

VHA EXTERNAL PEER REVIEW PROGRAM
SURGICAL CARE IMPROVEMENT PROJECT INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC CONTROL QIC BEGDTE REVDTE	Facility ID Control Number Abstractor ID Abstraction Begin Date Abstraction End Date	Auto-fill Auto-fill Auto-fill Auto-fill Auto-fill	
		Patient Identifiers		
	SSN PTNAMEF PTNAMEL BIRTHDT SEX MARISTAT RACE	Patient SSN First Name Last Name Birth Date Sex Marital Status Race	Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: can change Auto-fill: no change Auto-fill: no change	
		Administrative Data		
1	arivldt	Earliest documented date the patient arrived at this VAMC.	mm/dd/yyyy Abstractor may enter 99/99/9999 if arrival date is unable to be determined <div style="border: 1px solid black; padding: 5px; width: fit-content;">< = 72 hours prior to or = siadmdt and < = dtofdc</div>	Surgery may be scheduled/performed prior to actual formal admission. Arrival date is the earliest recorded date on which the patient arrived in the hospital's acute care setting. Arrival date may differ from admission date. ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); nursing admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures); vital signs graphic record Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

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				<ul style="list-style-type: none"> • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility. • Documentation outside of the ONLY ACCEPTABLE SOURCES list should NOT be referenced (e.g. ambulance record, physician office record, H&P). • Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted. <p>Example: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error.</p> <ul style="list-style-type: none"> • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. • For Observation Status: <ul style="list-style-type: none"> o If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED. o If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care. • For Direct Admits: <ul style="list-style-type: none"> o If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.

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				<p>o For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date.</p> <ul style="list-style-type: none"> • If arrival date is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99/99/9999.
2	arivltm	Earliest documented time the patient arrived at this VAMC.	<p>_____ UMT</p> <p>If unable to find the time of arrival, the abstractor can enter 99:99</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>< = 72 hours prior to or = siadmdt/sipadmtm and < = dtofdc/sipdctm</p> </div>	<p>Arrival time is the earliest recorded time the patient arrived in this hospital's acute care setting. Arrival time may differ from admission time. ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); nursing admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures); vital signs graphic record</p> <ul style="list-style-type: none"> • Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab as a direct admit. • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility. • Documentation outside of the ONLY ACCEPTABLE SOURCES list should NOT be referenced (e.g., ambulance record, physician office record, H&P). • Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE

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				<p>SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted.</p> <p>Example: ED face sheet lists arrival time 1320. ED registration 1325. ED triage 1330. ED consent to treat form has 1:17 with "AM" circled. ED record documentation suggests the 1:17 AM time is an obvious error. Enter 13:20 for Arrival Time.</p> <ul style="list-style-type: none"> • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT. • For Observation Status: <ul style="list-style-type: none"> ◦ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED. ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care. • For Direct Admits: <ul style="list-style-type: none"> ◦ If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time. ◦ For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time. • If arrival time is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99:99.

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3	siadmtdt	Date of admission to inpatient care:	mm/dd/yyyy Auto-filled: can be modified <div> <div>> = arivldt and < = dtofdc</div> <div>Warning if siadmtdt > = 6mos prior to dtofdc</div> </div>	Auto-filled; can be modified if abstractor determines that the date is incorrect. <ul style="list-style-type: none"> Admission date is the date the patient was actually admitted to acute inpatient care. For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used. ONLY ALLOWABLE SOURCES: Physician orders, face sheet Exclusion: admit to observation, arrival date
4	sipadmtn	Time of admission to inpatient care:	<div> <div>UMT</div> <div>Auto-filled: can be modified</div> <div>> = arivldt/arivltm and < dtofdc/sipdctm</div> </div>	Auto-filled: can be modified. Abstractor to verify admission time is correct. If correction is necessary, enter time in Universal Military Time. Admission time = time when the patient was formally admitted to inpatient status. Exclusion: Admit to observation time, Arrival time
5	dtofdc	Discharge date:	mm/dd/yyyy Auto-filled: cannot be modified <div> <div>> = siadmtdt</div> </div>	Auto-filled: cannot be modified. The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.

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6	sipdctm	Time of discharge:	<div><div>____</div><div>UMT</div><div>Abstractor may enter 99:99</div><div><div>> = anebegdt/anebegtm and > siadmtd/sipadmtm</div></div></div>	<p>Does not auto-fill. Discharge time must be entered.</p> <p>Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.</p> <p>If the patient expired, use the time of death as the discharge time.</p> <p>Suggested sources for patient who expire:</p> <p>Death record, resuscitation record, physician progress notes, physician orders, nurses notes</p> <p>For other patients:</p> <p>If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the "Reports Tab."</p> <p>If the time the patient was discharged is unable to be determined from medical record documentation, enter 99:99. If the discharge time is obviously in error and no other documentation is found that provides this information, enter 99:99.</p> <p>Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.</p> <p>Converting time to military time:</p> <p>If time is in the a.m., no conversion is required.</p> <p>If time is the p.m., add 12 to the clock hour time.</p>
7	prinpxdt prinpx	Enter the ICD-9-CM principal procedure code and date the procedure was performed. <div>Code Date</div> <div><div>____.____</div><div>/ / ____</div></div>	<div><div>____. ____</div><div>Abstractor can enter xx.xx in code field and 99/99/9999 in date field if there is no principal procedure</div><div>Cannot enter 00.00</div><div>Hard Edit: Principal procedure code entered is not on Table 5.10. Check</div></div>	<p>Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.</p> <ul style="list-style-type: none">VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMi if you are uncertain.If the principal procedure is not on Table 5.10, the case will be excluded. Do not search for another code and enter that one just because it is on Table 5.10 <u>if it is NOT</u> the principal procedure.

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			<div>code in record and re-enter.</div> <div>mm/dd/yyyy</div> <div>Abstractor can enter 99/99/9999</div> <div>If no procedure was performed, the record is excluded.</div> <div>Exclusion statement #1 will issue on the DNR report.</div> <div>If the ICD-9-CM principal procedure code is not in Table 5.10, the case is excluded.</div> <div>If prinpx is on Table 5.01, 5.02, 5.03, 5.04, 5.05, 5.06, 5.07, or 5.08 AND surgery type is not on VAMC Surgery Type table, the case is excluded.</div> <div>Exclusion statement #2 will issue on the DNR Report.</div> <div>> = arivldt and < = dtofdc</div>	<p>If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.</p> <p>Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.</p> <p>If the principal procedure date is unable to be determined from the medical record documentation, or the date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999.</p> <p>Exclusion Statement #1: The record indicates no procedure was performed in this case selected for Surgical Care Improvement Project.</p> <p>Exclusion Statement #2: The record indicates the procedure performed during this episode of care was not applicable to the SCIP measure population.</p>

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8	<div>othrpx1</div> <div>othrpx2</div> <div>othrpx3</div> <div>othrpx4</div> <div>othrpxdt5</div> <div>othrpxdt1</div> <div>othrpxdt2</div> <div>othrpxdt3</div> <div>othrpxdt4</div> <div>othrpx5</div>	<div>Enter the ICD-9-CM other procedure codes and dates.</div> <div><div>Code</div><div>Date</div><div><div><div>____. ____</div></div><div><div>/</div><div>/</div><div>_____</div></div></div></div>	<div><div>____. ____</div><div>Can enter 5 codes and dates</div><div>Abstractor can enter xx.xx in code field and 99/99/9999 in date field if no other procedure was performed</div><div>mm/dd/yyyy</div><div>Abstractor can enter 99/99/9999</div><div><div>Cannot enter 00.00</div><div>> = arivldt and < = dtofdc</div></div></div>	<div>Can enter 5 procedure codes, other than the principal procedure code. Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.</div> <div>If no other procedure was performed, the other procedure code fields may be filled with xx.xx and the date field with 99/99/9999.</div> <div>If no other procedures were performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.</div> <div>If the date of a procedure is unable to be determined from the medical record documentation, or the date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999.</div>
9	<div>princode</div>	<div>Enter the ICD-9-CM principal diagnosis code:</div>	<div><div>____. ____</div><div>(3 digits/decimal point/two digits)</div><div><div>Cannot enter 000.00, 123.45, or 999.99</div></div></div>	<div>Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.</div>

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10	othrdx1 othrdx2 othrdx3 othrdx4 othrdx5 othrdx12 othrdx7 othrdx8 othrdx9 othrdx10 othrdx11 othrdx6	Enter the other ICD-9-CM diagnosis codes:	<p>__ __ __. __ __ (3 digits/decimal point/two digits) May enter 12 codes</p> <p>Abstractor can enter xxx.xx in code field if no other dx found</p>	<p>Can enter 12 ICD-9-CM other diagnosis codes. Will auto-fill from PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.</p> <p>If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab.</p> <p>Enter xxx.xx in code field if no other diagnoses codes exist for this record.</p>
11	dcdispo	<p>What was the patient's discharge disposition on the day of discharge?</p> <ol style="list-style-type: none"> Home <ul style="list-style-type: none"> Assisted Living Facilities (ALFs) - includes assisted living care at nursing home/facility Court/Law Enforcement - includes detention facilities, jails, and prison Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement facilities, and homeless shelters Home with Home Health Services Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization Hospice - Home (or other home setting as listed in #1 above) Hospice - Health Care Facility <ul style="list-style-type: none"> General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities Acute Care Facility 	1, 2, 3, 4, 5, 6, 7, 99	<p>Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.</p> <ul style="list-style-type: none"> Only use documentation written on the day prior to discharge or the day of discharge when abstracting this data element. For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred to skilled care. Enter "5". Discharge disposition documentation in the discharge summary, a post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation. For example: Discharge planner note from day before discharge states "XYZ Nursing Home". Nursing discharge note on day of discharge states "Discharged: Home." Select "1". If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. <ul style="list-style-type: none"> Acute Care Facility

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		<ul style="list-style-type: none"> ◦ Acute Short Term General and Critical Access Hospitals ◦ Cancer and Children's Hospitals ◦ Department of Defense and Veteran's Administration Hospitals <p>5. Other Health Care Facility</p> <ul style="list-style-type: none"> ◦ Extended or Immediate Care Facility (ECF/ICF) ◦ Long Term Acute Care Hospital (LTACH) ◦ Nursing Home or Facility including Veteran's Administration Nursing Facility ◦ Psychiatric Hospital or Psychiatric Unit of a Hospital ◦ Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital ◦ Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed ◦ Transitional Care Unit (TCU) ◦ Veteran's Home <p>6. Expired</p> <p>7. Left Against Medical Advice/AMA</p> <p>99. Not documented or unable to determine</p>		<ul style="list-style-type: none"> ◦ Hospice - Health Care Facility ◦ Hospice - Home ◦ Other Health Care Facility ◦ Home <ul style="list-style-type: none"> • Values "2" and "3" hospice includes discharges with hospice referrals and evaluations • If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select "4". • If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select "5". • If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select "1". • Selection of option "7" (left AMA): <ul style="list-style-type: none"> ◦ Explicit "left against medical advice" documentation is not required (e.g., "Patient is refusing to stay for continued care"- select "7"). For the purposes of this data element, a signed AMA form is not required. ◦ If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. ◦ Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count. <p>Excluded Data Sources: Any documentation prior to the last two days of hospitalization, coding documents</p> <p>Suggested Data Sources: Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record</p>
		OR Information		

