|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Patient History** |  |  |
| 1 | heltrisk | Is there documentation the patient had risk for healthcare associated pneumonia?Determined by the presence of one of the following:* Acute care hospitalization within the last 90 days
* Residence in a nursing home or extended care facility for any amount of time within the last 90 days
* Chronic dialysis within the last 30 days prior to this hospitalization
* Wound care, tracheostomy, or ventilator care provided by a health care professional within the last 30 days
1. Yes
2. No

  | 1,2 | **For the purpose of the Pneumonia data collection:*** **If there is physician/nurse practitioner/physician assistant documentation that the patient has ‘healthcare associated pneumonia’, ‘HCAP’, or ‘nosocomial pneumonia’, select “1.”**
* If there is documentation of a ‘hospitalization’ or ‘admission’ within the last 90 days, assume it was an acute care hospitalization unless there is documentation that states otherwise.
* Do not make an assumption as to patient’s admission or hospitalization based on the procedure they received. For example, only use dates or phrases such as “in the hospital a couple of days last month.”
* An extended care facility is a non-apartment based institutional setting where 24-hour nursing care is provided
	+ **Include** nursing homes, skilled nursing facilities, ECF, ICF, hospice facilities, SNF rehab units, sub-acute care, transitional care, respite care, inpatient rehab unit or facility, and VA nursing facilities.
	+ **Exclude** assisted living, board and care, group homes, personal care homes, residential care, chemical dependency treatment, drug rehab, psych unit or facility, or hospice at home.
* Chronic dialysis is defined as ESRD (End Stage Renal Disease) with peritoneal dialysis or hemodialysis. Also include, continuous arterio-venous hemofiltration (CAVH) and continuous veno-venous hemofiltration (CVVH).
* If wound care is documented in the medical record without a timeframe to ascertain that the wound care was provided within the last 30 days (i.e., “history of”, “about a month ago”), select “no.”
* There does not have to be specific documentation that one of these events has occurred and is a risk for healthcare associated pneumonia. Documentation in the record of the event occurring (within the specified time period) is sufficient.

Suggested Data Sources: consultation notes, discharge summary, ED record, H&P, nursing admission notes, progress notes  |
| 2 | othrinf | Was there physician/APN/PA documentation of another **suspected** source of infection in addition to pneumonia within 24 hours of arrival?**(Refer to Inclusion and Exclusion List)** | 1,2 | **In order to answer “1,” there must be physician/APN/PA documentation of an infection/suspected infection, in addition to pneumonia, within 24 hours of arrival. For example, upon arrival, the physician documents the patient has a UTI or 2 hours after arrival the APN documents “suspect sepsis from decubitus ulcer,” select “1.”**Only consider infections/suspected infections that are being/will be treated by an ANTIBIOTIC listed in Joint Commission Table 2.1 (Appendix C), that are administered via routes PO, IM, or IV. There does not need to be documentation that ties the antibiotic to the infection/suspected infection.Documentation of signs or symptoms (e.g. fever, elevated white blood cells, etc.) should **not** be considered infections unless documented as an infection or possible/suspected infection.Do not assume a bacterial infection if there is only documentation with the suffix ‘itis’. For example, physician documents cystitis without documentation of UTI, bladder infection, or antibiotic treatment ordered for the cystitis.

|  |  |
| --- | --- |
| **Inclusion** | **Exclusion** |
| * Abscess outside of lung
* Infected skin ulcer
* Osteomyelitis or septic joint (infective arthritis)
* Urinary Tract Infection
 | * Any infection in the Respiratory Tract (sinusitis, laryngitis, bronchitis, pleurisy, other lung infection)
* Any yeast, viral or fungal infections
* Bacteremia or blood stream infection (unless there is documentation of another infection outside of the Respiratory Tract OR at the time of arrival, patient has a central intravenous catheter such as Hickman, PICC, Infusaport, etc.)
* Sepsis (unless there is another infection outside of the Respiratory Tract)
* Systematic Inflammatory Response Syndrome (SIRS)
 |

