

Surgical Site Infection (SSI)

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1. Introduction

This VICNISS SSI surveillance module is based on the National Health Safety Network (NHSN) Patient Safety Component Manual, Centers for Disease Control and Prevention (CDC) in the United States¹.

Despite advances in infection control practices including improved operating room ventilation, sterilisation methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity and mortality among hospitalised patients^{2,3}.

Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk^{4,5,6,7}. A successful surveillance program includes the use of epidemiologically sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback^{5,6}.

2. Methodology

This module requires active, patient-based, prospective surveillance of operative procedure-associated infections and the corresponding denominator data by a trained infection control professional (ICP). This means that the ICP shall seek out infections during a patient's stay by screening a variety of data sources, such as laboratory, pharmacy, admission/discharge/transfer, medical imaging, and pathology databases, and patient charts, including history, nurses/physicians notes, temperature charts, etc. Any combination of these methods is acceptable; however, VICNISS criteria for surgical site infection (SSI) must be used.

Due to the potential for poor documentation and the delay in obtaining patient histories from Medical Record (Health Information) offices, retrospective chart review should be used only when patients are discharged before all information can be gathered. To minimise the ICP's data collection burden, others may be trained to collect the denominator data (e.g., OR staff) and to screen data sources for these infections, however the ICP must make the final determination.

Setting

Surveillance can occur with surgical patients in any inpatient/outpatient setting where the selected VICNISS operative procedure(s) are performed.

Requirements

Refer to the [Type 1 VICNISS Performance Indicators](#) and [Type 2 VICNISS Performance Indicators](#) on the VICNISS website for required SSI surveillance activities. For further information also refer to the [VICNISS Type 1 Surveillance Manual \(section 4.1\)](#) and the [VICNISS Type 2 Surveillance Manual \(section 4.3\)](#) on the VICNISS website.

Collect numerator and denominator data on all procedures in the selected procedure group for the duration of the surveillance period.

Definitions

VICNISS Inpatient: is a patient whose date of admission to the healthcare facility and date of discharge are different calendar days.

VICNISS Outpatient: is a patient whose date of admission to the healthcare facility and date of discharge are the same calendar day.

VICNISS Operative Procedure: is a procedure that: 1) is performed on a VICNISS inpatient or outpatient; and 2) takes place during an operation (defined as a single trip to the operating room [OR] where a surgeon makes at least one incision through the skin or mucous membrane, including laparoscopic approach, and closes the incision before the patient leaves the OR); and 3) that is included in the nominated [VICNISS procedure groups](#) (section 4 below).

Note: If the skin incision edges do not meet because of wires or devices or other objects extruding through the incision, the incision is not considered primarily closed and therefore the procedure is not considered an operation. Further any subsequent infection is not considered a surgical site infection.

VICNISS Procedure Group: are combinations of clinically similar operative procedures that allow comparison of SSI rates in groups of patients undergoing similar operative procedures and most groups are identical to those used in the US NHSN system. The SSI rate in each procedure group is stratified by the SSI risk index in order that comparisons can be made between infection rates for each group. Refer to [section 4](#) below, or refer to either the full list of procedure groups and codes relevant to Type 1 participants [Type 1 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes](#), or to the selected list relevant to Type 2 participants [Type 2 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes](#) on the VICNISS website.

Implant: A nonhuman-derived object, material, or tissue that is permanently placed in a patient during a VICNISS operative procedure and is not routinely manipulated for diagnostic or therapeutic purposes. Examples include: porcine or synthetic heart valve, mechanical heart, metal rods, mesh, sternal wires, screws, cements, internal staples, hemoclips, and other devices. Non-absorbable sutures are excluded because ICPs may not easily identify and/or differentiate the soluble nature of suture material used.

VICNISS Surgical Site Infection (SSI): occurs in a VICNISS inpatient or outpatient following an operative procedure and there is no evidence that the infection was present or incubating at the time of hospital admission unless the infection was related to a previous VICNISS patient admission to this hospital and it meets the criteria for either superficial incisional, deep incisional, or organ/space SSI (as defined below).

Criteria for Surgical Site Infections

The criteria for each type of SSI (as defined below) must be met prior to reporting to VICNISS.

Superficial Incisional:

A superficial incisional SSI must meet the following criteria:

- Infection occurs within 30 days after the operative procedure, and
- involves only skin and subcutaneous tissue of the incision, and
- patient has at least one of the following:
 - a. purulent drainage from the superficial incision.
 - b. organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.
 - c. at least one of the following signs or symptoms of infection: pain or tenderness, localised swelling, redness, or heat, and superficial incision is deliberately opened by surgeon, and is culture-positive or not cultured. A culture-negative finding does not meet this criterion.
 - d. diagnosis of superficial incisional SSI by the surgeon or attending physician.

Comments:

- If a CBGB patient has infections at both chest and donor site enter as two separate infections
- Do **not** report a stitch abscess (minimal inflammation and discharge confined to the points of suture penetration) as a SSI.
- Do **not** report a localised stab wound infection as SSI
- If the incisional site infection involves or extends into the fascial and muscle layers, report as a deep incisional SSI.
- Classify infection that involves **both** superficial and deep incisional sites as deep incisional ie report the greatest of the infection types.
- A stoma infection does not meet the SSI criteria as the infection needs to be at the incision site.
- “Cellulitis” by itself does not meet the SSI criteria unless criterion c (above) is met.

Deep Incisional:

A deep incisional SSI must meet the following criteria:

- Infection occurs within 30 days after the operative procedure if no implant is left in place or within 365 days if implant is in place and the infection appears to be related to the operative procedure, and
- involves deep soft tissues (e.g., fascial and muscle layers) of the incision, and
- patient has at least one of the following:
 - a. purulent drainage from the deep incision but not from the organ/space component of the surgical site.
 - b. a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured and the patient has at least one of the following signs or symptoms: fever (>38°C), or localised pain or tenderness. A culture-negative finding does not meet this criterion.
 - c. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
 - d. diagnosis of a deep incisional SSI by a surgeon or attending physician.

