دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

General and Specialized Hospitals Jawda Guidance

Version 8

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1. Executive Summary

The Department of Health– Abu Dhabi (DOH) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in Healthcare for the community by monitoring the health status of its population.

The Emirate of Abu Dhabi is experiencing a substantial growth in the number of hospitals, centers and clinics. These range from school clinics and mobile units to internationally renowned specialist and tertiary academic centers. Although, access and quality of care has improved dramatically over the last couple of decades, mirroring the economic upturn and population boom of the Abu Dhabi Emirate. However, challenges remain in addressing further improvements.

The main challenges that are presented with increasingly dynamic population include an aging population with increased expectation for treatment, utilization of technology and diverse workforce leading to increased complexity of healthcare provision in Abu Dhabi. All of this results in an increased and inherent risk to quality and patient safety.

DOH has developed a dynamic and comprehensive quality framework in order to bring about improvements across the health sector. This guidance relates to the quality indicators that DOH is mandating the quarterly reporting against by the operating general and specialist hospitals in Abu Dhabi.

The guidance sets out the full definition and method of calculation for patient safety and clinical effectiveness indicators.

For enquiries about this guidance, please contact jawda@doh.gov.ae

This document is subject for review and therefore it is advisable to utilize online versions available on the DOH website at all times.

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2. Introduction

2.1 The Department of Health– Abu Dhabi (DOH) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi and ensures excellence in Healthcare for the community by monitoring the health status of the population. DOH is mandated:

- To achieve the highest standards in health curative, preventative and medical services and health insurance in the Emirate.
- To lay down the strategies, policies and plans, including future projects and extensions for the health sector in the Emirate, and to follow-up their implementation
- To apply the laws, rules, regulations and policies which are issued as they are related to its purposes and responsibilities, in addition to what is issued by the respective international and regional organizations in line with the development of the health sector.
- To follow up and monitor the operation of the health sectors, to achieve and exemplary Standard in the provision of health, curative, preventive and medicinal services and health insurance

2.2 DOH defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. In addition, DOH shapes the regulatory framework for the health system, inspects against regulations, enforce standards, and encourages adoption of world – class best practices and performance targets by all healthcare service providers in the Emirate of Abu Dhabi.

2.3 DOH also drives programs to increase awareness and adoption of healthy living standards among the residents of the Emirate of Abu Dhabi in addition to regulating scope of services, premiums and reimbursement rates of the health system in the Emirate of Abu Dhabi.

2.4 The Health System of the Emirate of Abu Dhabi is comprehensive, encompassing the full spectrum of health services and is accessible to all residents of Abu Dhabi. The system is driven towards excellence through continuous outcome improvement culture and monitoring achievement of specified indicators. Providers of health services are independent. Predominately private and follow highest international quality standards. The system is financed through mandatory health insurance.

In doing so DOH will:

- Drive structure, process and outcome improvements across health sector
- Put people first and champion their rights
- Focus on quality and act swiftly to eliminate poor quality of care
- Work with Stakeholders and apply fair processes.
- Gather information and utilize knowledge and expertise to improve care.
- Link the care to payment in a way that results in a continuous improvement and maximize the value of the care provided in Abu Dhabi.

3. Patient Safety and Clinical Effectiveness

Patient safety is 'the discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery'. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events. Clinical effectiveness is "the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice" Clinical effectiveness is about doing the right thing at the right time for the right patient and is concerned with demonstrating improvements in quality and performance.

- The right thing (evidence-based practice requires that decisions about health care are based on the best available, current, valid and reliable evidence)
- In the right way (developing a workforce that is skilled and competent to deliver the care required)
- At the right time (accessible services providing treatment when the patient needs them)
- In the right place (location of treatment/services).
- With the right outcome (clinical effectiveness/maximising health gain)

Patient safety, clinical effectiveness, equity, patient experience, efficiency, and timeliness are recognized as the main pillars of quality in healthcare. In Abu Dhabi, the measurement of data related to these pillars aims to identify strengths and

weaknesses in healthcare delivery, drive quality improvement, inform regulation, and promote patient choice. In addition to data on harm avoidance and success rates for treatments, providers will be assessed on aspects of care such as dignity and respect, compassion, and involvement in care decisions through patient satisfaction surveys. The inclusion of patient safety, clinical effectiveness, and patient experience in quality performance is often justified on the grounds of their intrinsic value. For example, clear information, empathetic two-way communication, and respect for patients' beliefs and concerns can lead to patients being more informed and involved in decision-making, creating an environment where they are more willing to disclose information.

4. Planning for data collection and submission

In planning for data collection and submission Healthcare must adhere to reporting, definition and calculation requirements as set out in this guidance. Healthcare providers must also consider the following:

- Nominate responsible data collection and quality leads(s).
- Ensure data collection leads are adequately skilled and resourced.
- Understand and identify what data is required, how it will be collected (sources) and when it will be collected.
- Create a data collection plan.
- Ensure adequate data collection systems and tools are in place.
- Maintain accurate and reliable data collection methodology.
- Data collation, cleansing and analysis for reliability and accuracy.
- Back up and protect data integrity.
- Have in place a data checklist before submission.
- Submit data on time and ensure validity.
- Review and feedback data findings to the respective teams in order to promote performance improvement.
- Failing to submit valid data will be in breach of the licensing condition and could result in fines being applied, penalties associated with performance or revoke of license.

- When needed, documentation and tracks will be provided instantly to DOH, or their representative, to assure DOH that all dues processes are being followed in collecting, analyzing, validating and submitting your performance

5. About this Guidance

5.1 This guidance sets out the Patient Safety and Clinical Effectiveness reporting requirements to ensure High quality and safety of healthcare services offered to patients in the Emirate of Abu Dhabi. The guidance sets out the definitions, parameters and frequency by which JAWDA Quality indicators will be measured and
Submitted to DOH and will ensure Healthcare Providers provide safe, effective and high quality services.

Q. Who is this guidance for?

All DOH Licensed Healthcare general and specialist Hospitals in the Emirate of Abu Dhabi

Q. How do I follow this guidance?

Each Hospital will nominate one member of staff to coordinate, collect, quality control, monitor and report relevant Inpatient data as per communicated dates. The nominated healthcare facility lead must in the first instance e-mail their contact details (if different from previous submission) to JAWDA@doh.gov.ae and submit the required quarterly quality performance indicators through Online Portal.

Q. What are the Regulation related to this guidance?

- Legislation establishing the Health Sector
- As per DoH Policy for Quality and Patient Safety issued January 15th 2017, this guidance applies to all DOH Licensed Hospital Healthcare Facilities in the Emirate of Abu Dhabi in accordance with the requirements set out in this Standard.

Glossary

INPATIENT: *Is a beneficiary registered and admitted to a hospital for bed occupancy for purposes of receiving healthcare services and is medically expected to remain confined overnight and for a period in excess of 12 consecutive hours.*

- *Daycase admission is not included in INPATIENT.*
- *Beds **excluded** from the inpatient bed complement:*
  - ***Beds/cots for healthy newborns***
  - *Beds in Day Care units, such as surgical, medical, pediatric day care, interventional radiology*
  - *Beds in Dialysis units*
  - *Beds in Labor Suites (e.g. birthday beds, birthing chairs)*
  - *Beds in Operating Theatre*
  - *Temporary beds such as stretchers*
  - *Chairs, Cots or Beds used to accommodate sitters, parents, guardians accompanying patients or sick children and healthy baby accompanying a hospitalized breast-feeding mother*
  - *Beds closed during renovation of patient care areas when approved by the competent authority*

DAYCASE*: Daycase beds, also known as observation beds, are beds used in Day Care units such as surgical, medical, pediatric day care interventional radiology. They are not included in the inpatient bed complement.*

LONG TERM CARE PATIENTS: They will be reported under LTCF Jawda Guidance. ***Service codes (not limited to)****: 17-13, 17-14, 17-15, 17-16, 17-27, 17-28, 17-30, 17-31, self-pay LTC, etc.*

CRITICAL CARE AREA: A patient is in a Critical Care Area if they are receiving active cardiac monitoring (including telemetry) in an Intensive Care Unit, Emergency Room, Urgent Care Centre, Operating Room, Procedure Room, Anesthetic Induction Room or Recovery Area.

Type: Quality Indicator **Indicator Number:** QI002

KPI Description (title):	**Percentage of transfusion-associated adverse reactions**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Percentage of transfusion-associated adverse reactions that are possibly, probably, or definitely related to a transfusion of blood products per 100 transfused units.
Calculation:	***Numerator:*** Count number of defined adverse reactions (see below) that occurred during the reporting period. **Defined Adverse Reactions:** • Transfusion-associated circulatory overload (TACO) - ***E87.71*** • Transfusion-related acute lung injury (TRALI) - ***J95.84*** • Transfusion-associated dyspnea (TAD) – (**T80.89XA, *T80.89XD, T80.89XS+ R06.09***) • Allergic reaction (where severity is severe, life threatening, or death) – Anaphylactic / Anaphylactoid reactions- **T78.2XXA, T78.2XXD, T78.2XXS**. • Hypotensive transfusion reaction- **(T80.89XA, *T80.89XD, T80.89XS+I95.89)*** • Febrile non-hemolytic transfusion reaction (FNHTR)-**R50.84** • Acute hemolytic transfusion reaction (AHTR) - ***T80.910A, T80.910D, T80.910S*** • Delayed hemolytic transfusion reaction (DHTR) –(***T80.311A, T80.311D, T80.311S, T80.411A, T80.411D, T80.411S, T80.911A, T80.911D, T80.911S, T80.919A, T80.919D, T80.919S, T80.A11A, T80.A11D, T80.A11S)*** • Delayed serologic transfusion reaction (DSTR) • Transfusion-associated graft vs. host disease (TAGVHD)- **(T80.89XA, *T80.89XD, T80.89XS* + D89.810, D89.811, D89.812, D89.813)** • Post-transfusion purpura (PTP)- **D69.51** • Transfusion-transmitted infection (TTI)- ***T80.22XA, T80.22XD*** ***Denominator:*** Total number of units transfused during the reporting period. ***HCPCS codes:*** P9010, P9011, P9012, P9016, P9017, P9019, P9020, P9021, P9022, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9038, P9039, P9040, P9044, P9050, P9051, P9052, P9053, P9054, P9055, P9056, P9057, P9058, P9059, P9060, P9070, P9071, P9073
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	National Healthcare Safety Network Biovigilance Component Hemovigilance Module Surveillance Protocol
Desired direction:	Lower is better
Notes for all providers	

Data sources and guidance:	- Hospital internal adverse event and incident reporting system - Blood bank department transfusion card - Patient medical record

