

VHA EXTERNAL PEER REVIEW PROGRAM
PNEUMONIA INSTRUMENT
ACUTE CARE MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Patient History		
1	othrcond	<p>Is there documentation the patient <u>has a condition that justifies an alternative antimicrobial regimen?</u></p> <p>Determined by the presence of one of the following:</p> <ul style="list-style-type: none"> • Risk for Healthcare-Associated PN <ul style="list-style-type: none"> ◦ 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 • Physician/APN/PA or pharmacist documentation the patient has healthcare-associated pneumonia • Physician/APN/PA or pharmacist documented prolonged QT interval within 24 hours of hospital arrival <p>1. Yes 2. No, or unable to determine</p>	1, 2	<p>The ONLY acceptable conditions are the conditions listed:</p> <p>1. Healthcare-Associated Pneumonia (HCAP) or Risk of HCAP</p> <ul style="list-style-type: none"> • If there is physician/APN/PA or pharmacist documentation that the patient has "healthcare (or hospital) associated (or acquired) 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. • An extended care facility is a non-apartment based institutional setting where 24-hour nursing care is provided <ul style="list-style-type: none"> ◦ 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). • 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." • If wound care is documented in the medical record <u>without</u> 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." <p>2. Other Conditions:</p> <ul style="list-style-type: none"> • Physician/APN/PA or pharmacist documentation within 24 hours of hospital arrival that the patient has a "prolonged" QT interval (QTc).

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				Suggested Data Sources: Consultation notes, Discharge Summary, ED record, H&P, Nursing admission notes, Progress notes												
2	othrinf2	<p>Was there physician/APN/PA documentation of <u>another suspected</u> source of infection in addition to pneumonia within 24 hours of arrival?</p> <p>(Refer to Inclusion and Exclusion List)</p> <p>1. Yes, there was another source of bacterial infection in addition to pneumonia within 24 hours after arrival</p> <p>2. Yes, there was documentation of <i>Francisella tularensis</i> (tularemia) or <i>Yersinia pestis</i> (pneumonic plague) in addition to pneumonia within 24 hours after arrival</p> <p>99. There was <u>no</u> other source of bacterial infection within 24 hours after arrival or unable to determine from medical record documentation</p>	<p>1, 2, 99</p> <p>Warning if 2: Are you certain Tularemia or Pneumonic Plague was documented within 24 hours of arrival?</p>	<p>For the purposes of this data element, an infection/suspected infection includes any of the following:</p> <p>1) Physician/APN/PA documentation of a named bacterial infection outside of the respiratory tract OR of an identified pathogen that is documented as currently present. NOTE: The specific pathogen must be named and documented as currently present. Suspicion of or a history of a pathogen is NOT acceptable.</p> <p>2) Suspicion or known infection with <i>Francisella tularensis</i> (tularemia) or <i>Yersinia pestis</i> (pneumonic plague) documented by a Physician/APN/PA. If there is documentation of both "1" and "2", answer "1."</p> <p>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."</p> <p>Only consider infections/suspected infections that are being/will be treated by an ANTIBIOTIC listed in TJC Appendix C, Table 2.1, 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.</p> <p>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.</p> <p>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.</p> <p>Include:</p> <table><tr><td>Abscess outside of lung</td><td>Pahvant Valley Plague</td></tr><tr><td>Bubonic plague</td><td>Pneumonic plague</td></tr><tr><td>Deerfly fever</td><td>Rabbit fever</td></tr><tr><td>Francisella tularensis</td><td>Septicemic plague</td></tr><tr><td>Infected skin ulcer</td><td>Urinary Tract Infection</td></tr><tr><td>Ohara disease; Ohara fever</td><td>Yersinia pestis</td></tr></table>	Abscess outside of lung	Pahvant Valley Plague	Bubonic plague	Pneumonic plague	Deerfly fever	Rabbit fever	Francisella tularensis	Septicemic plague	Infected skin ulcer	Urinary Tract Infection	Ohara disease; Ohara fever	Yersinia pestis
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				<div>Osteomyelitis or septic joint (infective arthritis)</div> <div> Exclude: <ul style="list-style-type: none"> Any infection in the Respiratory Tract (sinusitis, laryngitis, bronchitis, pleurisy, other lung infection) with exception of Tularemia and Pneumonic Plague 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) with exception of Septicemic plague Systematic Inflammatory Response Syndrome (SIRS) </div>

