



## Nursing Home PA-PSRS FAQs

### Criteria Questions

#### **If a skin and soft tissue infection progresses to osteomyelitis, do we report both infections or only one? Which one?**

Both infections are reported if they are in the list of reportable infections. The only time a “secondary” infection is not reported is in the case of a **bloodstream infection** whereby a primary source such as a UTI or LRTI is the documented source of the bloodborne infection. Then that primary infection only would be documented.

#### **Is a confirmed case of Shingles reportable as a skin and soft tissue HAI?**

Shingles is NOT reportable. It was eliminated from the list of infections.

#### **What timeframe applies to Clostridium difficile and is it reportable by the NH if the resident was on antibiotic therapy?**

CDC defines a C.difficile laboratory confirmed infection as health-care acquired if it presents greater than (>) 3 days after admission (i.e., on or after day 4). If a resident is admitted on Monday, and on Thursday he/she has a positive stool toxin assay for C.difficile, the nursing home would report this as a Gastrointestinal Tract infection. If the infection meets the criteria then it is reported as an HAI, regardless of antibiotic therapy.

#### **How do we determine if a C.difficile infection is recurring or a newly acquired one?**

If a C.diff infection has been treated or resolves spontaneously (absence of diarrhea is considered resolved) and signs and symptoms occur again after the cessation of previous symptoms, a new infection should be reported.

#### **Primary bloodstream infection (BSI) requires a blood culture result. If a resident is transferred to an ER with signs and symptoms that meet the NH criteria for a BSI, how do we obtain the information about a blood culture?**

The NH should contact the hospital (either the laboratory directly or the infection preventionist) and request the blood culture results in order to confirm the infection.

**If a resident exhibits signs and symptoms of an infection that meet criteria for a UTI or lower respiratory tract infection AND a bloodstream infection at the same time, are both infections reported?**

A bloodstream infection occurring together with an infection at another site is considered a SECONDARY bloodstream infection and must not be reported. Only the primary infection (UTI or LRTI) must be reported.

**How do we use the results of urinalysis and urine cultures?**

Urinalysis and urine cultures are not used as criteria when determining whether a resident has a nursing home-reportable HAI. They may be used to determine whether a resident had a pre-existing HAI upon admission to the nursing home. If a resident is transferred to a nursing home with positive laboratory results, this indicates that the urinary tract infection was incubating or present on admission, and it is therefore not reportable by the nursing home.

Positive laboratory results include:

- For URINALYSIS, one or more of the following must be positive IN the presence of defined signs and symptoms.
  - Positive leukocyte esterase and/or nitrate
  - Pyuria (greater or equal to 10 white blood cells)
- For a urine CULTURE, greater or equal to 100,000 microorganisms per cc of urine with no more than 2 species of microorganisms must be present together WITH defined signs and symptoms.

A positive urinalysis CANNOT be used as a sign of “change of character of urine”. There needs to be a visible change in the character when looking at the urine with the naked eye.

**If a resident develops a UTI after removal of a catheter, what is the allowable time-frame from removal of the catheter to development of a SUTI to consider it a catheter associated UTI (CAUTI)?**

Nursing homes are to follow the latest UTI module from CDC/NHSN. CDC considers a symptomatic UTI as catheter related IF the catheter was removed within 48 hours of the onset of signs and symptoms. Therefore, if the resident develops signs and symptoms within 48 hours of catheter removal, the criteria for a catheter associated (CAUTI) will need to be met and entered into PA-PSRS.

**If a resident has a suprapubic catheter and develops a UTI, how is it reported?**

A UTI that develops in a patient with a suprapubic catheter is reported as a UTI in a resident WITHOUT a urinary catheter.

### **Is pyelonephritis reportable?**

Unless the condition fits the definition and criteria of a UTI, other genito-urinary infections are not reportable as per Act 52.

### **If a resident only has 1 qualifying urinary tract symptom but their urine culture is positive for a multi-drug resistant organism, is this reportable?**

Urinary tract infections rely strictly on signs and symptoms and a urine culture (which will reveal the MDRO) and urinalysis do NOT play a role in the confirmation or rule-out of an infection. One sign and symptom will not meet the criteria for a UTI.