Type: Quality Indicator **Indicator Number:** QI004

KPI Description (title):	**Percentage of Surgical Site Infection (SSI) for Abdominal Hysterectomy (HYST)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Percentage of patients meeting CDC NHSN SSI infection criteria within 30 days of Abdominal Hysterectomy per 100 operative procedures
Calculation and criteria to define SSI in Abdominal Hysterectomy (HYST)	***Numerator:*** Number of all SSI identified within 30 days for all patients undergoing Abdominal Hysterectomy (HYST) **ICD 10 CODES FOR SSI (but not limited to**): T81.40XA, T81.40XD, T81.40XS, T81.41XA, T81.41XD, T81.41XS, T81.42XA, T81.42XD, T81.42XS, T81.43XA, T81.43XD, T81.43XS, T81.44XA, T81.44XD, T81.44XS, T81.49XA, T81.49XD, T81.49XS ***SSI could be presented as:*** **Superficial incisional SSI:** Must meet the following criteria: Date of event for infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date) **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 identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST). c) superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat.

	d) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee. **Deep incisional SSI:** Must meet the following criteria: The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 **AND** involves deep soft tissues of the incision (for example, fascial and muscle layers) **AND** patient has at least ***one*** of the following: a) purulent drainage from the deep incision. b) a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee **AND** organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed **AND** patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion. c) an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test. **Organ/Space SSI:** Must meet the following criteria: Date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 **AND** infection involves any part of the body deeper than the fascial/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 into the organ/space(for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage) b) organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).

	c) an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection. **AND** meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter. **REPORTING INSTRUCTIONS for Superficial SSI** ***The following do not qualify as criteria for meeting the definition of superficial SSI***: a) A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration) b) A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this guidance. Note: a laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound. c) Diagnosis/treatment of "cellulitis" (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or culture (+) is not considered a cellulitis. d) Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module. e) An infected burn wound is classified as BURN and is not reportable under this module. **Definition of an NHSN Operative Procedure** An NHSN Operative Procedure is a procedure: a) that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping **And** b) takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure **And** c) takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated[11]. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. ***Denominator:*** Total number of all inpatients undergoing Abdominal Hysterectomy during the reporting period

	Abdominal Hysterectomy CPT Codes: *(58150, 58152, 58180, 58200, 58210, 58541, 58542, 58543, 58544, 58548, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956)* **<u>Denominator Exclusions</u>:** • Procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance. ***ICD-10 CM codes***: G93.82
Reporting Frequency:	Quarterly
Unit of Measure:	Percentage
International comparison if available	OECD, AHRQ and DOH standards
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation. - Patient medical record.

Type: Quality Indicator **Indicator Number:** QI005

KPI Description (title):	**Rate of Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) for patients ages 18 years and older.
Calculation:	***Numerator:*** All adults who had surgical discharges in the reporting quarter and developed proximal Deep Vein Thrombosis or Pulmonary Embolism within 30 days from the date of the surgical procedure. (In case of multiple procedures, count from the first procedure). Numerator guidance use: • Secondary diagnosis postoperative DVT in the same encounter. • Primary and/or secondary diagnosis postoperative DVT for the first readmission or succeeding readmission or revisiting encounters within 30 days timeframe. ***ICD-10-CM Diagnosis Codes, as follows:*** • ***Proximal Deep Vein Thrombosis:*** ***ICD 10 CM Codes****: (I80.10, I80.11, I80.12, I80.13, I80.201, I80.202, I80.203, I80.209, I80.211, I80.212, I80.213, I80.219, I80.221, I80.222, I80.223, I80.229, I80.291, I80.292, I80.293, I80.299, I82.401, I82.402, I82.403, I82.409, I82.411, I82.412, I82.413, I82.419, I82.421, I82.422, I82.423, I82.429, I82.431, I82.432, I82.433, I82.439, I82.4Y1, I82.4Y2, I82.4Y3, I82.4Y9)* • ***Pulmonary Embolism:*** ***ICD 10 CM Codes:*** *(I26.01, I26.02, I26.09, I26.90, I26.92, I26.93, I26.94, I26.99)* ***Denominator:*** Total number of adult (18 years and older) inpatient surgical discharges during the reporting period (for operating room procedures). ***Service codes***: 20, 20-01, 20-02, 20-03 **Denominator Exclusions**: • *Patients with a principal ICD-10-CM Diagnosis Code or secondary diagnosis present on admission for: proximal deep vein thrombosis Deep Vein Thrombosis and Pulmonary Embolism (please see above codes)* • *Patients where a procedure for interruption of vena cava occurs before or on the same date as the first operating room procedure (CPT Procedure Code: 37619, 37191.* • where a procedure for pulmonary arterial or dialysis access thrombectomy occurs before or on the same day as the first operating room procedure • where the only operating room procedure(s) is for pulmonary arterial or dialysis access thrombectomy • with any ICD-10-CM diagnosis code present on admission for

	acute brain or spinal injury • with any listed procedure code for extracorporeal membrane oxygenation (ECMO) • All Long-term care patients. (see glossary) • Patients who received treatment as an inpatient for burns injury (any degree). (Refer to Burn Jawda Guidance) • *Admission for pregnancy, childbirth, and puerperium (**ICD-10 codes:** O00.00 - O9A.53)*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1,000 adult surgical discharges
International comparison if available	PSI_12_Perioperative_Pulmonary_Embolism_or_Deep_Vein_Thrombosis_Rate.pdf (ahrq.gov) Also using OECD, CQC of UK with modification following discussion with local experts and taking local culture into consideration.
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Hospital internal adverse event system and complication log - Based on list of discharged patients with specific ICD 10 Diagnosis and Procedure codes - Patient medical record.

Type: Quality Indicator **Indicator Number:** QI006

KPI Description (title):	**Rate of Healthcare-Associated Multidrug-Resistant Organism (MDRO) Bloodstream Infection (All inpatients)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of the healthcare-associated MDRO bloodstream infections who meet MDRO definitions during the reporting period.
Calculation and criteria to define n (MDRO) infections	***Numerator:*** Count the total number of MDRO infections that meet MDRO definitions. **ICD 10 CODES**: A49.02, B95.62, J15.212, Z16.10, Z16.11, Z16.12, Z16.19, Z16.20, Z16.21, Z16.22, Z16.23, Z16.24, Z16.29, Z16.30, Z16.31, Z16.32, Z16.33, Z16.341, Z16.342, Z16.35, Z16.39) ***MDRO Definitions:*** ***KPI MDRO-01*** – Methicillin-resistant Staphylococcus aureus (MRSA): Number of ***S. aureus*** isolates cultured from blood specimen that test oxacillin-resistant by standard susceptibility testing methods. ***KPI MDRO-02*** – Vancomycin-resistant Enterococci (VRE): Number of ***Enterococcus faecalis, Enterococcus faecium, and other Enterococcus species*** isolates cultured from blood specimen that test resistant to vancomycin by standard susceptibility testing methods. ***KPI MDRO-03-*** CephR-Klebsiella: Number of ***Klebsiella oxytoca*** **or** ***Klebsiella pneumoniae*** isolates cultured from blood specimen that test non-susceptible (specifically, either resistant or intermediate) to at least ONE of the following cephalosporin antibiotics: *ceftazidime, cefotaxime, ceftriaxone, or cefepime* by standard susceptibility testing methods ***KPI MDRO-04*** – Carbapenemase-Producing Organisms (CPO): Number of ***Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae*****, and** ***Enterobacter spp.*** isolates cultured from blood specimen that test resistant by standard susceptibility testing methods to at least ONE of the following carbapenem antibiotics: (Carbapenem, Imipenem, Meropenem, Doripenem) **Numerator Inclusions:** - Patient admitted to hospital (Inpatients) only, including ICU and non-ICU inpatient wards - Healthcare Facility-Onset (HO): specimen collected >3 days after admission to the facility (specifically: on or after day 4 after admission, with the admission day counting as day one). • Isolates identified from clinical specimen only (diagnosis and treatment of infection) • Isolates from blood culture specimen only. First isolate per patient only during a 14 day interval. **Numerator Exclusion:**

	• Community-Onset (CO): Positive lab tests results for specimens collected at an inpatient location ≤3 days after admission to the facility (i.e., on day 1, 2 or 3 after admission, with the admission day counting as day one. • MDROs from patients in an outpatient location (e.g. outpatient clinics, emergency department, home nursing). • MDROs from patients in an Inpatient Rehabilitation Facility or Inpatient Psychiatric Facility • Duplicate MDRO isolates for the same patient and specimen type (blood) within 14 days after the first MDRO isolate, based on specimen collection date. • Isolates identified through screening or active surveillance: ***Denominator***: Total number of inpatient days during the reporting period. (See glossary) ***Denominator Exclusion***: • *Healthy newborns* (See glossary) • *Burn cases* (Refer to Burn Jawda Guidance) • *Psychiatric Inpatients.* (Refer to Mental Health Jawda Guidance)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 inpatient days
International comparison if available	Indicators are based on US CDC NHSN MDRO/CDI Module: http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf) OECD Quality indicators, AHRQ, CQC
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	a) Lab test results of all specimen b) Captured by microbiologist and infection control team/ nursing as part of regular surveillance activities and infection control documentation. c) Patient medical record.

Type: Quality Indicator **Indicator Number:** QI007

KPI Description (title):	**30-day all-cause readmission rate for inpatients with planned Hernia repair procedure**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmission for adult patients (18 years and older) undergoing a planned hernia repair within 30 days of discharge. All related and unrelated readmissions to be included (please indicate if it related or unrelated in the notes section).
Calculation:	***Numerator:*** Number of unplanned adult admissions to hospital within 30-days of discharge from the index hospitalization of having planned Hernia Repair (all types) (***If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator***). ***Denominator:*** Number of adult inpatients (age 18 and older) with planned hernia repair discharged during the reporting period. **Hernia Repair CPT Codes:** (43281, 43282, 43332, 43333, 43334, 43335, 43336, 43337, 44050, 44346, 49505, 49507, 49520, 49521, 49525, 49540, 49550, 49553, 49555, 49557, 49560, 49561, 49565, 49566, 49568, 49570, 49572, 49585, 49587, 49590, 49650, 49651, 49652, 49653, 49654, 49655, 49656, 49657) ***Denominator Exclusions:*** • Patients who are discharged/left against medical advice (AMA). • Patients having a planned hernia repair procedure during the index hospitalization and subsequently transferred to another acute care facility. • Episodes with a discharge of death • Readmissions within 30 days from the index discharge
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 hernia repair discharges
International comparison if available	Developed locally by modifying similar indicators used by AHRQ, OECD and CQC
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Mortality and Morbidity record - Hospital internal adverse event and incident report system - Hospital patient data source

