NHSN Surveillance: Summary of Major 2026 Updates

Speaker

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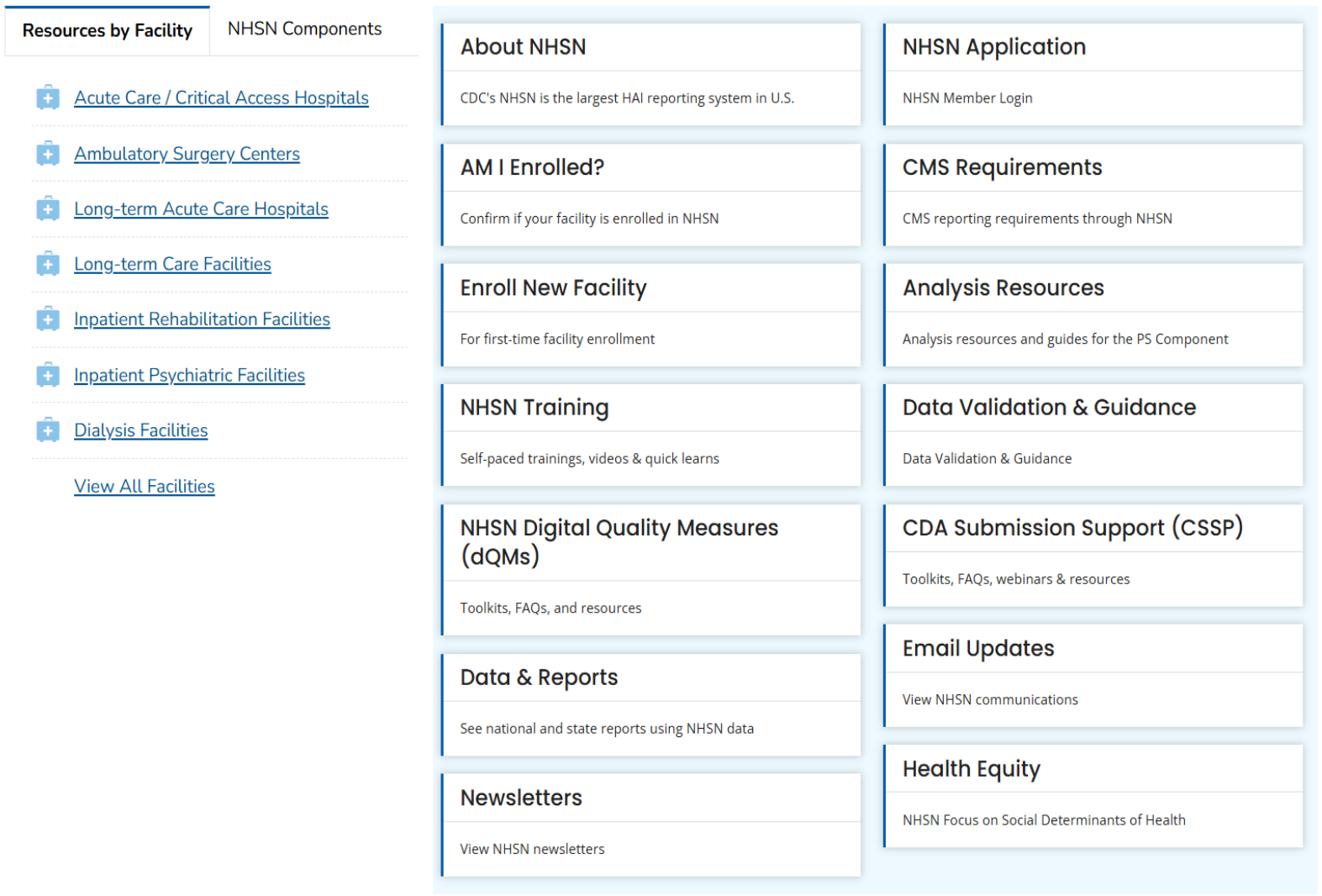
  - Ms. Holmes has experience in mentoring novice Infection Preventionists and program management in a wide range of healthcare settings including acute care, long term acute care, and rehabilitation facilities.
  - Ms. Holmes has been a Fellow of APIC since 2024, obtained her AL-CIP in 2025, is a contributing author to the APIC text, has published abstracts and papers on inter-rater reliability for surveillance, and is currently the co-host for APIC's 5 second rule podcast.