Comments:

- If a CBGB patient has infections at both the chest and donor sites enter as two separate infection episodes.
- Classify infection that involves both superficial and deep incisional sites as deep incisional.

Organ / Space:

An organ/space SSI involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure. Specific sites are assigned to organ/space SSI to further identify the location of the infection. Listed below are the specific sites that must be used to differentiate organ/space SSI. An example is appendectomy with subsequent subdiaphragmatic abscess, which would be reported as an organ/space SSI at the intraabdominal specific site⁸.

An organ/space SSI must meet the following criterion:

- Infection occurs within 30 days after the operative procedure if no implant is left in place or within 365 days if implant is in place and the infection appears to be related to the operative procedure, and
- infection involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure, and
- patient has at least one of the following:
 - a. purulent drainage from a drain that is placed through a stab wound into the organ/space.
 - b. organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
 - c. an abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
 - d. diagnosis of an organ/space SSI by a surgeon or attending physician.

Comments:

- Occasionally an organ/space infection drains through the incision. Such infection generally does not involve re-operation and is considered a complication of the incision. Therefore, classify it as a deep incisional SSI.
- When there is no drainage through the incision, the SSI remains an organ/space.
- If there is no spontaneous drainage through the incision, but the wound is deliberately opened – remains an organ/space SSI. Note: It does not matter where the wound was deliberately opened, e.g., ward, operating suite.
- Report mediastinitis following cardiac surgery that is accompanied by osteomyelitis as mediastinitis rather than osteomyelitis
- If meningitis and a brain abscess are present together, report infection as intracranial, brain abscess.
- Report CSF shunt infection as an SSI if it occurs \leq 1 year of placement; if later or after manipulation/access, it is not considered an SSI and is not reportable
- The following are specific sites of an Organ/Space SSI:

▪ Arterial or Venous Infection	▪ Intracranial, Brain Abscess or Dura
▪ Breast Abscess or Mastitis	▪ Joint or Bursa
▪ Disc Space	▪ Mediastinitis
▪ Endocarditis	▪ Meningitis or Ventriculitis
▪ Endometritis	▪ Myocarditis or Pericarditis
▪ GI Tract	▪ Osteomyelitis
▪ Hepatitis	▪ Other Female Reproductive Tract
▪ Intra-abdominal, not specified elsewhere	▪ Spinal Abscess without Meningitis
- Each specific site of organ/space (listed above) have specific criteria which must be met in order to qualify as a VICNISS event. These criteria are in addition to the general criteria for organ/space SSI above, and can be found in the [CDC/NHSN criteria](#) on the VICNISS website.

Denominator Data

The requirements for the SSI Surveillance module are:

- A. One or more VICNISS Surgical Procedure Groups are selected for monitoring surgical patients. ALL of the ICD-10-AM codes in that Procedure Group **must** be included.
- B. For **all** patients having an operative procedure in the selected VICNISS procedure group complete the [Surgical Site Procedure \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form ensuring all the data fields are completed as specified. For further explanation of required data fields see [Instructions for Completion of SSI Data Forms](#) on the VICNISS website. For more information on how to register and obtain access to web forms please see the [Web Based Data Collection Forms \(Web Forms\) User Guide](#) on the VICNISS website.
- C. Caesarean Section (CSEC) procedures require additional risk factor data fields and a procedure specific [Caesarean Section \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form (which includes the additional Caesarean Section fields) must be completed.
- D. If operative procedures in more than one VICNISS surgical procedure group are performed during the same trip to the OR even if performed through the same incision, a [Surgical Site Procedure \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form is to be completed for each operative procedure being monitored. For example, if a CARD and CBGC are done through the same incision, a [Surgical Site Procedure \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form is reported for each.
Exception: If a patient has both a CBGC and CBGB during the same trip to the OR, report only as a CBGB. Only report as a CBGC when there is a chest incision only. CBGB and CBGC are never reported for the same patient for the same trip to the OR. For bilateral procedures see #H below.
- E. If more than one VICNISS operative procedure from the same VICNISS Surgical Procedure Group is performed through the same incision, record only one procedure for that procedure group. For example, if your hospital is performing surveillance for both CBGB and CARD procedure groups, and a patient undergoes an aortocoronary bypass of one coronary vessel (CBGB) and the replacement of both the mitral and tricuspid valves (both CARD) during the same trip to the OR, you would complete a [Surgical Site Procedure \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form for the CBGB and another one for the CARD.
- F. If more than one VICNISS operative procedure group is performed through the same incision, record the combined duration of all procedures, which is the time from skin incision to primary closure on each denominator form.
- G. Each denominator form should include a description/list of all procedures performed during that trip to the operating room.
- H. For bilateral operative procedures (e.g., KPRO, HER), one denominator procedure form is completed. To document duration of the bilateral procedure, indicate the incision start time to end time for the entire procedure if performed concurrently. If performed sequentially and there are two procedure durations submit the longest duration. Record bilateral on the form where indicated ('bilateral/2 incisions').
- I. Laparoscopic hernia repairs are considered one procedure, regardless of the number of hernias that are repaired in that trip to the OR. In most cases there will be only one incision time documented for this procedure. If more than one time is documented, total the durations. In

this situation if more than one of the incisions should become infected only report as a single SSI.

Note: If more than one open (i.e. non-laparoscopic) hernia repair is performed via a separate incision during the same visit to the OR (i.e. two incisions are made to repair two defects, e.g. umbilical and femoral hernia) complete one denominator procedure form. Record two incisions on the form where indicated ('bilateral/2 incisions'). To document duration of the procedure see #H above, same as bilateral procedure.

- J. If a patient goes to the OR more than once during the same admission and another procedure is performed through the same incision within 24 hours of the original operative incision (end time), report only one procedure on the [Surgical Site Procedure \(Denominator\)](#) paper form or [Surgical Site Procedure \(Denominator\)](#) web form, combining the durations for both procedures. For example, a patient has a CBGB lasting 4 hours. He returns to the operating suite 6 hours later to correct a bleeding vessel. The surgeon reopens the initial incision, makes the repairs, and recloses in 1.5 hours. Record the operative procedure as one CBGB and the duration of operation as 5 hours 30 minutes. If the wound class has changed report the higher wound class. If the ASA score has changed, report the higher ASA score.

