**Nursing Report Card Metrics - NDNQI Definitions – March 2012**

***Fall/per 1,000 Patient Days:***

A patient fall is an unplanned descent to the floor with or without injury to the patient, and occurs on an NDNQI eligible reporting nursing unit. \* Include falls when a patient lands on a surface where you wouldn’t expect to find a patient. All unassisted and assisted (see definition below) 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.

Exclude falls by:

* Visitors
* Students
* Staff members
* Falls on other units not eligible for reporting
* Patients from eligible reporting units, however patient was not on unit at time of the fall (e.g., patient falls in radiology department)

\*The nursing unit area includes the hallway, patient room and patient bathroom. A therapy room (e.g., physical therapy gym), even though physically located on the nursing unit is not considered part of the unit.

***Fall with Injury/per 1,000 Patient Days:***

When the initial fall report is written by the nursing staff, the extent of injury may not yet be known. Hospitals have 24 hours to determine the injury level, e.g., when you are awaiting diagnostic test results or consultation reports.

Level of Injury:

* **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, pain, 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 a fall
* **Death**—the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

***Catheter-Associated Urinary Tract Infection Rate:***

*Indwelling Urinary Catheter*

A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a closed collection system; also called a Foley catheter. Does not include straight in-and-out catheters.

*Healthcare-associated Infection (HAI)*

A healthcare-associated infection (HAI) is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxins(s). There must be no evidence that the infection was present or incubating at the time of admission to the care setting.

*CAUTI* For the purposes of this indicator, a CAUTI is defined as a urinary tract infection that:

* Meets the Centers for Disease Control (CDC) definition of one of the following types of urinary tract infections (See CAUTI Appendix for criteria):
	+ Asymptomatic Bacteremic UTI (ABUTI)
	+ Symptomatic UTI (SUTI)
* The associated patient had an indwelling urinary catheter at the time of or within 48 hours before the onset of the UTI.

Example – Patient has a Foley catheter in place on an inpatient unit. It is discontinued, and 4 days later the patient meets the criteria for UTI. This is not reported as a CAUTI because the time since the Foley was indwelling exceeded 48 hours.

Note – There is no minimum period of time that the catheter must be in place in order for the UTI to be considered catheter-associated.

*Urinary Catheter Days (device days)*

The number of patients on a unit each day with an indwelling catheter device, summed across all days of the month. Catheter day data should be collected at the same time each day. They should not be collected as a “running total” over the 24- hour period, but as a count of the patients with urinary catheters present on the unit at a **given time**. When catheter days are available from electronic databases, these sources may only be used as long as the counts are not substantially different (+/- 5%) from manual counts. To assist, the Device Day collection tool may be downloaded from the NDNQI® website. Device day counts are inaccurate if the number device days exceed the number of patient days submitted for the unit each month.

**Data Collection Procedure**

The numerator and denominator should be collected concurrently. A trained infection control professional should determine daily those patients who meet the criteria for CAUTI (see CAUTI Appendix). In addition, patients with indwelling urinary catheters are followed for evidence of CAUTI for 48 hours after removal of the urinary catheter or for 48 hours after discharge from a unit. Record CAUTI events daily and sum across all the days in a month. Each CAUTI should be counted in the month of discovery. This date will be when the first clinical evidence appeared or the date the specimen used to meet the criterion was collected, whichever came first.

EXCEPTION: If a CAUTI develops within 48 hours of transfer from one inpatient location to another in the same facility, the infection is attributed to the transferring location. This is called the **Transfer Rule** and the date of discovery changed to the day of discharge from the transferring unit.

The number of patients with an indwelling urinary catheter is collected daily at the same time each day. The daily numbers are summed across all the days in a month.

***Central Line-Associated Bloodstream Infection (CLABSI) Rate:***

**Definitions**

*Central Line*

An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered ***great vessels*** for the purposes of reporting central-line BSI and counting central-line days:

* Aorta
* Pulmonary artery
* Superior/inferior vena cava
* Brachiocephalic veins
* Internal jugular veins
* Subclavian veins
* External iliac veins
* Common iliac veins
* Femoral veins
* Umbilical artery/vein (in neonates)

NOTES –

1. Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart to qualify as a central line.
2. An introducer is considered an intravascular catheter, and depending on the location of its tip, may be a central line.
3. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are ***not*** considered central lines, because fluids are not infused, pushed, nor withdrawn through such devices.
4. The following devices are ***not*** considered central lines: extracorporeal membrane oxygenation (ECMO), femoral arterial catheters and intraaortic balloon pump (IABP) devices.