Type: Quality Indicator **Indicator Number:** QI009

KPI Description (title):	**30-day all-cause readmission rate for inpatients with Pneumonia**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) with a principal discharge diagnosis of Pneumonia. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator:*** Number of unplanned adult admissions to hospital within 30-days of discharge from the index hospitalization with principal discharge diagnosis of Pneumonia. (***If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator***). ***Denominator:*** Number of adult inpatients 18 years and older discharged from hospital with principal discharge diagnosis of Pneumonia during the reporting period. ***Pneumonia ICD-10-CM Codes****; (A01.03, A02.22, A37.01, A37.11, A37.81, A37.91, A50.04, A54.84, B01.2 , B05.2 , B06.81, B77.81, B95.3, B96.0, B96.1, J09.X1, J10.00, J10.01, J10.08, J11.00, J11.08, J12.0, J12.1, J12.2, J12.3, J12.81, J12.82, J12.89, J12.9, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J17, J18.0, J18.1, J18.2, J18.8, J18.9, J20.0, J82.81, J82.82, J84.111, J84.116, J84.117, J84.2, J85.1, J95.851).* **Denominator Exclusions:** • Patients who are discharged/left against medical advice (AMA) • Patients having a principal diagnosis of pneumonia during the index hospitalization and subsequently transferred to another acute care facility. • Episodes with a discharge of death • Readmissions within 30 days from the index discharge
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 pneumonia discharges
International comparison if available	CMS: 2018 Condition-Specific Measures Updates and Specifications Report Hospital-Level 30-Day Risk-Standardized Readmission Measures
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	-Hospital internal adverse event and incident reporting system. -Mortality and morbidity record -Hospital patient data source

Type: Quality Indicator **Indicator Number:** QI010

KPI Description (title):	**30-day all-cause readmission rate for inpatients with Urinary Tract Infection (UTI)**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) with a principal discharge diagnosis of UTI. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator***: Number of unplanned adult admissions to hospital within 30-days of discharge from the index hospitalization with principal discharge diagnosis of UTI. (***If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator****).* ***Denominator:*** Number of all adult inpatients (age 18 and older) discharged from hospital with principal discharge diagnosis of UTI during the reporting period. ***ICD 10 CM Codes****: (A18.10, A18.11, A18.12, A18.13, A52.75, A52.76, A54.00, A54.01, A54.1, A54.21, A56.00, A56.01, A59.03, B37.41, B37.49, N00.0, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N00.A, N01.0, N01.1, N01.2, N01.3, N01.4, N01.5, N01.6, N01.7, N01.8, N01.9, N01.A, N05.0, N05.1, N05.2, N05.3, N05.4, N05.5, N05.6, N05.7, N05.8, N05.9, N05.A, N10, N11.0, N12, N13.6, N15.1, N15.8, N15.9, N28.85, N28.86, N30.00, N30.01, N30.30, N30.31, N30.40, N30.41, N30.80, N30.81, N30.90, N30.91, N33, N34.0, N34.1, N34.2, N39.0, N99.511, N99.521, N99.81, T83.510A, T83.510D, T83.510S, T83.511A, T83.511D, T83.511S, T83.512A, T83.512D, T83.512S, T83.518A, T83.518D, T83.518S, T83.590A, T83.590D, T83.590S, T83.591A, T83.591D, T83.591S, T83.592A, T83.592D, T83.592S, T83.593A, T83.593D, T83.593S, T83.598A, T83.598D, T83.598S)* **Denominator Exclusions:** • Chronic and recurrent UTI- ICD-10-CM Excluded codes (***but not limited to)***: (N30.10, N30.11, N30.20, N30.21, N11.0, N11.1, N11.8, N13.70, N13.71, N13.721, N13.722, N13.729, N13.731, N13.732, N13.739, N13.9, P37.5, P39.3, O03.38, O03.88, O07.38, O04.88, O08.83, O23.00, O23.01, O23.02, O23.03, O23.10, O23.11, O23.12, O23.13, O23.20, O23.21, O23.22, O23.23, O23.30, O23.31, O23.32, O23.33, O23.40, O23.41, O23.42, O23.43, O75.3, O86.20, O86.21, O86.22, O86.29.) • Patients who are discharged/left against medical advice (AMA) • Patients having a principal diagnosis of UTI during the index hospitalization and subsequently transferred to another acute care facility. • Episodes with a discharge of death • Readmissions within 30 days from the index discharge

Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 UTI discharges
International comparison if available	Developed locally by modifying similar indicators used by AHRQ, OECD and CQC
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Hospital internal adverse event and incident reporting system. - Mortality and morbidity record - Hospital patient data source

Type: Quality Indicator **Indicator Number:** QI011

KPI Description (title):	**Rate of cardiopulmonary arrests outside critical care area per 1000 inpatient days**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of cardiopulmonary arrest incidents that occurred outside critical care area per 1000 inpatient days.
Calculation:	***Numerator:*** Total number of all cardiac arrests occurring outside critical care irrespective of outcome during the reporting period. ***Cardiac arrests occurring ICD-10 CM Codes:*** *(I46.2, I46.8, I46.9, I97.120, I97.121, I97.710, I97.711, O03.36, O03.86, O04.86, O07.36, O08.81, O29.111, O29.112, O29.113, O29.119, P29.81)* **Cardiac arrests occurring CPT Codes:** *92950* **Numerator inclusions:** • Cardiac or respiratory arrests outside of critical care wards • All inpatients: Adults only **Numerator Exclusions:** • Cardiac or respiratory arrests occurred in OR, ICU (critical care wards) and ED. • Cardiac or respiratory arrests occurred in outpatients or visitors • Still births: ***ICD-10 CM Codes:*** *Z37.1, Z37.3, Z37.4, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, P95* • Patients that are prone to cardiac arrest but kept out of critical care due to clinical or palliative reasons. e.g.; patient with end stage cancer. ***Denominator***: Total number of inpatient days during the reporting period. *(see glossary)* ***Denominator Inclusion***: Number of In-hospital inpatient cardiopulmonary arrests that occurred outside the critical care area. (See glossary) ***Denominator Exclusion****:* • All Long-term care and Post-acute Rehab patients
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 inpatient days
International comparison if available	Definition based on IHI literature
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Data from telephone operator regarding activated code “blue” and “code pink” calls and CPR Record or a similar system. - Mortality and Morbidity Record - Patient Medical Record

Type: Quality Indicator **Indicator Number:** QI012

KPI Description (title):	**Rate of hospital acute inpatient falls resulting in any injury per 1,000 inpatient days.**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of inpatient falls resulting in any injury per 1000 all inpatient Days
Calculation:	***Numerator:*** Total number of inpatient falls resulting in injury (minor, moderate, major, or death) to the patient in the measurement quarter **Numerator Inclusions**: Patient falls with injury: minor, moderate, major, or death. A ***fall*** is an unplanned descent to the floor. Include falls when a patient lands on a surface where you wouldn't expect to find a patient. All unassisted and assisted falls are to be included whether they result from physiological reasons (fainting) or environmental reasons (slippery floor). Also report patients that roll off a low bed onto a mat as a fall. The National Database of Nursing Quality Indicators ***NDNQI definitions for injury*** follow: •None -patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan or other post fall evaluation results in a finding of no injury. •"Minor- resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise or abrasion. •Moderate-resulted in suturing, application of steri-strips/skin glue, splinting or muscle/joint strain. •Major- resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of the fall. •Death-the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)." ***Numerator Exclusions:*** Patient falls, but no harm was evident ***Denominator***: Total number of inpatient days during the reporting period. *(see glossary)* **Denominator Exclusion:** • *Healthy newborn* (See glossary) • All Long-term care, home care and Post-acute Rehab patients • *Psychiatric Patients.* (Refer to Mental Health Jawda Guidance) **Rate:** Calculation: [numerator / denominator] x 1000
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 inpatient days

International comparison if available	• Developed locally by modifying similar indicators used by AHRQ, OECD and CQC following local discussion and taking local culture and setting into consideration • Definition is based on NDNQI Glossary & Reference Guide to Clinical Indicators, 2014
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Hospital internal adverse event and incident reporting system

Type: Quality Indicator **Indicator Number:** QI013

KPI Description (title):	**Rate of hospital associated or worsening pressure injury (Stage 2 and above) per 1000 adult inpatient days**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Hospital Associated or worsening Pressure Injury (Stage II and above) Rate per 1000 adult inpatient days).
Calculation:	***Numerator:*** Number of patients with newly acquired pressure injury or with worsening pressure injury Stage 2, 3, 4, Unstageable or Deep Tissue Injury (DTI) within the measurement quarter. **Hospital associated or worsening Pressure Injury (Stage 2 and above) ICD-*10 CM Codes:*** *L89.42, L89.43, L89.44, L89.40, L89.45, L89.812, L89.813, L89.814, L89.819, L89.810, L89.522, L89.523, L89.524, L89.529, L89.520, L89.322, L89.323, L89.324, L89.329, L89.320, L89.022, L89.023, L89.024, L89.029, L89.020, L89.622, L89.623, L89.624, L89.629, L89.620, L89.222, L89.223, L89.224, L89.229, L89.220, L89.142, L89.143, L89.144, L89.149, L89.140, L89.122, L89.123, L89.124, L89.129, L89.120, L89.892, L89.893, L89.894, L89.899, L89.890, L89.512, L89.513, L89.514, L89.519, L89.510, L89.312, L89.313, L89.314, L89.319, L89.310, L89.012, L89.013, L89.014, L89.019, L89.010, L89.612, L89.613, L89.614, L89.619, L89.610, L89.212, L89.213, L89.214, L89.219, L89.210, L89.132, L89.133, L89.134, L89.139, L89.130, L89.112, L89.113, L89.114, L89.119, L89.110, L89.152, L89.153, L89.154, L89.159, L89.150, L89.502, L89.503, L89.504, L89.509, L89.500, L89.302, L89.303, L89.304, L89.309, L89.300, L89.002, L89.003, L89.004, L89.009, L89.000, L89.602, L89.603, L89.604, L89.609, L89.600, L89.202, L89.203, L89.204, L89.209, L89.200, L89.102, L89.103, L89.104, L89.109, L89.100, L89.92, L89.93, L89.94, L89.90, L89.95, L89.46, L89.816, L89.526, L89.326, L89.026, L89.626, L89.226, L89.146, L89.126, L89.896, L89.516, L89.316, L89.016, L89.616, L89.216, L89.136, L89.116, L89.156, L89.506, L89.306, L89.006, L89.606, L89.206, L89.106, L89.96*

***Guide on stage is defined below*;**

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.

	Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions **<u>Numerator Inclusions</u>:** • Hospital Associated Pressure Injury (not present or present but with a lower stage on admission to hospital). **<u>Numerator Exclusions</u>:** • Patients with pressure Injury present on admission, that stayed the same stage or improved following hospital stay • Hospital Associated Pressure Stage I ***ICD- 10 CM Codes****: (L89.001, L89.011, L89.021, L89.101, L89.111, L89.121, L89.131, L89.141, L89.151, L89.201, L89.211, L89.221, L89.301, L89.311, L89.321, L89.41, L89.501, L89.511, L89.521, L89.601, L89.611, L89.621, L89.811, L89.891, L89.91.* • ***<u>Denominator</u>***: Total number of adult (age 18 and older) inpatient days during the reporting period. (see glossary) **<u>Denominator Exclusion</u>:** • *Burn cases* (Refer to Burn Jawda Guidance) • *Psychiatric inpatients.* (Refer to Mental Health Jawda Guidance) • *All Long-term care and Post-acute Rehab patients*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 inpatient days
International comparison if available	CQC of UK with modification following discussion with local experts and taking local culture into consideration npiap_pressure_injury_stages.pdf (ymaws.com)
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Manual Data Collection - Patient record or EMR (Medical Chart Review): Skin and Wound Assessment Chart- - Hospital internal adverse event system

Type: Quality Indicator **Indicator Number:** QI014

KPI Description (title):	**30-day all-cause readmission rate for inpatients with heart failure**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) with a principal discharge diagnosis of heart Failure (HF). All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator***: Number of unplanned adult admissions to hospital within 30-days of discharge from the index hospitalization with a principal discharge diagnosis of heart failure (HF) (***If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator***). ***Denominator:*** Total number of adult inpatients 18 years and older having a principal discharge diagnosis of heart failure during the reporting period. ***Heart failure ICD-10-CM Codes:*** *I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, I02.0, I01.8, I09.81, I13.0, I13.2, I11.0, I97.130, I97.131)* **Denominator Exclusions:** • Admissions for patients who are discharged/left against medical advice (AMA) • Admissions for patients having a principal diagnosis of HF during the index hospitalization and subsequently transferred to another acute care facility • Episodes with a discharge of death • Readmissions within 30 days from the index discharge
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 heart failure discharges
International comparison if available	CMS: 2018 Condition-Specific Measures Updates and Specifications Report Hospital-Level 30-Day Risk-Standardized Readmission Measures
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Mortality and morbidity record - Hospital patient data source

Type: Quality Indicator **Indicator Number:** QI015

KPI Description (title):	**30-Day All-Cause Readmission Rate for inpatients with Unplanned Appendectomy Procedure**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) after undergoing an emergency appendectomy of all types using all surgical methods. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator*:** Number of unplanned adult admissions to hospital within 30-days of discharge from the index post emergency appendectomy (all types and all approaches) (***If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator)*** ***Denominator*:** Total number of adult inpatients (age 18 and older) who had an emergency appendectomy procedure and discharged during the reporting period. **Appendectomy *CPT Codes:*** *44950, 44955, 44960, 44970* **Denominator Exclusions:** • Appendectomy for cancer cases ***ICD-10CM Codes:*** *C18.1, C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, D01.40, C78.5, D12.1, D37.3* • Pheochromocytome ***ICD-10CM Codes:*** *C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C79.70, C79.71, C79.72, D09.3, D35.00, D35.01, D35.02* • Admissions for patients who are discharged/left against medical advice (AMA) • Admissions for patients having unplanned appendectomy procedure during the index hospitalization and subsequently transferred to another acute care facility • Operation where appendectomy is part of a larger procedure e.g., Meckel's diverticulum, right hemicolectomy etc. ***CPT Codes:*** *44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44213* • Episodes with a discharge of death • Readmissions within 30 days from the index discharge
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 appendectomy discharges
International comparison if available	Developed locally by modifying similar indicators used by AHRQ, OECD and CQC
Desired direction:	Lower is better
Notes for all providers	

Data sources and guidance:	- Hospital internal mortality and morbidity. - Hospital patient data source.

Type: Quality Indicator **Indicator Number:** QI016

KPI Description (title):	**CAUTI rate per 1000 device days (all inpatients)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	**Catheter-associated UTI (CAUTI):** A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1 ***AND*** An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated. **Indwelling catheter**: A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a drainage bag (including leg bags). These devices are also called Foley catheters. Condom or straight in-and-out catheters are not included nor are nephrostomy tubes, ileoconduits, or suprapubic catheters unless a Foley catheter is also present. Indwelling urethral catheters that are used for intermittent or continuous irrigation are included in CAUTI surveillance. **Location of Attribution:** The inpatient location where the patient was assigned on the date of event is the location of attribution (**Exception to Location of Attribution:** *Transfer Rule*: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location) **Date of Event (Event Date):** The Date of Event is the date the first element used to meet site-specific infection criterion occurs for the first time within the seven-day infection window period. **Infection Window Period:** Infection Window Period is defined as the 7-days during which all site-specific infection criteria must be met. It includes the day the first positive diagnostic test that is an element of the site-specific infection criterion, was obtained, the 3 calendar days before and the 3 calendar days after. **Indwelling catheter days:** Indwelling urinary catheter days, which are the number of patients with an indwelling urinary catheter device, are collected daily, at the same time each day. Criteria used to define CAUTI in Adult Patients: **Criteria 1a.** Patient must meet 1, 2, and 3 below:

	• Patient had an indwelling urinary catheter that had been in place for > 2days on the date of event (day of device placement = Day 1) ***AND*** was either: • Still present on the date of event, OR • Removed the day before the date of event • Patient has at least ***one*** of the following signs or symptoms: • fever (>38.0°C) • suprapubic tenderness • costovertebral angle pain or tenderness • urinary urgency • urinary frequency • dysuria • Patients have a urine culture with no more than two species of organisms, at least one of which is a bacteria of ≥10^5 CFU/ml. All elements of the UTI criterion must occur during the Infection Window Period **Criteria used to define CAUTI for Patients ≤1 year**: Patient must meet 1, 2, and 3 below: • Patient is ≤1 year of age (an indwelling urinary catheter in place for >2 calendar days)) • Patient has at least ***one*** of the following signs or symptoms: 1. fever (>38.0°C) 2. hypothermia (<36.0°C) 3. apnea 4. bradycardia 5. lethargy 6. vomiting 7. suprapubic tenderness • Patients have a urine culture with no more than two species of organisms, at least one of which is a bacterium of ≥10^5 CFU/ml. All elements of the SUTI criterion must occur during the Infection Window Period.
Calculation and Criteria to define CAUTI:	***Numerator:*** Number of patients with CAUTI that is identified during the period selected for surveillance. ***ICD-10 CM codes*** (not limited to): T83.511A, T83.511D, T83.511S, T83.518A, T83.518D, T83.518S ***Transfer Rule***: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location) **Numerator Exclusion**: Repeated infection for the same type during 14 days from Date of Event ***Denominator***: Total number of catheter device inpatient days during the reporting period. (see glossary) **Denominator Exclusions:** • Outpatients • The following organisms cannot be used to meet the UTI definition:

	○ Candida species or yeast not otherwise specified ○ Mold ○ Dimorphic fungi or ○ Parasites ○ Mixed flora (urine specimen) • *Burn cases* (Refer to Burn Jawda Guidance) • *Psychiatric inpatients.* (Refer to Mental Health Jawda Guidance) • All Long-term care and Post-acute Rehab patients (see glossary)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 urinary catheter days
International comparison if available	AHRQ and DOH standards http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Captured by infection control team • Patient's records • Lab reports • Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number:** QI017

KPI Description (title):	**CLABSI Rate per 1000 Central Line-Days (All Adult Inpatients)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	**Central line-associated BSI (CLABSI):** A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days on the date of event, with day of device placement being Day 1, **AND** A CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharged (as per the Transfer Rule). Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance. **Central line**: An intravascular catheter that terminates at, close to the heart, or in one of the great vessels that used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line BSI and counting central-line days in the NHSN system: 1. Aorta

	2. Pulmonary artery 3. Superior vena cava 4. Inferior vena cava 5. Brachiocephalic veins 6. Internal jugular veins 7. Subclavian veins 8. External iliac veins 9. Common iliac veins 10. Femoral veins 11. In neonates, the umbilical artery/vein. **Umbilical catheter**: A central vascular device inserted through the umbilical artery or vein in a neonate. **Infusion:** The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes, IV antimicrobial administration, or blood transfusion or hemodialysis. **Temporary central line:** A non-tunneled, non- implanted catheter. **Permanent central line**: Includes 12. Tunneled catheters, including certain dialysis catheters 13. Implanted catheters (including ports) **Location of Attribution:** The inpatient location where the patient was assigned on the date of event is the location of attribution (**Exception to Location of Attribution:** *Transfer Rule*: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location) **Date of Event (Event Date):** The Date of Event is the date the first element used to meet site-specific infection criterion occurs for the first time within the seven-day infection window period. **Infection Window Period:** Infection Window Period is defined as the 7-days during which all site-specific infection criteria must be met. It includes the day the first positive diagnostic test that is an element of the site-specific infection criterion, was obtained, the 3 calendar days before and the 3 calendar days after. **Central Line days** are the number of patients with an indwelling central line, are collected daily, at the same time each day.
Calculation and Criteria to define CLABSI:	***Numerator:*** Each CLABSI that is identified during the period selected for surveillance in all adult inpatient settings. ***ICD-10 CM codes*** (not limited to): T80.211A, T80.211D, T80.211S **Laboratory-Confirmed Bloodstream Infection (LCBI) Criteria to define BSI:** **LCBI 1.**

	• Patient has a recognized pathogen cultured from one or more blood cultures **AND** • Organism cultured from blood is not related to an infection at another site **LCBI 2.** • Patient has at least one of the following signs or symptoms: fever (>38.0C), chills, or hypotension **AND** • Organism cultured from blood is not related to an infection at another site **AND** The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], Bacillus spp. [not *B. anthracis*], Propionibacterium spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, Aerococcus spp., and *Micrococcus* spp.) is cultured from two or more blood cultures drawn on separate occasions. ***Transfer Rule*:** If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location) **Numerator Exclusion**: • MBI-LCBI • Secondary bloodstream infections • Repeated infection for the same type during 14 days from Date of Event ***Denominator***: Number of all central line inpatient days for all adult patients (age 18 and older) during the reporting period. (See glossary) • It is not required for a BSI to be associated with a specific device when more than one line is present. • Only one central line per patient is counted per calendar day regardless of the number of central lines present. All central lines on inpatient units should be included in device day counts regardless of access. ***Applicable CPT codes (not limited to):*** 36555-36590 **Denominator Exclusion:** • Pediatric (it will be reported under pediatric Jawda guidance) • Neonates (from zero to 28 days) it will be reported under maternal Jawda guidance • Patients who received treatment as an inpatient for burns injury (any degree). They will be reported under Burn Jawda Guidance • All Long-term care patients. (see glossary)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 central line days
International comparison if available	AHRQ and DOH standards http://www.cdc.gov/nhsn/acute-care-hospital/CLABSI/index.html

Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Captured by infection control team • Patient's records • Lab reports • Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number:** QI018

KPI Description (title):	**Percentage of surgical site infection (SSI) for appendectomy procedures**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Percentage of patients meeting CDC NHSN SSI infection criteria within 30 days of emergency appendectomy surgery procedure.
Calculation and Criteria to define SSI in appendectomy:	***Numerator:*** Number of all SSI identified within 30 days of emergency appendectomy during the reporting period. ***ICD 10 CODES FOR SSI (but not limited to)****: T81.40XA, T81.40XD, T81.40XS, T81.41XA, T81.41XD, T81.41XS, T81.42XA, T81.42XD, T81.42XS, T81.43XA, T81.43XD, T81.43XS, T81.44XA, T81.44XD, T81.44XS, T81.49XA, T81.49XD, T81.49XS* ***SSI could be presented as:*** **Superficial incisional SSI:** Must meet the following criteria: Date of event for infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date) **AND** involves only skin and subcutaneous tissue of the incision **AND** patient has at least ***one*** of the following: • purulent drainage from the superficial incision. • organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST). • superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture-based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat.