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12	anebegdt	Enter the date the anesthesia was started for the principal procedure.	mm/dd/yyyy Abstractor can enter 99/99/9999 <div style="border: 1px solid black; padding: 2px; width: fit-content;"> > = arivldt and < = dtofdc </div>	<p>The Anesthesia Start Date is the date associated with the start of anesthesia for the principal procedure. If a patient enters the operating room, but the surgery is canceled before incision and the principal procedure is performed on a later date, the Anesthesia Start Date is the date the principal procedure was actually performed.</p> <p>NOTE: The anesthesia record is the priority data source for this element.</p> <ul style="list-style-type: none"> • If a valid Anesthesia Start Date is found on the anesthesia record, enter that date. • If a valid Anesthesia Start Date is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia Start Date. • If an Anesthesia Start Date is not documented, use surrounding documentation to determine the date anesthesia started. Example: The Anesthesia End Date is 10/02/20XX, Anesthesia Start Time is 23:30 and Anesthesia End Time is 00:45. Abstract Anesthesia Start Date as 10/01/20XX because the date would change if the anesthesia ended after midnight and the start time was prior to midnight. <p>When the date documented is obviously invalid (not a valid format/range such as 11-39-20XX or after the Discharge Date or Anesthesia End Date) and no other documentation can be found that provides the correct information, enter 99/99/9999.</p> <p>If the Anesthesia Start Date cannot be determined from the medical record documentation, enter 99/99/9999.</p> <p>If the Anesthesia Start Date is incorrect but it is a valid date and the correct date can be supported with other documentation in the medical record, the correct date may be entered. If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented or at "face value."</p>

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13	anebegtm	Enter the time the anesthesia was started for the principal procedure.	<p>_____ UMT Abstractor can enter 99:99</p> <div>> = arivltm and < = 6 hours prior to or = incizetm</div> <div>Warning if > 3 hours prior to incizetm</div>	<p>The Anesthesia Start Time is the time associated with the start of anesthesia for the principal procedure.</p> <p>If a patient enters the operating room, but the surgery is canceled before incision and the principal procedure is performed on a later date, the Anesthesia Start Time is the time the principal procedure was actually performed.</p> <p>NOTE: The anesthesia record is the priority data source for this element.</p> <ul style="list-style-type: none"> • Locate an inclusion term (anesthesia start, anesthesia begin, anesthesia initiated) on the anesthesia record. If an inclusion term associated with a time is found, enter that time. Use the earliest time associated with an inclusion term that represents Anesthesia Start Time. • If a valid Anesthesia Start Time is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia Start Time. • If no inclusion terms are found, look for alternative terms associated with the Anesthesia Start Time. <p>If the <i>Anesthesia Start Time</i> cannot be determined from medical record documentation or is obviously invalid (not a valid format/range [26:33] or after the <i>Anesthesia End Time</i>) and no other documentation is found that provides the correct information, the abstractor should enter 99:99.</p> <p>If the <i>Anesthesia Start Time</i> is obviously incorrect (in error) but it is a valid time and the correct time can be supported with other documentation in the medical record, the correct time may be entered. If supporting documentation of the correct time cannot be found, the medical record must be abstracted at "face value."</p>
14	incizedt	Enter the date the incision was made for the principal procedure.	<p>mm/dd/yyyy Abstractor can enter 99/99/9999</p> <div>> = anebegdt and < = dtofdc</div>	<p>If the date that the incision was made is not specified, use surrounding documentation to determine the date the incision was made. Examples:</p> <ul style="list-style-type: none"> • The Anesthesia Start Date is 03-16-20XX, the Anesthesia Start Time is 0800, the Surgical Incision Time is 0810. Use 03-16-20XX as the Surgical Incision Date because it is clear by using data from the surrounding documentation that the date of incision was the same date as the anesthesia started.

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15	incizetm	Enter the time the initial incision was made for the principal	_____	Surgical Incision Time is the time the initial incision was made for the

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		<p>procedure.</p> <p>Follow priority order. If multiple times are found, select the earliest time among the highest priority.</p> <p>Note: Priority order applies to items in inclusion table, not to source document.</p>	<p>UMT</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p style="text-align: center;">></p> <p>=anebegdt/anebegtm and <=dtofdc/sipdctm</p> </div> <p>Abstractor may enter 99:99 if the initial incision time cannot be found in any source.</p>	<p>principal procedure. Times designated as <i>Surgical Incision Time</i> or including the term incision time are to be taken as first priority terms.</p> <p>EXCEPTIONS:</p> <p>A. Cystoscopy: If a patient has a cystoscopy prior to the Principal Procedure, during the same surgical episode, AND antibiotics were given prior to this procedure, use the Surgery Start/Begin Time (or other synonym) for the cystoscopy. If no antibiotics were given prior to the start of the cystoscopy, use the time that the Principal Procedure began as the Surgical Incision Time.</p> <p>B. Laparoscopy to Open: If the first procedure is a laparoscopic procedure or a procedure performed with a scope (e.g., colonoscopy) AND antibiotics were given prior to the first procedure and it is followed by an open procedure, abstract the start/begin time (or other synonym) that is documented for the first procedure. If the procedure starts as a laparoscopic procedure or as a procedure performed with a scope (e.g., colonoscopy) AND antibiotics were NOT given prior to this procedure and it is followed by an open procedure, abstract the <i>Surgical Incision Time</i> that is documented for the open procedure.</p> <p>C. Multiple Procedures: If multiple procedures occur during the same surgical episode, and the incision for the Principal Procedure is not the first incision made, the <i>Surgical Incision Time</i> captured will be for the incision that occurs first.</p> <p>Guidelines: Starting with the first priority, look in the record (not limited to suggested data sources) for all items listed. If multiple times are found, select the <u>earliest time</u> among the highest priority. Times designated as Surgical Incision Time or including the term incision time are to be taken as first priority. If none of the first priority items are found, look for all items in the second priority before going to the third priority.</p> <p>Inclusion List: First Priority:</p> <ul style="list-style-type: none"> • Surgical Incision Time

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				<ul style="list-style-type: none"> • Incision (with a time) • Incision Began • Incision Made • Incision Start • Incision Time <p>Second priority:</p> <ul style="list-style-type: none"> • Surgery begin time • Operation start time • Procedure start time • Start of surgery (SOS) • Surgery start time • Symbol or letters used on grid and indicated in legend to be incision time <p>Third priority:</p> <ul style="list-style-type: none"> • Chest time • Leg time • Skin time • Sternotomy time <p>Fourth priority:</p> <ul style="list-style-type: none"> • Anesthesia begin time • Anesthesia start time • Operating room start time <p>If the time of the initial incision cannot be found in ANY source, abstractor can enter 99:99. If the initial incision 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> <p>Suggested Sources: Anesthesia Record, Circulation Record, OR nurses record, Operative report</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
16	anesendt	Enter the date the anesthesia ended for the principal procedure	mm/dd/yyyy Abstractor can enter 99/99/9999 <div> >= anebegdt and < = dtofdc </div>	<p>The Anesthesia End Date occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the postoperative anesthesia care in the post-anesthesia care area, intensive care unit, or other non-PACU recovery area.</p> <p>NOTE: The anesthesia record is the priority data source for this element.</p> <ul style="list-style-type: none"> • If a valid Anesthesia End Date is found on the anesthesia record, enter that date. • If a valid Anesthesia End Date is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia End Date. • If an anesthesia end date is not documented, use surrounding documentation to determine the date anesthesia ended. Example: The anesthesia start date is 10/01/20XX, anesthesia start time is 23:20 and anesthesia end time is 00:45. Abstract anesthesia end date as 10/02/20XX because the date would change if the anesthesia ended after midnight. <p>If the Anesthesia End Date cannot be determined in ANY source, abstractor can enter 99/99/9999.</p> <p>If the Anesthesia End 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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
17	anendtm	Enter the time the anesthesia ended for the principal procedure.	<div> <div>—</div> <div>UMT</div> <div>Abstractor can enter 99:99</div> <div>>=</div> <div>anebegdt/anebegtm and < dtofdc/sipdctm</div> <div>Hard edit: anesendt/anendtm cannot be < incizedt/incizetm</div> <div>Warning: anesendt/anendtm cannot be > 24 hours after anebegdt/anebegtm</div> </div>	<p>The anesthesia end time is the time associated with the end of anesthesia for the principal procedure. If multiple procedures occur during the same surgical episode as the principal procedure, the <i>Anesthesia End Time</i> will be the time associated with the end of anesthesia for the end of the surgical episode that included the principal procedure.</p> <p>The Anesthesia End Time occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the postoperative anesthesia care in the post-anesthesia care area, intensive care unit, or other non-PACU recovery area.</p> <p>NOTE: The anesthesia record is the priority data source for this element.</p> <ul style="list-style-type: none"> • Locate an inclusion term (anesthesia end, anesthesia finish, anesthesia stop) on the anesthesia record. If an inclusion term associated with a time is found, enter that time. Use the latest time associated with an inclusion term that represents Anesthesia End Time. • If a valid Anesthesia End Time is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia End Time. • If no inclusion terms are found, look for alternative terms associated with the Anesthesia End Time. • If multiple procedures occur during the same surgical episode as the principal procedure, the Anesthesia End Time will be the time associated with the end of anesthesia for the surgical episode that included the principal procedure • If a patient leaves the operating room with an open incision (for closure at a later date/time), use the Anesthesia End Time of the principal procedure. Do NOT use the time the patient returns to the OR for closure. <p>If the Anesthesia End Time cannot be found in ANY source, abstractor can enter 99:99.</p> <p>Suggested data sources: Anesthesia record, circulation record, intraoperative record, operating room notes</p>