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| 3 | pospatid | Is there documentation that results of a positive culture or diagnostic test for a pathogen were available upon arrival or within 24 hours after arrival to the hospital?**For the purposes of this measure, a positive diagnostic test for a pathogen includes any of the following:*** Positive culture (blood, urine, sputum, wound, etc.) for bacteria
* Positive urinary antigen test for Streptococcus pneumoniae or Legionella pneumophilia
* Positive Polymerase Chain Reaction (PCR) test for Legionella pneumophilia
1. Yes
2. No
 | 1,2 | **The results of a positive culture or diagnostic test for a pathogen must be available upon arrival or within 24 hours after arrival.** If the medical record contains documentation of a positive culture performed within a week prior to arrival, select “1.”Physician/APN/PA documentation of a known pathogen within 24 hours of arrival is acceptable. For example, physician documents in ED H&P, “has chronic history of pseudomonas,” select “1.”If a culture is drawn prior to arrival or within 24 hours of arrival but results documenting a pathogen are not available within 24 hours of arrival, select “2.”Gram stain results alone are not acceptable--a pathogen must be identified. For example, a sputum report notes gram positive cocci, but an organism has not been identified, select “2.” The 24 hours after arrival time is the same for patients who arrive through the ED or as a direct admit.**Exclude:** Tests collected/drawn but not available/reported within 24 hours after arrival to the hospital, gram stain results (e.g. positive cocci, gram negative rods, normal flora) that do not list a pathogen, standing orders used to screen a population of patients or ALL patientsSuggested data sources: Lab results |
| 4 | compcond | Is there documentation the patient had a compromising condition? (see definitions/decision rules for additional instruction**)** **No timeframe necessary:**AIDS, AIDS related complex (ARC)HIV, HIV positiveAny “Immunodeficiency Syndrome”Chronic Lymphocytic Leukemia (CLL)Congenital or hereditary ImmunodeficiencyOrgan transplant**Within the last 3 months OR as diagnosed/administered for the first time during this hospitalization**:Leukemia Lymphocytic leukemiaLymphomaMarked or significant neutropeniaMyelogenic leukemiaMyelomaMyelodysplasiaPancytopeniaSystemic ChemotherapySystemic Radiation therapy**Within the last 3 months prior to this hospitalization:**Systemic Corticosteroid/prednisone therapy Systemic ChemotherapySystemic Immunosuppressive therapySystemic Radiation therapy1. Yes2. No or unable to determine | 1,2 | **Compromising condition** = **The patient has a clinical condition that could cause an impaired immune system or is on a therapy that puts them at a higher risk for infection.** **The only acceptable compromising conditions are the conditions listed.** **Select “1” if any of the following are documented:*** **Physician/APN/PA documentation that the patient is immunocompromised.**
* **Documentation that the patient is currently undergoing systemic chemotherapy or radiation therapy or received chemotherapy or radiation therapy within the last 3 months prior to hospitalization.**
* **Documentation of a compromising condition within the timeframe specified (see below)**

**1) No timeframe necessary:** Acquired Immune Deficiency Syndrome, AIDS, AIDS related complex, any “immunodeficiency syndrome”, ARC, chronic lymphocytic leukemia (CLL), congenital or hereditary immunodeficiency, HIV +, HIV, or organ transplant **2) Compromising conditions within the last 3 months OR as diagnosed for the first time during this hospitalization:** leukemia, lymphocytic leukemia, lymphoma, marked or significant neutropenia, myelogenic leukemia, myeloma, myelodysplasia, pancytopenia, systemic chemotherapy, systemic radiation therapy. If there is physician documentation of “possible”, “suspected”, etc., in reference to any of the above conditions, select “1,” unless there is documentation that the condition was ruled out within 24 hours of arrival. * If there is no timeframe documented in the medical record to indicate the condition has been present within the last 3 months (e.g., ‘history of’, etc.), do not select “1”

**3) Systemic corticosteroid/prednisone therapy must have occurred within the last three months prior to this hospitalization**. **Cont’d next page** |
|  |  |  |  | **Compromised cont’d*** Systemic corticosteroids listed as “home meds” or “current meds” are considered chronic, unless there is documentation the steroid therapy is a one time course or listed as “PRN”.
* One time use or one course of systemic corticosteroids is NOT considered compromised.
* If there is documentation of chronic ‘steroids’, select “1.”

**Exclude:** any steroid therapy that is not systemic (i.e., inhaler, eyedrops, topical, etc.), or administered via epidural/spinal injections**Medication References:** Joint Commission (JC) Appendix C, Table 2.2 “Immunosuppressive Medications” and Table 2.15 “Systemic Corticosteroids”. Suggested data sources: consultant notes, discharge summary, ED record, H&P, nursing admission notes |
| 5 | prevhosp | Is there documentation the patient had an acute care hospitalization within 14 days prior to this episode of care? 1. Yes2. No or unable to determine | 1,2 | **In order to select value “1”, the patient must be discharged from an acute care facility for inpatient care to a non-acute setting (e.g., home, SNF, ICF or rehabilitation facility) before the second admission to the same or different acute care facility.** This question is the second part of the compromising condition question. If the patient had a prior hospitalization within 14 days, the intent is to exclude possible nosocomial (hospital acquired) infections. For the purposes of this data element, if there is documentation of a ‘hospitalization’ or ‘admission’, assume it was an acute care hospitalization unless there is documentation that states otherwise.Suggested data sources: consultant notes, discharge summary, ED record, H&P, nursing admission notes |