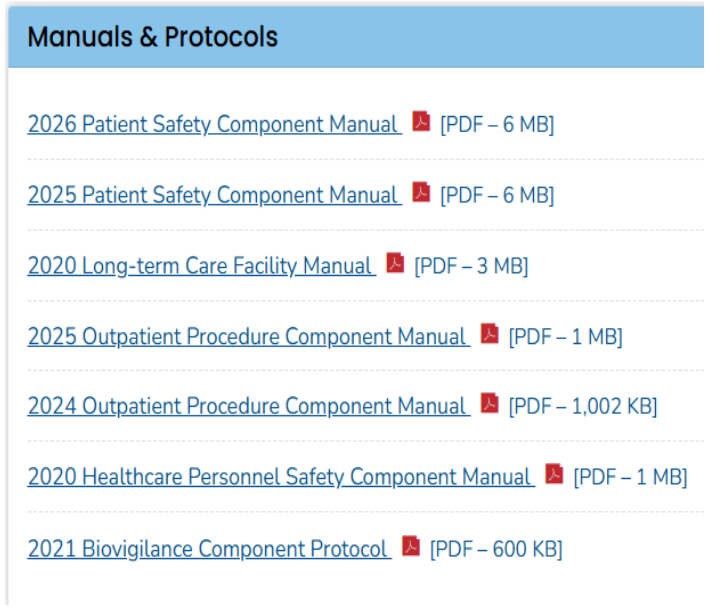
Objectives

- Summarize key changes in the 2026 NHSN Patient Safety Component Manual
- Interpret changes to surveillance timeframes for BONE criteria
- Apply updated 2026 SSI criteria
- Review updates in the NHSN application

NHSN Materials for Enrolled Facilities



At the bottom of the page links to the full manuals are listed:



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2026 NHSN Patient Safety Component Manual

NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2026

National Healthcare Safety Network (NHSN) Patient Safety Component Manual

Table of Contents

Please Note: The NHSN Patient Safety Component Manual is updated annually based on subject matter expert review and user feedback. Over time, certain chapters have been retired or moved to other components. To avoid confusion, the chapters in the PSC manual do not shift to account for these changes; therefore, chapters 5, 8, and 13 are not listed in the Table of Contents or included in this

Chapter 2: Identifying Healthcare-associated (HAIs) in NHSN

- Additions
  - Added vector-borne bacteria to list of community organisms that cannot be used to meet any NHSN definition
    - Anaplasma spp., Ehrlichia spp., Borrelia spp., Rickettsia spp.
    - Language updated in multiple chapters (UTI, BSI, SSI, VAE)
  - Added an extended Infection Window Period (IWP), increasing it to 21 days, for the osteomyelitis (BONE) definition
    - Repeat Infection Timeframe (RIT) continues for the duration of current admission
    - Secondary BSI attribution period includes the 21-day IWP and all remaining days of the patient's current admission.
    - Due to the extended SBAP, secondary BSI pathogen assignment is limited to blood organisms that match those used to meet the BONE definition

Example SBAP determination for BONE

Scenario:

BONE definition met using:

- BONE-1 with culture (*P.aeruginosa*) *OR*
- BONE-3a with blood (*P.aeruginosa*)

During BONE secondary BSI attribution period:

- Blood culture grows:
  - *P.aeruginosa* and *E.coli*

What can be assigned to the BONE event?

- *P.aeruginosa* – matches organism used to meet BONE definition, can be assigned as secondary BSI
- *E.coli* – does NOT match organism used to meet BONE definition, cannot automatically be assigned to BONE

What happens to the E.coli?

- Determine if the E.coli blood specimen can be used to meet the BONE criteria
- If YES → both organisms may be assigned
- If NO → identify as secondary to another site-specific infection OR code as primary BSI

Chapter 4: Bloodstream Infections

- Additions
  - CLABSI exclusion for patients with a Total Artificial Heart (TAH)
    - BSIs meeting LCBI criteria with an eligible central line meet the exclusion when the TAH is in place for more than 2 days on the BSI DOE and remains in place on the DOE or the day before.