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18	anestype	<p>Was there documentation that the principal procedure was performed using general or neuraxial anesthesia?</p> <p>1. Procedure performed using general anesthesia</p> <p>2. Procedure performed using neuraxial anesthesia</p> <p>3. Procedure performed using both general and neuraxial anesthesia</p> <p>99. No documentation that the procedure was performed using either general or neuraxial anesthesia or unable to determine</p>	1, 2, 3, 99	<p>If there is documentation that the surgical case was converted from a different type of anesthesia, such as a MAC (monitored anesthesia care), to a general or neuraxial anesthesia, select "1" or "2" as applicable.</p> <p>If an attempt to use neuraxial anesthesia was unsuccessful and general anesthesia was used, select "3" because both methods were documented.</p> <p>If general anesthesia is used AND an epidural catheter is placed preoperatively or up to 24 hours after Anesthesia End Time for anesthesia or other reasons such as postoperative pain control, select "3."</p> <p>If an epidural catheter is placed preoperatively or up to 24 hours after Anesthesia End Time for anesthesia or other reasons such as for postoperative pain control, select "2."</p> <p>Include:</p> <p>General anesthesia - inhaled anesthetic gases, endotracheal, laryngeal mask airway or anesthesia (LMA), total intravenous anesthesia (TIVA)</p> <p>Neuraxial anesthesia - spinal block, epidural block, spinal anesthesia, subarachnoid blocks</p> <p>Exclude: Conscious sedation, monitored anesthesia care (MAC), local with sedation, local with stand-by, peripheral nerve blocks, saddle block, deep sedation, paravertebral blocks</p> <p>Suggested Sources: Anesthesia Record, operative note, intraoperative record, PACU/recovery room record, procedure note</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
19	clntrial	<p>During this hospital stay, was the patient enrolled in a clinical trial in which patients undergoing surgery were being studied?</p> <p>1. Yes 2. No</p>	<p>*1, 2</p> <p>*If 1, the record is excluded from the SCIP National Hospital Quality Measures (Partial Abstraction Only)</p> <p>If 2, go to hairgone</p>	<p>The clinical trial should be relevant to one or more of the SCIP measures. Examples include, but are not limited to:</p> <p>The clinical trial involved the use of antibiotics.</p> <p>The clinical trial involved testing a new beta-blocker.</p> <p>The clinical trial involved the use of VTE prophylaxis.</p> <p>In order to answer "Yes", BOTH of the following must be documented:</p> <p>1. There must be a signed consent form for the clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received; AND</p> <p>2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients undergoing surgery were being studied. Patients may be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.</p> <p>In the following situations, select "No":</p> <p>1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries).</p> <p>2. It is not clear whether the study described in the signed patient consent form is experimental or observational.</p> <p>3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if the study population is not specified.</p> <p>ONLY ACCEPTABLE SOURCE: Signed consent form for clinical trial</p> <p>Exclusion Statement: Enrollment of the patient in a clinical trial during this hospital stay relevant to patients undergoing surgery partially excludes the case from the SCIP National Hospital Quality Measures.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
20	hairgone1 hairgone2 hairgone3 hairgone4 hairgone5 hairgone6 hairgone8 hairgone99	<p>What method of surgical site hair removal was performed prior to the principal procedure?</p> <p>Select all that apply:</p> <p>1. No documented hair removal or no hair removal performed</p> <p>2. Razor</p> <p>3. Clippers/Scissors</p> <p>4. Depilatory</p> <p>5. Other method of hair removal</p> <p>6. Patient performed their own hair removal</p> <p>8. Hair removal performed with a razor from the scrotal area OR from the scalp after a current traumatic head injury</p> <p>99. Unable to determine method</p>	<p>1, 2, 3, 4, 5, 6, 8, 99</p> <p>Cannot enter 1 or 99 with any other number</p>	<p>Surgical site hair removal should only be abstracted from data sources that document actual hair removal. If hair removal was not required for the procedure and there is no documentation of hair removal, select "1."</p> <p>If more than one method of hair removal is documented, select all methods documented. Option 1 or 99 cannot be selected with any other option. In cases of conflicting information where "not applicable" (NA) is documented in one source and a method of hair removal is documented in another source, select the method of hair removal documented. For example, preop record notes hair removal by "clippers" and intraop record has "NA." Select "3."</p> <p>If the surgeon documents in the operative note, "patient was shaved and prepped in the usual fashion," do not accept as documentation of actual hair removal.</p> <p>3 = documentation that hair was removed using clippers (or scissors). For example, if there is documentation that a "shave prep was done with clippers" or "clippers were used to perform the shave prep," select "3."</p> <p>4 = Depilatory includes Surgi-Lotion Hair Removal, One Touch Hair Removal, Neet, Nair, other commercial brands</p> <p>5= some other method of hair removal was used</p> <p>6 = Patient performed own hair removal: either prior to hospital arrival or in the hospital prior to surgery, the patient performed his/her own hair removal, using own tools or tools requested from the hospital.</p> <p>Select "99" if unable to determine the method of hair removal.</p> <p>Exclude: Hair removal not at surgical site, hair removal involved in daily hygiene</p> <p>Suggested data sources: nursing notes, OR record, OR nurses record, pre-operative checklist/note, surgical checklist</p>
21	othrsurg1 othrsurg2 othrsurg3 othrsurg4 othrsurg5 othrsurg6 othrsurg7 othrsurg8 othrsurg99	<p>Were there any other procedures requiring general or spinal/epidural anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay?</p> <p>Indicate all that apply:</p> <p>1. CABG</p> <p>2. Other Cardiac surgery (not CABG)</p> <p>3. Hip arthroplasty</p> <p>4. Knee arthroplasty</p>	<p>1, 2, 3, 4, 5, 6, 7, 8, 99*</p> <p>*99 cannot be entered with any other number</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Warning if othrsurg1= -1 and prinpx = code in Table 5.01, or othrsurg2=-1 and</p> </div>	<ul style="list-style-type: none"> This data element is used to identify cases that have another major surgical procedure (requiring an incision and general or spinal/epidural anesthesia) performed within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay. For the purposes of this question, if pocketed cardiac devices (pacemakers, defibrillator, pulse generators, medication pumps, etc.) are implanted during this hospital stay and within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal

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		5. Colon surgery 6. Hysterectomy 7. Vascular surgery 8. Other 99. No other procedure performed within this timeframe	<p>prinpx=code in Table 5.02, or othrsurg3=-1 and prinpx=code in Table 5.04, or othrsurg4=-1 and prinpx=code in Table 5.05, or othrsurg5=-1 and prinpx=code in Table 5.03, or othrsurg6=-1 and prinpx=code in Table 5.06 or 5.07, or othrsurg7=-1 and prinpx=code in Table 5.08</p> <p>If princode is an ICD-9-CM code in Joint Commission Table 5.09 (Appendix A), SCIP Infection data collection ends; go to periexpr (Partial Abstraction only)</p>	<p>procedure, select "8."</p> <p>The following two scenarios must be clarified:</p> <p>1. If multiple procedures are performed during the <u>same surgical episode</u>, select "99."</p> <p>2. If other procedures are performed during <u>separate surgical episodes</u> requiring general or spinal/epidural anesthesia and occur within 3 days (4 days for CABG or Other Cardiac Surgery) of the principal procedure during this hospital stay, the answer to the question will be 1 through 8, as applicable.</p> <ul style="list-style-type: none"> For other surgical procedures requiring general or spinal/epidural anesthesia performed prior to the principal procedure during this hospital stay, the 3 days (4 days for CABG or Other Cardiac Surgery) window begins at the Anesthesia End Date of the earlier procedure and ends at the Anesthesia Start Date of the principal procedure. For other surgical procedures requiring general or spinal/epidural anesthesia that occur after the principal procedure during this hospital stay, the 3 days (4 days for CABG or Other Cardiac Surgery) window begins at the Anesthesia End Date of the principal procedure and ends at the Anesthesia Start Date of the subsequent procedure.
22	infecdoc	Did the patient have an infection during this hospitalization prior to the principal procedure? (Requires Physician, APN, or PA documentation) 1. Yes 2. No	<p>1*, 2</p> <p>*If 1, the record is excluded from SCIP Infection Measures; go to periexpr Partial Abstraction</p>	<p>Only answer 1, if there is <u>preoperative documentation by a physician, APN, or PA</u> that the patient had an infection or a possible/suspected infection during this hospitalization prior to the principal procedure.</p> <p>1) The physician/APN/PA documentation of preoperative infection must be in place prior to surgery. Do not accept documentation of a preoperative infection documented anytime after Anesthesia Start Time.</p> <p>2) Exclude any documentation of an infection found in the Operative</p>

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			<p style="text-align: center;">only</p> <p>If 2 AND prinpx <> ICD-9-CM code from JC Table 5.01, 5.02, 5.03, 5.04, 5.05, 5.06, 5.07, or 5.08, go to periexpr (Partial Abstraction only); else if 2, go to recvanti</p>	<p>Report except documentation that a joint revision or hardware removal was performed as noted in the Exception below: Select "Yes" if the current principal procedure was a joint revision.</p> <ul style="list-style-type: none"> To be considered a joint revision, the same joint as the principal procedure must have been operated on in a previous surgery that was a total or partial arthroplasty, OR there must be documentation that hardware was removed during the current principal procedure. <p>3) If there are two or more history and physicals (H&P), use the most current. An H&P, consult, pre-op clearance, pre-op chest x-ray, or other form dated prior to admission that includes documentation of an infection, must be updated after admission and prior to surgery. It must be noted that there have been no changes since the form was filled out previously and documentation must indicate that the infection or possible/suspected infection is current.</p> <p>4) If an infection is documented as "chronic," there must be additional documentation that the infection is current or still present preoperatively, during the hospital stay. If an infection is only documented as "chronic" without other documentation that the infection is still present preoperatively, select "2."</p> <p>5) Documentation of symptoms (such as fever, elevated white blood cells) should not be considered infections unless documented as an infection or possible/suspected infection.</p> <p>Include: abscess, acute abdomen, aspiration pneumonia, blood stream infection, bone infection, cellulitis, Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation, Crohn's Disease, endometritis, fecal contamination, free air in abdomen, gangrene, H.pylori, necrotic/ischemic/infarcted bowel, necrosis, osteomyelitis, other documented infection, perforation of bowel, penetrating abdominal trauma, pneumonia or other lung infection, purulence/pus, sepsis, surgical site or wound infection, Systemic Inflammatory Response Syndrome (SIRS), Ulcerative Colitis, urinary tract infection (UTI)</p> <p>Exclude: Avascular necrosis, bacteria in urine (bacteriuria), 'carditis' (e.g. pericarditis) without mention of an infection, colonized or positive screens for MRSA, VRE, or for other bacteria, fistulas without documentation of abscess or fecal contamination, fungal infections, history of infection, recent infection or</p>