Numerator Data

ALL patients are monitored for signs of SSI from the date of the VICNISS operative procedure until discharge from the acute hospital. A [Surgical Site Infection \(Numerator\)](#) paper form or [Surgical Site Infection \(Numerator\)](#) web form is completed for each patient found to have an SSI. For further explanation of required data fields see [Instructions for Completion of SSI Data Forms](#) on the VICNISS website. For more information on how to register and obtain access to web forms please see the [Web Based Data Collection Forms \(Web Forms\) User Guide](#) on the VICNISS website.

There must be no evidence that the infection was present or incubating at the time of hospital admission.

- Information used to determine the presence and classification of an infection should be a combination of:
 - Clinical data - derived from direct observation of the infection site or review of information in the patient's chart or other ward or unit records
 - Laboratory results - cultures, antigen or antibody detection tests, or direct visualisation methods.
 - Diagnostic studies - routine x-rays, ultrasound, CT scan, magnetic resonance imaging (MRI), nuclear scans, endoscopic procedures, biopsies, or needle aspiration.
 - A physician's or surgeon's diagnosis of infection - derived from direct observation during a surgical operation, endoscopic examination, diagnostic studies or from clinical judgment unless there is compelling evidence to the contrary.
- If a patient has several VICNISS operative procedures prior to an infection, report the infection as a result of the operation that was performed most closely in time prior to the infection date, unless there is evidence that the infection is associated with a different operation.
- If a procedure from more than one VICNISS operative procedure group was done through a single incision, attempt to determine the procedure that is thought to be associated with the infection. If it is not clear (as is often the case when the infection is a superficial SSI), attribute the infection to the surgery which has the highest risk of infection (see [VICNISS Procedure Infection Hierarchy](#), section 5 below).
- All patients with an SSI (i.e., meets VICNISS SSI criteria) readmitted to the hospital where the surgical procedure was performed must be reported to VICNISS.

- If an SSI (that meets VICNISS criteria) develops post-discharge, however the onset of clinical signs and symptoms were evident in hospital, the infection is reported as during admission, i.e. in hospital.
- If an SSI is identified by another facility (i.e. patient with SSI was admitted to a facility other than the one in which the operation was performed) it is reported as post-discharge.
- Patients who have an implant insitu are to be followed for development of SSI for 365 days from the date of the procedure.

Exclusions:

- SSIs that are **not** included in VICNISS reporting:
 - SSIs that become evident after hospital discharge. These infections will not be included in the VICNISS reported rates **unless** the infection was detected upon readmission to the hospital (see [VICNISS Type 1 Surveillance Manual \(section 2.4.2, Post Discharge Surveillance\)](#) on the VICNISS website.
 - Infections associated with complications or extensions of infections already present on admission, unless a change in pathogen or symptoms strongly suggests the acquisition of a new infection.
 - A patient admitted with an existing SSI from a procedure that was performed elsewhere. In this case VICNISS make the following comments:
 - Communication is encouraged with the hospital where the procedure was performed to notify them of the SSI.
 - VICNISS could facilitate this communication process if requested.
- The following conditions are not infections:
 - **Colonisation**, which means the presence of microorganisms on skin, on mucous membranes, in open wounds, or in excretions or secretions but are not causing adverse clinical signs or symptoms.
 - Inflammation that results from tissue response to injury or stimulation by non-infectious agents, such as the use of chemicals.

3. Data Analyses

The SSI rates per 100 operative procedures are calculated by dividing the number of SSIs by the number of specific operative procedures and multiplying the results by 100. SSIs will be included in the numerator of a rate based on the date of procedure, not the date of event. Rate calculations will be performed separately for the different types of operative procedures and stratified by risk index. Standardized infection ratios are also calculated using indirect standardization or multivariate models.

- Basic SSI Risk Index. The index used in NHSN assigns surgical patients into categories based on the presence of three major risk factors:
 - Operation lasting more than the duration cut point hours, where the duration cut point is the approximate 75th percentile of the duration of surgery in minutes for the operative procedure.
 - Contaminated (Class 3) or Dirty/infected (Class 4) wound class.
 - ASA classification of 3, 4, or 5.

The patient's SSI risk category is simply the number of these factors present at the time of the operation.

For further information see [VICNISS Type 1 Surveillance Manual \(section 3, Interpretation of Surveillance Results\)](#) on the VICNISS website.

4. VICNISS Procedure Groups

Refer to either the full list of procedure groups and codes relevant to Type 1 participants [Type 1 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes](#), or to the selected list relevant to Type 2 participants [Type 2 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes](#) on the VICNISS website.

Code	Operative Procedure	Description
AAA	Abdominal aortic aneurysm repair	Resection of abdominal aorta with anastomosis or replacement
APPY	Appendix surgery	Operation of appendix (not incidental to another procedure)
BRST	Breast surgery	Excision of lesion or tissue of breast including radical, modified or quadrant resection, lumpectomy, incisional biopsy or mammoplasty
CARD	Cardiac surgery	Procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation
CBGB	Coronary artery bypass graft with both chest and donor site incisions	Chest procedure to perform direct revascularisation of heart; includes obtaining suitable vein from donor site for grafting
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct revascularisation of heart using, for example, the internal mammary (thoracic) artery
CEA	Carotid endarterectomy	Endarterectomy on vessels of head and neck (includes carotid artery and jugular vein)
CHOL	Gallbladder surgery	Cholecystectomy and cholecystotomy
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis. Includes operations on rectum.
CRAN	Craniotomy	Excision repair, or exploration of the brain or meninges; does not include taps or punctures
CSEC	Caesarean section	Obstetrical delivery by Caesarean section
FUSN	Spinal fusion	Immobilisation of spinal column NOTE: cannot compare this group to NHSN
FPOP	Femoro-popliteal and femoro-tibial bypass grafts	Femoro-popliteal and femoro-tibial bypass grafts NOTE: this procedure differs from NHSN