  - Updated excluded LCBI pathogens to include Shiga toxin-producing *E.coli*, Enterotoxigenic *E.coli*, Enteroinvasive *E.coli*, Enteroaggregative *E.coli*, diffusely adherent *E.coli*, and *Giardia*
    - These organisms remain eligible for use in secondary BSI determinations

Chapter 4: Bloodstream Infections

- Clarifications

Notes:

1. Neither the type of device nor the insertion site is used to determine if a device is considered a central line for NHSN reporting purposes. Any intravascular catheter (such as introducers, midlines, or arterial catheters) depending on the location of the tip and its use, may be considered a CL.

Devices **Not** Considered Central Lines for NHSN Reporting Purposes:

- Arterial catheters unless in the pulmonary artery, aorta, or umbilical artery
- Arteriovenous fistula
- Arteriovenous graft
- Extracorporeal life support (ECMO)
- Hemodialysis reliable outflow (HERO) dialysis catheter
- Intra-aortic balloon pump (IABP) devices
- Peripheral IV
- Midlines unless the central line definition is met
- Total Artificial Heart (TAH)
- Ventricular Assist Device (VAD)

Blood Specimen Collection

The “two or more blood specimens drawn on separate occasions” criterion is met if there is blood collected from at least two separate blood draws* on the same or consecutive calendar days.

*Two separate blood draws mean the blood cultures are assigned separate specimen numbers, processed individually, and are reported separately in the final laboratory report.

Chapter 7: Urinary Tract Infection

- Addition
  - Added a new subsection titled ‘Identifying a CAUTI’

Identifying a CAUTI

NHSN surveillance is aimed at identifying risk to the patient that is the result of indwelling urinary catheter use. IUC device days are counted by calendar day, not to be mistaken as 24-hours. If an IUC is present for any part of a calendar day, it will count as a device day even if it was removed and a new one was inserted. The device day count is only interrupted and starts anew if a full calendar day passes with no IUC present.

Example

Two patients, A and B, are in an inpatient unit and had indwelling urinary catheters (IUCs) inserted on the same day. Later, on Hospital Day 4, both patients had their IUCs removed. The device utilization for Patients A and B varied for the remainder of their admissions (see Figure 1 below).

Figure 1. Indwelling Urinary Catheter Utilization Timeline, CAUTI Eligibility

	March 29th	**March 30th**	**March 31st**	**April 1st**	**April 2nd**	**April 3rd**	**April 4th**	**April 5th**
Patient A	IUC Inserted (Day 1)	IUC (Day 2)	IUC (Day 3)	IUC Removed (Day 4)	IUC Inserted (Day 5)	IUC Inserted (Day 6)	IUC Removed (Day 7)	No IUC
Patient B	IUC Inserted (Day 1)	IUC (Day 2)	IUC (Day 3)	IUC Removed (Day 4)	No IUC	IUC Inserted (Day 1)	IUC (Day 2)	IUC (Day 3)

- **Rationale (*Patient A*):** A UTI with a date of event on or between March 31st and April 5th, would be a CAUTI since the patient had an IUC in place for greater than two consecutive days. Please note, a UTI with a date of event on April 5th does qualify as a CAUTI, even though the IUC was removed the day prior (see Table 1).

- **Rationale (*Patient B*):** A UTI with a date of event on or between March 31st and April 2nd, would be a CAUTI since the patient had an IUC in place for greater than two consecutive days. A UTI with a date of event on April 2nd does qualify as a CAUTI, even though the IUC was removed the day prior (see Table 1). Additionally, Patient B becomes eligible again for a CAUTI on April 5th.

Chapter 7: Urinary Tract Infection

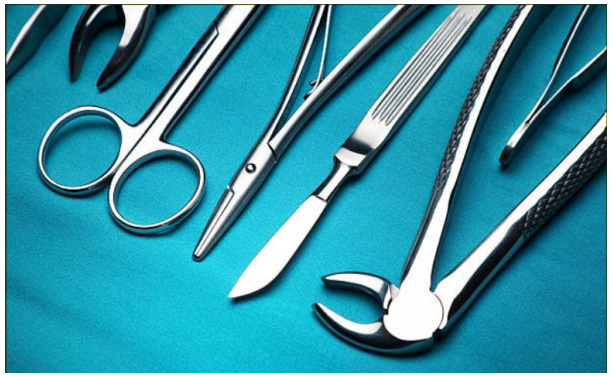
- Clarifications
  - Moved “All elements of the SUTI criterion must occur during the IWP’ out of each criterion and into a note above Table 1
  - Moved ‘Fever and hypothermia are non-specific symptoms of infection and cannot be excluded from UTI determination because they are clinically deemed due to another recognized cause’ out of each SUTI criterion and into the SUTI Comments section
  - Revised ABUTI element ‘3’ for clarity