- diagnosis of a superficial incisional SSI by the surgeon or attending physician** or another designee.

Deep incisional SSI: Must meet the following criteria:
The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2
AND
involves deep soft tissues of the incision (for example, fascial and muscle layers)
AND
patient has at least ***one*** of the following:

- purulent drainage from the deep incision.
- a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee
  AND
  organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed
  AND
  patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.
- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

Organ/Space SSI: Must meet the following criteria:
Date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2
AND
infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure
AND
patient has at least ***one*** of the following:

- purulent drainage from a drain that is placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).
- an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

AND

	meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter. **REPORTING INSTRUCTIONS for Superficial SSI** ***The following do not qualify as criteria for meeting the definition of superficial SSI***: • A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration) • A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this guidance. Note: a laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound. • Diagnosis/treatment of "cellulitis" (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or culture (+) is not considered a cellulitis. • Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module. • An infected burn wound is classified as BURN and is not reportable under this module. **Definition of an NHSN Operative Procedure** An NHSN Operative Procedure is a procedure: • that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping **And** • takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure **And** • takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated11. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. ***Denominator***: Total number of all inpatients undergoing emergency appendectomy during the reporting period. **Appendectomy CPT Codes: (**44950, 44955, 44960, 44970) **Denominator Exclusions:** • Procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance. **ICD-10 CM code: G93.82**
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 appendectomy SSI

International comparison if available	Developed locally by modifying similar indicators used by CDC/ NHSN
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation. - Patient's records - Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number**: QI027

KPI Description (title):	**Percentage of surgical Site Infection (SSI) for Cholecystectomy procedures (CHOL)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of all patients developing an SSI within 30 days all cholecystectomy procedures
Calculation and Criteria to define SSI in appendectomy:	***Numerator:*** Number of all SSI identified within 30 days of cholecystectomy procedures during the reporting period. ***ICD-10 CM codes*** (not limited to): T81.4XXA, T81.4XXD, T81.4XXS ***SSI could be presented as:*** **Superficial incisional SSI:** ***Must meet the following criteria***: Date of event for infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date) **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 identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST). c) superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture-based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. d) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

Deep incisional SSI: Must meet the following criteria:
The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND
involves deep soft tissues of the incision (for example, fascial and muscle layers)
AND
patient has at least ***one*** of the following:

a) purulent drainage from the deep incision.
b) a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee
   AND
   organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed
   AND
   patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.
c) an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

Organ/Space SSI: Must meet the following criteria:
Date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2
AND
infection involves any part of the body deeper than the fascial/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 into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage)
b) organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).
c) an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

AND
meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

	REPORTING INSTRUCTIONS for Superficial SSI ***The following do not qualify as criteria for meeting the definition of superficial SSI***: f) A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration) g) A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this guidance. Note: a laparoscopic trocar site for an NHSN operative procedure is not considered a stab wound. h) Diagnosis/treatment of "cellulitis" (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or culture (+) is not considered a cellulitis. i) Circumcision is not an NHSN operative procedure. An infected circumcision site in newborns is classified as CIRC and is not reportable under this module. j) An infected burn wound is classified as BURN and is not reportable under this module. **Definition of an NHSN Operative Procedure** An NHSN Operative Procedure is a procedure: a) that is included in the ICD-10-PCS or CPT NHSN operative procedure code mapping **And** b) takes place during an operation where at least one incision (including laparoscopic approach and cranial Burr holes) is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure **And** c) takes place in an operating room (OR), defined as a patient care area that met the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed or renovated11. This may include an operating room, C-section room, interventional radiology room, or a cardiac catheterization lab. ***Denominator***: Total number of all inpatients who have undergone a chole-cystectomy procedures within the reporting period. **Cholecystectomy CPT Codes:** (47562, 47563, 47564, 47570, 47579, 47600, 47605, 47610, 47612, 47620) **Denominator Exclusions:** • Procedures that are assigned an ASA score of 6 are not eligible for NHSN SSI surveillance. **ICD-10 CM code: G93.82**
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 cholecystectomy SSI
International comparison if available	CDC, AHRQ
Desired direction:	Lower is better
Notes for all providers	

Data sources and guidance:	- Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation. - Patient's records - Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number:** QI028

KPI Description (title):	**30-Day All-Cause Unplanned Hospital Readmission Rate for Cholecystectomy**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) after discharge from the index cholecystectomy admission. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)
Calculation:	***Numerator:*** Number of adult inpatients who were readmitted to a hospital within 30 days of discharge from index **Cholecystectomy admission. (*If a patient has more than one readmission within 30 days of discharge from the index admission, only the first is considered as readmission count for numerator*).** ***Denominator:*** Number of adult inpatients (age 18 and older) who were discharged after a cholecystectomy procedure during the index admission. **Cholecystectomy CPT Codes**: (47562, 47563, 47564, 47570, 47579, 47600, 47605, 47610, 47612, 47620) ***Denominator Exclusion***: • Patients who are discharged/left against medical advice (AMA) • Patients having a principal procedure of **Cholecystectomy** during the index hospitalization and subsequently transferred to another acute care facility. • Episodes with a discharge of death. • Readmissions within 30 days from the index discharge
Reporting Frequency:	Rate per 100 cholecystectomy discharges
Unit of Measure:	Percentage
International comparison if available	Developed locally by modifying similar indicators used by AHRQ, OECD and CQC
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Mortality and morbidity record - Hospital patient data source - OT register for surgeries

Type: Quality Indicator **Indicator Number:** QI029

KPI Description (title):	**30-Day All-Cause Unplanned Hospital Readmission Rate for Medical And Surgical Patients**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Percentage of unplanned readmissions for adult patients (18 years and older) after discharge for any condition, including a different condition than the reason for their original hospital admission. All related and unrelated readmissions should be included (please indicate whether each readmission is related or unrelated in the notes section)

Calculation:	***Numerator*:** Number of adult inpatients who were readmitted to a hospital within 30 days of discharge from index hospitalization. (*If a patient has more than one readmission within 30 days of discharge from the index admission, only the first is considered as readmission).*
	
	Numerator Exclusion:
	Presence of at least one of the following:
	• Readmission was for a planned procedure /treatment protocol
	• Readmission with the following admittance status:
	  ○ Elective
	  ○ Transfer admission from acute care
	• Admission was for obstetric care, including labor and delivery ***(Primary or secondary code series O00-O9A, Pregnancy, childbirth and the puerperium Chapter)***
	• *Psychiatric Patients.* (Refer to Mental Health Jawda Guidance)
	• Admission with a principal diagnosis or treatment of malignancy or status of chemotherapy (Malignant neoplasms ***(C00-C96)***, In situ neoplasms ***(D00-D09), Z51.11*** Encounter for antineoplastic chemotherapy, & ***Z51.12*** Encounter for antineoplastic immunotherapy), **Z51.0 (**Encounter for antineoplastic radiation therapy)
	• Admission for palliative care (ICD-10-CM: Z51.5)
	
	Denominator: Total number of adult inpatients (age 18 and older) discharged from a hospital during the reporting period.
	
	Denominator Exclusion:
	• Episodes with a discharge of death
	• Patients who were discharged/left against medical advice (AMA)
	• Patients who were transferred to another acute care facility during the index hospitalization
	• Records with an unavailable discharge date or time.
	• Readmissions within 30 days from the index discharge
	• Admission was for obstetric care, including labor and delivery ***(Primary or secondary code series O00-O9A, Pregnancy, childbirth and the puerperium Chapter)***
	• *Psychiatric Patients.* (Refer to Mental Health Jawda Guidance)

	• Admission with a principal diagnosis or treatment of malignancy or status of chemotherapy (Malignant neoplasms ***(C00-C96)***, In situ neoplasms ***(D00-D09), Z51.11*** Encounter for antineoplastic chemotherapy, & ***Z51.12*** Encounter for antineoplastic immunotherapy), **Z51.0 (**Encounter for antineoplastic radiation therapy) • Admission for palliative care (***Primary or secondary ICD-10-CM: Z51.5***)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 adult discharges
International comparison if available	Health Quality Ontario 2023 MIPS Measure #479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | MDinteractive
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	- Hospital patient data source

Type: Quality Indicator **Indicator Number:** QI030

KPI Description (title):	**Rate of Unexpected ICU Admissions Within 24 Hours of Surgical Procedure**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of unplanned admissions to an ICU within 24 hours of a surgical procedure. An unplanned ICU admission ***is defined*** as an admission to ICU that was not planned, within twenty-four hours prior to ICU admission.
Calculation:	***Numerator:*** Number of unplanned admissions from the denominator population within 24 hours of a surgical procedure to an intensive care unit (ICU). ***Service codes***: 4, 5, 6, 7, 8, 27, 28, 31, 4-01, 4-02, 4-03, 17-07, 17-07-01, 17-07-02, 17-07-03 **Numerator Exclusions:** • Cases with emergency admissions to ICU (those who had not undergone a surgical procedure within 24 hours prior to the admission) • Cases admitted in ICU before surgery ***Denominator:*** All adult inpatients with surgical procedure done in ***Operating Room by*** the reporting facility during the reporting period. ***Denominator guidance:*** For multiple procedures done in the same operative session, count only once. For more than one surgical procedure in the same or separate inpatient encounters which are more than 24 hrs apart will be counted as separate procedures. **Denominator Exclusion:** Emergency/unplanned surgery within 24 hours of admission.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 surgical patients
International comparison if available	• Vlayen A, Verelst S, Bekkering GE, Schrooten W, Hellings J, Claes N. Incidence and preventability of adverse events requiring intensive care admission: A systematic review. J Eval Clin Pract 2012;18:485-97 • Piercy M, Lau S, Loh E, Reid D, SantLAMAria J, Mackay P. Unplanned admission to the Intensive Care Unit in postoperative patients – An indicator of quality of anaesthetic care? Anaesth Intensive Care 2006;34:592-8 • Haller G, Myles PS, Wolfe R, Weeks AM, Stoelwinder J, McNeil J. Validity of unplanned admission to an Intensive Care Unit as a measure of patient safety in surgical patients. Anesthesiology 2005;103:1121-9 • Assessment of an unplanned admission to the intensive care unit as a global safety indicator in surgical patients. Anaesth Intensive Care. 2008 Mar;36(2):190-200. https://www.ncbi.nlm.nih.gov/pubmed/18361010 • http://www.biomedsearch.com/article/Unplanned-admission-to-Intensive-Care/188739789.html
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Hospital incident reports • Hospital ICU admission log