Code	Operative Procedure	Description
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication
HERN	Herniorrhaphy	Repair of inguinal, femoral, umbilical, or anterior abdominal wall hernia; does not include repair of diaphragmatic or hiatal hernia or hernias at other body sites
HPRO	Hip prosthesis	Arthroplasty of hip; includes total, partial and revision arthroplasties; does not include Birmingham hip resurfacing
HYST	Abdominal hysterectomy	Abdominal approach with uterine removal
KPRO	Knee prosthesis	Arthroplasty of knee
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures
RFUSN	Refusion of spine	Refusion of spine
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis
THOR	Thoracic surgery	Noncardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach
VHYS	Vaginal hysterectomy	Vaginal approach with uterine removal
VSHN	Ventricular shunt	Ventricular shunts operations, including revision and removal of shunt

5. VICNISS Procedure Infection Hierarchy

Principle Operative Procedure Selection Lists. The following lists are derived from the above table, VICNISS Operative Procedure Groups. The operative procedures with the highest risk of surgical site infection are listed before those with a lower risk.

Priority	Code	Abdominal Operations
1	SB	Small bowel surgery
2	COLO	Colorectal surgery
3	GAST	Gastric surgery
4	CSEC	Caesarean section
5	APPY	Appendix surgery
6	HYST	Abdominal hysterectomy
7	VHYS	Vaginal hysterectomy
8	HERN	Hernia repair
9	CHOL	Cholecystectomy
10	AAA	Abdominal aortic aneurysm repair
Priority	Code	Thoracic Operations
1	CBGB	Coronary artery bypass graft and donor
2	CBGC	Coronary artery bypass graft, chest incision only
3	CARD	Cardiac surgery
4	THOR	Thoracic surgery
Priority	Code	Neurosurgical (Spine) Operations
1	RFUSN	Refusion of spine
2	FUSN	Spinal fusion
3	LAM	Laminectomy
Priority	Code	Neurosurgical (Brain) Operations
1	VSHN	Ventricular shunt
2	CRAN	Craniotomy

6. References

1. Centers for Disease Control and Prevention. The National Healthcare Safety Network (NHSN) Manual. Patient Safety Component Protocol. 2011 www.cdc.gov/nhsn/TOC_PSCManual.html.
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4. Condon RE, Schulte WJ, Malangoni MA, Anderson-Teschendorf MJ. Effectiveness of a surgical wound surveillance program. *Arch Surg* 1983;118:303-7.
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6. Haley RW, Culver DH, White JW, Morgan WM, Emori TG, Munn VP. The efficacy of infection surveillance and control programs in preventing nosocomial infections in US hospitals. *Am J Epidemiol* 1985;121:182-205.
7. Centers for Disease Control and Prevention. Guidelines for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol*, 1999;20(4):247-278.
8. Centers for Disease Control and Prevention. CDC/NHSN surveillance definition of health-care associated infection and criteria for specific types of infections in the acute care setting. *AJIC* 2008;36:309-32.

Instructions for Completion of SSI Data Forms

Please refer to the table below for instructions on each VICNISS **required data field** relating to the following forms. **A denominator form is to be completed for all surgical procedures and a numerator form is to be completed for each surgical site infection.**

Surgical Site Procedure (Denominator) ([paper form](#)) ([web form](#))

Caesarean Section Procedure (Denominator) ([paper form](#)) ([web form](#); same as SSI above)

Data Field	Instructions for Data Collection
Hospital Code Number	Enter the VICNISS assigned hospital code number.
MRN (UR No.)	Enter the patient UR Number. This is the alphanumeric patient identifier assigned by the hospital and may consist of a combination of numbers, letters, spaces, dashes or leading zeroes, e.g., 000-123-A.
Sex	Tick Male or Female to indicate the gender of the patient.
DOB	Enter the date of the patient's birth using this format: day/month/year (DD/MM/YYYY).
Date Admitted to Hospital	Enter the date the patient was admitted to the acute hospital using this format: DD/MM/YYYY.
Date Discharged from Hospital	Enter the date the patient was discharged (alive or deceased) from the acute hospital setting or has been transferred to home or a HITH program and is not on temporary leave from the hospital (e.g., weekend pass) using this format: DD/MM/YYYY.
Procedure Date	Enter the date the VICNISS procedure was performed using this format: DD/MM/YYYY.
<i>Surgeon (coded)</i>	Optional field. Enter code of surgeon who performed the principle operative procedure. The code, if used, is generated and maintained by the hospital.
VICNISS Procedure Group	<p>Tick the VICNISS procedure group that includes the operative procedure performed. Refer to Surgical Site Infection Protocol (section 4) for a full list of VICNISS procedure groups or refer to either the full list of procedure groups and codes relevant to Type 1 participants Type 1 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes, or to the selected list relevant to Type 2 participants Type 2 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes on the VICNISS website.</p> <p>If a patient has more than one procedure and these fall into different VICNISS procedure groups which are currently under surveillance (e.g., CBGB and CARD), a denominator form is generated for each procedure group.</p>
Name of Procedure	Enter the name of the operative procedure performed. If more than one procedure performed, record all procedures.