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| 6 | rskpseud | Did the patient have risk of pseudomonas as evidenced by documentation of one of the following?* Structural lung disease **AND** documented history of repeated antibiotics or chronic systemic corticosteroid use. Repeated antibiotics and/or chronic systemic corticosteroid use can be for any reason. It does not have to be linked to the structural lung disease.
* Bronchiectasis documented as a possible consideration by a physician/APN/PA or pharmacist at the time of admission
* Physician/APN/PA or pharmacist documented pseudomonal risk

1. Yes2. No | 1,2 | **For the purposes of this data element, structural lung disease includes:** * Chronic Bronchitis
* COPD
* Emphysema
* Interstitial lung disease – any of a group of diseases that affect the tissue and space around the air sacs of the lungs and may lead to progressive scarring of lung tissue
* Restrictive lung disease – any of a group of diseases that result in reduced lung volume

**Exclude reactive lung diseases such as asthma.****One time use or one course of antibiotics or systemic corticosteroids is not considered chronic.** **There must be documentation of both repeated antibiotics and/or (chronic or long term) systemic corticosteroid therapy taken within the last 3 months AND structural lung disease in order to select “1.”** Example: “Patient is taking chronic steroids for Lupus and they also have COPD.” * If there is documentation of chronic ‘steroids’, select “1.”
* Corticosteroids listed as “home meds” or “current meds”, are considered “chronic”, unless there is documentation it is a one time course, or if it is listed as ‘PRN’. “Home meds” or “current meds” do not require physician/APN/PA or pharmacist documentation.
* “Repeated antibiotics” are defined as documentation of multiple “rounds” or “courses” of antibiotics taken within the last 3 months prior to hospital arrival.

Refer to Appendix C Table 2.15 for a comprehensive list of Systemic Corticosteroids. **Cont’d next page** |
|  |  |  |  | **Risk of Pseudomonas cont’d****Bronchiectasis is defined as chronic dilation of a bronchus or bronchi, with a secondary infection that usually involves the lower portion of the lung. Dilation may be in an isolated segment or spread throughout the bronchi.**Select “1” if there is physician/APN/PA or pharmacist documentation of:* A history of, current or suspected bronchiectasis. Examples: ‘rule out bronchiectasis’, ‘need to evaluate for bronchiectasis’.
* Risk for pseudomonas, select “1.” Examples: ‘will cover for pseudomonas’, ‘suspect pseudomonas’.

If there is documentation of doubt for bronchiectasis or pseudomonas, select “2.”If there is a preprinted form, such as a PN pathway with a heading of Pseudomonas Risk, selection of antibiotics alone is not sufficient to select “1.” However, if there is a marked checkbox next to the heading of Pseudomonas Risk, this will abstract as “1.”  |
| 7 | drpnursk | Did the patient have any documented risk factors for drug-resistant pneumococcus as evidenced by documentation of any of the following?For the purposes of the Pneumonia Project, the risk factors are: * Patients 65 and over
* ICU Patients – within 24 hours of arrival
* Alcoholism—any mention in chart
* Systemic antibiotic therapy in the last 3 months (prior to arrival)
* Medical co-morbidities
* Exposed to child in daycare
* Injection drug user—only illicit drugs

1. Yes2. No | 1,2

|  |
| --- |
| Computer will auto-fill as 1 if patient age >= 65 or adm24icu = 1 |

 | For the purposes of this question:* Medical co-morbidities are defined as: renal, heart, lung or liver disease documented within the last 3 months, diabetes mellitus (DM), asplenia, malignancy documented within the last 3 months.
* “Exposed to child in daycare” would consist of living with a child who attends daycare or the patient works at a daycare. Casual contact or visiting a family with a child who has been in daycare is not considered “exposure.”
* Only select “4” if antibiotic therapy was given in the last 3 months prior to arrival. Do not consider antibiotics given during this admission. See Joint Commission Table 2.1 (Appendix C) for a comprehensive list of antimicrobial medications.
* Alcoholism includes alcoholic and alcohol abuse
* Injection drug user (illicit drugs) includes IVDU, IV user, needles for drugs, needle user