### **IF a resident is severely impaired and cannot verbalize “burning pain, frequency, flank or supra pubic pain or tenderness” but has only one symptom, being a change in mental status, is that a reportable HAI?**

If the resident does not meet the criteria for a UTI, regardless of their overall status, it must not be reported as such.

### **How do we report residents who suffer with chronic infections?**

If a resident is treated for an infection that has been reported to PSRS and following treatment, the symptoms resolve for a reasonable period of time (clinical judgment should be used to determine “reasonable”), if the symptoms return and the resident once again meets the criteria, this should be reported as a second infection.

For example, if a resident suffers from recurrent urinary tract infections (UTIs), and after treatment with either antimicrobials or removing the catheter, the symptoms have cleared for a reasonable period of time, and the onset of signs and symptoms occurs once again if the criteria are met, the nursing home must report a new UTI, despite the resident’s history of chronic infection. However, if the resident exhibits ongoing signs and symptoms and does not clear even with treatment or removal of the catheter, the infection should be reported only once.

### **How do we use the results of chest x-rays?**

Chest x-rays are not used as criteria when determining whether a resident has an HAI. They may be used to determine whether a resident had a pre-existing pneumonia upon transfer from another facility or from the community.

If a chest x-ray is obtained, and a physician or radiologist’s report confirms the presence of pneumonia IN the presence of defined signs and symptoms, this indicates that the pneumonia was present on admission and is therefore not reportable by the nursing home.

**What are the criteria to determine how long to wait until MRSA clears? Some patients will always test positive. How long do you wait to determine if an infected ulcer has cleared to determine if you need to report the infection again?**

MRSA colonization is not reportable. Criteria to determine an infection must be met in order to report, regardless of the organism. For determination of a re-infection, refer to the question above.

**If the resident has an access device for dialysis and becomes infected, is this reportable? (The resident goes out for the dialysis and the nursing home staff don't touch the site)**

If the resident is residing in the nursing home and meets the criteria for a skin and soft tissue infection at the device site, the infection must be reported as an HAI, even though the site is not touched by the nursing home staff. In the event that a resident receiving dialysis develops a PRIMARY bloodstream infection with no signs and symptoms of a skin and soft tissue infection or other infection, the bloodstream infection will be reportable as an HAI as it is presumed to be related to an indwelling device.

**Do all of the signs and symptoms need to present on the same day? For example, if a resident is confused on day 1 and extra fluids were given, and on day 2 the resident has cloudy urine and flank pain but is no longer confused.**

It needs to be a snap-shot with all of the symptoms present at once while doing the chart surveillance.

**If a resident is transferred to a hospital with symptoms of an infection, but the criteria are not met while in the nursing home, is this considered a nursing home HAI if the resident develops subsequent symptoms in the hospital?**

The nursing home must conduct surveillance using the resident's "in house" records after transfer to the hospital and determine if the signs and symptoms prior to transfer meet the criteria. If the criteria are NOT met for nursing home HAIs then regardless of the diagnosis in the hospital, the nursing home will not report the infection.

**A resident is transferred to hospital for change in mental status and has a skin tear when transferred. He stays 24 hours and returns 24 hours later. The resident develops a cellulitis at the skin tear site within 48 hours of readmission. Is this infection considered hospital-acquired?**

If the resident, upon return to the nursing home, meets the criteria for a skin and soft tissue infection, this infection will be counted as a nursing home related infection as it occurred within 48 hours of RE-ADMISSION and does not involve insertion of an invasive device while in the hospital. It is considered "incubating at the time of transfer to the hospital for the mental status change."

**How should facilities address any conflicts between Minimum Data Set (MDS) coding (RAI criteria) and Act 52 HAI definitions?**

Act 52 has its own set of unique criteria for reporting of HAIs to the state and has no bearing on other criteria or coding for reporting of infections to other agencies such as CMS. The Authority and DOH cannot make recommendations for the use of Act 52 criteria for other purposes.