Data Field	Instructions for Data Collection
ICD10AM code/s	If known, enter ICD10AM code. Refer to either the full list of procedure groups and codes relevant to Type 1 participants Type 1 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes , or to the selected list relevant to Type 2 participants Type 2 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes on the VICNISS website..
HPRO/KPRO/BRST/ HERN/CEA Procedures Only Left Right Bilateral/2incisions	Required field if procedure was a hip replacement (HPRO), knee (KPRO) replacement, breast surgery (BRST), hernia surgery (HERN) and carotid endarterectomy (CEA). Tick if the procedure was conducted on the left side of the body only. Tick if the procedure was conducted on the right side of the body only. Tick if two procedures (from the same procedure group) requiring 2 incisions were performed at the same time, e.g. left and right KPRO, umbilical and femoral HER. (NB: Refer to “Start and End Times” and “Duration of Procedure” for notes re recording these details when a ‘bilateral/2 incisions’ procedure has been performed).
HPRO/KPRO Procedures Only Partial Total Primary Revision	Required field if procedure was a hip (HPRO) or knee (KPRO) replacement. Tick if partial joint replacement was performed. Tick if a total joint replacement was performed. Tick if the procedure performed was primary surgery. Tick if the procedure performed was a revision. Note: When hardware is inserted for the first time, use the ‘primary’ designation; otherwise indicate the procedure was a revision.
FUSN/RFUSN Procedures Only Diabetes Melitis	Required field if procedure was a spinal fusion (FUSN) or refusion (RFUSN) Tick Yes if patient known to have diabetes mellitus, otherwise tick No
FUSN/RFUSN Procedures Only Spinal Level Atlas-Axis Atlas-Axis/Cervical Cervical Cervical/Dorsal/Dorsolumbar Dorsal/dorsolumbar Lumbar/Lumbosacral Not specified	Required field if procedure was a spinal fusion (FUSN) or refusion (RFUSN) Tick appropriate spinal level of procedure from picklist. C1-C2 only C1-C7 (any combination excluding C1-C2 only) C3-C7 (any combination) Extends from any cervical through any lumbar levels T1 – L5 (any combination of thoracic and lumbar) L1-S5 (any combination of lumbar and sacral) Level not specified (should be used rarely)
FUSN/RFUSN Procedures Only Approach/Technique	Required field if procedure was a spinal fusion (FUSN) or refusion (RFUSN) Tick appropriate surgical approach or technique from the picklist: Anterior, Posterior, Anterior and Posterior, Lateral Transverse or Not specified.

Data Field	Instructions for Data Collection
<p>Start Time</p> <p>End Time</p>	<p>Enter the time of incision using: hour:minute (HH:MM).</p> <p>Enter the time of closure of wound using HH:MM.</p> <p>If a second (or third) operative procedure is performed through the same incision within 24 hours of the original operative incision end time, record the “Start Time” and “End Time”, and label as ‘Procedure 2’ (or procedure 3 etc).</p> <p>If two procedures (from the same procedure group) requiring 2 incisions were performed at the same time, e.g. left and right KPRO (bilateral), umbilical and femoral HER record the surgery times as follows:</p> <ul style="list-style-type: none"> • If procedures performed <u>concurrently</u>, the “Start and End Times” should be inclusive of both the procedures e.g ‘Left’ and ‘Right’ • If procedures performed <u>sequentially</u>, and there are two “Start and End Times” documented, submit the longest duration. <p>If operation times are not available, enter duration of procedure or not available (N/A).</p>
<p>Duration of procedure</p>	<p>Enter time interval between the skin incision and wound closure in HH:MM.</p> <p>If a bilateral procedure is performed:</p> <ul style="list-style-type: none"> • Concurrently, the duration of procedure should be inclusive of both the ‘Left’ and ‘Right’ procedures. • Sequentially, and there are two procedure durations documented, submit the longest duration. <p>If all surgery times are not available record ‘not available’. Do not enter an approximate duration.</p> <p><i>Duration of Procedure should be entered only if the Start and End Time are not available.</i></p>
<p>ASA Score</p>	<p>Circle the numeric ASA score (anaesthetist assessment of the patient's preoperative physical condition) at the time of the operative procedure from the picklist: 1, 2, 3, 4 or 5.</p> <p>If the patient goes to the operating room more than once within 24 hours of the original operative incision, enter the highest ASA classification recorded.</p> <p>Circle ‘Not Available’ if an ASA score is not available, do not enter an approximate score.</p>
<p>Wound Class</p> <p>Clean</p>	<p>Circle the appropriate wound class from the picklist:</p> <p>If the patient goes to the operating room more than once within 24 hours of the original operative incision, report the wound class that reflects the highest degree of contamination of the wound (i.e., the "dirtiest" class).</p> <p>Enter for uninfected operative wounds in which no inflammation is encountered and the respiratory, alimentary, genital, or urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.</p>

Data Field	Instructions for Data Collection
<p>Clean-contaminated</p> <p>Contaminated</p> <p>Dirty or infected</p> <p>NA</p>	<p>Enter for operative wounds in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.</p> <p>Enter for open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered are included in this category.</p> <p>Enter for old traumatic wounds with retained devitalised tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.</p> <p>Circle NA (not available) if all attempts to obtain a wound class are unsuccessful.</p>
<p>Implant</p>	<p>Tick Yes if an implantable object is placed in a patient during an operative procedure, otherwise tick No.</p> <p>An implant is a nonhuman-derived object, material, or tissue that is permanently placed in a patient during a VICNISS operative procedure and is not routinely manipulated for diagnostic or therapeutic purposes. Examples include: porcine or synthetic heart valve, mechanical heart, metal rods, mesh, sternal wires, screws, cements, internal staples, hemoclips, and other devices.</p>
<p>Laparoscopic Approach</p>	<p>Tick Yes if the entire operative procedure was performed using a laparoscopic approach.</p> <p>If the operation began as a laparoscopic procedure and was subsequently converted to an open procedure, tick No.</p> <p>Note: For CBGB, if the donor vessel was harvested using an endoscope, tick Yes.</p>
<p>Trauma</p>	<p>Tick Yes if operative procedure was performed because of blunt or penetrating traumatic injury to the patient, otherwise tick No.</p> <p>Example of a blunt trauma is a fracture resulting from a fall.</p>
<p>General Anaesthesia</p>	<p>Tick Yes if general anaesthesia was used for the operative procedure, otherwise tick No.</p>
<p>Emergency</p>	<p>Tick Yes if operative procedure was an emergency procedure, i.e. nonelective, unscheduled procedure, otherwise tick No. Emergency operative procedures are those that do not allow for the standard immediate preoperative preparation normally done within your hospital for a scheduled operation (e.g., stable vital signs, adequate antiseptic skin preparation, colon decontamination in advance of colon surgery, etc)</p>
<p>CSEC: Height</p>	<p>If the operative procedure is Caesarean section enter patient height in metres (m) and centimetres (cm). Tick NA if height not available.</p>
<p>CSEC: Weight</p>	<p>If the operative procedure is Caesarean section enter patient weight at time of delivery in kilograms (kg). If weight at delivery is not available, please provide pre-pregnancy weight. Tick NA if weight not available.</p>