Suggested Sources: Physician notes, nursing notes, H&P, progress notes |
| 8 | ptallerg | Is there documentation of patient allergies, sensitivities, or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications? | 1,2 | Allergy can be defined as acquired abnormal immune response to a substance (allergen) that does not normally cause a reaction.**If the patient was noted to be allergic to “cillins,” “penicillin,” or “all cillins,” enter “1.”** **If a physician, APN, PA, or pharmacist documents a specific reason not to give penicillin, beta lactams or cephalosporins, enter “1.”****Include:** adverse drug event, adverse effect, adverse reaction, anaphylactic reaction, anaphylaxis, hives, rash |
| 9 | blcltdon | Did the patient have blood cultures collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival? 1. Initial blood culture **collected in the ED prior to admission order**
2. Initial blood culture collected during this hospitalization but after admission order for ED patients (OR within 24 hours after arrival for Direct Admit patients)
3. Documentation that the patient had a blood culture collected the day prior to arrival up until the time of presentation to the hospital
4. Blood culture was not collected the day prior to arrival, the day of arrival, or within 24 hours after arrival or unable to determine from medical record documentation
 | 1,2,3,4**If 4, auto-fill blcltdt as 99/99/9999 and blcltme as 99:99, and go to abrecvd**

|  |
| --- |
| **Hard edit: Cannot = 1 if pnedpt = 2** |
| **Warning if 2 and pnedpt = 1** |

 | **Blood culture information abstraction should demonstrate actual collection of the blood culture. Do not use physician orders as they do not demonstrate collection of the blood culture.** * **For the purposes of this measure, a patient is no longer considered an ED patient after the admission order is written, regardless of whether the patient is still in the ED.**
* **If there are multiple admit orders, use the time of the earliest admit order. For the purposes of this data element, any form of a physician admit order can be used to determine admission time (e.g. physician order, nurse documentation of physician order, disposition or status change to admit).**
* **If the blood culture was collected in the ED, it is important to determine whether the blood culture was collected prior to OR after the admission order in order to appropriately select option “1” or “2.”**

**If there is documentation the initial blood culture was collected for the ED patient prior to the admission order (observation or inpatient), select “1.”** If a blood culture is ordered and there is a documented unsuccessful attempt to collect it or the specimen was contaminated during or after the draw, select “1” or “2” as applicable.If the patient was being held in ED following an admission order, and there is documentation the initial blood culture was collected while the patient was still in the ED but after the admission order, select “2.” For patients with documentation of blood cultures performed the day prior to arrival or the day of arrival prior to presentation to the hospital AND within 24 hours after arrival to the hospital, select value “2”. If the patient is a direct admit and a blood culture is collected within 24 hours after arrival, select value “2” regardless of the admit order timing.  |
|  |  |  |  | **Blood Cultures collected cont’d**If it is evident a blood culture was performed within 24 hours after arrival to the hospital, but you are unable to determine from medical record documentation if the blood culture was performed in the ED prior to admission or performed after admission, select “2.”If blood cultures were not collected within 24 hours after hospital arrival or if unable to determine from medical record documentation that a blood culture was collected after arrival, select “4.” **Include**: **BC, blood cultures, blood cultures collected on patients in observation, blood cultures done in VHA physician/APN/PA’s office, VHA outpatient clinic, NHCU, or other VHA treatment setting, initial blood culture collected within 24 hours after hospital arrival** **Exclude**: **Blood cultures collected more than 1 day prior to arrival, cultures collected in any treatment setting outside VHA, i.e., community nursing home, private physician’s office, private sector clinic, blood cultures collected more than 24 hours after hospital arrival** |
| 10 | blcltdt | Enter the date of the initial blood culture collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival. | mm/dd/yyyyAbstractor can enter 99/99/9999If blcltdon = 4, will be auto-filled as 99/99/9999If blcltdon = 3, auto-fill blcltme as 99:99, and go to abrecvd

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| If blcltdon = 1, >= arrvdate and <= admdt |
| If blcltdon = 2> = arrvdate and < = 1 day after arrvdate and < = leftdate |
| If blcltdon = 3< = 1 day prior to arrvdate and < = arrvdate |

 | **Do not include blood cultures collected more than 1 day prior to hospital arrival or greater than 24 hours after hospital arrival.**Documentation must specify **blood culture**. **Documentation such as “lab at bedside to draw blood culture” or “lab at bedside – blood drawn” is not acceptable (does NOT demonstrate blood culture collection took place).** If a blood culture is ordered and there is a documented unsuccessful attempt to collect the specimen or the specimen was contaminated during or after the draw, enter the date of the attempted blood culture collection. If there is supportive documentation that a blood culture was collected and it is the earliest mention of a blood culture, this date and time can be used, e.g., ‘BC sent to lab’, ‘blood culture received time’. Do not use physician orders as they do not demonstrate collection of the blood culture. **Include:** Blood culture (BC) within 24 hours after hospital arrival, blood culture (BC) the day prior to hospital arrivalIf the initial blood culture collection date is unable to be determined from medical record documentation, enter 99/99/9999.If the date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999. |

