

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>