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				<p>recurrent infection not documented as a current or active infection, viral infections, orders for preoperative tests or screens without documentation of an infection or suspected infection</p> <p>Do NOT use Joint Commission Table 5.09 (Appendix A) as a reference for this data element.</p> <p>Exclusion Statement: Preoperative infectious disease and/or treatment for infection precluded assignment to the SCIP Infection measure population.</p>
		Medications		
23	recvanti	<p>Did the patient receive an antibiotic via an appropriate route? (PO, NG, PEG, IV, perfusion, or IM)</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>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 during hospital stay (not prior to arrival)</p> <p>4. Antibiotic not received or unable to determine from medical record documentation</p>	<p>1, 2, 3, 4*</p> <p>If 1, 2, or 3 AND prinpx is ICD-9 code on JC Table 5.03, go to oralabx</p> <p>If 1 AND prinpx < ICD-9 code on JC Table 5.03, go to periexpr</p> <p>If 2 or 3 AND prinpx < ICD-9 code on JC Table 5.03, auto-fill oralabx as 95, and go to allerbio; else if 2 or 3, go to oralabx</p> <p>*If 4, go to periexpr</p>	<p>Only consider antibiotics listed in Joint Commission Table 2.1, Appendix C. Include only antibiotic routes listed in the SCIP inclusions for administration routes [PO or by NG or PEG tube, intravenous (IV) or perfusion, or intramuscular (IM)].</p> <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 medical record must be abstracted as documented (taken at "face value"). When the documented date is an invalid date or 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 consider that date or time at face value. If the date and/or time for an antibiotic dose is an obvious error and the correct date or time can be found on the same source, the correct date or time may be considered. If the correct date or time cannot be found on that same source, the date must be abstracted at face value. Example: An

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				<p>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> <p>Exclude: abdominal irrigation, chest irrigation, eardrops, enema/rectally, eyedrops, 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 room record, perfusion record</p>

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24	oralabx	<p>Is there documentation that a combination of (oral Neomycin Sulfate + Erythromycin Base) OR (oral Neomycin Sulfate + Metronidazole) was administered the day prior to the day of surgery or within 24 hours prior to surgery?</p> <p>1. Yes 2. No 95. Not applicable</p>	<p>1, 2, 95</p> <p>Will be auto-filled as 95 if recvanti = 2 or 3 AND prinpx <> ICD-9 code on JC Table 5.03</p> <p>If 1 or 2 AND recvanti = 1, go to periexpr; else if 1 or 2 AND recvanti = 2 or 3, go to allerbio</p>	<p>This element is used to prevent colon surgeries from being excluded from the appropriate measures if the <u>patient receives either of these oral antibiotic combinations the day prior to the day of surgery or within 24 hours of surgery.</u></p> <ul style="list-style-type: none"> • If there is documentation that oral Neomycin Sulfate + Erythromycin Base OR oral Neomycin Sulfate + Metronidazole was received by the patient on the day prior to the day of surgery or within 24 hours prior to surgery, select "1" regardless of whether the patient received other antibiotics. • If there is documentation that the patient was receiving any antibiotic <u>other</u> than these oral combinations of antibiotics the day prior to the day of surgery or within 24 hours prior to surgery (e.g., patient received amoxicillin the day prior to surgery, but did not receive one of the oral antibiotic combinations), select "2". • The combination of oral antibiotics can be received before hospitalization and/or during this hospital stay. • If there is documentation that the patient received a combination of these oral antibiotics on the day prior to the day of surgery, assume it was given within 24 hours and select "1". A time and date is not needed. • If there is documentation of a Nichol's Bowel Prep used the day prior to the day of surgery or within 24 hours prior to surgery, select "1." Nichol's Bowel Prep contains the recommended oral antibiotics for Colon Surgery. • If there is documentation of instructions or that prescriptions were given to the patient in regard to the oral antibiotic combinations listed above or for a Nichol's Bowel Prep, to be taken on the day prior to the day of surgery or within 24 hours prior to surgery, select "1."

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25	allerbio	Does the record document a history or current finding of antibiotic allergy, sensitivity, or intolerance to beta-lactam, penicillin, or cephalosporins? 1. Yes 2. No	1, 2 If 1, auto-fill vancopro1 = -1	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 the record documents an allergy, sensitivity, or intolerance to beta-lactam/penicillin or cephalosporin antibiotics, enter "1". Include: adverse drug event, adverse effect, adverse reaction, anaphylactic reaction, anaphylaxis, hives, rash
26	bioname bodate biotime bioroute	Document the name of each antibiotic dose (s) administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery). May have 75 entries. Enter the date each antibiotic was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery). Enter the time each antibiotic dose was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery). Enter the route of administration of each antibiotic dose that	_____ antibiotic name If an antibiotic from Table 3.8 is not entered in bioname, auto-fill vancopro = 95 Date of Administration mm/dd/yyyy Abstractor can enter 99/99/9999 if date cannot be determined	Only collect antibiotics (Joint Commission Table 2.1, Appendix C) administered by an appropriate route (PO, NG, PEG, IV, perfusion, and IM). Exclude all other routes. Each antibiotic name must be accompanied by the Date of antibiotic, Time of antibiotic, and Route of antibiotic. If an antibiotic name is misspelled or abbreviated in the medical record and the abstractor can determine from supporting documentation which antibiotic was administered, that antibiotic may be entered for name. Only select "Antibiotic NOS" for the following situations: <ul style="list-style-type: none">• New antibiotics that are not yet listed in JC 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.

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		<p>was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).</p> <ol style="list-style-type: none"> 1. PO, NG, PEG tube (Oral) 2. IV (Intravenous, perfusion) 3. IM (Intramuscular) 99. UTD (Unable to determine route) 	<div> <p>If prinpx=code in Table 5.03, 5.04, 5.05, 5.06, 5.07 or 5.08 > = arivldt and < = 2 days after anesendt and <=dtofdc</p> <p>If prinpx=code in Table 5.01 or 5.02 > = arivldt and < = 3 days after anesendt and <=dtofdc</p> </div>	<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, date, time, and route) 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

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			<p>Time of Administration</p> <p>UMT</p> <p>Abstractor can enter 99:99 if time cannot be determined</p> <div style="border: 1px solid black; padding: 5px;"> <p>If prinpx=code in Table 5.03, 5.04, 5.05, 5.06, 5.07, or 5.08 > = arivldt/arivltm and < = 48 hrs after anesendt/anendtm and <=dtofdc/sipdctm</p> <p>If prinpx=code in Table 5.01 or 5.02, > = arivldt/arivltm and < = 72 hrs after anesendt/anendtm and <=dtofdc/sipdctm</p> </div> <p>Route 1, 2, 3, 99</p>	<p>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.</p> <ul style="list-style-type: none"> • 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. • Do not abstract antibiotics from sources that do not represent actual administration. Examples: <ul style="list-style-type: none"> ◦ Pre-Op Checklist states: X IV Started at 1730 X Preop Antibiotic Given at 1800 ◦ Operative report states: IV antibiotics were given prior to procedure. ◦ Pre-op note states: Ancef given in ED. • Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe. For example, narrative states: "Ancef 1 gram given IV prior to incision." No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data. • 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." • 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.

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27	vancopro1 vancopro2 vancopro3 vancopro4 vancopro5 vancopro6 vancopro7 vancopro8 vancopro10 vancopro11 vancopro95 vancopro99	<p>What reason for using vancomycin was documented?</p> <p>Select all that apply:</p> <p>1. Documentation of beta lactam (penicillin or cephalosporin) allergy</p> <p>2. Documentation of colonization with MRSA, positive MRSA screen, an MRSA infection, or a history of MRSA</p> <p>3. Documentation of patient being high-risk due to acute inpatient hospitalization within the last year</p> <p>4. Documentation of patient being high-risk due to nursing home or extended care facility setting within the last year, prior to admission</p> <p>5. Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or procedure-specific</p> <p>6. Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis</p> <p>7. Documentation of continuous inpatient stay more than 24 hours prior to the principal procedure</p> <p>8. Other physician/APN/PA or pharmacist documented reason</p> <p>10. Physician/APN/PA or pharmacist documentation of patient undergoing valve surgery</p> <p>11. Documentation of patient being transferred from another inpatient hospitalization after a 3-day stay</p> <p>95. Not applicable</p> <p>99. No documented reason</p>	<p>1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 95, 99</p> <p>If allerbio = 1, computer will auto-fill vancopro1 = -1</p> <div style="border: 1px solid black; padding: 2px;">Cannot enter 99 with any other number</div> <p>Will be auto-filled as 95, if bioname <> antibiotic on Table 3.8</p>	<p>Physician/APN/PA, pharmacist or infection control practitioner documentation of the reason for the use of Vancomycin as prophylaxis must have been entered into the medical record <u>preoperatively</u> to select options 2, 5, 6, 8, and 10.</p> <p>Infection Control Practitioner = may be a medical technician, nurse, physician/APN/PA, or pharmacist</p> <p>For this question, infection control practitioner documentation is acceptable if it is specifically designated as "infection control" documentation in the medical record. For example, in a progress noted with the heading, "infection control," the physician/APN/PA or pharmacist documents, "vancomycin is used because of the hospital's high MRSA rate."</p> <p>1 = Abstractor may select "1" based on allergies listed in medical record</p> <p>4 = For nursing home/extended care facility:</p> <ul style="list-style-type: none"> • Include: hospice facility - skilled respite, intermediate care facility, respite care, skilled nursing facility, sub-acute care, swing bed/unit, transitional care unit. • Exclude: assisted living, board and care, group home/personal care home, residential care, residential or outpatient chemical dependency treatment, psychiatric unit or facility, hospice at home <p>10 = If the medical record contains preprinted orders (signed by a physician) prescribing vancomycin for all valve surgeries, select "10."</p> <p>11= For hospitalization: acute inpatient, long-term care hospital, inpatient rehabilitation unit or facility, inpatient drug rehabilitation</p> <p>"99" cannot be entered with any other number.</p>

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28	periexpr	Is there documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/ recovery area? 1. Yes 2. No	1*, 2 *If 1 and prinpx is on JC Table 5.11, auto-fill noglucose as 1, and go to priorwar; else if 1 and prinpx < JC Table 5.11, go to priorwar If 2, go to yextabx1	For this data element, the timeframe for Perioperative Death is from surgical incision through discharge from the post anesthesia care/recovery area. Examples: <ul style="list-style-type: none"> • The patient expired while undergoing surgery; select "1." • The patient died while in the post anesthesia care/recovery area; select "1." • A discharge order from the post anesthesia care/recovery area was written for a surgery patient at 11:05 a.m. and at 11:17 a.m. the patient developed a complication and ultimately expired. The order for discharge was written, but the patient did not leave the recovery area, select "2." • The patient was not discharged from the post anesthesia care/recovery area, developed a complication and then expired; select "1." • The patient was discharged from the post anesthesia care/recovery area and on the way to the floor, developed complications and expired; select "2." <p>To determine the end of Perioperative Period: For patients discharged from surgery and admitted to the PACU: The end of the perioperative period occurs when the patient is discharged from the PACU. For patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU): The perioperative period would end a maximum of six hours after arrival to the recovery area.</p>
		Reasons to Extend Antibiotics		
29	yextabx1	Within 2 days (3 days for CABG or Other Cardiac Surgery) after Anesthesia End Time, did the physician/APN/PA document that the patient had an infection? 1. Yes 2. No	1, 2	Only documentation written or dictated after incision and within 2 days (3 days for CABG or Other Cardiac Surgery) after Anesthesia End Time may be used to abstract this data element. 1) There must be documentation of a current infection or current possible/suspected infection. 2) Documentation of symptoms (example: fever, elevated white blood cells, wound condition, etc.) should not be considered infections unless documented as a current infection or current possible/suspected infection. 3) This data element has an inclusion table to use as a guideline that provides the types of infection that are acceptable. Please reference this inclusion table when answering this data element.