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| --- | --- | --- | --- | --- | --- | --- |
| 11 | blcltme | Enter the time of the initial blood culture collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival. | \_\_\_\_UMTIf blcltdon = 3 or 4, will be auto-filled as 99:99Abstractor can enter 99:99

|  |
| --- |
| If blcltdon = 1, >=arrvdate/arrvtime and <= admdt/pneadmtm |
| If blcltdon = 2, >=arrvdate/arrvtime and < = 24 hours after arrvdate/arrvtime and <= leftdate/leftime |

 | **If multiple times of blood culture collection are documented, abstract the earliest (initial) time that demonstrates collection of the blood culture.** **Examples:**Nurse’s note stating time that blood culture was collected (or terms such as drawn, obtained), or documentation of lab draw time, collection time, or time blood culture obtained Documentation must specify **blood culture**. **Documentation such as “lab at bedside to draw blood culture” or “lab at bedside – blood drawn” is not acceptable (does NOT demonstrate blood culture collection took place).** If a blood culture is ordered and there is a documented unsuccessful attempt to collect the specimen or the specimen was contaminated during or after the draw, enter the time of the attempted blood culture collection. If the initial blood culture collection time is unable to be determined from medical record documentation, enter 99:99.**If BLCLTDON = 3, but the time the blood culture was collected cannot be found, the abstractor can enter 99:99 only if the date the blood culture was collected is the same as the arrival date. If the date the blood culture was collected is not the same as the arrival date, and no time is available, the accuracy of “within 24 hours prior to arrival” is questionable. Return to question BLCLTDON and enter “4.”** If the time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. |
|  |  | **Medications** |  |  |
| 12 | abrecvd | Did the patient receive antibiotics via an appropriate route (PO, NG, PEG, IM, or IV)?1. **Antibiotic received only within 24 hours prior to arrival or the day prior to arrival and not during hospital stay**
2. **Antibiotic received within 24 hours prior to arrival or the day prior to arrival and during hospital stay**
3. **Antibiotic received only during hospital stay (not prior to arrival)**
4. **Antibiotic not received or unable to determine from medical record documentation**
 | 1\*,2 ,3,4\*\*If 1 or 4, go to smokcigsIf 2 or 3, go to antiname

|  |
| --- |
| Warning: If abrecvd = 1  |

  | **Only consider antibiotics listed in Joint Commission Table 2.1 (Appendix C).****Include only antibiotic routes listed in the PN inclusions for administration routes (PO or by NG or PEG tube, intramuscular (IM), or intravenous or perfusion).** Antibiotics listed as “current” or “home meds” should be inferred as taken within 24 hours prior to arrival or the day prior to arrival, unless there is documentation they were **not** taken within 24 hours prior to arrival. Documentation that a prescription for antibiotics was given to the patient is not sufficient. If the medical record contains documentation of medication administration and the antibiotic is not listed as a current medication and there is NO specific documentation to suggest the medication was taken within 24 hours of arrival or the day prior to arrival, do not consider it given within this time frame. **Example:** “Patient started on antibiotics two days ago.” • If there is other documentation to support that antibiotics were taken within 24 hours of arrival or the day prior to arrival consider it taken within 24 hours of or the day prior to arrival. **Example: “**Patient has been maintained on Rocephin for the last 5 days.” • If the date and/or time for an antibiotic dose is an obvious error but it is a valid date and/or time and that is prior to the patient’s arrival, the chart must be abstracted at face value and this information should be used to answer “yes” to antibiotics prior to arrival as applicable. **Example:** An arrival time is documented as 1400 and the antibiotic is documented as given at 1352 on the same date. The dose cannot be abstracted as given during the hospital stay and should be used to abstract *Antibiotic Received* as Value 1 or 2 as applicable.**Exclude:** abdominal irrigation, chest irrigation, eardrops, enema/rectally, eye drops, inhalation, intracoronary, joint irrigation, mixed in cement, mouthwash, nasal sprays, peritoneal dialysate (antibiotic added to), peritoneal irrigation, swish and spit, swish and swallow, topical antibiotics, troches, vaginal administration, wound irrigation Cont’d next page |
|  |  |  |  | **Antibiotic Received cont’d****Suggested Sources: any source documenting antibiotic administration,** anesthesia record, ED record, ICU flowsheet, IV flowsheet, Medication Administration Record, nursing notes, operating room record, PACU/recovery room record, perfusion record |
| 13 | antinameantidateantitimerouteadm | What was the name of the antibiotic dose (s) administered from hospital arrival through 24 hours after hospital arrival?Beginning with the first antibiotic administered following hospital arrival, enter the name of each antibiotic administered during the first 24 hours after hospital arrival.(Abstractor will enter first few letters of antibiotic name, and full name will appear in box. If incorrect, abstractor can select from drop box of Joint Commission Antimicrobial Medications Table 2.1.) What was the date of administration for the antibiotic dose?What was the time of administration for the antibiotic dose?Enter the route of administration of the antibiotic.1. PO, NG, PEG tube (Oral)
2. IV (Intravenous)
3. IM (Intramuscular)
4. UTD (Unable to determine route)