Table 1. Urinary Tract Infection Criteria

Note: All elements of the UTI criterion must occur during the IWP (see IWP Definition Chapter 2 Identifying HAIs in NHSN).

Criterion	Urinary Tract Infection
	Symptomatic UTI (SUTI) Must meet at least ***one*** of the following criteria:
SUTI 1a **Catheter-associated Urinary Tract Infection (CAUTI) in any age patient**	Patient must meet 1, 2, and 3 below: 1. Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event AND was either: • Present for any portion of the calendar day on the date of event†, **OR** • Removed the day before the date of event‡ 2. Patient has at least ***one*** of the following signs or symptoms:
Asymptomatic Bacteremic Urinary Tract Infection (ABUTI) (Any age patient)	
	Patient must meet 1, 2, and 3 below: 1. Patient with* or without an indwelling urinary catheter has no signs or symptoms of SUTI 1 or 2 regardless of age. 2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of ≥100,000 CFU/ml (see Comments below). 3. Patient has recognized pathogen(s) identified** from blood specimen with at least ***one*** matching bacterium to the ≥100,000 CFU/ml bacterium identified in the urine specimen **OR** Patient is eligible to meet LCBI 2 with chills or hypotension (not fever) and common commensal(s) in the blood and urine specimens match.

Chapter 9:
Surgical Site Infection (SSI) Event



- Additions
  - Definition of Ambulatory Surgery Center for Outpatient Procedure Component reporting
    - Entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and expected duration of services would not exceed 24 hours following an admission
  - Added AORN active link for wound classification descriptions
  - Definition of ‘spontaneous dehiscence’:
    - Re-opening of a surgical incision that is <u>not due</u> to external factors such as direct trauma
  - For SSI Event Reporting Instruction #3 (PATOS):
    - For C-section (CSEC) procedures ONLY – chorioamnionitis (including suspected) documented in the operative narrative is eligible for PATOS at organ space level

Surgical Site Infection (SSI) Event: Superficial Incisional SSI ‘c’ updated

2025

- Superficial Incisional SSI ‘c’ :
  - a superficial incision that is deliberately opened or re-accessed by a surgeon, physician* or physician designee, and culture or non-culture based testing of the superficial incision or subcutaneous tissue is not performed
  - **AND**
  - patient has at least one of the following signs or symptoms: localized pain or tenderness; localized swelling; erythema; or heat

2026

- Superficial Incisional SSI ‘c’ updated:
  - a superficial incision that is deliberately opened, re-accessed or aspirated by a surgeon, physician* or physician designee
  - **AND**
  - the surgeon, physician*, or physician designee initiates or continues antibiotic or antifungal therapy **on or in the two calendar days following the date of deliberate opening, re-access, aspiration** with a duration of two calendar days or longer
  - **AND**
  - patient has at least one of the following signs or symptoms: new or worsening localized pain or tenderness; localized swelling; erythema; or heat

Surgical Site Infection (SSI) Event: Deep Incisional SSI

2025

Deep incisional SSI
Must meet the following criteria:

Date of event occurs within 30 or 90 days following 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 is deliberately opened*, re-accessed, or aspirated by a surgeon, physician** or physician designee or spontaneously dehisces
   AND
   organism(s) identified from the deep soft tissues of the incision 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. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.
   AND
   patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness
c. an abscess or other evidence of infection involving the deep incision detected on gross anatomical exam, histopathologic exam, or imaging test

2026

Deep incisional SSI
Must meet the following criteria:

