Infections

Criteria	Comments
A. Cellulitis/soft tissue/wound infection At least **one** of the following criteria is present 1. Pus present at a wound, skin, or soft tissue site 2. New or increasing presence of at least **four** of the following sign/symptom sub-criteria a) Heat at affected site b) Redness at affected site c) Swelling at affected site d) Tenderness or pain at affected site e) Serous drainage at affected site **f) One** constitutional criteria	More than one resident with streptococcal skin infection from the same serogroup (e.g., A, B, C, G) in a LTCF may suggest an outbreak For wound infections related to surgical procedures: LTCF should use the CDC's NHSN surgical site infection criteria and report these infections back to the institution performing the original surgery Presence of organisms cultured from the surface (e.g., superficial swab culture) of a wound is not enough evidence that the wound is infected

SPICE

72

Skin, Soft Tissue and Mucosal Infections

Criteria	Comments
B. Scabies	Care must be taken to rule out rashes due to skin irritation, allergic reactions, eczema, and other non-infectious skin conditions
Both criteria 1 and 2 present 1. A maculopapular and/or itching rash 2. At least **one** of the following sub-criteria: a) Physician diagnosis b) Laboratory confirmation (scrapping or biopsy) c) Epidemiologic linkage to a case of scabies with laboratory confirmation	An epidemiologic linkage to a case can be considered if there is evidence of geographic proximity in the facility, temporal relationship to the onset of symptoms, or evidence of a common source of exposure (i.e., shared caregiver).

73

Skin, Soft Tissue and Mucosal Infections

Criteria	Comments
C. Fungal oral/perioral and skin infections	Mucocutaneous candida infections are usually due to underlying clinical conditions such as poorly controlled diabetes or severe immunosuppression. Although not transmissible infections in the healthcare setting, they can be a marker for increased antibiotic exposure
Oral candidiasis: **Both** criteria 1 and 2 present: 1. Presence of raised white patches on inflamed mucosa, or plaques on oral mucosa 2. Medical or dental provider diagnosis	
Fungal skin Infection: **Both** criteria 1 and 2 present: 1. Characteristic rash or lesion 2. Either a medical provider diagnosis or laboratory confirmed fungal pathogen from scrapping or biopsy	Dermatophytes have been known to cause occasional infections, and rare outbreaks, in the LTC setting.

74

Skin, Soft Tissue and Mucosal Infections

Criteria	Comments
D. Herpes viral skin infections Herpes simplex infection **Both** criteria 1 and 2 present: 1. A vesicular rash 2. Either physician diagnosis or laboratory confirmation Herpes zoster infection **Both** criteria 1 and 2 present: 1. A vesicular rash 2. Either physician diagnosis or laboratory confirmation	Reactivation of old herpes simplex ("cold sores") or herpes zoster ("shingles") is not considered a healthcare-associated infection Primary herpes viral skin infections are very uncommon in LTCF, except in pediatric populations where it should be considered healthcare-associated.

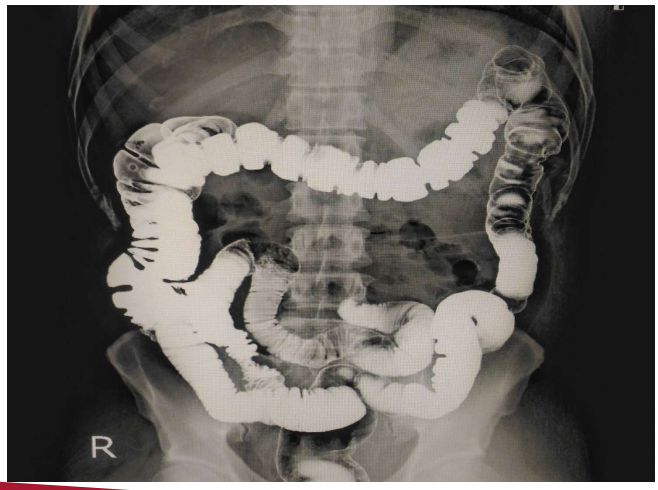
75

Skin, Soft Tissue and Mucosal Infections

Criteria	Comments
E. Conjunctivitis At least **one** of the following criteria present: 1. Pus appearing from one or both eyes, present for at least 24 hours 2. New or increasing conjunctival erythema, with or without itching. 3. New or increased conjunctival pain, present for at least 24 hours.	Conjunctivitis symptoms ("pink eye") should not be due to allergic reaction or trauma.