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				<p>Note: Do NOT use Table 5.09 as a reference for identifying infections. Use the Inclusion list below.</p> <p>Inclusion Table for Infection:</p> <table><tr><td>Abscess</td><td>Necrosis</td></tr><tr><td>Acute abdomen</td><td>Necrotic/ischemic/infarcted bowel</td></tr><tr><td>Aspiration pneumonia</td><td>Osteomyelitis</td></tr><tr><td>Bloodstream infection</td><td>Other documented infection</td></tr><tr><td>Bone infection</td><td>Penetrating abdominal trauma</td></tr><tr><td>Cellulitis</td><td>Perforation of bowel</td></tr><tr><td>Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation</td><td>Pneumonia or other lung infection</td></tr><tr><td>Crohn's Disease</td><td>Purulence/pus</td></tr><tr><td>Endometritis</td><td>Sepsis</td></tr><tr><td>Fecal Contamination</td><td>Surgical site or wound infection</td></tr><tr><td>Free air in abdomen</td><td>Systemic Inflammatory Response Syndrome (SIRS)</td></tr><tr><td>Gangrene</td><td>Ulcerative Colitis</td></tr><tr><td>H. pylori</td><td>Urinary tract infection (UTI)</td></tr></table> <p>Exclusion Table for Infection:</p> <table><tr><td>Avascular Necrosis</td><td>Fungal infections</td></tr><tr><td>Bacteria in urine (Bacteriuria)</td><td>History of infection, recent infection or recurrent</td></tr><tr><td>"carditis" (such as pericarditis) without mention of an infection</td><td>Orders for post-operative tests or screens without documentation of an infection or suspected infection</td></tr><tr><td>Colonization or positive screens for MRSA, VRE, or for other bacteria</td><td>Viral infections</td></tr><tr><td>Fistulas without documentation of abscess or fecal contamination</td><td></td></tr></table> <p>Excluded Data Sources:</p>	Abscess	Necrosis	Acute abdomen	Necrotic/ischemic/infarcted bowel	Aspiration pneumonia	Osteomyelitis	Bloodstream infection	Other documented infection	Bone infection	Penetrating abdominal trauma	Cellulitis	Perforation of bowel	Chronic Obstructive Pulmonary Disease (COPD) acute exacerbation	Pneumonia or other lung infection	Crohn's Disease	Purulence/pus	Endometritis	Sepsis	Fecal Contamination	Surgical site or wound infection	Free air in abdomen	Systemic Inflammatory Response Syndrome (SIRS)	Gangrene	Ulcerative Colitis	H. pylori	Urinary tract infection (UTI)	Avascular Necrosis	Fungal infections	Bacteria in urine (Bacteriuria)	History of infection, recent infection or recurrent	"carditis" (such as pericarditis) without mention of an infection	Orders for post-operative tests or screens without documentation of an infection or suspected infection	Colonization or positive screens for MRSA, VRE, or for other bacteria	Viral infections	Fistulas without documentation of abscess or fecal contamination	
Abscess	Necrosis																																							
Acute abdomen	Necrotic/ischemic/infarcted bowel																																							
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				<ul style="list-style-type: none"> Any preoperative documentation. Any postoperative documentation of infection from pathology reports.
30	yextabx2	<p>Did the record document the principal procedure was a lower extremity original or revision arthroplasty AND did the physician/APN/PA document a current benign or malignant bone tumor of the operative extremity?</p> <p>1. Yes 2. No</p>	<p>1, 2</p> <p>Will be auto-filled as 2 if prinpx < ICD-9 code on JC table 5.04 or 5.05</p>	<ul style="list-style-type: none"> Documentation of a current bone tumor can be found preoperatively or postoperatively. The lower extremity includes the hip, knee and foot joints. Documentation of a current bone tumor of the lower extremity includes but is not limited to: <ul style="list-style-type: none"> Bony tumor of lower operative extremity Sarcoma of lower operative extremity Primary malignancy of lower operative extremity Metastatic malignancy of lower operative extremity <p>Suggested data sources: Anesthesia record, consultation notes, discharge summary, operative report, physician order forms, progress notes</p>
31	yextabx3	<p>Did the physician/APN/PA document any of the following reasons to extend antibiotics?</p> <ul style="list-style-type: none"> Erythromycin was administered postoperatively for the purpose of increasing gastric motility; OR An antibiotic was administered postoperatively for the treatment of hepatic encephalopathy; OR An antibiotic was administered postoperatively for the treatment of pulmonary fibrosis; OR An antibiotic was administered postoperatively as prophylaxis of Pneumocystis pneumonia (PCP); OR Demeclocycline was administered postoperatively for the treatment of syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) or hyponatremia; OR An antibiotic was administered postoperatively for the treatment of acne or rosacea <p>1. Yes 2. No</p>	<p>1, 2</p>	<ul style="list-style-type: none"> Physician/APN/PA documentation of the reasons specified can be found preoperatively or postoperatively. The physician/APN/PA documentation must include reasons that are specific to the listed conditions. Documentation of other terms for "increasing gastric motility" may include but is not limited to: treatment of gastroparesis, treatment of delayed gastric emptying, postoperative ileus, decreased gastric motility or a prokinetic effect. Documentation of Pneumocystis <i>pneumonia</i> can include but is not limited to: pneumocystis carinii pneumonia or PCP in a patient with a diagnosis of AIDS. Pneumocystis pneumonia may be referred to as PCP or pneumocystis carinii pneumonia or pneumocystis jiroveci pneumonia. Please reference Table 2.1 Antimicrobial Medications for the names of medications that are erythromycin. <p>Suggested data sources: Anesthesia record, consultation notes, discharge summary, operative report, physician order forms, progress notes</p>

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		If prinpx = ICD-9 code on JC Table 5.11 AND princode is not ICD-9 code on JC Table 5.09, 5.14 or 5.15, go to noglucose; else go to urincath3 as applicable		
		Postoperative Glucose		
32	noglucose	<p>Is there documentation that the patient experienced one of the following after surgery and prior to 24 hours after <i>Anesthesia End Time</i>?</p> <ul style="list-style-type: none"> • Patient was discharged • Patient expired • Patient left Against Medical Advice (AMA) • Patient underwent another surgery after the ICD-9-CM Principal Procedure <p>1. Yes 2. No</p>	<p>1, 2 Will be auto-filled as 1 if periexpr = 1 and prinpx is on JC Table 5.11 If 1, go to urincath3 as applicable</p>	<ul style="list-style-type: none"> • If the patient underwent CPR or another surgery, was discharged or expired after surgery and prior to 24 hours after <i>Anesthesia End Time</i>, select "1". • To select "1", the CPR must be documented as occurring in the specified timeframe after Anesthesia End Time. Do not consider documentation of resuscitation with medications only or defibrillation only.
33	glucose1	<p>Was the patient's blood glucose level controlled in the timeframe of 18 to 24 hours after <i>Anesthesia End Time</i>?</p> <p>1. All blood glucose levels collected were <= 180 mg/dL in the specified timeframe</p> <p>2. A single blood glucose level collected was > 180 mg/dL but ALL other values after the higher value were <= 180 mg/dL prior to the endpoint of 24 hours after <i>Anesthesia End Time</i></p>	<p>1, 2, 3, 4 If 1, 2, or 3, go to urincath3 as applicable</p> <div style="border: 1px solid black; padding: 2px;">Warning if 1, 2, or 3 and anendtm = 99:99</div>	<p>ONLY ALLOWABLE SOURCES: Consultation notes, diabetic or finger stick blood sugar flow sheet, laboratory reports, nursing graphic sheets, nursing notes, PACU/recovery room record, progress notes</p> <p>Review blood glucose levels obtained between 18 and 24 hours after <i>Anesthesia End Time</i>, using any of the Only Allowable Sources.</p> <p>If no blood glucose levels were collected between 18 and 24 hours after <i>Anesthesia End Time</i>, select "4."</p>

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		<p>3. A single blood glucose level collected was > 180 mg/dL and NO other values after the higher value were <= 180 mg/dL prior to the endpoint of 24 hours after Anesthesia End Time</p> <p>OR</p> <p>Two or more blood glucose levels were > 180 mg/dL in the specified timeframe</p> <p>4. No blood glucose levels were collected in the specified timeframe</p> <p>OR</p> <p>Any blood glucose level was unable to be determined from medical record documentation</p>		<ul style="list-style-type: none"> • If blood glucose levels in the specified timeframe reflected one value > 180 mg/dL but all of the other values after that value were <= 180, select "2." To select "2," there must be at least one level <= 180 mg/dL after the single high value. Examples: 160, 185, 170, 175 160, 170, 185, 175 • If no further blood glucose levels were collected after a single blood glucose level > 180 mg/dL in the specified timeframe, select "3." Examples: 174, 176, 177, 178, 182 174, 182 • If two or more values in the specified time frame were > 180 mg/dL, select "3." Examples: 185, 170, 175, 190, 175 174, 176, 177, 182, 185 • If any blood glucose level during the timeframe of 18 to 24 hours after <i>Anesthesia End Time</i> is unable to be determined from medical record documentation, select "4." • When the blood glucose level is recorded as "low" without a numerical value, consider the level to be <= 180 mg/dL. When the blood glucose level is recorded as "high" without a numerical value, consider the level to be > 180 mg/dL • If a blood glucose level reading is obtained and documented as being inaccurate due to equipment malfunction or user error and if the glucose level is documented as retaken, use the corrected blood glucose level. • If <i>Anesthesia End Time</i> is not documented, select "4" because the postoperative timeframe cannot be calculated.
34	glucose2	Was the patient's blood glucose level controlled in the	1, 2, 3, 4	ONLY ALLOWABLE SOURCES: Consultation notes, diabetic or finger

