Scenario 1

In the following scenario, what type of HAI criteria are met?

8/22 44-year-old male patient admitted for a routine colectomy due to diverticulitis with chronic abscess formation. He has a Laparoscopic Sigmoid Colectomy. He stayed overnight and was discharged the following day having adequately met ERAS protocol for discharge.
The procedure was coded-0DBN4ZZ

On 8/25 he returned to the ED. According to the ED Provider record: Temp 102. Physical Exam: Abdominal: abdominal pain and tenderness. He is admitted for observation from the ED.

8/26 Surgery H&P- wound is concerning for dehiscence. Unable to fully assess due to patient's severe abdominal incisional pain. Will order CT of the Abdomen and Pelvis with potential return to OR for wound revision.
8/26 CT ABD PEL- trace ascites throughout the abdomen. Hernia to abdominal wall with a fluid collection containing gas and air.

8/27 Operative Report: Incision and debridement of Abdominal Incision

Notes: Proximal portion of the wound with dehiscence of skin and fascia of about 2 cm with bowel visible. Small amount of serous fluid noted. Wound cleansed with Vashe. Fascia sutured and skin reapproximated with staples.

Does the patient have an SSI?
If this is an SSI, what procedure would this be attributed to?
What is the surveillance period for this type of procedure (30 or 90 days)?
If this is an SSI, what is the deepest criteria met (superficial, deep, organ/space):
List all NHSN criteria met at this deepest level (examples SUTI 1b, OREP1, BONE 1):
If this is an SSI, is it PATOS?
What is the Date of Event (DOE)?

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Scenario 2

72-year-old female patient with a history right hip osteoarthritis was admitted on 7/30 for an elective right total hip arthroplasty procedure. She was discharged to rehab after a 3-day admission in good condition.
Coding received CPT 27130

She was readmitted 8/11 from the rehab facility to another neighboring facility. The IP faxes records to you including: an Emergency Department report, an Operative Report, and positive culture results.

8/11 ED Note: At admission she reports right hip pain and bloody/serous drainage to her right hip dressing.
8/11 Blood culture result: Staphylococcus aureus

8/12 Incision & Drainage Op Report: I opened the previous incision through the fascia. Upon entry, copious amounts of purulence were suctioned from the wound and a culture of this fluid was submitted as a specimen. The hardware and joint capsule seemed intact and healthy. I did not feel it prudent to pursue any additional debridement.
8/12 Right Hip wound culture result: Staphylococcus aureus

Does the patient have an SSI?
If this is an SSI, what procedure would this be attributed to?
If this is an SSI, what is the deepest criteria met (superficial, deep, organ/space):
List all NHSN criteria met at this deepest level (examples SUTI 1b, OREP1, BONE 1):
If this is an SSI, is it PATOS?
What is the Date of Event (DOE)?