*UmbilicalCatheter*

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 or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.

*Temporary &PermanentCentral Lines*

A temporary central line is a non-tunneled catheter.

A permanent central line includes tunneled catheters, certain dialysis catheters and implanted catheters (ports).

*Healthcare-associated Infection (HAI)*

A healthcare-associated infection (HAI) is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxins(s). There must be no evidence that the infection was present or incubating at the time of admission to the care setting.

*CLABSI*

For the purposes of this indicator, a CLABSI is defined as a primary blood stream infection that:

 Meets the Centers for Disease Control (CDC) definition of laboratory-confirmed bloodstream infection (LCBI) (See CLABSI Appendix for criteria) and is not secondary to an infection at another body site

 Is associated with a central line, i.e., patient had central line or umbilical catheter in place at the time of, or within 48 hours before, onset of the event.

 Patients are followed for 48 hours after the removal of the central line/umbilical catheter or discharge from the unit for the development of a CLABSI.

Note – There is no minimum period of time that the central line must be in place in

order for the BSI to be considered central line-associated.

*Central Line Days (device days)*

The number of patients on a unit each day with a central line or umbilical catheter, summed across all days of the month. Central line day data should be collected at the same time each day. They should not be collected as a “running total” over the 24- hour period, but as a count of the patients with central lines present on the unit at a **given time**. When central line days are available from electronic databases, these

sources may only be used as long as the counts are not substantially different (+/- 5%) from manual counts. To assist with accurate data collection, the Device Day collection tool may be downloaded from the NDNQI® website. Device day counts are the unit each month.

Device-day denominator data that are collected differ according to the location of the patients being monitored. In NICUs, because of differing infection risks, the number of patients with umbilical catheters and those with non-umbilical central lines is collected separately. If a patient has both an umbilical catheter and a non-umbilical central line, count as one ***umbilical catheter*** day. For locations other than NICUs, if a patient has more than one central line in place count as one ***central line*** day.

**Data Collection Procedure**

The numerator and denominator should be collected concurrently. A trained infection control professional should determine daily those patients who meet the criteria for CLABSI (See CLABSI Appendix). In addition, patients are followed for evidence of CLABSI for 48 hours after removal of the central line or for 48 hours after discharge from the unit. Record CLABSI events daily and sum across all the days in a month. Each CLABSI should be counted in the month of discovery. This date will be when the first clinical evidence appeared or the date the specimen used to meet the criterion was collected, whichever came first.

EXCEPTION: If a CLABSI develops within 48 hours of transfer from one inpatient location to another in the same facility, the infection is attributed to the transferring location. This is called the **Transfer Rule** and the date of discovery changed to the day of discharge from the transferring unit.

The number of patients with a central line is collected daily at the same time each day. The daily numbers are summed across all the days in a month.

*Inclusions/Exclusions*

Include patients of any age on eligible reporting units.

Exclude bloodstream infections present or incubating on admission to the unit.

***Pressure Ulcer - % Hospital Acquired (Prevalence Study):***

**Measures of Pressure Ulcer Occurrence**

*Prevalence*

Prevalence is a common measure of pressure ulcer occurrence.

Definition—A cross-sectional count of the number of cases in a population. It measures the total number of persons with a pressure ulcer in a hospital/hospital unit on the day of the NDNQI® pressure ulcer survey. Includes those admitted to the healthcare facility with a pressure ulcer ***and*** those who developed one between admission and the time of the survey.

Calculation of this indicator requires documentation on ***all*** patients who are on the reporting unit(s) on the designated survey date.

*Prevalence Rate (also called a point prevalence:)*

Total number of patients with a pressure ulcer at a particular point in time divided by Total number of patients in the population studied at a particular point in time

*HAPU Rate*

HAPU rate is a separate measure of pressure ulcer occurrence and an estimate of

pressure ulcer incidence.