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		<p>timeframe of 12 to 18 hours after <i>Anesthesia End Time</i>?</p> <p>1. All blood glucose levels collected were ≤ 180 mg/dL in the specified timeframe</p> <p>2. A single blood glucose level collected was > 180 mg/dL but ALL other values after the higher value were ≤ 180 mg/dL prior to the endpoint of 18 hours after <i>Anesthesia End Time</i></p> <p>3. A single blood glucose level collected was > 180 mg/dL and NO other values after the higher value were ≤ 180 mg/dL prior to the endpoint of 18 hours after <i>Anesthesia End Time</i></p> <p>OR</p> <p>Two or more blood glucose levels were > 180 mg/dL in the specified timeframe</p> <p>4. No blood glucose levels were collected in the specified timeframe</p> <p>OR</p> <p>Any blood glucose level was unable to be determined from medical record documentation</p>	<div>Warning if 1, 2, or 3 and anendtm = 99:99</div>	<p>stick blood sugar flow sheet, laboratory reports, nursing graphic sheets, nursing notes, PACU/recovery room record, progress notes</p> <p>Review blood glucose levels obtained between 12 and 18 hours after <i>Anesthesia End Time</i>, using any of the Only Allowable Sources.</p> <p>If no blood glucose levels were collected between 12 and 18 hours after <i>Anesthesia End Time</i>, select "4."</p> <ul style="list-style-type: none"> If blood glucose levels in the specified timeframe reflected one value > 180 mg/dL but all of the other values after that value were ≤ 180, select "2." To select "2," there must be at least one level ≤ 180 mg/dL after the single high value. Examples: 160, 185, 170, 175 160, 170, 185, 175 If no further blood glucose levels were collected after a single blood glucose level > 180 mg/dL in the specified timeframe, select "3." Examples: 174, 176, 177, 178, 182 174, 182 If two or more values in the specified time frame were > 180 mg/dL, select "3." Examples: 185, 170, 175, 190, 175 174, 176, 177, 182, 185 If any blood glucose level during the timeframe of 12 to 18 hours after <i>Anesthesia End Time</i> is unable to be determined from medical record documentation, select "4." When the blood glucose level is recorded as "low" without a numerical value, consider the level to be ≤ 180 mg/dL. When the blood glucose level is recorded as "high" without a numerical value, consider the level to be > 180 mg/dL If a blood glucose level reading is obtained and documented as being inaccurate due to equipment malfunction or user error and if the glucose level is documented as retaken, use the corrected blood glucose level.

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				<ul style="list-style-type: none"> If <i>Anesthesia End Time</i> is not documented, select "4" because the postoperative timeframe cannot be calculated.
		If (prinpx or othrp) = ICD-9-CM code on JC Table 5.16 (Appendix A) OR if DTOFDC - ANESENT < 2 days, go to priorwar; else go to urincath3		
		Urinary Catheter		

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35	urincath3	<p>Is there documentation that a urinary catheter was placed during the specified timeframe AND that one was still in place at the time of discharge from the recovery/post-anesthesia care area? The specified timeframe is defined as from hospital arrival through discharge from the recovery/post-anesthesia care area.</p> <p>1. Yes 2. No or unable to determine</p>	<p>1, 2</p> <p>If 2, auto-fill cathout as 95, reascath as 95, and go to priorwar, else go to cathout</p>	<p>For patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU): The specified timeframe ends at a maximum of six hours after arrival to the recovery area.</p> <ul style="list-style-type: none"> To select "1", there must be documentation of the insertion of an indwelling urethral catheter to determine that one was placed during the specified timeframe. If there is not documentation of the insertion of the catheter, do not select "1". For "1", to determine whether an indwelling catheter was still in place at discharge from the recovery area, there must be documentation within 24 hours after <i>Anesthesia End Time</i> that a catheter was still in place. Example: A catheter was placed in the operating room and notes in the PACU do not indicate whether or not the catheter was in place at discharge but later the nurses' notes show that a catheter was present, that is sufficient documentation to show the catheter was still in place at discharge from the recovery area. If multiple indwelling urethral catheters are placed and removed prior to surgery and there is documentation that later an indwelling urethral catheter was placed during the specified timeframe AND that one was still in place at the time of discharge from the recovery/post-anesthesia care area, select "1". If the patient had a urinary diversion (Example: urostomy, ileal conduit or suprapubic catheter) OR had an indwelling urethral urinary catheter OR was being intermittently catheterized prior to the specified timeframe select "2". <p>Include: indwelling urethral catheter Exclude: External catheter, Texas catheter Suggested data sources: Intraoperative record, operative report, PACU record, nurses notes</p>

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36	cathout	<p>Is there documentation the urinary catheter was removed on Postoperative Day 0 (POD 0) through Postoperative Day Two (POD 2) with Anesthesia End Date being POD 0?</p> <p>1. Urinary catheter was removed on POD 0 through POD 2 2. Urinary catheter was not removed on POD 0 through POD 2 95. Not applicable 99. Unable to determine from medical record documentation whether the urinary catheter was removed on POD 0 through POD 2</p>	<p>1, 2, 95, 99 Will be auto-filled as 95 if urincath3 = 2 If 1, auto-fill reascath as 95, and go to priorwar, else go to reascath</p>	<p>The Anesthesia End Date is postoperative day zero (POD 0). Postoperative day 2 (POD 2) ends at midnight of the second postoperative day. Documentation of catheter removal does NOT need to be found within the perioperative period, but must reflect that the catheter was removed on POD 0 through POD 2.</p> <ul style="list-style-type: none"> • If there is documentation the catheter was removed beyond POD 2, select "2". • If the patient expires before the end of POD 2 prior to catheter removal, select "1". • If the catheter was discontinued or was unintentionally removed on POD 0 through POD 2 and was not reinserted, select "1". This includes catheter removal by the patient. • If the catheter was removed (includes catheter removal by the patient) and was reinserted prior to the end of POD 2 due to an inability to void or urinary retention, select "1". • If the catheter was removed (includes catheter removal by the patient) and was replaced or exchanged with a catheter that remained in place beyond POD 2, select "2". • If there is documentation that a catheter was inserted during the specified timeframe and there is documentation the patient voided/urinated on POD 0 through POD 2, after the time that the catheter was inserted, select "1."
37	reascath1 reascath2 reascath95 reascath99	<p>Was there documentation of a reason for not removing the urinary catheter postoperatively on POD 1 or POD 2?</p> <p>Indicate all that apply:</p> <p>1. Documentation that the patient was in the intensive care unit (ICU) and receiving one or more of the listed medications (diuretic, vasopressor/inotropic, or paralytic therapy)</p>	<p>1, 2, 95, 99 Will be auto-filled as 95 if urincath3 = 2, or cathout = 1 99 cannot be entered with any other number</p>	<p>Documentation of a reason for not removing the urinary catheter must be found on POD 1 or POD 2. The Anesthesia End Date is postoperative day zero. The intent is that the physician/APN/PA will evaluate the patient on POD 1 and POD 2 and document regarding the necessity for continuing the catheter such as, physician order to keep the catheter for a specific reason or time frame.</p>

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		<p>2. Physician/APN/PA documentation of a reason for not removing the urinary catheter postoperatively</p> <p>95. Not applicable</p> <p>99. No documentation of a reason for not removing the urinary catheter postoperatively or unable to determine from medical record documentation</p>		<ul style="list-style-type: none"> • Value "1" does not require physician/APN/PA documentation. If the patient is in the intensive care unit (ICU) on POD 1 or POD 2 AND it is documented that the patient received even one dose of diuretics OR vasopressors/inotropics OR paralytics (examples include, but are not limited to: pancuronium, succinylcholine, vecuronium) , select "1." BCMA documentation can be used to determine whether the patient in the ICU is receiving one of the listed medications. • Diuretics, vasopressor/inotropic, paralytic medications - Refer to Joint Commission, Appendix C: <ul style="list-style-type: none"> ◦ Table 3.13 for a list of diuretics ◦ Table 3.14 for a list of inotropic and vasopressor agents ◦ Table 3.15 for a list of paralytic agents • To select option "2" there must be physician/APN/PA documentation of a reason or plan to continue the urinary catheter. For example, physician notes, "Patient on total bed rest. Continue catheter." is acceptable. • A physician order to leave the catheter in place without documentation of a reason is not sufficient. Example: "Continue catheter" is not acceptable. • To select value "2", based on a medical staff-approved facility protocol, there must be physician/APN/PA documentation on POD 0, POD 1, or POD 2 ordering or instructing the nursing staff to follow the formal urinary catheter protocol AND there must be documentation on POD 1 or POD 2 of a reason to continue urinary catheterization contained in the protocol found in the medical record. The reason may be documented by a nurse in this situation. • Patient refusal to have a catheter removed does not have to be documented by a physician/APN/PA, but must be documented on POD 1 or POD 2 in order to select "2". <p>Exclude: risk/high risk of falls</p>
		VTE Prophylaxis		

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38	priorwar	Was there documentation that the patient was on continuous oral anticoagulation therapy prior to admission? 1. Yes 2. No	1, 2 If an ICD-9-CM code in Table 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24 is NOT entered in prinpx, the case is excluded from the SCIP VTE measures. If prinpx < an ICD-9-CM code in Table 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24 AND periexpr = 2, go to preadmbb. If periexpr = 1, go to end. If 1, auto-fill norxpro as 95, nomecpro as 95, vtelaxis as 95, and go to preadmbb If 2 and periexpr = 2, go to norxpro as applicable	Refer to the first column of Joint Commission Table 2.1 in Appendix H, VTE Prophylaxis Inclusions, for a list of alternate names for warfarin (Coumadin). If there is documentation that an oral anticoagulant was a "home" or "current" medication, select "1." If an oral anticoagulant was listed as a "home" or "current" medication, but placed on hold prior to surgery, select "1." If the oral anticoagulant was placed on hold greater than 7 days prior to surgery, select "2." If the documentation indicates that the physician ordered one dose of an oral anticoagulant to be taken at home in the 24 hours prior to incision, answer "2". Inclusion Guidelines (The list of drug categories is all inclusive, but the examples of drug names are not.): <ul style="list-style-type: none">• Direct thrombin inhibitors (such as dabigatran, dabigatran etexilate, Pradaxa)• Factor Xa inhibitors (such as rivaroxaban, Xarelto)• Warfarin sodium (such as Coumadin, Jantoven, warfarin) Exclusion Statement: The record indicates the principal procedure performed was not applicable to the Surgical Care Improvement Project VTE measure population.
		If princode is an ICD-9-CM code on Joint Commission Table 5.14 (Appendix A), OR if anesendt + anendtm - anebegdt + anebegtm <= 60 minutes OR if dtofdc-siadmdt < 2 days, go to preadmbb; otherwise go to norxpro		
39	norxpro	Is there documentation by the physician, APN, PA, or pharmacist in the medical record of a reason for not administering pharmacological venous thromboembolism	1, 2, 95 Will be auto-filled as	Physician, APN, PA, or pharmacist documentation of a reason for not administering pharmacological venous thromboembolism prophylaxis must be found within the timeframe of arrival to 24 hours after surgery end time.