Data Field	Instructions for Data Collection
CSEC: BMI	If height and weight are not available , enter patient's body mass index (BMI) at delivery or pre-pregnancy if available.
CSEC: Date Weight Recorded: Pre-pregnancy At delivery NA	Enter the date the pregnant patient's weight (or BMI) was recorded from the picklist: Tick if weight was measured pre pregnancy. Tick if weight was measured at delivery. Tick if date weight recorded not available or weight not measured pre-pregnancy or at delivery.
CSEC: In active labour in Hospital If 'Yes', number of hours:	Tick Yes if the patient was in active labour in the hospital (after admission), otherwise, enter No. Record number of hours patient laboured (in the hospital prior to operative procedure) in whole numbers, i.e., round down to nearest hour if <30 minutes, round up to nearest hour if >30 minutes.
CSEC: Estimated Blood Loss	Record the patient's blood loss during the Caesarean section in millilitres (ml) or record approximate blood loss from the pick list: ≤ 600 ml, 601 – 900 ml, > 900 ml, NA (Not Available).
Prophylactic Antibiotic	Tick Yes if prophylactic antibiotics were given for the operative procedure (with the intent of preventing infections at the surgical site), otherwise tick No. Does not include antibiotics that have been given as a course leading up to the procedure.
If 'No' was Prophylaxis known to be withheld because: Patient already on antibiotics sufficient for surgical prophylaxis; or Patient having joint revision, and antibiotics to be given after old prosthesis removed for culture	Tick Yes, if the patient was already on a treatment course of antibiotics appropriate for prophylaxis, or the prophylactic antibiotics were to be given after the old prosthesis was removed for culture in the patient having joint revision, otherwise tick No.
Antibiotic (Generic Name) 1 st Dose 2 nd Dose: If the procedure was prolonged, was a second dose of beta lactam antibiotic given intraoperatively	Enter the generic name of the prophylactic antibiotic that the patient was administered. Record names of all prophylactic antibiotics given initially For operative procedures that continue > 4 hours after incision, record yes if a second dose of beta lactam antibiotic (e.g. flucloxacillin, dicloxacillin, cephalothin, cefazolin) was given intraoperatively, otherwise record no. Record the name of the second dose beta lactam antibiotic.
Time of administration Time Given	Record the times the antibiotic administration (infusion or stat dose) commenced. Note: IV antibiotics should be given as soon as the patient is stabilised after induction of anaesthesia, except for vancomycin that requires a slower infusion, which should be completed within 1 hour of induction. IM antibiotics should be given at the time of premedication for surgery. Enter exact time each antibiotic administration (infusion or stat dose) commenced as HH:MM.

Data Field	Instructions for Data Collection
<p>Tick a box ONLY if exact time is not available</p> <p>1st Dose:</p> <ul style="list-style-type: none"> > 1 hr prior to incision ≤ 1 hr prior to incision On induction After Incision Not recorded <p>2nd Dose:</p> <ul style="list-style-type: none"> < 2.5 hrs after incision Between 2.5 and 3.5 hrs after incision > 3.5 hrs after incision Not recorded 	<p>If exact time of antibiotic administration not available enter an option from the picklist below:</p> <p>Tick if antibiotic given more than 1 hour prior to the incision.</p> <p>Tick if antibiotic given within 1 hour prior to the incision</p> <p>Tick if antibiotic given on induction.</p> <p>Tick if antibiotic given after incision.</p> <p>Tick if antibiotic administration time is not recorded.</p> <p>Tick if 2nd dose antibiotic given less than 2.5 hours after incision.</p> <p>Tick if 2nd dose antibiotic given between 2.5 and 3.5 hours after incision</p> <p>Tick if 2nd dose antibiotic given more than 3.5 hours after incision</p> <p>Tick if 2nd dose antibiotic administration time is not recorded</p>
<p>Antibiotic continued >24 hours</p>	<p>Tick Yes where the antibiotic prophylaxis was continued for greater than 24 hours, otherwise tick No.</p> <p>Tick Yes if antibiotic prophylaxis given in theatre (e.g., cephazolin) was marginally changed (e.g., cephalothin) and continued for greater than 24 hours.</p> <p>Tick No in cases where several doses are administered after surgery, e.g., 3 x 8 hourly, and this goes for slightly longer than 24 hours.</p>
<p>Infection Detected</p>	<p>Tick Yes if a SSI that meets VICNISS criteria is detected, otherwise tick No.</p>
<p>Infection Date</p>	<p>Enter the date that the first clinical evidence of the SSI appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first, using this format: DD/MM/YYYY.</p> <p>If a patient is readmitted with an SSI record infection date as date of admission unless otherwise known.</p>
<p>CBGB Procedures Only: Infection Site</p>	<p>If infection detected following CBGB tick the location/s of the infection site in relation to incision (chest, radial or saphenous).</p> <p>For each infection detected, complete a separate infection data sheet – indicate which infection site the form relates to.</p>

Surgical Site Infection (Numerator) ([paper form](#)) or ([web form](#))