Specific HAI reporting requirements under Act 52 for PA-PSRS reporting do not change the nursing home's obligations to other entities that require HAI reporting.

**Does a nursing home report infections that were present on admission from the hospital or the community?**

Infections reported by the nursing home must **not** be present or incubating on admission. Each type of infection should be considered individually when assessing the incubation period.

**How do I determine if an individual is colonized with MRSA or an MDRO?**

MRSA screening by the hospital is mandatory when a resident is transferred from a nursing home to the hospital. There are no State requirements for routine screening of residents presently residing in a facility. Once a resident is identified as MRSA positive, the nursing home is mandated to have policies and procedures for placement of residents with MDROs.

**Does Norovirus fall into the HAI reportables?**

Yes, individual cases of Norovirus, regardless of how many occur, must be reported to PA-PSRS as individual infections as well as other county/State Norovirus reporting requirements.

**If you admit a neutropenic resident to a unit and they develop an infection, is that an HAI?**

All residents exhibiting signs and symptoms of a possible infection, regardless of their admission diagnosis, must undergo surveillance procedures to rule out or confirm an infection. If the neutropenic resident fits the criteria for an HAI, this must be reported to PA-PSRS.

**Are the hospitals required under Act 52 to report positive MRSA or other MDROs (including VRE) to the nursing homes? If so, does the report need to be in writing or can it be given verbally?**

Under Act 52, hospitals have a legal requirement to screen all nursing home residents admitted to the hospital for MRSA. In addition, Act 52 requires that hospitals

communicate all cases of positive MDROs including MRSA to receiving facilities. There are no legal requirements or rules as to how the communication should occur. However, it is suggested that documentation of communication between facilities be maintained.

**If a resident develops an infection after being discharged to home and the nursing home finds out this information, is this required to be reported?**

The nursing home should do retrospective surveillance if the resident was recently discharged. As there is no specific rule as to how long after discharge an infection would be considered an HAI, it is suggested that the IPD assess each infection individually and consider 48 to 72 hours as a general guide, depending on the infection.

**If a resident is able to be educated about infections, is written documentation of education of the resident required?**

There is no state mandate for documentation of resident education.

## **PHYSICIANS**

**Are Physicians being informed/trained about the definitions/criteria.**

It is in the best interests of the individual nursing homes to educate the physicians as is required by Act 52 for distribution of advisories. The Authority is responsible for HAI prevention education and works in conjunction with the Pennsylvania Medical Directors Association to share information with physicians.

**Can PSA include Physicians in their electronic distribution of Advisories?**

The Pennsylvania Medical Directors Association (PMDA) is on the distribution list for receipt of all correspondence including Advisories.

**Are there any recommendations for physicians who visit multiple buildings and are receiving multiple copies of the Advisory article?**

Act 52 does not state how the advisories should be distributed and the agencies have no recommendations for multiple copies being received by physicians.

## **Surveillance**

**How often should surveillance for the purpose of identification of HAIs be conducted?**

Act 52 does not stipulate timelines for confirming an infection. Industry standards suggest “timely surveillance.” Please note, however, that it is essential to conduct surveillance in a timely manner determined by each facility.

It is suggested that a surveillance worksheet be developed by each facility for the purpose of maintaining a working record. DOH surveyors may ask to see worksheets and other documentation of the onset of symptoms and confirmation of infection (i.e., once surveillance is completed the infection is confirmed) and, therefore, untimely surveillance may result in a citation.

Surveillance for the benefit of confirmation or rule-out of infection must not affect daily ongoing communication between staff members/residents and families with respect to standards of care. Walking rounds and chart/cardex reviews are essential to identify immediate and day to day issues and potential action taken to rectify the problems or prevent outbreaks of infection. Surveillance must not interfere with any medical treatment rendered by Physicians.

**Do all of the signs and symptoms need to present on the same day? For example, if a resident is confused on day 1 and extra fluids were given, and on day 2 the resident has cloudy urine and flank pain but is no longer confused.**

It needs to be a snap-shot with all of the symptoms present at once while doing the chart surveillance.