Definition—A count of the number of patient who acquired (developed) a new pressure ulcer after admission to the hospital. Intended to differentiate hospital acquired pressure ulcers from those acquired in the community.3 For patients with pressure ulcers, the origin of the pressure ulcer also must be determined (hospital, hospital/unit or community acquired).

Calculation of the HAPU rate requires the record of any patient with a pressure ulcer at the time of the survey be examined for evidence of a pressure ulcer on admission. If a review of the patient record finds no evidence of the pressure ulcer on admission (present on admission), then the pressure ulcer is hospital acquired.

*HAPU Rate:*

Number of patients who acquired a pressure ulcer after admission to the hospital divided by Total number of patients in the population studied

*Unit Acquired Rate*

Unit acquired rate is a subset of hospital acquired ulcers and a NDNQI specific measure.

Definition—A new pressure ulcer that developed after arrival to the unit. Intended to differentiate HAPU that are acquired on the survey unit from HAPU acquired on other units.

Calculation of this rate requires the record of any patient with a pressure ulcer at the time of the survey be examined for evidence of a pressure ulcer on arrival to the unit. If there is no documentation that the pressure ulcer was present on arrival to the survey unit, then the pressure ulcer is counted as unit acquired.

*Unit Acquired Pressure Ulcer Rate:*

Number of patients who acquired a pressure ulcer after arrival to the unit divided by Total number of patients in the population studied

**PRESSURE ULCER and STAGING DEFINITIONS**

**Definitions**

*Pressure Ulcer*

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.

* ***Pressure*** – Pressure is the force that is applied vertically or perpendicular to the surface of the skin. Pressure compresses underlying tissue and small blood vessels hindering blood flow and nutrient supply. Tissues become ischemic and are damaged or die.
* ***Shear*** – Shear occurs when one layer of tissue slides horizontally over another, deforming adipose and muscle tissue, and disrupting blood flow (e.g., when the head of the bed is raised > 30 degrees). Both require pressure exerted by body against bed/chair surface to create the tissue injury.
* ***Other locations*** – Pressure ulcers can develop on any skin surface subject to excess pressure such as under oxygen tubing, drainage tubing, casts, cervical collars or other medical devices.

A number of contributing or confounding factors also are associated with pressure ulcers; the significance of these factors is yet to be elucidated. The nurse observer should be able to distinguish a pressure ulcer from other types of wounds and skin conditions [e.g., venous ulcers, arterial ulcers, diabetic ulcers, incontinence associated dermatitis, skin tears, and others such as yeast infections, maceration, or

operating room-acquired cautery burns] and to stage pressure ulcers.

*Pressure Ulcer Staging*

Pressure ulcers are staged (classified) to reflect the level of tissue injury or damage. Use the 2009 NPUAP-EPUAP *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline*,4 to identify the staging of each **hospital and unit acquired** pressure ulcer.

Staging is used to define the maximum anatomic depth of tissue damage and should not take into account the extent of pressure ulcer healing.

Note—Descriptions of the pressure ulcer stages that follow include the terms *partial thickness* and *full thickness.* A partial thickness wound involves only the epidermis and dermis. A full thickness wound involves the epidermis and dermis and extends into deeper tissues (subcutaneous fat, muscle, etc.).

*Category/Stage I*

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further Description

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. May indicate “at risk” persons. Stage I may be difficult to detect in individuals with dark skin tones.

*Category/Stage II* Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled

or serosanguineous-filled blister.

Further Description

Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal (incontinence associated) dermatitis, maceration or excoriation.

*Category/Stage III* Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or

muscle are not exposed. Some slough may be present. May include undermining and tunneling.

Further Description

The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

*Category/Stage IV* Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar

may be present. Often include undermining and tunneling.

Further Description

The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/tendon is visible or directly palpable.

*Unstageable/Unclassified*

Full thickness tissue loss in which the base of the ulcer is completely covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further Description

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined but it will be either a Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

*Suspected DeepTissue Injury (DTI)*

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further Description

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

*Indeterminable* This is not a pressure ulcer stage within the NPUAP staging system. Rather it is a category created by NDNQI to count:

* Known pressure ulcers located under a non-removal dressing or device that cannot be visualized at the time of the skin inspection and the ulcer stage is not documented in the patient’s record
* Pressure ulcers on mucous membranes (see below).