76

Gastrointestinal Tract Infections



SPICE

77

Gastrointestinal Tract Infections

Criteria	Comments
A. Gastroenteritis At **least one** of the following criteria present 1. Diarrhea, three or more liquid or watery stools above what is normal for the resident within a 24-hour period 2. Vomiting, two or more episodes in a 24-hour period 3. Both of the following sign/symptom sub-criteria present: a) A stool specimen positive for a pathogen (such as Salmonella, Shigella, E. coli 0157:H7, Campylobacter species, rotavirus) b) At least one of the following GI sub-criteria present i. Nausea ii. Vomiting iii. Abdominal pain iv. Diarrhea	Care must be taken to exclude non-infectious causes of symptoms. For instance, new medication may cause diarrhea, nausea/vomiting; initiation of new enteral feeding may be associated with diarrhea; nausea or vomiting may be associated with gallbladder disease. Presence of new GI symptoms in a single resident may prompt enhanced surveillance for additional cases. In the presence of an outbreak, stool from specimens should be sent to confirm the presence of norovirus, or other pathogens (such as rotavirus and E. coli 0157:H7).

SPICE

78

Gastrointestinal Tract Infections

Criteria	Comments
B. Norovirus gastroenteritis Both criteria 1 and 2 present 1. At least one of the following GI sub-criteria a) Diarrhea, three or more liquid or watery stools above what is normal for the resident within a 24-hour period b) Vomiting, two or more episodes in a 24-hour period 2. A stool specimen positive for detection of norovirus either by electron microscopy, enzyme immune assay, or by a molecular diagnostic test such as polymerase chain reaction (PCR).	**In the absence of laboratory confirmation, an outbreak (2 or more cases occurring in a LTCF) of acute gastroenteritis due to norovirus infection in a LTCF may be assumed to be present if all of the following criteria are present ("Kaplan criteria")** **a) Vomiting in more than half of affected persons** **b) A mean (or median) incubation period of 24-48 hours** **c) A mean (or median) duration of illness of 12-60 hours** **d) No bacterial pathogen is identified in stool culture.**

79

Criteria	Comments
C. Clostridium difficile gastroenteritis **Both** criteria 1 and 2 present **1. One** of the following GI sub-criteria a) Diarrhea, three or more liquid or watery stools above what is normal for the resident within a 24-hour period b) The presence of toxic megacolon (abnormal dilation of the large bowel documented on radiology) **2. One** of the following diagnostic sub-criteria a) The stool sample yields a positive laboratory test result for *C. difficile* toxin A or B, or a toxin-producing *C. difficile* organism is identified in a stool culture or by a molecular diagnostic test such as PCR b) Pseudomembranous colitis is identified during endoscopic examination or surgery, or in histopathologic examination of a biopsy specimen.	A **"primary episode"** of *C. difficile* infection (CDI) is defined as one that has occurred without any previous history of CDI., or that has occurred more than 8 weeks after the onset of a previous episode of CDI. A **"recurrent episode"** of CDI is defined as an episode of CDI that occurs 8 weeks or less after the onset of previous episode, provided the symptoms from the earlier (previous) episode resolved Individuals previously infected with *C. difficile* may continue to remain colonized even after symptoms resolve In the setting of a GI outbreak, individuals could test positive for *C. difficile* toxin due to ongoing colonization and be co-infected with another pathogen. It is important that other surveillance criteria are used to differentiate infections in this situation.

Gastrointestinal Tract Infections

80

CDI LabID Event (*different than an infection*)

- *C. difficile* positive laboratory assay, tested on a loose-unformed stool specimen, and collected while a resident is receiving care from the LTCF, and the resident has no prior *C. difficile* positive laboratory assay collected in the previous two weeks (<14 days) while receiving care from the LTCF

SPICE

81

Why is *C. difficile* Surveillance Important?