**If a resident is transferred to a hospital with symptoms of an infection, but the criteria are not met while in the nursing home, is this considered a nursing home HAI if the resident develops subsequent symptoms in the hospital?**

The nursing home must conduct surveillance using the resident's "in house" records after transfer to the hospital and determine if the signs and symptoms prior to transfer meet the criteria. If the criteria are NOT met for nursing home HAIs then regardless of the diagnosis in the hospital, the nursing home will not report the infection.

**A resident is transferred to hospital for change in mental status and has a skin tear when transferred. He stays 24 hours and returns 24 hours later. The resident develops a cellulitis at the skin tear site within 48 hours of readmission. Is this infection considered hospital-acquired?**

If the resident, upon return to the nursing home, meets the criteria for a skin and soft tissue infection, this infection will be counted as a nursing home related infection as it occurred within 48 hours of RE-ADMISSION and does not involve insertion of an invasive device while in the hospital. It is considered "incubating at the time of transfer to the hospital for the mental status change."

**Is the "48 hour incubation rule" evidence based?**

There is no rule for an incubation period. CDC does not define such, however, infection control professionals have chosen a 48 – 72 hour "rule" of their own, but assess each infection separately as the "incubation period" can be different for different Infections.

**How do we know whether to report infections related to invasive devices shortly after admission?**

See slides 27 and 28 of the power point presentation provided during training (Appendix A in training manual)

**Are the hospitals required under Act 52 to report positive MRSA or other MDROs (including VRE) to the nursing homes? If so, does the report need to be in writing or can it be given verbally?**

Under Act 52, hospitals have a legal requirement to screen all admitted to the hospital for MRSA. In addition, Act 52 requires that hospitals communicate all cases of positive MDROs including MRSA to receiving facilities. There are no legal requirements or rules as to how the communication should occur. However, it is suggested that documentation of communication between facilities be maintained. Act 52 also requires that nursing homes communicate known MDRO information to receiving facilities.

**If a resident develops an infection after being discharged to home and the nursing home finds out this information, is this required to be reported?**

The nursing home should do retrospective surveillance if the resident was recently discharged. As there is no specific rule as to how long after discharge an infection would be considered an HAI, it is suggested that the IPD assess each infection individually and consider 48 to 72 hours as a general guide, depending on the infection.

**If a resident is able to be educated about infections, is written documentation of education of the resident required?**

There is no state mandate for documentation of resident education.

**How do nursing homes report infections related to surgical procedures?**

If a resident has surgery and is transferred back to the nursing home and subsequently develops an infection as a result of the surgery (e.g., intra-abdominal abscess/peritonitis) the nursing home should contact the Infection Preventionist at the hospital or ambulatory surgical facility (ASF) that performed the procedure to discuss whether this is an HAI related to the surgery.

In the case of surgery not involving implantables\*:

- If the infection occurs within 30 days of the surgery, the infection is attributable to the hospital or ASF. The nursing home does not report it.
- If the infection occurs beyond 30 days of the surgery and the resident has been back in the nursing home for more than 72 hours, the nursing home should report the infection.

In the case of surgery that does involve implantables

- If the infection occurs within one year of surgery, the infection is attributable to the hospital or ASF. The nursing home does not report it.
- If the infection occurs beyond one year of surgery, the nursing home should report the infection.

**\*Definition of implantables taken from CDC’s NHSN reporting system:**

*A nonhuman-derived object, material, or tissue (eg, prosthetic heart valve, nonhuman vascular graft, mechanical heart, or hip prosthesis) that is permanently placed in a patient during an operative procedure and is not routinely manipulated for diagnostic or therapeutic purposes.*

*Solid organ transplant surgery is not considered an “implantable” surgery unless a nonhuman-derived object was inserted into the patient during the transplantation. If an infection develops after transplantation, the 30 day look back rule applies.*

**What is the nursing home’s obligation regarding infections attributable to hospitals or ASFs?**

If a nursing home identifies an infection attributable to a hospital or ASF, the nursing home’s obligation is to contact the other facility’s Infection Preventionist or designee. Depending on the circumstances, the other facility may be required to report it. The nursing home’s obligation, if the infection is not reportable by the nursing home, is to communicate the information it has relevant to the patient/resident’s infection to the other facility. Document your communication with the transferring facility.