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		(VTE) prophylaxis? 1. Yes 2. No 95. Not applicable	95 if priorwar=1	<ul style="list-style-type: none"> • If the physician orders a transfusion and the blood products are administered in the timeframe of arrival to 24 hours after <i>Anesthesia End Time</i>, select "1." • Blood or blood products administered during surgery and documented on the anesthesia record or in the operative report should be considered an order for transfusion, select "1." • If there is documentation that the patient is on continuous IV heparin therapy <u>within 24 hours before or after surgery</u>, select "1." • Patient refusal of pharmacological VTE prophylaxis does NOT have to be documented by a physician/APN/PA, or pharmacist, but must be documented within the timeframe from arrival to 24 hours after <i>Anesthesia End Time</i> • Physician/APN/PA documentation of the VTE risk alone is not sufficient as a reason. The physician/APN/PA or pharmacist must document an inclusion or a specific reason for not administering pharmacological VTE prophylaxis. EXCEPTION: For General Surgeries only (refer to Appendix A, Table 5.19), if there is documentation of a Roger's VTE risk factor score < 7 or a Caprini VTE risk factor score of 0 (zero), select "1". <p>Examples of reasons for not administering VTE pharmacological prophylaxis include, but are not limited to: active bleeding (gastrointestinal or GI bleeding, cerebral hemorrhage, retroperitoneal bleeding), bleeding risk, hemorrhage, patient refusal, risk of bleeding, thrombocytopenia</p> <p>Unacceptable documentation of a reason for not administering VTE prophylaxis:</p> <ul style="list-style-type: none"> • An order to hold VTE prophylaxis without a documented reason by the physician/APN/PA or pharmacist • Documentation of "history of bleeding" without mention of active bleeding or bleeding risk • A timeframe for starting or holding VTE prophylaxis is not sufficient as a reason for not administering VTE prophylaxis in the allowable timeframe. Example: "Hold heparin 48 hours postop." This is an order to hold, but does not include a reason.

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				<ul style="list-style-type: none"> • Re-infusion of blood products (blood salvage) collected with blood recovery systems, plasma or volume expanders and platelet gels. • Documentation of an allergy or adverse reaction to ONE type of pharmacological prophylaxis. For example, "patient allergic to Coumadin" would not be acceptable. • Physician documentation of bleeding risk or active bleeding in reference to the normal risk of bleeding or to the normal bleeding associated with surgery is not considered a reason for not administering pharmacological VTE prophylaxis. For example, physician documents, "Discussed risks and benefits of surgery. Included risk of infection and bleeding." • If pharmacological VTE prophylaxis is not administered based on physician parameters, there must be substantiating documentation. Example: Hold heparin for INR > 2.5. To be sufficient as reason, there must be documentation that the heparin was held due to an INR value > 2.5 during the applicable timeframe. <p>Exclude: bleeding risk described in the informed consent process, history of bleeding, minimal or scant bleeding or oozing, serosanguinous drainage from drain or surgical dressing, chronic anemia</p> <p>Pharmacological prophylaxis = medications used to prevent VTE such as subQ low dose heparin, warfarin (Coumadin), or enoxaparin (Lovenox)</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
40	nomecpro	Is there documentation by the physician, APN, PA, or pharmacist in the medical record of a reason for not administering mechanical venous thromboembolism (VTE) prophylaxis? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be autofilled as 95 if priorwar=1 If 1 AND norxpro=1, auto-fill vtelaxis as 95, and go to preadmbb	Physician, APN, PA, or pharmacist documentation of a reason for not administering mechanical venous thromboembolism prophylaxis must be found within the timeframe from arrival to 24 hours after <i>Anesthesia End Time</i>. Mechanical prophylaxis = compression devices or stockings such as anti-embolism hose used to prevent VTE If there is documentation that the patient is on continuous IV heparin therapy <u>within 24 hours before or after surgery</u> , select "1." Patient refusal of mechanical VTE prophylaxis does not have to be documented by a physician/APN/PA, or pharmacist, but refusal must be documented in the timeframe from arrival to 24 hours after <i>Anesthesia End Time</i>. An order to hold mechanical VTE prophylaxis without a documented reason for not administering mechanical VTE prophylaxis by the physician/APN/PA or pharmacist is not acceptable. Examples of reasons for not administering VTE mechanical prophylaxis include, but are not limited to: arterial insufficiency of lower extremities, bilateral amputee, patient refusal, bilateral lower extremity trauma, massive leg edema, pulmonary edema, severe peripheral artery disease, severe peripheral neuropathy, major leg deformity, or dermatitis
41	yeslaxis1 vtelaxis95 yeslaxis3 yeslaxis4		Will be autofilled as 95 if priorwar=1, or if norxpro=1 AND nomecpro=1	VTE Prophylaxis Inclusion: Refer to Joint Commission Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table for a complete list. The intent of this question is to determine what VTE prophylaxis (mechanical and pharmacologic) was ordered and whether the ordered VTE prophylaxis was

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
yeslaxis5 yeslaxis6 yeslaxis7 yeslaxis8 vtelaxis1 vtelaxis2 vtelaxis3 vtelaxis4 vtelaxis5 vtelaxis6 vtelaxis7 vtelaxis8 vtelaxisA yeslaxis2	What venous thromboembolism (VTE) prophylaxis was ordered anytime from hospital arrival to 24 hours after Anesthesia End Time?	Was there documentation that the ordered VTE prophylaxis was received within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time?	<div style="border: 1px solid black; padding: 5px;">vtelaxisA cannot be checked with any other box</div> <p>For any vtelaxis=-1, abstractor must check yes or no before going to the next vtelaxis checkbox</p> <p>For any vtelaxis <-1, clear corresponding yes and no checkbox</p>	<p>received within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time.</p> <p>1. Venous thromboembolism (VTE) prophylaxis can be ordered anytime from hospital arrival to 24 hours after Anesthesia End Time.</p> <ul style="list-style-type: none"> For the purposes of abstraction, mechanical VTE prophylaxis does not require a physician order to be abstracted; there is no order or copy of hospital protocol required. Abstract any form of mechanical VTE prophylaxis that is documented as ordered or as placed on the patient at anytime from hospital arrival to 24 hours after <i>Anesthesia End Time</i>. For VTE pharmacologic prophylaxis the ONLY ACCEPTABLE SOURCE is physician orders. <p>Abstract any pharmacological VTE prophylaxis that was ordered anytime from hospital arrival to 24 hours after <i>Anesthesia End Time</i>. If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract both medications for <i>VTE Prophylaxis</i> and for <i>VTE Timely</i>. Note: No copy of the formulary or protocol is required in the medical record.</p> <p>To select "9", there must be an order for aspirin for VTE prophylaxis.</p> <p>Examples:</p> <ul style="list-style-type: none"> Lovenox is ordered and not received and is substituted with Arixtra, which is received by the patient. Abstract Lovenox as Value "2" for <i>VTE Prophylaxis</i> and "No" for <i>VTE Timely</i>. Abstract Arixtra as Value "5" for <i>VTE Prophylaxis</i> and abstract <i>VTE Timely</i> accordingly. Lovenox is ordered and not received; Heparin SC is ordered and is received. SCD's are placed. Abstract Lovenox as Value "2" for <i>VTE Prophylaxis</i> and "No" for <i>VTE Timely</i>. Abstract Heparin SC as Value "1" and SCD's as Value "3" for <i>VTE Prophylaxis</i> and abstract <i>VTE Timely</i> accordingly. <p>2. For each VTE Prophylaxis ordered, review the record to determine whether the ordered VTE prophylaxis was administered within 24 hours prior to Anesthesia Start Time to 24 hours after Anesthesia End Time.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		1. Low dose unfractionated HEPARIN (Subcutaneous route only)	Yes No	<ul style="list-style-type: none"> If the ordered VTE prophylaxis was received within the appropriate timeframe, check "yes." If the VTE prophylaxis was ordered and not administered, check "no." If the VTE prophylaxis was ordered and not administered within the appropriate timeframe, check "no." <p>Examples of each VTE prophylaxis category (refer to TJC Appendix H, Table 2.1 for complete list) such as: Low dose unfractionated heparin (LDUH) - only include heparin administered by <u>subcutaneous</u> route (SC, SQ, SubQ): heparin (Calcilean, Calciparine, Liquaemin) Low molecular weight heparin (LMWH): dalteparin (Fragmin), danaparoid (Orgaran), enoxaparin (Lovenox), tinzaparin (Innohep) Intermittent pneumatic compression devices (IPC): AE pumps (anti-embolic pumps) calf/thigh, DVT boots-calf/thigh, sequential compression device (SCD) Graduated compression stockings (GCS) knee or thigh high: Anti-embolism stockings, TED hose (TEDS), Jobst stockings Factor Xa Inhibitor: Fondaparinux (Arixtra) Warfarin such as: Coumadin, Jantoven, Panwarfin, Warfilone Venous foot pumps: AE pumps - foot only, Kendall boots, Pneumoboosts - foot only Oral Factor Xa - rivaroxaban (Xarelto) Aspirin - acetylsalicylic acid (ASA), aspirin Suggested data sources: graphic/flow sheets, medication administration record, nursing notes, progress notes</p>
		2. Low molecular weight heparin (such as enoxaparin)	Yes No	
		3. Intermittent pneumatic compression devices (such as SCDs)	Yes No	
		4. Graduated compression stockings (such as TED hose)	Yes No	

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		5. Parenteral Factor Xa Inhibitor (such as fondaparinux)	Yes No	
		6. Warfarin	Yes No	
		7. Venous foot pumps (VFP)	Yes No	
		8. ORAL factor Xa Inhibitor (such as rivaroxaban)	Yes No	
		9. Aspirin	YesNo	
		A. None of the above		
		95. Not applicable		
		Perioperative Beta-Blocker Therapy		

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42	preadmbb	<p>Is there documentation that the patient was on <u>daily</u> beta-blocker therapy prior to arrival?</p> <p>1. Yes 2. No</p>	<p>1, *2</p> <p>*If 2, go to end</p>	<p>The intent of the question is to determine if the patient was on daily beta-blocker therapy prior to arrival.</p> <p>Exclude: eye drops containing beta-blocker, "PRN" beta-blocker, beta-blockers taken daily for non-cardiac reasons</p> <ul style="list-style-type: none"> • If there is documentation that the beta-blocker was taken daily at "home" or is a "current" medication, select "1." • If the patient was transferred from a facility where they were started on a beta-blocker as a daily medication, select "1". • If a beta-blocker is listed as a home medication without designation of how often or when it is taken, select "1." • If the beta-blocker is listed as a daily "home" or "current" medication and the physician/APN/PA documents to discontinue or hold the beta-blocker before surgery WITHOUT a documented reason for not administering, select "1". • If the beta-blocker is listed as a daily "home" or "current" medication and the physician/APN/PA documents to discontinue or hold the beta-blocker before surgery WITH a documented reason for not administering, select "2". • The use of hypotension or bradycardia as a reason must be substantiated by documentation that the blood pressure was \leq 100 mmHg or that the heart rate was less than 50 bpm respectively. • Specific documentation that a beta-blocker was/was not a daily home medication takes priority over a checklist (e.g., Preoperative nursing note includes a beta-blocker on home medication list and checklist on anesthesia form indicates beta-blocker as "no"; select "1". • When conflicting documentation exists concerning whether the beta-blocker was being taken on a daily basis or if the patient stopped taking it at home, there must be clear documentation that the beta-blocker was not being taken daily or had been stopped in order to select "2". Documentation that the patient missed one dose or did not take the beta-blocker the day prior to arrival is not sufficient to select "2". • If there is documentation that the beta-blocker is on a schedule other than daily or given on PRN basis for cardiac or non-cardiac reasons, select "2". • If there is documentation the patient stopped taking the beta-blocker prior to