Type: Quality Indicator **Indicator Number**: QI031

KPI Description (title):	**Rate of healthcare associated infection (HAI) Clostridium Difficile Infection (CDI) in all adult inpatients**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Rate of healthcare associated Clostridium Difficile Infection (CDI) that meet CDI definitions during the reporting period.
Criteria to define HAI) Clostridium Difficile Infection (CDI)	***Numerator:*** Total number of adult 18 years and older who meets ***NSHN CDI*** definitions for healthcare-associated C. difficile infections (CDI) during the reporting period. **ICD 10 CODES (not limited to):** A04.71, A04.72 ***CDI Definitions:*** *both of the following criteria must be present:* ***1. At least one of the following:*** a) Three or more liquid or watery stools above what is normal for the patient within a 24-hour period b) Presence of toxic mega colon (abnormal dilation of the large bowel, documented radiologically) ***AND*** ***2. At least one of the following diagnostic criteria:*** a) a stool sample yields a positive laboratory test result for C. difficile toxin A or B, or a toxin-producing C. difficile organism is identified from a stool sample b) pseudomembranous colitis is identified during endoscopic examination or surgery or in histopathology examination of a biopsy specimen ***Numerator Inclusions:*** • All adult patients (=> 18 years old) • Patient admitted in hospital (Inpatients) • All Inpatient wards (Excluding Inpatient Rehabilitation Facilities and Inpatient Psychiatric Facilities) • Report all healthcare-associated infections where C. difficile, identified by a positive toxin result including toxin producing gene [PCR]), is the associated pathogen • Report each new CDI according to the Repeat Infection Timeframe (RIT) rule for HAIs ***Numerator Exclusions*:** • Present on Admission (POA) • Positive Lab Tests results for collected specimens in an outpatient location • Positive Lab Tests results for collected specimens in an Inpatient Rehabilitation Facility and Inpatient Psychiatric Facility • Repeated infection for the same type during 14 days from Date of Event

	Denominator: Total number of adult (age 18 and older) inpatient days during the reporting period. (See glossary) **Denominator Exclusion**: • *Psychiatric Inpatients (*Refer to Mental Health Jawda Guidance) • *Post-acute rehabilitation (PAR) inpatients.*
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1000 inpatient days
International comparison if available	Indicators are based on US CDC NHSN MDRO/CDI Module: http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf Quality indicators, AHRQ, healthcare associated infections definitions are based on CDC/NHSN Surveillance Definitions for Specific Types of Infections https://www.cdc.gov/nhsn/pdfs/pscmanual/17pscnosinfdef_current.pdf
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Lab test results of all specimen • Captured by infection control team/ nursing as part of regular surveillance activities and infection control documentation. • Patient medical record.

Type: Quality Indicator **Indicator Number**: QI032

KPI Description (title):	**VAE (Ventilator associated event)**
Domain	**Safety**
Indicator Type	**Outcome**
Definition	VAEs are identified by using a combination of objective criteria: • Deterioration in respiratory status after a period of stability or improvement on the ventilator, • Evidence of infection or inflammation, and • Laboratory evidence of respiratory infection. The VAE rate per 1000 ventilator days is calculated by dividing the number of VAEs by the number of ventilator days and multiplying the result by 1000 (ventilator days). *NOTE: patient must be mechanically ventilated for at least 4 calendar days to fulfill VAE criteria (where the day of intubation and initiation of mechanical ventilation is day 1). The earliest date of event for VAE (the date of onset of worsening oxygenation) is day 3 of mechanical ventilation.*
Population	All adult patients 18 years and above who are being cared for in the hospital are using a ventilator device.
Criteria to define VAE (Ventilator associated event)	***Numerator:*** *Check one:* ***Specific Event:** □ VAC *Ventilator-Associated Condition ,* □ IVAC *Infection related Ventilator-Associated Complication* □ PVAP *Possible Ventilator Associated Pneumonia* ***Specify Criteria Used:** **STEP 1: VAC (≥1 REQUIRED)** At least one: □ Daily min FiO2 increase ≥ 0.20 (20 points) for ≥ 2 days† OR

	□ Daily min PEEP increase ≥ 3 cm H2O for ≥ 2 days† †after 2+ days of stable or decreasing daily minimum values. **STEP 2: IVAC** Both criteria: □ Temperature > 38°C or < 36° OR □ White blood cell count ≥ 12, 000 or ≤ 4, 000 cells/mm3 AND □ A new antimicrobial agent(s) is started, and is continued for ≥ 4 days **STEP 3: PVAP** One of the following criteria is met: □ ***Criterion #1:*** Positive culture of one of the following specimens, meeting quantitative or semi-quantitative thresholds, ‡ without requirement for purulent respiratory secretions: □ Endotracheal aspirate □ Lung tissue □ Broncho alveolar lavage □ Protected specimen brush ***OR*** □ ***Criterion #2:*** Purulent respiratory secretions‡ (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100]) plus organism(s) identified from one of the following specimens (to include qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):‡ □ Sputum □ Endotracheal aspirate □ Lung tissue □ Broncho alveolar lavage □ Protected specimen brush OR □ ***Criterion #3***: One of the following positive tests (as outlined in the protocol): ‡ □ Organism(s) identified from pleural fluid □ Diagnostic test for Legionella species □ Lung histopathology □ Diagnostic test for selected viral pathogens ‡collected after 2 days of mechanical ventilation and within +/- 2 days of onset of increase in FiO2 or PEEP. **ICD 10 CODES FOR VAP**: J95.850, J95.851, J95.859 ***Numerator Exclusion:*** If the date of the VAE (i.e., day 1 of the ≥ 2-day period of worsening oxygenation) occurs on the day of transfer/discharge or the next day, indicate the transferring /discharging facility, not the current facility of the patients in the comments box. This patient will be excluded from the numerator count of the hospital facility. For further information please see surveillance algorithm on page 18 of the VAE module: https://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf patients on high frequency ventilation or extracorporeal life support , Non-acute care locations in acute care facilities are not eligible to participate in VAE surveillance Do not report as VAE, if the date of event (date of onset of worsening oxygenation) is on or after the date of documentation that the patient is being supported for organ donation purposes.

	• Repeated infection for the same type during 14 days from Date of Event ***Denominator:*** Ventilator days: Number of patients managed with ventilator devices, are collected daily, at the same time each day. These daily counts are summed and only the total for the month is used. **Denominator Inclusion:** • All ventilator days are counted, including ventilator days for residents on mechanical ventilation for < 3 days. • Patients undergoing weaning from mechanical ventilation are included in ventilator day counts as long as the patient is receiving support from a mechanical ventilator and is eligible for VAE surveillance **Denominator Exclusion:** • *Burn cases* (Refer to Burn Jawda Guidance) • All Long-term care (see glossary) and Post-acute Rehab patients (Refer to Long term care and PAR Jawda Guidance)
Reporting Frequency	Quarterly
Unit Measure	Rate per 1000 ventilator days
International comparison if available	https://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf https://www.cdc.gov/nhsn/inpatient-rehab/vae/index.html https://www.cdc.gov/nhsn/forms/57.112_VAE_BLANK.pdf
Desired Direction	Lower is better
Data Source	• Captured by infection control team • Patient's records • Lab reports • Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number:** QI034

KPI Description (title):	**Adult Postoperative Sepsis Rate**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	Postoperative sepsis cases (secondary diagnosis) per 1,000 surgery discharges for patients more than 18 years of age at the time of discharge(inpatients)
Calculation:	***Numerator:*** All adult patients who had surgical discharges in the reporting quarter and developed Sepsis within 30 days from the date of the surgical procedure. (In case of multiple procedures, count from the first procedure***)*** **ICD-10 CM:** T81.44XA, T81.44XD, T81.44XS, A02.1, A22.7, A26.7, A32.7, A40.0, A40.1, A40.3, A40.8, A40.9, A41.01, A41.02, A41.1, A41.2, A41.3, A41.4, A41.50, A41.51, A41.52, A41.53, A41.59, A41.81, A41.89, A41.9, A42.7, A54.86, B37.7 ***Denominator:*** Total number of adult inpatient (more than 18 years) surgical discharges during the reporting period (for operating room procedures). ***Service codes***: 20, 20-01, 20-02, 20-03 ***Denominator Inclusion****:* • *Admission for pregnancy, childbirth, and puerperium* **Denominator Exclusions**: • Patients with a principal ICD-10-CM Diagnosis Code or secondary diagnosis present on admission for **Sepsis** • *L*ong term care patients. (see glossary)
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1,000 surgical discharges
International comparison if available	PSI_13_Postoperative_Sepsis_Rate.pdf (ahrq.gov)
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Captured by infection control team • Patient's records • Lab reports • Hospital internal mortality and morbidity

Type: Quality Indicator **Indicator Number:** QI035

KPI Description (title):	**All-cause mortality rate**
Domain	**Effectiveness**
Indicator Type	**Outcome**
Definition:	Rate of all-cause mortality for patients ages 18 years and older.
Calculation:	***Numerator:*** Number of patients (18 years of age and older) in denominator who died during the hospital stay or within 30 days of the discharge date of the denominator cases. ***Denominator:*** *Number* of all adult inpatient discharges (18 years and older) during the reporting period. ***Denominator Inclusions****:* • All admissions (including, LTC, PAR, intensive care units) • Admissions resulting in a transfer to another acute care facility. • A transfer from another healthcare facility. **Denominator Exclusion:** • Left against medical advice • Never demonstrated spontaneous circulation following arrival in the hospital.
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 1,000 discharges
International comparison if available	https://academic.oup.com/ijcoms/article/3/2/lyad010/7231468 Summary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, July 2022 – June 2023: Background quality report (digital.nhs.uk)
Desired direction:	Lower is better
Notes for all providers	
Data sources and guidance:	• Hospital internal adverse event system and complication log • Based on list of discharged patients with specific ICD 10 Diagnosis • Patient medical record.

