Health-Care Associated Infection Surveillance

Using standardized surveillance definitions, including Revised McGeer Criteria, to identify trends and drive prevention.

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Objectives

1. Identify HAI Events:

Apply McGeer criteria consistently and document required surveillance data

2. Monitor & Analyze Trends:

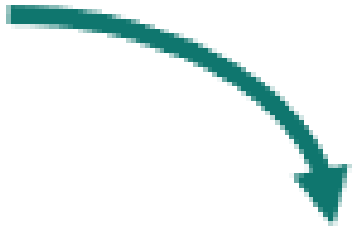
Track infections and rates. Identify risks and patterns

3. Drive Prevention Actions:

Share findings with leadership. Implement and monitor improvements

Why SNF HAI Surveillance Matters

- Identify infections and clusters early.
- Monitor adherence to IPC practices.
- Reduce spread among residents, staff and visitors.
- Use data for public health action and safer care.
  - Comply with State and Federal requirements



Identify → Analyze → Act

Clinical vs. Surveillance

- **Clinical Diagnosis**
  - **Patient-centered.**
  - **Used by providers to evaluate and treat the individual resident.**

Surveillance Definition

- **Population-based.**
- **Applied the same way each time for tracking, trending and comparison.**

Not meeting surveillance criteria does not always exclude clinical infection.

Minimum data set

- Resident baseline and new or worsening symptoms.
- Onset date for each symptom.
- Vitals: temperature, O2 saturation, respiratory rate.
- Microbiology, imaging and diagnostic information.
- Device status, antibiotics and transfers/readmissions.

Surveillance Workflow: From Trigger to Prevention

1 Find triggers

Antibiotic starts, new symptoms, positive labs, transfers/readmissions and staff reports.

2 Review evidence

Confirm baseline, onset, signs/symptoms, diagnostics, device status and alternate explanations.

3 Apply criteria

Use Revised McGeer definitions consistently. Count only events that meet criteria.

4 Trend & report

Calculate rates, identify clusters or unusual patterns, and communicate findings to leaders.

5 Act & sustain

Assign owners, implement prevention strategies, audit process measures and reassess impact.

Document the rationale: “Meets criteria,” “Does not meet,” or “Needs additional information.”

Revised McGeer Criteria: What Staff Need to Know

Core principles when applying criteria

Principle

New or acutely worse

Chronic symptoms alone are not enough. Compare with resident baseline.

Principle

Not a single data point

Consider symptoms plus microbiology/radiology when available.

Principle

Rule out noninfectious causes

Examples include dehydration, medication effects, tube feeding, CHF, trauma or allergies.

Principle

Clinical care continues

Surveillance criteria are for tracking, not for deciding whether to treat.

Often included in routine LTC surveillance

Respiratory infections • UTI • GI/CDI • Skin/soft tissue • Conjunctivitis • Scabies • BSI/unexplained fever as applicable

McGeer Criteria Quick Reference: Common SNF Infections

Use as a high-level reminder. Always refer to the full written criteria for case classification.

Syndrome	Surveillance focus	Key evidence to capture
Constitutional criteria	Fever, leukocytosis, acute mental status change, acute functional decline	Temperature value and route; WBC/bands; CAM-type mental status criteria; ADL change from baseline
UTI	Catheter status determines which UTI criteria apply	Localizing urinary symptoms, fever/leukocytosis as applicable, catheter dates, urine culture source and colony count
Respiratory	Cold/pharyngitis, influenza-like illness, pneumonia, lower respiratory tract infection	New/increased cough, sputum, O2 saturation change, lung exam, respiratory rate, chest imaging when done
GI / C. difficile	Norovirus, other gastroenteritis and CDI definitions	Stool frequency and consistency, vomiting episodes, toxin/PCR/culture, pseudomembranous colitis, alternate causes
Skin / soft tissue	Cellulitis, wound infection, scabies, fungal/herpes, conjunctivitis	New signs at site, drainage, rash pattern, provider diagnosis, culture/biopsy when available, epidemiologic link

Reminder: A positive urinalysis or urine culture alone does not meet UTI surveillance criteria without compatible symptoms.

Documentation Tips to Make Surveillance Reliable

Clear documentation helps the IP accurately apply criteria and identify preventable patterns.

Documentation examples	Goal: describe the change from baseline and the onset date.
Fever	100.1°F oral at 0800; baseline 97.6°F
Shortness of breath	RR 28, O2 sat 90% RA, new oxygen need
Cough	New productive cough with yellow sputum
Confused	Acute onset, fluctuating, inattentive, disorganized thinking
Loose stool	4 watery stools in 24 hours above baseline

Ask during chart review: Is it new? When did it start? What objective data supports it? Is there an alternate explanation?

Report Out Template: Turn Surveillance into Prevention

Finding	Analysis	Barrier	Action / Owner
UTI pattern	Events associated with catheter use or documentation gaps	Device indication and removal not consistently visible	Daily catheter necessity review; reinforce alternatives and handoff documentation
Respiratory cluster	New cough/fever symptoms on one unit	Delayed recognition or late isolation escalation	Line list review; reinforce symptom reporting and transmission-based precautions
CDI concern	Loose stool and positive lab triggers need criteria review	Alternate causes not consistently documented	Review stool count, baseline, laxative/tube feeding status and testing algorithm

1 Validate

Confirm criteria and data source.

2 Trend

Review by unit, resident group, device, organism, time.

3 Intervene

Assign owners for education, audit, isolation, cleaning, device care.

4 Sustain

Monitor process measures and reassess impact.

Surveillance is valuable when findings are shared with those who can act.

References

1 California Department of Public Health, Healthcare-Associated Infections Program. Infection Surveillance in Skilled Nursing Facilities. Last updated 2018. View CDPH SNF Infection Surveillance PDF

2 Stone et al. Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria. Infect Control Hosp Epidemiol. 2012;33(10):965-977.