**How should I document communication to the hospital that a resident was transferred back to the nursing home with a probable or confirmed hospital acquired HAI?**

The State agencies do not make any recommendations for documentation of communication; however, the facilities are obligated to communicate with each other and it is suggested that facilities document in the resident’s record that they have had communication with the hospital. It is up to the discretion of the nursing home as to where they document this. Records should be accessible at all times.

**What admission date do we use as the most recent admission?**

If a resident is formally discharged from the facility and returns to the facility as a new admission in the nursing home records, that date will be the most recent one. If however, a bed is held for a transfer and the resident is NOT formally discharged and admitted again, then the original admission will be the most recent one.

**How do you calculate catheter days?**

Collect and record the number of residents with indwelling Foley catheters on each unit/care area on a DAILY basis. Catheter days should be collected at the same time each day at a time decided by the facility. PA-PSRS does not prescribe a specific time of day.

At the end of each month, for each unit, add all the daily numbers of catheterized residents to get the total number of catheter-days for that unit for that month. Only the monthly total for each unit is reported to PA-PSRS.

For example: Consider a unit with 20 residents, 5 of whom have an indwelling Foley catheter. If the same residents are on the unit throughout a 30-day month, and the 5 residents with catheters remain catheterized throughout the month, the number of catheter-days reported at the end of the month would be:

$$5 \text{ residents} \times 30 \text{ days} = 150 \text{ catheter-days.}$$

**Do we count the day the catheter was inserted or removed? Do you count the day the resident was admitted with a catheter in?**

Because facilities are asked to count resident and catheter days at the same time each day (for example, at midnight), the time of day will be the determinant as to whether to count the insertion or removal day. If the catheter was inserted at 9:00 p.m. and the catheter count occurs at midnight that day, it counts as a catheter day. If the catheter was removed at 9:00 p.m. and the catheter count occurs at midnight that day, it does not count as a catheter day.

**Do we count suprapubic catheters in the catheter days collection?**

NO you do NOT count suprapubic catheters as an in-dwelling catheter. See slide # 36 for the definition of an indwelling catheter.

**If a resident stays overnight in the ED for observation and isn't admitted, does this count as a resident day?**

If a bed is held for a resident this bed is **not** counted as a resident day. Only physically OCCUPIED beds are considered for the daily count.

**How does a Nursing Home manage surveillance and reporting when the sole IPD is absent from work?**

It is encouraged that every nursing home designate a back up or back ups for the IPD in the event of a work absence. The Department of Health will not accept that "no-one was available at the NH to do surveillance".

**Written Notice (Serious Event Letter)**

**Act 52 requires that nursing homes provide written notice of the occurrence of a Serious Event. Do we send notification to the residents and their families or POA?**

If the resident is considered competent, the written notice should be given to the resident. If the resident is not considered competent, the written notice should be given to the responsible party.

**What information should the written notification letter contain?**

The State agencies do not make recommendations for content of serious event notification letters. It is up to the individual facilities to make that determination.

**When notifying family/resident of a serious event, does the term “serious event” need to appear in the notice?**

MCARE, Section 308 (b) states the following: A medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee. The MCARE statute does not provide specific verbiage for the written notice.

**Should a copy of the letter be kept in the resident’s chart?**

It is suggested that copies of all forms/letters/worksheets relating to HAIs be kept as part of the resident’s record but ultimately, it is up to the discretion of the individual facility as to whether they choose to keep copies and where they are placed.

**Does the letter have to be mailed?**

The MCARE statute does not specify what methods to use when providing written notification.