C. difficile is the leading cause of acute diarrhea in nursing home residents

C. difficile infections contribute to approximately 14,000 deaths/year

~ 90% elderly

Prevention activities, like antimicrobial stewardship programs and hand hygiene are shown to prevent the spread of *C. difficile* and other infections

SPICE

82

SETTING OF NOROVIRUS OUTBREAKS REPORTED THROUGH THE NATIONAL OUTBREAK REPORTING SYSTEM (NORS), 2009-2012

Exposure setting	Number of Outbreaks	Percentage of Outbreaks
Health care facility	2189	62.7%
Restaurant or banquet facility	771	22.1%
School or day-care facility	214	6.1%
Private residence	69	1.9%
Other/multiple settings	251	7.2%

Data on specific settings are restricted to outbreaks with a single exposure setting; for foodborne outbreaks, setting refers to the setting where implicated food was consumed.

https://www.cdc.gov/norovirus/images/settings-lg.jpg

Knowledge Check

SPICE

83

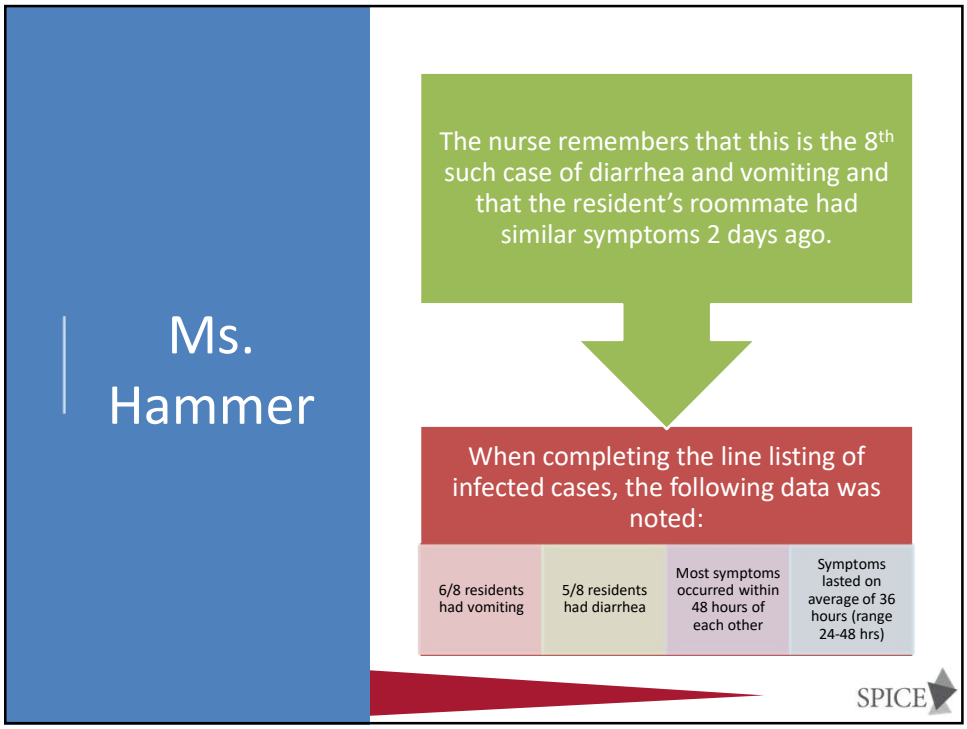
Knowledge Check # 1

Mrs. Hammer is admitted to your facility for rehab after having hip replacement surgery at the local hospital. While in the hospital she received treatment for *C. difficile* infection

Two weeks later, resident complains that she has had multiple episodes of vomiting (4 times a day) and diarrhea (5-6 times a day)

SPICE

84



85

What type of infection does Ms. Hammer have?

A. C. difficile

B. Gastroenteritis

C. Norovirus

D. Just an upset stomach

SPICE

86

Questions?

SPICE

87