**May enter 25 antibiotics** | \_\_\_\_\_\_**antiname****antidate**mm/dd/yyyy**If date cannot be determined, the abstractor can enter 99/99/9999**

|  |
| --- |
| > = arrvdate and < = 1 day after arrvdate and < = leftdate |

**antitime**\_\_\_\_\_UMT**If time cannot be determined, the abstractor can enter 99:99**

|  |
| --- |
| > = arrvdate/arrvtime and < = 24 hrs after arrvdate/arrvtime and < = leftdate/leftime |

**routeadm**1,2,3,99 | **If an antibiotic is administered more than once by the same route during the first 24 hours after hospital arrival, only record the antibiotic name once.** **If the ROUTE of administration for the same antibiotic changes during the first 24 hours, record the antibiotic with each route change.****Only select “Antibiotic NOS” for the following situations:*** New antibiotics that are not yet listed in Joint Commission Table 2.1 (Appendix C)
* When the Antibiotic Name is missing or if there is documentation that a medication was administered and it cannot be determined what the name of the medication is. It must be apparent that the medication is an antibiotic.

**NOTE:** Abbreviations or minor misspellings in an antibiotic name can be overlooked as long as the abbreviated name/spelling error is readily recognizable or if it can be determined using supporting documentation from the same source as that antibiotic dose. Example: Ansef would be abstracted as Ancef.**Antibiotic Abstraction Guidelines:*** **Do not abstract antibiotic administration information for a specific antibiotic dose from more than one source.** If all information (name, route, date, and time) is not contained in a single data source for the specific antibiotic, enter the default for the missing information.
* **Antibiotic administration information should only be abstracted from documentation that demonstrates actual administration of the specific antibiotic.** **Either a signature or initials signifying administration of the antibiotic is required to abstract a specific antibiotic.** For example, do NOT abstract doses from a physician order unless they are clearly designated as given on the physician order form.
* **In the ED any narrative documentation of an antibiotic being administered may be abstracted. This includes antibiotics that are hung, infusing, infused, etc. However, outside the ED, narrative documentation can ONLY be abstracted if it is the ONLY documentation of a specific antibiotic found in the medical record.**
 |
|  |  |  |  | **Antibiotic Guidelines cont’d*** Statements such as “Ancef given in ED” or “Antibiotic given per MAR” should NOT be abstracted as they do not demonstrate an antibiotic was given at this time.
* **The time for an antibiotic administered via IV infusion refers to the time the antibiotic infusion was started.** The use of “hang time” or “infusion time” is acceptable as antibiotic administration time when other documentation cannot be found.
* A dose can be abstracted that is given by one person and documented as being given by another person if that dose is not documented by the person that actually administered it. Example: ED nurse, S.Smith RN, documents, “Cefazolin 1 gm IV given at 05:00 per J. Doe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.
* Authentication (i.e., date or signature/initials) on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
* The medical record must be abstracted as documented (taken at “face value”). When the date/time documented is an invalid date/time (not a valid format/range or outside of the parameter of care) and no other documentation is found on that same source that provides this information, the abstractor should enter the applicable default (i.e., 99/99/9999, 99:99).
* If the route of administration of an antibiotic cannot be determined (e.g. azithromycin 500 mg 1 tablet), enter “99” for route.