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3	pospatid	<p>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?</p> <p>For the purposes of this measure, a positive diagnostic test for a pathogen includes any of the following:</p> <ul style="list-style-type: none"> • Positive culture (blood, urine, sputum, wound, etc.) for bacteria • Positive urinary antigen test for Streptococcus pneumoniae or Legionella pneumophila • Positive Polymerase Chain Reaction (PCR) test for Legionella pneumophila <p>1. Yes 2. No</p>	1, 2	<p>The results of a positive culture or diagnostic test for a pathogen must be available upon arrival or within 24 hours after arrival.</p> <ul style="list-style-type: none"> • If the medical record contains documentation of a positive culture performed within a week prior to arrival, 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. <p>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 patients Suggested data sources: Lab results</p>
4	compcond	<p>Is there documentation the patient had a compromising condition/therapy? (see definitions/decision rules for additional instructions)</p> <p>No timeframe necessary: AIDS, AIDS related complex (ARC) HIV, HIV positive Any "Immunodeficiency Syndrome" Chronic Lymphocytic Leukemia (CLL) Congenital or hereditary Immunodeficiency Organ transplant</p> <p>Within the last 3 months OR as diagnosed/administered for the first time during this hospitalization: Leukemia</p>	1, 2	<p>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 or could justify alternative antibiotic treatment. The ONLY acceptable compromising conditions are the conditions listed. Select "1" if any of the following are documented:</p> <ul style="list-style-type: none"> • 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)

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		<p>Lymphocytic leukemia Lymphoma Marked or significant neutropenia Myelogenic leukemia Myeloma Myelodysplasia Pancytopenia Systemic Chemotherapy Systemic Radiation therapy</p> <p>Within the last 3 months prior to this hospitalization: Systemic Corticosteroid/prednisone therapy Systemic Chemotherapy Systemic Immunosuppressive therapy Systemic Radiation therapy</p> <p>1. Yes 2. No or unable to determine</p>		<p>1) No timeframe necessary: Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), any "immunodeficiency syndrome", chronic lymphocytic leukemia (CLL), congenital or hereditary immunodeficiency, Human Immunodeficiency Virus (HIV), HIV +, or organ transplant</p> <p>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.</p> <ul style="list-style-type: none"> 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" <p>3) Systemic corticosteroid/prednisone therapy and/or systemic immunosuppressant therapy must have occurred within the last three months prior to this hospitalization.</p> <ul style="list-style-type: none"> 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." If a medication is listed on both TJC Appendix C, Table 2.2 (Immunosuppressant Medications) and Table 2.15 (Systemic Corticosteroid Medications) consider the medication a systemic corticosteroid as documentation of chronic use is required for a systemic corticosteroid but not for an immunosuppressant. <p>Exclude: any steroid therapy that is not systemic (i.e., inhaler, eyedrops, topical, etc.), or administered via epidural/spinal injections</p>

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				<p>Medication References: TJC Appendix C, Table 2.2 "Immunosuppressive Medications" and Table 2.15 "Systemic Corticosteroids".</p> <p>Suggested data sources: consultant notes, discharge summary, ED record, H&P, nursing admission notes</p>
5	rskpseud	<p>Did the patient have risk of pseudomonas as evidenced by documentation of one of the following?</p> <ul style="list-style-type: none"> 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 <p>1. Yes 2. No</p>	1, 2	<p>For the purposes of this data element, structural lung disease includes:</p> <ul style="list-style-type: none"> 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 <p>Exclude reactive lung diseases such as asthma.</p> <p>One time use or one course of antibiotics or systemic corticosteroids is not considered chronic.</p> <p>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."</p> <ul style="list-style-type: none"> If there is documentation of chronic "steroids", select "1." Corticosteroids and/or antibiotics 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. <p>Refer to TJC Appendix C, Table 2.15 for a comprehensive list of Systemic Corticosteroids.</p> <p>Bronchiectasis is defined as chronic dilation of a bronchus or bronchi, with</p>