Data Field	Instructions for Data Collection
Hospital Code Number	Enter the VICNISS assigned hospital code number.
MRN (UR No.)	Enter the patient UR Number. This is the alphanumeric patient identifier assigned by the hospital and may consist of a combination of numbers, letters, spaces, dashes or leading zeroes, e.g., 000-123-A.
DOB	Enter the date of the patient's birth using this format: day/month/year (DD/MM/YYYY).
Procedure Date	Enter the date the VICNISS procedure was performed using this format: DD/MM/YYYY.
VICNISS Procedure Group	<p>Tick the VICNISS procedure group that includes the operative procedure performed. Refer to Surgical Site Infection Protocol (section 4) for a full list of VICNISS procedure groups or refer to either the full list of procedure groups and codes relevant to Type 1 participants Type 1 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes, or to the selected list relevant to Type 2 participants Type 2 VICNISS Procedure Groups, ICD10-AM Codes, & CMBS Codes on the VICNISS website.</p> <p>If a patient has more than one procedure and these fall into different VICNISS procedure groups which are currently under surveillance (e.g., CBGB and CARD), a denominator form is generated for each procedure group.</p>
Infection Date	<p>Enter the date that the first clinical evidence of the SSI appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first, using this format: DD/MM/YYYY.</p> <p>If a patient is readmitted with an SSI record infection date as date of admission unless otherwise known.</p>
Infection Detected During admission <i>Post discharge surveillance</i> <i>HITH</i> Readmission	<p>Record the time of presentation of infection from the picklist:</p> <p>Infection was detected during the current acute hospital admission.</p> <p>Optional field. Infection was detected post discharge. Includes patients with SSI identified by another facility (i.e. patient with SSI was admitted to a facility other than the one in which the operation was performed)</p> <p>Optional field. Infection was detected whilst in the hospital in the home (HITH) program.</p> <p>Patient was readmitted with an SSI to the hospital where the operation was performed.</p>
Infection Type Superficial incisional Deep incisional Organ/Space	<p>Enter the type of infection according to the picklist:</p> <p>Tick if SSI meets VICNISS criteria for superficial incisional infection.</p> <p>Tick if SSI meets VICNISS criteria for deep incisional infection.</p> <p>Tick if SSI meets VICNISS criteria for organ/space infection.</p>

Data Field	Instructions for Data Collection
CBGB Procedures Only: Infection Site	<p>If infection detected following CBGB tick the location of the infection site in relation to incision (chest, radial or saphenous).</p> <p>For each infection detected, complete a separate infection data sheet – indicate which infection site the form relates to.</p>
Bilateral/2 Incision Procedures Only Location of Infection	<p>Where a bilateral procedure was performed, tick either Left or Right to indicate what side of the body the infection was located.</p> <p>Where 2 procedures (from the same procedure group) requiring 2 incisions (e.g. HER – umbilical & femoral) were performed at the same time, tick Other to indicate an infection has occurred and specify location e.g. umbilical</p>
If 'Yes' for organ space infection, what was the Organ Space Site	<p>Tick the specific location of the organ/space infection according to the picklist: Arterial or venous infection, Breast abscess or mastitis, Disc space, Endocarditis, Endometritis, Intraabdominal not specified elsewhere, Intracranial, brain abscess or dura, Joint or bursa, GI tract, Mediastinitis, Meningitis or ventriculitis, Myocarditis or pericarditis, Osteomyelitis, Other infections of the lower respiratory tract, Other infections of the urinary tract, Other male or female reproductive tract, Spinal abscess without meningitis, Upper respiratory tract, Vaginal cuff.</p>
Pathogen Isolated	<p>Tick Yes if a pathogenic organism has been isolated from an appropriate specimen, otherwise tick No.</p>
Name of Pathogen	<p>Enter the name of the pathogenic organism causing the infection.</p>
Antimicrobial Susceptibility	<p>If pathogen (recorded above) was Coagulase negative staph., <i>Enterococcus faecalis</i>, <i>Enterococcus faecium</i>, <i>Staphylococcus aureus</i>, <i>Acinetobacter spp.</i>, <i>Enterobacter spp.</i>, <i>E. coli</i>, <i>K. oxytoca</i>, <i>K. pneumonia</i>, <i>P. aeruginosa</i>, <i>S. marcescens</i> or <i>S. maltophilia</i> enter antimicrobial susceptibility according to the picklist. For each antibiotic listed enter the susceptibility – sensitive, resistant, intermediate or unknown.</p> <p>If organism is not listed, antimicrobial susceptibility is not required.</p>

SURGICAL SITE PROCEDURE (DENOMINATOR)

If you have any queries regarding the completion of this form please contact VICNISS