|  |  |
| --- | --- |
| **Include any antibiotics given:**Any feeding tubes (NG, PEG)IV, perfusionIMOrally (PO) | **Exclude:****All** other routes |

 |
|  |  | **Patient Education** |  |  |

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| --- | --- | --- | --- | --- |
| 14 | smokcigs | Did the adult patient smoke cigarettes any time during the year prior to hospital arrival?1. yes
2. no or unable to determine from medical record documentation
 | 1,2**If 2, auto-fill tobcess as 95** | This question refers only to smoking cigarettes and is not pertinent to other forms of tobacco**. If the record documents “tobacco use” or “+smoker” but the type of product is not specified, assume this refers to** **cigarette smoking unless documentation in another Only Acceptable Source suggests that the tobacco product is pipe, cigar, or chewing tobacco.** If there is definitive documentation anywhere in the **ONLY ACCEPTABLE SOURCES** that the patient either currently smokes or is an ex-smoker that quit less than one year prior to hospital arrival, select “yes,” **regardless of whether or not there is conflicting documentation.** Examples of smoking within the past year include, but are not limited to: “Former smoker. Quit recently.”“History – quit smoking 7 months ago”“Quit smoking several months ago”“Social habits = current smoking”“Tobacco history – current cigarette smoker”**If there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES select “No.”** The following examples would **not count** as inclusions (**select “No”**): * “Smoked in the last year: ?”
* “Probable smoker”
* “Most likely quit 3 months ago”

Disregard documentation of smoking history or history of tobacco use if current smoking status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history”, “History of tobacco abuse”). Do not include documentation of smoking history referenced as a risk factor (e.g., “risk factor: tobacco,” “risk factor: smoking,”), where current smoking status is indeterminable. **ONLY ACCEPTABLE SOURCES:** Emergency department record, history and physical, nursing admission assessment /nursing admission notes, respiratory therapy notes, smoking/tobacco use assessment forms**Exclude:** Documentation from a transferring facility or a previous admission |
| 15 | tobcess | Did the patient/caregiver receive smoking/tobacco use cessation advice or counseling during the hospitalization?1. yes
2. no
3. not applicable
 | 1,2,95If smokcigs = 2, will be auto-filled as 95 | The caregiver is defined as the patient’s family or any other person (e.g., home health, prison official or other law enforcement provider) who will be responsible for care of the patient after discharge.**Adult Smoking Counseling:**Documentation indicating the patient/caregiver received one of the following:* Direct discussion with patient/caregiver to stop smoking (stop using tobacco) whether or not the patient is currently smoking
* Viewing a smoking/tobacco use cessation video
* Given brochure or handouts on smoking/tobacco use cessation
* Referred to a smoking cessation class or clinic
* Prescribed a smoking cessation aid, e.g., Habitrol, Nicoderm, Nicorette, Nicotrol, Prostep, Zyban, or Chantix, during hospital admission or at discharge
* Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if specifically prescribed as a smoking cessation aid.

If the patient smoked within the year prior to arrival but does not currently smoke, they should still be advised not to smoke. Cessation counseling is still required.**Respond “1” if the patient/caregiver was given advice, a brochure, pamphlet, or video relative to smoking cessation even if the patient uses another form of tobacco**.**If the patient refused smoking cessation advice or counseling during this hospital stay, answer “1.”**2 = advice/counseling not done, or unable to determine from medical record documentation**Suggested Data Sources**: Consultation notes, Discharge instruction sheet, Discharge summary, ED record, H&P, Medication administration record, Nursing notes, Progress notes, Respiratory therapy notes, Teaching sheet**Exclude:** Any documentation dated/timed after discharge, **except** discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay) |
| **If DCDISPO = 1, 5, or 99, go to PNEURISK1; else auto-fill PNEURISK, VAXSTAT, and FLUSTAT as 95, and if age >= 65 enable Delirium Risk Module** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Vaccination Status** |  |  |
| 16 | pneurisk1pneurisk2pneurisk3pneurisk4pneurisk5pneurisk7pneurisk95pneurisk99 | Was the patient in one or more of the following pneumococcal pneumonia high-risk categories? **Indicate all that apply:**1. institutional resident age 50 or older
2. diabetes mellitus
3. chronic cardiac disease (past MI, CHF, or cardiomyopathy)
4. chronic pulmonary disease (COPD or emphysema)
5. anatomic asplenia (includes sickle cell disease or splenectomy)
6. HIV positive
7. not applicable

99. none of the above | 1,2,3,4,5,7,95,99Cannot enter 99 with any other number Cannot enter “1” if patient age is < 50 | **High Risk Groups for Which Vaccination is Recommended**1 = resident of long-term care facility, Domiciliary, etc. prior to admission for this episode of care3= includes past MI, congestive heart failure and cardiomyopathies4 = includes COPD and emphysema5 = includes sickle cell disease and splenectomy |
| 17 | vaxstat | What is the patient’s pneumococcal vaccination status?1. Pneumococcal vaccination was given during this hospitalization
2. Pneumococcal vaccination was received in the past, not during this hospitalization
	1. Documentation of:
* Allergy/sensitivity to pneumococcal vaccine, OR
* Is medically contraindicated because of bone marrow transplant within the past 12 months, OR
* Currently receiving a scheduled course of chemotherapy or radiation therapy, or received chemotherapy or radiation during this hospitalization or less than 2 weeks prior, OR
* Received the shingles vaccine (Zostavax) within last 4 weeks
1. Not applicable