**Department of Health**

**Why do we have to continue to report “Communicable Diseases” to DOH?**

Reporting is mandated by different regulations/laws and every nursing home must report these infections to PA-PSRS if meets the nursing home criteria AND to DOH if it is required for reporting as a “communicable disease.”

**Will DOH use the HAI data/rates as part of the survey process?**

DAAC and DNCF surveyors will not receive the infection data. HAIP staff will receive and review HAI data. Surveyors will continue to survey for care and service issues and determine if it is related to failure to implement the infection control plan. HAI data and rates will be used by HAIP staff to help facilities identify problems and formulate

solutions for infection reduction.

**What should facilities do with updates to their prevention plans submitted to DOH?**

Hold onto updates until you receive a call from DOH. Nursing homes will need to submit all updates in duplicate the same as the original. The nursing homes should use this process for all updates.

**How are corporate IC plans going to be approved?**

DOH will still contact each facility to confirm contacts.

**What are the ramifications for the nursing homes if they miss a report?**

DOH has the authority to fine up to \$1000 a day for failure to report. This is only likely to occur if sufficient evidence exists to support that the facility purposely attempted to misrepresent themselves by not reporting. If it is a legitimate error, DOH will work consultatively with facilities to help them do better. If it appears that there is refusal to report, fines will ensue.

**What is the DOH going to do with the event reports? Will DOH look at the data?**

Initially, DOH will look at event reports for data validation. Eventually, risk-adjusted benchmarking for certain infections (adjusted for differences in nursing homes) will take place. At the time of manual development, timelines have not been put in place yet.

**Will infection rates be published to the Public?**

Nursing Home benchmarking with subsequent rate reporting will be established in the future.

**What if the facility is late on reporting infections after confirmation?**

Nursing homes should do their best to report within 24 hours of confirmation. If patterns develop, DOH may have to call to determine the cause. All nursing homes should have at least one back-up staff member to cover for vacations, sick time and other situations whereby the key staff member is absent from work.

**What happens if the system goes down or you have a power failure that prevents timely reporting?**

Use the comment box to note the issue, however, if a pattern develops, DOH will investigate for validity of ongoing issues.

**Will this legislation extend to AL and IL? Will electronic surveillance be required eventually?**

Currently, Act 52 legislation involves hospitals and nursing homes only. Legislation for AL and IL will require separate legislation of which there is none to date.

**What documentation will the DOH surveyors look for?**

PSA plans to work with the DOH HAI prevention section to educate field offices and surveyors with respect to the mandatory reporting requirements. It is suggested by DOH that all relevant information be documented such as communication with transferring facilities and written proof of sending serious event notices etc.

**If the hospital cites HIPAA as a reason to refuse to send clinical notes, how should this be handled?**

Try to work it out by explaining that Act 52 supersedes HIPAA. If that approach doesn't work, contact DOH.

**Are hospitals only required to communicate positive MRSA lab results? If so, how can the nursing home be assured that MRSA screening was actually done. If the hospital isn't doing MRSA screening, what should the nursing home do?**

Contact DOH as they are the enforcement agency.

**Which infections have to be reported to the Department of Health separately from PA-PSRS?**

All HAIs reported through PA-PSRS are available both to the Patient Safety Authority and the Infection Prevention Section of the Department of Health. PA-PSRS handles all of the reporting requirements for both agencies under Act 52 of 2007, or Chapter 4 of MCARE.

Nursing homes must continue to report communicable diseases to the Department of Health under the nursing home regulations, Chapter 211.1. Types of infections that are required under both reporting statutes include:

- Viral hepatitis
- Meningitis
- Specific G.I. related bacterial infections (for complete list, see Chapter 211.1 communicable disease list)

**Will DOH accept a physician's diagnosis of a healthcare associated UTI if it does not meet the criteria?**

The DOH assisted with the development of HAI criteria for nursing homes and will not accept a physician's diagnosis of UTI if the criteria for signs and symptoms are not met.