DATA CAN BE SUBMITTED to VICNISS via FAX (9342 2633) or ELECTRONICALLY USING A WEBFORM

Hospital Code Number:				
Patient & Procedure Details <i>(Do not attach a bradma label)</i>				
MRN (UR No.):		Sex: M <input type="checkbox"/> F <input type="checkbox"/>	DOB: / /	
Date Admitted to Hospital: / /		Date Discharged from Hospital: / /		
Procedure Date: / /		Surgeon (coded):		
VICNISS Procedure Group:	AAA <input type="checkbox"/>	CBGB <input type="checkbox"/>	COLO <input type="checkbox"/>	
	APPY <input type="checkbox"/>	CBGC <input type="checkbox"/>	CRAN <input type="checkbox"/>	
	BRST <input type="checkbox"/>	CEA <input type="checkbox"/>	CSEC ¹ <input checked="" type="checkbox"/>	
	CARD <input type="checkbox"/>	CHOL <input type="checkbox"/>	FPOP <input type="checkbox"/>	
			FUSN <input type="checkbox"/>	
			GAST <input type="checkbox"/>	
			HERN <input type="checkbox"/>	
			HPRO <input type="checkbox"/>	
			HYST <input type="checkbox"/>	
			KPRO <input type="checkbox"/>	
			LAM <input type="checkbox"/>	
			RFUSN <input type="checkbox"/>	
			SB <input type="checkbox"/>	
			THOR <input type="checkbox"/>	
			VHYS <input type="checkbox"/>	
			VSHN <input type="checkbox"/>	
Name of Procedure:		ICD10AM code/s:		
HPRO/KPRO/BRST/HERN/CEA Procedures Only Left <input type="checkbox"/> or Right <input type="checkbox"/> or Bilateral/2 Incisions ² <input type="checkbox"/>				
HPRO/KPRO Procedures Only Partial <input type="checkbox"/> or Total <input type="checkbox"/> Primary <input type="checkbox"/> or Revision <input type="checkbox"/>				
FUSN/RFUSN Procedures Only		Diabetes Mellitus: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Spinal Level: <i>(tick one)</i> Atlas-axis <input type="checkbox"/> Atlas-axis/Cervical <input type="checkbox"/> Cervical <input type="checkbox"/> Cervical/Dorsal/Dorsolumbar <input type="checkbox"/>				
Dorsal/Dorsolumbar <input type="checkbox"/> Lumbar/Lumbarsacral <input type="checkbox"/> Not specified <input type="checkbox"/>				
Approach/Technique: <i>(tick one)</i>				
Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior and Posterior <input type="checkbox"/> Lateral Transverse <input type="checkbox"/> Not specified <input type="checkbox"/>				
Start Time³:		End Time³:		
		Or →		
		Duration of Procedure³: hrs mins		
<i>(if Start & End Times not available)</i>				
ASA Score: 1 2 3 4 5 Not Available (NA)		Wound Class: C CC CO D NA		
Implant: Yes <input type="checkbox"/> No <input type="checkbox"/>		Laparoscopic Approach: Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Trauma: Yes <input type="checkbox"/> No <input type="checkbox"/>		
General Anaesthesia: Yes <input type="checkbox"/> No <input type="checkbox"/>		Emergency: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Antibiotic Prophylaxis		Prophylactic Antibiotic: Yes <input type="checkbox"/> No <input type="checkbox"/>		
* If 'No', was Prophylaxis known to have been withheld because:				
▪ patient already on antibiotics that are sufficient for surgical prophylaxis; or		Yes <input type="checkbox"/> No <input type="checkbox"/>		
▪ patient having joint revision and antibiotics to be given after old prosthesis removed for culture				
Antibiotic (Generic Name)	Time of Administration			Antibiotic Continued >24hrs ⁴
	Time Given	Please provide EXACT TIME GIVEN OR tick a box below ONLY if exact time is not available		
1st Dose:				
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/>	Not Recorded <input type="checkbox"/>
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/>	Not Recorded <input type="checkbox"/>
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/>	Not Recorded <input type="checkbox"/>
2nd Dose: If the procedure was prolonged ⁵ , was a second dose of beta lactam antibiotic ⁶ given intraoperatively: Yes <input type="checkbox"/> No <input type="checkbox"/>				
		Less than 2.5hrs after Incision <input type="checkbox"/>	Between 2.5 and 3.5hrs after Incision <input type="checkbox"/>	
		More than 3.5hrs after Incision <input type="checkbox"/>	Not Recorded <input type="checkbox"/>	
Outcome		Infection Detected: Yes <input type="checkbox"/> No <input type="checkbox"/>		Infection Date: / /
CBGB Procedures Only Infection Site(s)⁷: Chest <input type="checkbox"/> R Radial <input type="checkbox"/> L Radial <input type="checkbox"/> R Saphenous <input type="checkbox"/> L Saphenous <input type="checkbox"/>				

¹Use Caesarean Section Procedure (Denominator) Form, ²Tick if two procedures (from the same procedure group) requiring 2 incisions were performed at the same time, e.g. left and right KPRO, umbilical and femoral HER. ³If bilateral/2incisions HPRO/KPRO/BRST/HERN/CEA procedures are performed concurrently, duration of procedure should be inclusive of both procedures e.g. left and right procedures. If performed sequentially and there are two procedure durations documented, submit the longest duration, ⁴If an 8 hourly 3rd dose exceeds the 24 hours still tick N (No). It is recognised the intent is to cease within 24 hours, ⁵Prolonged procedures are those that continue greater than 4 hours after incision, ⁶Beta lactam antibiotics include flucloxacillin, dicloxacillin, cephalothin and cefazolin. If another antibiotic is given please contact VICNISS to confirm if it is a beta lactam antibiotic. ⁷Indicate all infection sites and complete a separate Surgical Site Infection (Numerator) Form for each infection.

CAESAREAN SECTION PROCEDURE (DENOMINATOR)

If you have any queries regarding the completion of this form please contact VICNISS

DATA CAN BE SUBMITTED to VICNISS via FAX (9342 2633) or ELECTRONICALLY USING A WEBFORM

Hospital Code Number:				
Patient & Procedure Details <i>(Do not attach a bradma label)</i>				
MRN (UR No.):		DOB: / /		
Date Admitted to Hospital: / /		Date Discharged from Hospital: / /		
Procedure Date: / /	Surgeon (coded):	Emergency: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Start Time:	End Time:	Or →	Duration of Procedure: hrs mins <i>(if Start & End Times not available)</i>	
ASA Score: 1 2 3 4 5 Not Available (NA)		Wound Class: C CC CO D NA		
General Anaesthesia: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Obstetric/Labour details				
Height: _____ m NA <input type="checkbox"/>		Weight: _____ kg NA <input type="checkbox"/> Or → BMI: <i>(if Height & Weight NA)</i>		
Date Weight Recorded: Pre-pregnancy <input type="checkbox"/> At delivery <input type="checkbox"/> NA <input type="checkbox"/>				
In active labour in hospital: Yes <input type="checkbox"/> No <input type="checkbox"/>		Estimated Blood Loss: _____ mls		
If 'Yes', number of hours: _____ hrs		Or → ≤600ml <input type="checkbox"/> 601-900ml <input type="checkbox"/> >900ml <input type="checkbox"/> NA <input type="checkbox"/>		
Antibiotic Prophylaxis		Prophylactic Antibiotic: Yes <input type="checkbox"/> No <input type="checkbox"/>		
* If 'No', was Prophylaxis known to have been withheld because:		Yes <input type="checkbox"/> No <input type="checkbox"/>		
▪ patient already on antibiotics that are sufficient for surgical prophylaxis.				
Antibiotic (Generic Name)	Time of Administration			Antibiotic Continued >24hrs ¹
	Time Given	Please provide EXACT TIME GIVEN <i>OR tick a box below ONLY if exact time is not available</i>		
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/> Not Recorded <input type="checkbox"/>	
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/> Not Recorded <input type="checkbox"/>	
		More than 1hr prior to Incision <input type="checkbox"/>	Within 1hr prior to Incision <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
		On Induction <input type="checkbox"/>	After Incision <input type="checkbox"/> Not Recorded <input type="checkbox"/>	
Outcome				
Infection Detected: Yes <input type="checkbox"/> No <input type="checkbox"/>			Infection Date: / /	

¹ If an 8 hourly 3rd dose exceeds 24 hours still tick N (No). It is recognised the intent is to cease within 24 hours