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				<p>a secondary infection that usually involves the lower portion of the lung. Dilation may be in an isolated segment or spread throughout the bronchi.</p> <p>Select "1" if there is physician/APN/PA or pharmacist documentation of:</p> <ul style="list-style-type: none"> • 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". <p>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."</p>
6	ptallerg	<p>Is there documentation of patient allergies, sensitivities, or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications?</p> <p>1. Yes 2. No</p>	1, 2	<p>Allergy can be defined as acquired abnormal immune response to a substance (allergen) that does not normally cause a reaction.</p> <p>If the patient was noted to be allergic to "cillins," "penicillin," or "all cillins", enter "1."</p> <p>If the record documents an allergy, sensitivity, or intolerance to beta-lactam/penicillin or cephalosporin antibiotics, enter "1".</p> <p>Include: adverse drug event, adverse effect, adverse reaction, anaphylactic reaction, anaphylaxis, hives, rash</p>
7	blcltdon	<p>Did the patient have blood cultures collected <u>the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival</u>?</p>	<p>1, 2, 3, 4</p> <p>If 4, auto-fill blcltdt as 99/99/9999 and</p>	<p>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.</p>

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		<p>1. Initial blood culture <u>collected in the ED prior to admission order</u></p> <p>2. Initial blood culture collected during this hospitalization but <u>after admission order</u> for ED patients (OR within 24 hours after arrival for Direct Admit patients)</p> <p>3. Documentation that the patient had a blood culture collected the day prior to arrival up until the time of presentation to the hospital</p> <p>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</p>	<p>blcltme as 99:99, and go to abrecvd</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <p>Hard edit: Cannot = 1 if pnedpt = 2</p> <p>Warning if 2 and pnedpt = 1</p> </div>	<ul style="list-style-type: none"> • 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 <u>prior to OR after</u> the admission order in order to appropriately select option "1" or "2." <p>If there is documentation the initial blood culture was collected for the ED patient <u>prior to the admission order</u> (observation or inpatient), select "1."</p> <p>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.</p> <p>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."</p> <p>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".</p> <p>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.</p> <p>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."</p> <p>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."</p> <p><u>Include:</u> BC, blood cultures, blood cultures collected on patients in</p>

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				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 <u>Exclude:</u> 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			
8	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/yyyy Abstractor can enter 99/99/9999 If blcltdon = 4, will be auto-filled as 99/99/9999 If blcltdon = 3, auto-fill blcltme as 99:99, and go to abrecvd <table><tr><td>If blcltdon = 1, >= arrvdate and <= admdt</td></tr><tr><td>If blcltdon = 2 > = arrvdate and < = 1 day after arrvdate and < = leftdate</td></tr><tr><td>If blcltdon = 3 < = 1 day prior to arrvdate and < = arrvdate</td></tr></table>	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 arrival If 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.
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							

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9	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.	<p style="text-align: center;">____ UMT</p> <p>If blcltdon = 3 or 4, will be auto-filled as 99:99 Abstractor can enter 99:99</p> <div style="border: 1px solid black; padding: 5px; margin: 5px;"> <p>If blcltdon = 1, >=arrvdate/arrvtime and <= admtdt/pneadmtn</p> </div> <div style="border: 1px solid black; padding: 5px; margin: 5px;"> <p>If blcltdon = 2, >=arrvdate/arrvtime and <= 24 hours after arrvdate/arrvtime and <= leftdate/leftime</p> </div>	<p>If multiple times of blood culture collection are documented, abstract the <u>earliest (initial)</u> time that demonstrates collection of the blood culture.</p> <p>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.</p>
		Medications		
10	abrecvd	<p>Did the patient receive antibiotics via an appropriate route (PO, NG, PEG, IM, or IV)?</p> <p>1. Antibiotic received only within 24 hours prior to arrival or the day prior to arrival and not during hospital stay</p>	<p>1*, 2, 3, 4*</p> <p>*If 1 or 4, go to end If 2 or 3, go to</p>	<p>Only consider antibiotics listed in TJC Appendix C, Table 2.1. 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).</p>