Type: Quality Indicator **Indicator Number:** QI036

KPI Description (title):	**Rate of sentinel events (unexpected occurrence involving death or serious physical or psychological injury) within the facility premises**
Domain	**Safety**
Indicator Type	**Outcome**
Definition:	The rate of sentinel events. Sentinel events are unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof, which signal the need for immediate investigation and response.
Calculation:	***Numerator***: Count of all sentinel events that occur within the facility during the reporting period. ***Numerator Inclusion****:* Inpatient, Daycase, Emergency Department /Urgent care, Outpatient **Sentinel Events** are indicated in ***Table 2: List of Reportable events that are considered a sentinel event*** of **DOH Incident Reporting and Management Standard** ***Denominator***: Count of all Reported medical or nonmedical Safety Incidentss (level 1-4) within the facility during the reporting period. **Safety Incidents:** An event, incident, or condition that could have resulted or did result in harm to a patient. A patient safety incident can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. **Safety Incidents** (Level 1-4) are indicated in ***Table 1: Reported Safety Incidents*** of **DOH Incident Reporting and Management Standard**
Reporting Frequency:	Quarterly
Unit of Measure:	Rate per 100 incident report
International comparison if available	**The Joint Commission** **DOH Incident Reporting and Management Standard**
Desired direction:	Less than 0.1 of the total incidents reported
Notes for all providers	
Data sources and guidance:	- Hospital internal adverse event and incident reporting system - See provided guidance on reporting and categorization

Appendix –A Malignancy ICD 10 CODES

C00.0	C25.3	C44.222	C51.0	C71.4	C81.21	C82.68	C84.45	C90.30
C00.1	C25.4	C44.229	C51.1	C71.5	C81.22	C82.69	C84.46	C90.31
C00.2	C25.7	C44.291	C51.2	C71.6	C81.23	C82.80	C84.47	C90.32
C00.3	C25.8	C44.292	C51.8	C71.7	C81.24	C82.81	C84.48	C91.00
C00.4	C25.9	C44.299	C51.9	C71.8	C81.25	C82.82	C84.49	C91.01
C00.5	C26.0	C44.300	C52	C71.9	C81.26	C82.83	C84.60	C91.02
C00.6	C26.1	C44.301	C53.0	C72.0	C81.27	C82.84	C84.61	C91.10
C00.8	C26.9	C44.309	C53.1	C72.1	C81.28	C82.85	C84.62	C91.11
C00.9	C30.0	C44.310	C53.8	C72.20	C81.29	C82.86	C84.63	C91.12
C01	C30.1	C44.311	C53.9	C72.21	C81.30	C82.87	C84.64	C91.30
C02.0	C31.0	C44.319	C54.0	C72.22	C81.31	C82.88	C84.65	C91.31
C02.1	C31.1	C44.320	C54.1	C72.30	C81.32	C82.89	C84.66	C91.32
C02.2	C31.2	C44.321	C54.2	C72.31	C81.33	C82.90	C84.67	C91.40
C02.3	C31.3	C44.329	C54.3	C72.32	C81.34	C82.91	C84.68	C91.41
C02.4	C31.8	C44.390	C54.8	C72.40	C81.35	C82.92	C84.69	C91.42
C02.8	C31.9	C44.391	C54.9	C72.41	C81.36	C82.93	C84.70	C91.50
C02.9	C32.0	C44.399	C55	C72.42	C81.37	C82.94	C84.71	C91.51
C03.0	C32.1	C44.40	C56.1	C72.50	C81.38	C82.95	C84.72	C91.52
C03.1	C32.2	C44.41	C56.2	C72.59	C81.39	C82.96	C84.73	C91.60
C03.9	C32.3	C44.42	C56.9	C72.9	C81.40	C82.97	C84.74	C91.61
C04.0	C32.8	C44.49	C57.00	C73	C81.41	C82.98	C84.75	C91.62
C04.1	C32.9	C44.500	C57.01	C74.00	C81.42	C82.99	C84.76	C91.90
C04.8	C33	C44.501	C57.02	C74.01	C81.43	C83.00	C84.77	C91.91
C04.9	C34.00	C44.509	C57.10	C74.02	C81.44	C83.01	C84.78	C91.92
C05.0	C34.01	C44.510	C57.11	C74.10	C81.45	C83.02	C84.79	C91.A0
C05.1	C34.02	C44.511	C57.12	C74.11	C81.46	C83.03	C84.90	C91.A1
C05.2	C34.10	C44.519	C57.20	C74.12	C81.47	C83.04	C84.91	C91.A2
C05.8	C34.11	C44.520	C57.21	C74.90	C81.48	C83.05	C84.92	C91.Z0
C05.9	C34.12	C44.521	C57.22	C74.91	C81.49	C83.06	C84.93	C91.Z1
C06.0	C34.2	C44.529	C57.3	C74.92	C81.70	C83.07	C84.94	C91.Z2
C06.1	C34.30	C44.590	C57.4	C75.0	C81.71	C83.08	C84.95	C92.00
C06.2	C34.31	C44.591	C57.7	C75.1	C81.72	C83.09	C84.96	C92.01
C06.80	C34.32	C44.599	C57.8	C75.2	C81.73	C83.10	C84.97	C92.02
C06.89	C34.80	C44.601	C57.9	C75.3	C81.74	C83.11	C84.98	C92.10
C06.9	C34.81	C44.602	C58	C75.4	C81.75	C83.12	C84.99	C92.11
C07	C34.82	C44.609	C60.0	C75.5	C81.76	C83.13	C84.A0	C92.12
C08.0	C34.90	C44.611	C60.1	C75.8	C81.77	C83.14	C84.A1	C92.20
C08.1	C34.91	C44.612	C60.2	C75.9	C81.78	C83.15	C84.A2	C92.21
C08.9	C34.92	C44.619	C60.8	C76.0	C81.79	C83.16	C84.A3	C92.22
C09.0	C37	C44.621	C60.9	C76.1	C81.90	C83.17	C84.A4	C92.30
C09.1	C38.0	C44.622	C61	C76.2	C81.91	C83.18	C84.A5	C92.31
C09.8	C38.1	C44.629	C62.00	C76.3	C81.92	C83.19	C84.A6	C92.32
C09.9	C38.2	C44.691	C62.01	C76.40	C81.93	C83.30	C84.A7	C92.40
C10.0	C38.3	C44.692	C62.02	C76.41	C81.94	C83.31	C84.A8	C92.41
C10.1	C38.4	C44.699	C62.10	C76.42	C81.95	C83.32	C84.A9	C92.42

C10.2	C38.8	C44.701	C62.11	C76.50	C81.96	C83.33	C84.Z0	C92.50
C10.3	C39.0	C44.702	C62.12	C76.51	C81.97	C83.34	C84.Z1	C92.51
C10.4	C39.9	C44.709	C62.90	C76.52	C81.98	C83.35	C84.Z2	C92.52
C10.8	C40.00	C44.711	C62.91	C76.8	C81.99	C83.36	C84.Z3	C92.60
C10.9	C40.01	C44.712	C62.92	C77.0	C82.00	C83.37	C84.Z4	C92.61
C11.0	C40.02	C44.719	C63.00	C77.1	C82.01	C83.38	C84.Z5	C92.62
C11.1	C40.10	C44.721	C63.01	C77.2	C82.02	C83.39	C84.Z6	C92.90
C11.2	C40.11	C44.722	C63.02	C77.3	C82.03	C83.50	C84.Z7	C92.91
C11.3	C40.12	C44.729	C63.10	C77.4	C82.04	C83.51	C84.Z8	C92.92
C11.8	C40.20	C44.791	C63.11	C77.5	C82.05	C83.52	C84.Z9	C92.A0
C11.9	C40.21	C44.792	C63.12	C77.8	C82.06	C83.53	C85.10	C92.A1
C12	C40.22	C44.799	C63.2	C77.9	C82.07	C83.54	C85.11	C92.A2
C13.0	C40.30	C44.80	C63.7	C78.00	C82.08	C83.55	C85.12	C92.Z0
C13.1	C40.31	C44.81	C63.8	C78.01	C82.09	C83.56	C85.13	C92.Z1
C13.2	C40.32	C44.82	C63.9	C78.02	C82.10	C83.57	C85.14	C92.Z2
C13.8	C40.80	C44.89	C64.1	C78.1	C82.11	C83.58	C85.15	C93.00
C13.9	C40.81	C44.90	C64.2	C78.2	C82.12	C83.59	C85.16	C93.01
C14.0	C40.82	C44.91	C64.9	C78.30	C82.13	C83.70	C85.17	C93.02
C14.2	C40.90	C44.92	C65.1	C78.39	C82.14	C83.71	C85.18	C93.10
C14.8	C40.91	C44.99	C65.2	C78.4	C82.15	C83.72	C85.19	C93.11
C15.3	C40.92	C45.0	C65.9	C78.5	C82.16	C83.73	C85.20	C93.12
C15.4	C41.0	C45.1	C66.1	C78.6	C82.17	C83.74	C85.21	C93.30
C15.5	C41.1	C45.2	C66.2	C78.7	C82.18	C83.75	C85.22	C93.31
C15.8	C41.2	C45.7	C66.9	C78.80	C82.19	C83.76	C85.23	C93.32
C15.9	C41.3	C45.9	C67.0	C78.89	C82.20	C83.77	C85.24	C93.90
C16.0	C41.4	C46.0	C67.1	C79.00	C82.21	C83.78	C85.25	C93.91
C16.1	C41.9	C46.1	C67.2	C79.01	C82.22	C83.79	C85.26	C93.92
C16.2	C43.0	C46.2	C67.3	C79.02	C82.23	C83.80	C85.27	C93.Z0
C16.3	C43.10	C46.3	C67.4	C79.10	C82.24	C83.81	C85.28	C93.Z1
C16.4	C43.11	C46.4	C67.5	C79.11	C82.25	C83.82	C85.29	C93.Z2
C16.5	C43.12	C46.50	C67.6	C79.19	C82.26	C83.83	C85.80	C94.00
C16.6	C43.20	C46.51	C67.7	C79.2	C82.27	C83.84	C85.81	C94.01
C16.8	C43.21	C46.52	C67.8	C79.31	C82.28	C83.85	C85.82	C94.02
C16.9	C43.22	C46.7	C67.9	C79.32	C82.29	C83.86	C85.83	C94.20
C17.0	C43.30	C46.9	C68.0	C79.40	C82.30	C83.87	C85.84	C94.21
C17.1	C43.31	C47.0	C68.1	C79.49	C82.31	C83.88	C85.85	C94.22
C17.2	C43.39	C47.10	C68.8	C79.51	C82.32	C83.89	C85.86	C94.30
C17.3	C43.4	C47.11	C68.9	C79.52	C82.33	C83.90	C85.87	C94.31
C17.8	C43.51	C47.12	C69.00	C79.60	C82.34	C83.91	C85.88	C94.32
C17.9	C43.52	C47.20	C69.01	C79.61	C82.35	C83.92	C85.89	C94.40
C18.0	C43.59	C47.21	C69.02	C79.62	C82.36	C83.93	C85.90	C94.41
C18.1	C43.60	C47.22	C69.10	C79.70	C82.37	C83.94	C85.91	C94.42
C18.2	C43.61	C47.3	C69.11	C79.71	C82.38	C83.95	C85.92	C94.6
C18.3	C43.62	C47.4	C69.12	C79.72	C82.39	C83.96	C85.93	C94.80
C18.4	C43.70	C47.5	C69.20	C79.81	C82.40	C83.97	C85.94	C94.81
C18.5	C43.71	C47.6	C69.21	C79.82	C82.41	C83.98	C85.95	C94.82