Date of event occurs within 30 or 90 days following 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. organism(s) identified from the deep soft tissues of the incision by a culture- or nonculture- based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing [ASC/AST])
c. a deep incision that is deliberately opened⁺, re-accessed, or aspirated by a surgeon, physician‡ or physician designee or spontaneously dehisces¶
   AND
   the surgeon, physician‡, or physician designee initiates or continues antibiotic or antifungal therapy **on or in the two calendar days following the date of deliberate opening, re-access, aspiration or spontaneous dehiscence¶** with a duration of two calendar days or longer
   AND
   patient has at least ***one*** of the following signs or symptoms: fever (>38°C); new or worsening localized pain or tenderness
d. an abscess, or other evidence of infection involving the deep incision detected on gross anatomical exam, histopathologic exam, or imaging test

Example: HPRO Case Study

- 77-year old female had HPRO procedure on 1/17/26
- Return to the ED on 2/13 with left hip pain and recurrent left hip dislocation. Pt has left hip tenderness with deformity.
- 2/13 ESR 43mm/hr, CRP 64.9 mg/L
- Return to surgery on 2/14 for revision of left hip
- Medications:
  - IV Meropenem, 2/12-3/9
  - Oral Linezolid, 2/14-2/24

2/14 Operative note:

- The prior incision was entirely excised. Incision was taken down to the fascia using the laser cautery.
- The fascia was incised using electrocautery and the gluteus maximus muscle was split proximally. There was a hematoma which was evacuated, cultures were taken.
- Additional synovial tissue and joint fluid were sent for culture. There was no evidence of purulence.
- Culture results:
  - 2/14 Lt Hip Deep Wound – No growth
  - 2/14 Lt Hip Synovial Tissue +S.epidermidis
  - 2/14 Lt Hip Joint fluid – No growth

According to the 2026 NHSN SSI definition, does this patient meet criteria for infection?

Year-to-year Comparison

2025

- **Does NOT meet SSI-DIPb Criteria**
- Date of event occurs within 30 or 90 days following the NHSN operative procedure (**Proc 1/17**)
- **AND** involves deep soft tissues of the incision **AND** patient has at least ***one*** of the following:
- a deep incision that is deliberately opened, re-accessed, or aspirated by a surgeon **(Return to surgery 2/14)**
- **AND** organism(s) identified from the deep soft tissues of the incision by a culture, which is performed for purposes of clinical diagnosis or treatment, or a culture-based or non-culture-based microbiologic testing method is not performed. (**2/14 Op note – deep tissue negative)**
- **AND** patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness (**2/13 ED Notes – left hip pain/tenderness**)

2026

- **Meets SSI-DIPc**
  - Date of event occurs within 30 or 90 days following the NHSN operative procedure **(Proc 1/17, DOE 2/13/26)**
- **AND** involves deep soft tissues of the incision **AND** patient has at least one of the following:
- a deep incision that is deliberately opened, re-accessed, or aspirated by a surgeon **(2/14 Return to OR)**
- **AND** the surgeon, physician, or physician designee initiates or continues antibiotic or antifungal therapy on or in the two calendar days following the date of deliberate opening with a duration of two calendar days or longer **(IV Meropenem 2/12-3/9, Linezolid 2/14-2/24)**
- **AND** patient has at least one of the following signs or symptoms: fever (>38°C); new or worsening localized pain or tenderness (**2/13 ED Note: left hip pain**)

Chapter 12: MDRO & CDI

- Additions
  - Descriptive Analysis reports link
- Clarifications
  - Statement that the LabID event 14-day timeframe is between *positive specimens* in the location, not 14 days between *events*.
  - Updated 'Examples of Multi-step Testing Interpretation' table with more detailed examples and explanations

Note: NHSN recommends each facility keep an internal line listing log of all positive isolates as a reference in LabID event reporting to ensure the LabID event 14-day rule is applied correctly. The LabID event 14-day timeframe is between positive *specimens* in the location, not 14 days between *events*. The 14-day rule for LabID event reporting is specific to the location and resets each time a patient transfers to a new inpatient location.