98. Documentation of patient’s or caregiver’s refusal of pneumococcal vaccine1. None of the above/not documented/unable to determine from medical record documentation
 | 1,2,4,95,98,99 | **1 = the patient received pneumococcal vaccination during this episode of care, even if it was also given at any time in the past.**In order to answer “1,” there must be documentation that the vaccine was given including a date and signature.**2 = the patient received pneumococcal vaccination at anytime in the past****4 = Patients with specific documented allergy/sensitivity (should be accompanied by the exact complication) to vaccine including any component in the vaccine, including thimerosal. Also, sizeable local reaction at injection site ( > 10.2 cm), or the occurrence of any type of an immediate or delayed hypersensitivity reaction or the occurrence of neurological signs and symptoms following administration. May not be based solely on physician’s preference. Autologous stem cell transplant and ASCT are other names for a bone marrow transplant.** The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the care of the patient when the patient is unable to make this decision on his/her own. **99 = No documentation of pneumococcal vaccination status or unable to determine**If there is documentation that supports more than one of the allowable values (1, 2, 4, 98), select the smallest number. For example, nursing note documents patient refused pneumococcal vaccine and medication administration record documents pneumococcal vaccine was administered, select “1.” **EXCEPTION:** If documentation supports patient refusal option “98” and option “4,” select “98.”  |
| **If pneothdx = 487.0, auto-fill flustat as 95 and go to end** |
| 18 | flustat | What is the patient’s influenza vaccination status?1. Influenza vaccine was given during this hospitalization
2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization
	1. Allergy/sensitivity to influenza vaccine, OR is medically contraindicated because of bone marrow transplant within the past 6 months, OR prior history of Guillian-Barre syndrome within 6 weeks after a previous influenza vaccination
3. Only select this option if there is documentation vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution **AND** none of the other options apply

95. Not applicable1. Documentation of patient’s or caregiver’s refusal of influenza vaccine
2. None of the above/not documented/ unable to determine from medical record documentation

  | 1,2,4,6,95,98,99Will be auto-filled as 95 if pneothdx = 487.0 | **For the purposes of this project, all patients discharged during October, November, December, January, February, and March are included (discharges from April – September are excluded from scoring).** **Include documentation of**: flu immune, flu shield, flu shot, flu vaccine, Fluax, Fluogen, Fluvirin, Fluzone, influenza virus vaccine, trivalent influenza vaccine**Exclude:** Pandemic vaccine, e.g. H1N1In order to answer “1,” there must be documentation that the vaccine was given including a date and signature.If there is documentation the patient received the vaccine, and only the current year is documented, select “2.”If there is documentation the patient received the vaccine the year prior to the current year and the discharge is NOT January, February, or March, select “99.” For example, record documents the patient received the vaccine in 2010 and the discharge date for this hospital stay is October 2011, select “99.” If the discharge is in January, February or March 2012 AND there is documentation the patient received the vaccine in 2011, select “2.”4 = patients allergic to eggs or other specific allergy/sensitivity to the vaccine. The allergy/sensitivity must be accompanied by the exact complication. Should be a specific allergy/sensitivity, not just physician preference.6 = vaccine not available to hospital, due to shortage of vaccine. Only answer “6,” if the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution **AND** none of the other options apply. **To enter option #6, the abstractor must see the pharmacy record stating the date the vaccine arrived on station (shipping slip, inventory record, etc.) and date must be after the discharge date.**98 = Direct refusal documented in record = at the time of offer of flu vaccine, patient or caregiver states he/she does not wish to receive flu vaccination **Cont’d next page** |
|  |  |  |  | **Influenza vaccination cont’d**The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the care of the patient when the patient is unable to make this decision on his/her own. If there is conflicting documentation that supports more than one of the allowable values (1, 2, 4, 98), select the smallest number. For example, nursing note documents patient refused flu vaccine and MAR notes flu vaccine was administered, select “1.” **EXCEPTION:** If documentation supports patient refusal (option “98”) and option “4,” select “98. **Unacceptable**: * Patient is told to return post-discharge for flu vaccine.
* Flu vaccine not available
* Documented assumption “patient gets annual flu shot or vaccination”
 |
| **If age > = 65, enable Delirium Risk** |