**Do we need to report HAIs to other agencies such as the Area on Aging?**

Act 52 requires that nursing homes report HAIs to the Department of Health and Patient Safety Authority. This process will take place through a single web-based system known as PA-PSRS. Act 52 does not require reporting to other agencies, however, nursing homes must follow other reporting requirements that are separate from Act 52.

## **Reporting System**

**Does the timer at the top of the page on the Infection entry reports allow 15 minutes per page? Does one lose all the data if one is timed out?**

The timer allows 15 minutes per page, can be reset if you are running out of time and ALL data will be lost if you are timed out.

**Who will receive the ID/Password for PA-PSRS reporting?**

An e-mail will be sent to the Infection Prevention Designee (IPD) if one has been assigned. If there is no assigned IPD, the e-mail will go to the Administrator.

**At any time prior to submitting the report, can you cancel if you make a mistake?**

Yes, unless you click on the submit report button, you can shut down and start again.

**How long is data stored in PA-PSRS?**

The data is stored indefinitely. We may reach a point after several years where we begin archiving data, but there are no set plans to do so at this time.

**Can data reports be divided by unit instead of facility?**

The default setting for most analytical reports will be to display data for the entire facility. Most reports will allow you to “drill down” to the unit level, provided you have set up your care areas according to unit.

**How can I access each individual facility or corporate analytical reports as I oversee 6 facilities?**

Facility accounts follow the licensure, so that three locations licensed separately will have three facility accounts. An individual at the corporate level overseeing all three facilities would have to have a user account at each of the three facilities in this case. In response to suggestions made by individuals attending the first several nursing home training sessions, the Authority will investigate the feasibility of adding a new user type that would allow corporate users to see data from multiple facilities with one user account, but this will not be in place when mandatory reporting begins in June 2009.

**In the future, will reports be available by searching other identifiers versus the incident ID number? For example, the SSN.**

Yes, one analytical report we have planned will allow you to pull up a resident's infection history using the Social Security Number.

**Is it mandated that a report be amended to answer the laboratory and death related questions?**

Yes, it is required that a report be amended if additional information becomes available to the nursing home such as laboratory results pertinent to the infection, or if death occurs within the 45 day period of original submission of the report. The comment section should be used to provide additional information if available.

**Do we amend a report for a subsequent death only if the death occurred at the facility?**

A death **regardless** of where it occurred or the possible cause if identified after the report was submitted must be reported to PSRS for up to 45 days after the initial report by using the "amend report" function. The death does not have to take place at the facility. The comment section should be used to provide additional information if available.

**Should we report data from June 1<sup>st</sup> when this program of reporting is to start on June 15 or 22?**

Start reporting infections and collecting utilization data on June 15 and June 22 even though utilization data will only be for 15/16 days or 9/10 days.

**If we create a report and subsequently, a non-infectious diagnosis is made e.g. pleural effusion that mimics a LRTI, how do we amend the report to exclude the original report of an HAI?**

Once a report has been entered into PA-PSRS it cannot be deleted. It is suggested that an amended report, which will have to have the same criteria (a report cannot be entered if it does not meet the criteria), be entered with comments relating to the final "non infectious" diagnosis. The amended report and comments will be taken into consideration.

**Our corporation requires that we monitor other infections not required under Act 52. Can I use PA-PSRS to monitor these other infections?**

PA-PSRS is designed to collect only those infections determined by the Authority and DOH to be reportable. However, infections that are not in the reportable list can be collected internally for the nursing home database of infections such as conjunctivitis, mouth and peri-oral infections, and others.

**If a nursing home is part of a hospital, will the nursing home use the hospital's existing PSRS system?**

Nursing homes will receive their own PSRS system and will not share with the hospital.

**What is the procedure to update PA-PSRS with staff changes at a facility?**

All changes in contact information must be submitted to the PA-PSRS help desk – see slide # 77

**Can PA-PSRS be accessed from any computer?**

Yes, PA-PSRS can be accessed from any computer that has internet connection and a browser.

**Do we need to change our PA-PSRS password?**

Yes, the system will prompt you to change your password every ninety days for security reasons. Your password may be any combination of between six and eight letters or numbers.