EXAMPLE: Monitoring *Blood Specimens only* with multiple isolates from same location	On January 1, an ICU patient has a positive MRSA urine culture which is **not entered** into NHSN because blood specimens only are being monitored. On January 2, while in the same location (ICU), the same patient has a positive MRSA blood culture which **is entered** into NHSN. This starts the 14-day count. On January 5, while in the same location (ICU), the same patient has another positive MRSA blood culture which is **not entered** into NHSN because it has not been 14 days since the original positive MRSA blood culture while in the same location. The January 5 positive blood culture starts a new 14-day count. On January 19, while in the same location (ICU), the same patient has another positive MRSA blood culture. The January 19 MRSA blood culture **is entered** into NHSN because it has been more than 14 days since the patient's most recent positive blood culture (January 5) while in the **same** location (January 19 is day 15).

Date	Location	Specimen Body Site	Reportable?	
1-Jan	ICU	Urine – MRSA isolate	NO	
2-Jan	ICU	Blood – MRSA isolate	YES	
3-Jan	ICU			
4-Jan	ICU			
5-Jan	ICU	Blood – MRSA isolate	NO	1
6-Jan	ICU			2
7-Jan	ICU			3
8-Jan	ICU			4
9-Jan	ICU			5
10-Jan	ICU			6
11-Jan	ICU			7
12-Jan	ICU			8
13-Jan	ICU			9
14-Jan	ICU			10
15-Jan	ICU			11
16-Jan	ICU			12
17-Jan	ICU			13
18-Jan	ICU			14
19-Jan	ICU	Blood – MRSA isolate	YES	15

Non-blood isolate

<14 days from prior blood isolate -- no new blood isolate can be reported

>14 days -- new blood isolate should be reported

Chapter 17: Site-Specific Infections

- Addition:
  - Chapter 17, page 1
    - Note 3: Examples of “suspected infection”
  - BONE: Expanded timeframes
    - IWP 21 days
    - RIT extended to include the remainder of the patient’s current admission
    - SBAP is 21-day infection window period plus all subsequent days of the patient’s current admission
      - Limited to organism identified in blood specimen that matches the organism(s) used to meet the BONE definition
    - Added physician diagnosis of osteomyelitis with documentation of antimicrobial treatment (3c)

3. Examples of “suspected infection” include but are not limited to the following:
   a. Physician documentation of the suspected infection
   b. Physician documentation of antimicrobial therapy for a specified infection
   c. Imaging tests performed on the suspected infection location
   d. Site-specific specimen collection

Osteomyelitis must meet at least ***one*** of the following criteria:

1. Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

   And at least *one* of the following:

   a. organism(s) identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

   AND

   imaging test evidence definitive for infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for osteomyelitis.

   b. imaging test evidence definitive for infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician or physician designee diagnosis of osteomyelitis with documentation of antimicrobial treatment.

   c. physician or physician designee diagnosis of osteomyelitis with documentation of antimicrobial treatment.

** With no other recognized cause*

Chapter 17: Site-Specific Infections

- Additions
  - PJI 3: Two new elements added to minor criteria:
    - Synovial fluid alpha-defensin positive
    - Physician diagnosis of periprosthetic joint infection

PJI – Periprosthetic Joint Infection (for use as Organ/Space SSI following HPRO and KPRO only)

Periprosthetic joint or bursa infections must meet at least ***one*** of the following criteria:

1. ***Two*** positive periprosthetic specimens (*tissue or fluid*) with at least one matching organism, identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. A sinus tract* communicating with the joint, purulence, or other gross anatomic evidence of infection.
3. Having ***three*** of the following minor criteria:
   a. elevated serum C-reactive protein (CRP; >100 mg/L) ***and*** erythrocyte sedimentation rate (ESR; >30 mm/hr.)
   b. elevated synovial fluid white blood cell (WBC; >10,000 cells/µL) count *OR* "++" *(or greater)* change on leukocyte esterase test strip of synovial fluid.
   c. elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%)
   d. positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).
   e. organism(s) identified from a single positive periprosthetic specimen (*tissue or fluid*) by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
   f. Synovial fluid alpha-defensin positive.
   g. Physician diagnosis of periprosthetic joint infection.

* A sinus tract is defined as a narrow opening or passageway that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.

Chapter 17: Site-Specific Infections

- ENDO:
  - Criteria 5 &6: Immune complex-mediated glomerulonephritis criteria added to 'Notes'
  - Clarification of "new valvular regurgitation on auscultation"
    - For use when an echocardiogram is not available
  - Definition of "significant new valvular regurgitation" added
    - "Significant new valvular regurgitation" is defined as moderate or severe valvular regurgitation. This imaging finding is valve-specific and cannot be pre-existing. Worsening of this condition is **not** eligible for use (ex. mild to moderate tricuspid regurgitation).