*Pressure Ulcers on Mucous Membranes*

Pressure ulcers may develop on mucous membranes. Pressure applied to mucosal tissue by a medical device can cause ischemia and ulceration at the site. The staging system for pressure ulcers of the skin cannot be used to stage mucosal pressure ulcers because the histology of mucous membranes tissue is different than skin.

* Non-blanchable erythema cannot be seen in mucous membranes
* It is difficult to distinguish between partial thickness and full thickness tissue loss as tissue layers are thin
* Exposed muscle would seldom be seen
* Bone is not present in mucous membrane tissue

Pressure ulcers on mucous membranes should be counted and reported in the **Indeterminable** category.

*Kennedy TerminalUlcers*

Some patients toward the end of life may develop pressure ulcers that some call Kennedy terminal ulcers.5 ***Include*** these ulcers in your survey and stage them using the NPUAP pressure ulcer staging system.

*Healing/Closed or Healed Pressure Ulcers*

Pressure ulcers that are healing should not be reverse staged; rather they should be staged based on the maximum anatomic depth of tissue damage that was ***recorded*** in the patient’s record.

Pressure ulcers that have closed/healed are ***not*** counted as pressure ulcers.

**ORIGIN of PRESSURE ULCERS**

*Community Acquired Ulcer*

Pressure ulcers that developed ***prior*** to hospital admission. The existence of the pressure ulcer(s) was documented on the admission skin assessment or the survey was done on day 1 of the patient’s hospital stay and the pressure ulcer was already present. Pressure ulcers that are present on admission and ***worsen*** during the patient’s length of stay are still considered community acquired.

Standards of care for most hospitals require that an admission skin assessment be completed and documented within 24 hours of admission or sooner. Per Medicare guidelines, patients who are “transferred” between acute care, rehab or long term care units are considered as admitted/discharged, even if the units are located on the same campus. If a patient has been transferred between two campuses **and** the medical record number and admission status assigned on the first campus is in current use on the second campus, then substitute the unit admission assessment obtained on the second campus for the hospital admission assessment.

*Hospital Acquired Ulcer*

Hospital acquired refers to new pressure ulcer(s) that developed ***after*** admission to your facility. Also termed nosocomial or facility-acquired. The patient’s admission record should be reviewed for the documentation of a pressure ulcer. If there is no documentation that the pressure ulcer was present on admission, then the pressure ulcer should be counted as hospital acquired.

*Unit Acquired Ulcer* A new pressure ulcer that developed ***after*** arrival to the survey unit. The unit

admission assessment should be reviewed for the presence of pressure ulcers. If there is no documentation that the pressure ulcer was present on arrival to the unit, then the pressure ulcer should be counted as unit acquired.

Note—All unit acquired ulcers are a subset of hospital acquired ulcers.

***RN Education/Certification:***

*Highest Nursing Degree*

Determine the highest nursing degree (or US equivalent) for each eligible RN. If an RN has multiple degrees, count only the highest ***nursing*** degree. If US equivalent of nursing education obtained in foreign country is uncertain or you don’t know their degree, report nursing degree “unknown.” Exclude non-nursing degrees.

*Specialty Certification*

Formal recognition of specialized knowledge, skills and expertise demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes.1 Certification should be counted if it is in a specialty area of nursing practice and granted by a ***national*** nursing organization (e.g., ANCC or AACN). Non- US hospitals may count nursing specialty certifications granted by non-US, national or regional nursing organizations.

Count all nurses who have a current nursing specialty certification, even if their area of certification is not the primary specialty on the unit. For example, a nurse who is certified in critical care but works on a med/surg unit is to be counted. Count each certified RN only once.

Exclude nurses whose ***only*** credentials are:

* Employer-based competency or certification
* Completed courses for ACLS, PALS or TNCC
* A certification granted by a multidisciplinary organization, not limited to nursing

*Eligible RNs*

For highest nursing degree and specialty certification, count all RN employees (full time, part time, PRN) with direct patient care responsibilities at 50% or greater time who are listed on the staffing roster during the designated period of time. A nurse who normally works on this unit, but is temporarily absent due to vacation or medical leave should also be counted.

Exclude:

* Contract/agency staff
* Nurses who are not assigned to a single specific unit