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		<p>2. Antibiotic received within 24 hours prior to arrival or the day prior to arrival and during hospital stay</p> <p>3. Antibiotic received only <u>during</u> hospital stay (not prior to arrival)</p> <p>4. Antibiotic not received or unable to determine from medical record documentation</p>	<p>antiname</p> <div>Warning: If abrecvd = 1</div>	<ul style="list-style-type: none"> 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." The data elements <i>Arrival Date</i> and <i>Arrival Time</i> should be taken into consideration when determining if the antibiotic was given prior to arrival or during the stay. If a valid date/time for an antibiotic dose(s) found within the current record is an obvious error (in error) and the correct date/time can be found on the same source, the correct date/time may be used to determine if the antibiotic was given prior to arrival or during the stay. Note: The ED record is considered the same data source. If the date and/or time for the antibiotic dose(s) that was documented in error is not supported by other documentation in the same source, the chart must be abstracted at face value. 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 <i>Antibiotic Received</i> as Value 1 or 2 as applicable. <p>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</p> <p>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</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				room record, perfusion record
11	antidate routeadm antitime antinae	<p>What was the name of the antibiotic dose (s) administered from hospital arrival through 24 hours after hospital arrival?</p> <p>Beginning with the <u>first</u> 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.)</p> <p>What was the date of administration for the antibiotic dose?</p> <p>What was the time of administration for the antibiotic dose?</p> <p>Enter the route of administration of the antibiotic. 1. PO, NG, PEG tube (Oral) 2. IV (Intravenous) 3. IM (Intramuscular) 99. UTD (Unable to determine route)</p> <p>May enter 25 antibiotics</p>	<p>_____</p> <p>antinae</p> <p>antidate mm/dd/yyyy</p> <p>If date cannot be determined, the abstractor can enter 99/99/9999</p> <div style="border: 1px solid black; padding: 2px;"> <p>> = arrvdate and < = 1 day after arrvdate and < = leftdate</p> </div> <p>antitime</p> <p>_____</p> <p>UMT</p> <p>If time cannot be determined, the abstractor can enter 99:99</p> <div style="border: 1px solid black; padding: 2px;"> <p>> = arrvdate/arrvtime and < = 24 hrs after arrvdate/arrvtime and < = leftdate/lefttime</p> </div> <p>routeadm 1, 2, 3, 99</p>	<p>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.</p> <p>If the <u>ROUTE</u> of administration for the same antibiotic changes during the first 24 hours, record the antibiotic with each route change.</p> <p>Only select "Antibiotic NOS" for the following situations:</p> <ul style="list-style-type: none"> • New antibiotics that are not yet listed in TJC Appendix C, Table 2.1. • 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. <p>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.</p> <p>Antibiotic Abstraction Guidelines:</p> <ul style="list-style-type: none"> • 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.

VHA EXTERNAL PEER REVIEW PROGRAM
PNEUMONIA INSTRUMENT
ACUTE CARE MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES		
				<ul style="list-style-type: none">• 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. <table><tr><td><u>Include any antibiotics given:</u> Any feeding tubes (NG, PEG) IV, perfusion IM Orally (PO)</td><td><u>Exclude</u> All other routes</td></tr></table>	<u>Include any antibiotics given:</u> Any feeding tubes (NG, PEG) IV, perfusion IM Orally (PO)	<u>Exclude</u> All other routes
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		If age > = 65, enable Delirium Risk				