10. Immune complex-mediated glomerulonephritis is defined as **one** of the following:

    a. Unexplained presence of either acute kidney injury (new reduction of estimated glomerular filtration rate (eGFR) <60 mL/min/1.73 m^2)

    OR

    b. Unexplained acute on chronic kidney injury (for example: from "moderately decreased" to "severely decreased"; or from "severely decreased" to "kidney failure." (Interpretive ranges for eGFR: normal ≥60 mL/min/1.73 m^2; moderately decreased 30–59 mL/min/1.73 m^2; severely decreased 15–29 mL/min/1.73 m^2; kidney failure)

    AND

    Two of the following: hematuria, proteinuria, cellular casts on inspection of urinary sediment, hypocomplementemia, cryoglobulinemia, and/or presence of circulating immune complexes.

    c. Renal biopsy consistent with immune complex-mediated renal disease.

Updates on NHSN application

- March 19, 2026 Release:
  - Total Artificial Heart (TAH) CLABSI exclusion in the BSI event form.
    - Hold events or submit and edit after March 19 release
  - SCI-NB ICD10CM diagnosis codes in the UTI event form.

- PJI Criteria modification will not be available in NHSN in 2026

SCI-NB ICD10CM diagnosis codes	March 19, 2026	Hold the submission of UTI events where “Neurogenic Bladder” is “blank” or “Y” until the release. **OR** Enter UTI events where “Neurogenic Bladder” is “blank” or “Y”. The NHSN team will deploy a script to that will flag any UTI event where “Neurogenic Bladder” is “blank” or “Y” that was entered between January 1, 2026 and March 19, 2026 to be manually updated. **Additional Notes:** • If “Neurogenic Bladder” is “N,” no action is needed. • The “Neurogenic Bladder” field is required starting January 1, 2026. However, it will not be labeled as such in the UI, and business rules will not apply until March 19, 2026 release. • The “Neurogenic Bladder” field will remain optional via CDA until the September 24, 2026 CDA release (version R4D4). Users will have the option to edit UTI events manually in the UI prior to this release. • Users will have until August 17, 2026, to make SCI-NB ICD10CM Diagnosis codes updates for Q1 data submission.

PJI criteria modifications	Unavailable in 2026	Use the following instructions to enter Organ/Space SSI – PJI events for 2026 ONLY. Please note, to correctly capture Organ/Space SSI - PJI events in NHSN, both a General Organ/Space SSI criterion, and PJI definition elements must be selected in the NHSN application.
		
		• If General Organ/Space 'b' and PJI '1' are met using two periprosthetic specimens with organisms identified select **‘Organisms identified’** for General Organ/Space ‘b’ and select **‘Organisms identified from >= 2 periprosthetic specimens’** for PJI ‘1’. If a different General Organ/Space criterion is met, adjust as appropriate.
		• If General Organ/Space ‘c' and PJI '2' are met with a sinus tract communicating with the joint, purulence, or other gross anatomic evidence of infection select **‘Other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam.’** for General Organ/Space ‘c’. If a different General Organ/Space criterion is met, adjust as appropriate. For all PJI '2’ elements: Sinus tract, purulence or other gross anatomic evidence of infection, select **‘sinus tract’**.
		• If you are meeting General Organ/Space and PJI '3' with three minor criteria, the options will vary.
		  • Use **'other positive laboratory tests'** for Synovial fluid alpha-defensin positive.
		  • Use **'other evidence of infection found on invasive procedure, gross anatomic exam, or histopathologic exam'** for Physician diagnosis of periprosthetic joint infection.
		  • NHSN recommends using the 'comments' section to specify the PJI criteria applied denoting the elements used to satisfy criteria.

Questions

References:

- NHSN Home:

https://www.cdc.gov/nhsn/index.html

- Materials for Enrolled Facilities:

https://www.cdc.gov/nhsn/enrolled-facilities/index.html

- 2026 Patient Safety Component Manual

pcsmanual_current.pdf

- Analysis Reports

https://www.cdc.gov/nhsn/ps-analysis-resources/reference-guides.html