C18.6	C43.72	C47.8	C69.22	C79.89	C82.42	C83.99	C85.96	C95.00
C18.7	C43.8	C47.9	C69.30	C79.9	C82.43	C84.00	C85.97	C95.01
C18.8	C43.9	C48.0	C69.31	C80.0	C82.44	C84.01	C85.98	C95.02
C18.9	C44.00	C48.1	C69.32	C80.1	C82.45	C84.02	C85.99	C95.10
C19	C44.01	C48.2	C69.40	C80.2	C82.46	C84.03	C86.0	C95.11
C20	C44.02	C48.8	C69.41	C81.00	C82.47	C84.04	C86.1	C95.12
C21.0	C44.09	C49.0	C69.42	C81.01	C82.48	C84.05	C86.2	C95.90
C21.1	C44.101	C49.10	C69.50	C81.02	C82.49	C84.06	C86.3	C95.91
C21.2	C44.102	C49.11	C69.51	C81.03	C82.50	C84.07	C86.4	C95.92
C21.8	C44.109	C49.12	C69.52	C81.04	C82.51	C84.08	C86.5	C96.0
C22.0	C44.111	C49.20	C69.60	C81.05	C82.52	C84.09	C86.6	C96.20
C22.1	C44.112	C49.21	C69.61	C81.06	C82.53	C84.10	C88.0	C96.21
C22.2	C44.119	C49.22	C69.62	C81.07	C82.54	C84.11	C88.2	C96.22
C22.3	C44.121	C49.3	C69.80	C81.08	C82.55	C84.12	C88.3	C96.29
C22.4	C44.122	C49.4	C69.81	C81.09	C82.56	C84.13	C88.4	C96.4
C22.7	C44.129	C49.5	C69.82	C81.10	C82.57	C84.14	C88.8	C96.5
C22.8	C44.191	C49.6	C69.90	C81.11	C82.58	C84.15	C88.9	C96.6
C22.9	C44.192	C49.8	C69.91	C81.12	C82.59	C84.16	C90.00	C96.9
C23	C44.199	C49.9	C69.92	C81.13	C82.60	C84.17	C90.01	C96.A
C24.0	C44.201	C49.A0	C70.0	C81.14	C82.61	C84.18	C90.02	C96.Z
C24.1	C44.202	C49.A1	C70.1	C81.15	C82.62	C84.19	C90.10	
C24.8	C44.209	C49.A2	C70.9	C81.16	C82.63	C84.40	C90.11	
C24.9	C44.211	C49.A3	C71.0	C81.17	C82.64	C84.41	C90.12	
C25.0	C44.212	C49.A4	C71.1	C81.18	C82.65	C84.42	C90.20	
C25.1	C44.219	C49.A5	C71.2	C81.19	C82.66	C84.43	C90.21	
C25.2	C44.221	C49.A9	C71.3	C81.20	C82.67	C84.44	C90.22	

Appendix –B Specific Sites of an Organ/Space SSI

Code	Site	Code	Site
BONE	Osteomyelitis	MED	Mediastinitis
BRST	Breast abscess or mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity (mouth, tongue, or gums)
DISC	Disc space	OREP	Other infections of the male or female reproductive tract
EAR	Ear, mastoid	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess without meningitis
ENDO	Endocarditis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
IAB	Intraabdominal, not specified	USI	Urinary System Infection
IC	Intracranial, brain abscess or dura	VASC	Arterial or venous infection
JNT	Joint or Bursa	VCUF	Vaginal cuff
LUNG	Other infections of the lower respiratory tract		

Summary of Changes 2025

KPI #	**Changes**
Glossarys	**Added Glossary in page 9**
QI001, QI003	Retired. Replaced with QI036
QI002	• Added codes for numerator as well as denominator
QI004	• Added codes for numerator as well as denominator • Added: Denominator Inclusion: Inpatient • Denominator Exclusion: Revised

QI005	• Revised Denominator definition: Total number of adult (18 years and older) surgical discharges during the reporting period (for operating room procedures).
	• Added Service codes: 20, 20-01, 20-02, 20-03
	• Added Denominator Inclusion: Inpatient
	• Added in Numerator the "proximal" vessel for DVT. As per the updated AHRQ guidelines
	• Added in Denominator Exclusion:
	  • where a procedure for pulmonary arterial or dialysis access thrombectomy occurs before or on the same day as the first operating room procedure
	  • where the only operating room procedure(s) is for pulmonary arterial or dialysis access thrombectomy
	  • with any ICD-10-CM diagnosis code present on admission for acute brain or spinal injury
	  • with any listed procedure code for extracorporeal membrane oxygenation (ECMO)
	  • All Long-term care patients. (see glossary)
	  • Patients who received treatment as an inpatient for burns injury (any degree). (Refer to Burn Jawda Guidance)
	  • Admission for pregnancy, childbirth, and puerperium (ICD-10 codes: O00.00 - O9A.53)

QI006	• Revised Denominator definition: "inpatient days" (See glossary)
	  • Denominator Exclusion: Healthy newborn (See glossary)
	  • Daycase
	  • Burn cases (Refer to Burn Jawda Guidance)
	  • Psychiatric Patients. (Refer to Mental Health Jawda Guidance)

QI007-QI010, QI014, QI015, QI028, QI029	• Denominator Inclusion: Inpatient (See glossary) • Updated few codes along with old codes

QI011-QI012	• Revised Denominator: Total number of inpatient days during the reporting period.
	• Added denominator exclusion:
	  • **Healthy newborn (See glossary)**
	  • **Daycase**
	  • **All Long-term care and Post-acute Rehab patients**
	  • *Psychiatric Patients.* (Refer to Mental Health Jawda Guidance)s

QI012	• Added denominator exclusion: *Psychiatric Patients.* (Refer to Mental Health Jawda Guidance)s • Revised or rephrased the Numerator definition and title
QI013	• Updated the Press Injury Stage guidance • Updated 2021 codes for pressure injuries • Revised Denominator definition: "adult (age 18 and older) inpatient days" • Revised or rephrase the Numerator definition.

	• Removed numerator exclusion: Daycare
	• Revised Denominator Exclusions:
	  • Daycase (See glossary)
	  • Burn cases (Refer to Burn Jawda Guidance)
	  • Psychiatric Patients. (Refer to Mental Health Jawda Guidance)
	  • All Long-term care and Post-acute Rehab patients

QI014	• Revised or rephrase the numerator and definitioin. • Rephrase the denominator “inpatient”
QI015	• Removed “Planned Readmissions” in denominator exclusion • Added codes in denominator exclusions: Appendectomy for cancer cases, Pheochromocytome, Operation where appendectomy is part of a larger procedure • Rephrase the numerator and definition • Rephrase the denominator “inpatient”

QI016	• Revised bacterial count: ≥10^5 CFU/ml
	• Added in Numerator: *ICD-10 CM codes (not limited to): T83.511A, T83.511D, T83.511S, T83.518A, T83.518D, T83.518S*
	• Duplicated under Numerator: *Transfer Rule: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location)*
	• Revised Denominator Exclusions:
	  • Daycase (see glossary)
	  • Burn cases (Refer to Burn Jawda Guidance)
	  • Psychiatric Patients. (Refer to Mental Health Jawda Guidance)
	  • All Long-term care and Post-acute Rehab patients (see glossary)

QI017	• Duplicated under Numerator: Transfer Rule: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location)
	• Added Denominator inclusion:
	  • Temporary central line: A non-tunneled, non- implanted catheter.
	  • Permanent central line: Includes
	  • Tunneled catheters, including certain dialysis catheters
	  • Implanted catheters (including ports)
	• Revised Denominator Exclusions:
	  • Daycase (see glossary)
	  • Burn cases (Refer to Burn Jawda Guidance)
	  • Psychiatric Patients. (Refer to Mental Health Jawda Guidance)
	  • All Long-term care and Post-acute Rehab patients (see glossary)

QI018	• Added in Numerator: *ICD-10 CM codes (not limited to): T81.40XA, T81.40XD, T81.40XS, T81.41XA, T81.41XD, T81.41XS, T81.42XA, T81.42XD, T81.42XS, T81.43XA, T81.43XD, T81.43XS, T81.44XA, T81.44XD, T81.44XS, T81.49XA, T81.49XD, T81.49XS* • Added: *Denominator Inclusion: Inpatient*
QI027, QI028	• Added CPT code**:** (47562, 47563, 47564, 47570, 47579, 47600, 47605, 47610, 47612, 47620) • *Added: Denominator Inclusion: Inpatient* • *Added: Denominator Exclusion: Daycase* • Added in Numerator: *ICD-10 CM codes (not limited to): T81.4XXA, T81.4XXD, T81.4XXS* • *Revised the Numerator and Definition.*
QI029	• Revised Numerator Exclusion: • Principal diagnosis of malignancy (Refer Appendix-A) or treatment of oncology (ICD-10-CM: Z51.0, Z51.11, Z51.12)

	• Psychiatric Patients. (Refer to Mental Health Jawda Guidance) • A Denominator Exclusion Guidance have been revised as "Admission for patients who were transferred to another acute care facility during the index hospitalization" instead of "Readmission" • A Denominator Exclusion Guidance have been revised as "Admission for rehabilitation (CPT codes: 97001 - 97755)" instead of "Principal diagnosis of rehabilitation" • Added and update codes wherever applicable
QI030	• Revised KPI definition words from "An unplanned ICU admission *is defined* as an admission to ICU that was not planned more than twenty-four hours in advance of admission to the ICU." to "An unplanned ICU admission *is defined* as an admission to ICU that was not planned, within twenty-four hours prior to ICU admission." • Added service codes for ICU in numerator. Service codes: 4, 27, 4-01, 4-02, 4-03 • Added numerator exclusions: Cases with emergency admissions to ICU (those who had not undergone a surgical procedure within 24 hours prior to the admission) • Revised denominator: ***Denominator:*** All inpatients with surgical procedure done in Operating Room by the reporting facility during the reporting period. • Denominator guidance: For multiple procedures done in the same operative session, count only once. For more than one surgical procedure in the same or separate inpatient encounters which are more than 24 hrs apart will be counted as separate procedures. • Unit of measure: "patients" • Added Denominator exclusions: Emergency/unplanned surgery within 24 hours of admission.
QI031	• Revised Denominator: Total number of adult (age 18 and older) inpatient days during the reporting period. (See glossary) • Denominator Exclusion: • Daycase (See glossary) • Psychiatric Patients (Refer to Mental Health Jawda Guidance)
QI032	• Added codes for numerator • Added in Denominator Exclusions: • Burn cases (Refer to Burn Jawda Guidance) • All Long-term care (see glossary) and Post-acute Rehab patients (Refer to Longtermcare and PAR Jawda Guidance)
QI033	• Removed from QI KPIs and moved to Pediatric KPIs
QI034-QI036	• Added 3 KPIs • QI034-Revised the title, definition, numerator and denominators. • QI036-Aligned with patient safety indicators.
Appendix	• Revised Appendix A to Malignancy Codes • Revised the Domain and indicator types based on IOM domain site