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>arrival, but was started on a beta-blocker in the hospital prior to surgery, select "2."</p> <p>Some examples of beta-blockers include atenolol, carvedilol (Coreg), metoprolol (Lopressor), and propranolol.</p> <p>Refer to TJC Appendix C, Table 1.3 for a comprehensive list of Beta-Blocker Medications.</p> <p>Suggested data sources: Admitting notes, anesthesia records, consultation notes, medication reconciliation form, history and physical, nursing admission assessment, preoperative record, progress notes</p>
43	pregnant	<p>Was the patient taking the beta-blocker prior to arrival pregnant?</p> <p>1. Yes</p> <p>2. No</p> <p>95. Not applicable</p> <p>99. Unable to determine</p>	<p>*1, 2, 95*99</p> <p>*If 1 or 99, go to end</p> <p>Computer will auto-fill as 95 if sex = 1</p> <div style="border: 1px solid black; padding: 5px;"> <p>Hard edit:</p> <p>Cannot enter 1 if age >= 50; otherwise, warning if = 1</p> </div>	<p>Review the medical record documentation to determine whether the patient was pregnant upon arrival. If there is documentation that the patient was pregnant upon arrival, enter "1."</p> <p>Do not rely on ICD-9-CM codes to determine that the patient was pregnant upon arrival.</p> <p>Suggested data sources: Anesthesia evaluation, consult notes, history and physical, operating room record, physician orders, progress notes, operative report</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
44	bbpreor	<p>Did the patient receive a beta-blocker on the day <u>prior</u> to surgery or the day of surgery?</p> <p>3. Beta-blocker received the day prior to surgery</p> <p>4. Beta-blocker received the day of surgery</p> <p>5. Beta-blocker received the day prior to surgery AND day of surgery</p> <p>99. Beta-blocker not received the day prior to surgery or day of surgery</p>	<p>3, 4, 5, 99</p> <p>If 3, 4, or 5, auto-fill nobbpre as 95 and go to bbpostop as applicable</p>	<ul style="list-style-type: none"> • There must be documentation that reflects that the beta-blocker was taken on the days specified in each allowable value to select that specific value. • To select "3", there must be a date or other documentation that the last dose of the beta-blocker was taken on the day prior to the day of surgery. This can include a date for the last dose or specific documentation on the day of surgery that the patient took the beta-blocker on the day before surgery, such as "patient states they took beta-blocker last night before going to bed" or "states took beta-blocker yesterday". • To select "4", there must be documentation that the patient received a beta-blocker on the day of surgery. Example: The patient arrived at the hospital on the day of surgery and metoprolol is documented as a home (or current) medication. In the pre-op assessment the nurse documents, "patient took all medications," select "4." • Day of surgery includes documentation a beta-blocker was administered before, during, or after surgery on the day of surgery (same calendar day). <p>Suggested data sources: Anesthesia records, history and physical, medication administration record, medication reconciliation record, nursing admission assessment, operative/preoperative report, progress notes</p>
45	nobbpre3 nobbpre4 nobbpre95 nobbpre99	<p>Was there documentation of a reason(s) for not administering a beta-blocker on the day prior to surgery or day of surgery?</p> <ul style="list-style-type: none"> • Bradycardia (heart rate less than 50 bpm) • Hypotension (systolic \leq 100 mm/Hg) • Concurrent use of intravenous inotropic medications during the perioperative period • Other reasons documented by physician/APN/PA or pharmacist <p>Indicate all that apply:</p> <p>3. Documentation of a reason for not administering a beta-blocker <u>on the day prior to surgery</u></p>	<p>3, 4, 95, 99</p> <p>Will be auto-filled as 95 if bbpreor = 3, 4, or 5</p>	<ul style="list-style-type: none"> • Documentation of a reason for not administering a beta-blocker must be found on the day prior to surgery or day of surgery. There must be a reason documented for each day the beta-blocker is held or not administered in order to select the corresponding value. Example: The physician documents on the day prior to surgery: Will hold beta-blockers today since the patient is hemodynamically unstable, select "3". • Documentation to hold the beta-blocker must include the reason it is being held. Example: On day of surgery physician noted, "Hold beta-blocker until cardiac consult." Select "4". • Patient refusal does not have to be documented by a physician/APN/PA, but must be documented in timeframe corresponding to applicable value.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>4. Documentation of a reason for not administering a beta-blocker <u>on the day of surgery</u></p> <p>95. Not applicable</p> <p>99. There is NO documentation of a reason for not administering a beta-blocker on day prior to surgery or day of surgery or unable to determine from medical record documentation</p>		<p>In order to consider documentation of bradycardia, hypotension or concurrent use of intravenous inotropic medications during perioperative period as a reason for not administering a beta-blocker, the following is required:</p> <ul style="list-style-type: none"> • A documented systolic blood pressure of less than 100 mm/Hg and/or a heart rate less than 50 bpm during the time period represented in the value being abstracted, is sufficient to select that value. • Vital signs obtained while patient is on cardiopulmonary bypass machine or while being removed from bypass cannot be used to determine bradycardia. • Documentation of bradycardia or hypotension as a reason must be substantiated by documentation of a heart rate of less than 50 bpm or systolic blood pressure \leq 100 mm/Hg respectively during the timeframe for the applicable value. • If the physician writes an order to hold the beta-blocker when the patient's vital signs are outside certain parameters and there is documentation that the beta blocker was held because the vital signs were outside the parameters during the period specified in the allowable value(s), select the appropriate value(s). The vital signs to support this documentation are required and must be documented as present during the timeframe for the applicable value(s). Example: The physician writes the order, "Hold atenolol for SBP less than 100" and the nurse documents that the atenolol was held for a blood pressure of 90/50 on the day of surgery, select "4". A notation on the MAR or in the nursing narrative that the beta-blocker was held is acceptable. • If intravenous use of inotropic medication (e.g., amrinone, dopamine - see TJC Appendix C, Table 3.14 for complete list) is initiated or being administered during the timeframe represented in an allowable value, select that value. <p>Unacceptable documentation:</p> <ul style="list-style-type: none"> • Preoperative documentation that the patient is NPO or due to NPO status alone. • Documentation to hold all meds or to hold all PO meds, alone, is not acceptable.

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				Refer to TJC Appendix C, Table 1.3 for a comprehensive list of Beta- Blockers. Suggested data sources: Anesthesia record, consultation notes, history and physical, medication administration record, nursing notes, physician orders, progress notes, vital signs record
		If dtofdc- anesendt > = 2 days, go to bbpostop; else go to end		
46	bbpostop	Did the patient receive a beta-blocker on postoperative day 1 (POD 1) or postoperative day 2 (POD 2)? 3. Beta-blocker received on POD 1 only 4. Beta-blocker received on POD 2 only 5. Beta-blocker received on POD 1 AND POD 2 99. Beta-blocker not received on POD 1 or POD 2	3, 4, 5, 99 If 99, go to nobbpod3; else go to end	Day of surgery is day zero. There must be documentation that indicates the beta-blocker was received on the days specified in each allowable value to select that specific value. Example: Day of surgery is 12/03/20xx and BCMA documentation indicates metoprolol was given on 12/04/20xx. No documentation is found that indicates beta-blocker was given on 12/05/20xx (POD2). Select "3". Refer to TJC Appendix C, Table 1.3 for a comprehensive list of Beta- Blocker Medications. Exclusion: Eye drops containing beta-blocker (e.g., Cosopt)
47	nobbpod3 nobbpod4 nobbpod99	Was there documentation of any of the following reason(s) for not administering a beta-blocker on POD 1 or POD 2? <ul style="list-style-type: none">• Bradycardia (heart rate less than 50 bpm)• Hypotension (systolic <= 100 mm/Hg)• Concurrent use of intravenous inotropic medications during the perioperative period• Other reasons documented by physician/APN/PA or pharmacist Indicate all that apply: 3. Documentation of a reason for not administering a beta-blocker on POD 1 4. Documentation of a reason for not administering a beta-blocker on POD 2	3, 4, 99	<ul style="list-style-type: none">• Day of surgery is day zero.• Documentation of reasons for not administering a beta-blocker must be made on the day corresponding to the value. There must be a reason documented for each day the beta-blocker is held or not administered in order to select the corresponding value. Example: The physician documents on POD 1: Will hold beta-blockers today since the patient is hemodynamically unstable, select "3".• Documentation to hold the beta-blocker must include the reason it is being held. Example: On POD 1, physician noted, "Hold beta-blocker until cardiac consult." Select "3".• Patient refusal does not have to be documented by a physician/APN/PA, but must be documented in timeframe corresponding to applicable value.

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		99. There is NO documentation of a reason for not administering a beta-blocker on POD 1 or POD 2 or unable to determine from medical record documentation		<p>In order to consider documentation of bradycardia, hypotension or concurrent use of intravenous inotropic medications during perioperative period as a reason for not administering a beta-blocker, the following is required:</p> <ul style="list-style-type: none"> • A documented systolic blood pressure of less than 100 mm/Hg and/or a heart rate less than 50 bpm during the time period represented in the value being abstracted, is sufficient to select that value. • Vital signs obtained while patient is on cardiopulmonary bypass machine or while being removed from bypass cannot be used to determine bradycardia. • Documentation of bradycardia or hypotension as a reason must be substantiated by documentation of a heart rate of less than 50 bpm or systolic blood pressure \leq 100 mm/Hg respectively during the timeframe for the applicable value. • If the physician writes an order to hold the beta-blocker when the patient's vital signs are outside certain parameters and there is documentation that the beta blocker was held because the vital signs were outside the parameters during the period specified in the allowable value(s), select the appropriate value(s). The vital signs to support this documentation are required and must be documented as present during the timeframe for the applicable value(s). Example: The physician writes the order, "Hold atenolol for SBP less than 100" and the nurse documents that the atenolol was held for a blood pressure of 90/50 on POD 1, select "3". A notation on the MAR or in the nursing narrative that the beta-blocker was held is acceptable. • If intravenous use of an inotropic medication (e.g., amrinone, dopamine - see TJC Appendix C, Table 3.14 for complete list) is initiated during the timeframe represented in an allowable value, select that value. <p>Unacceptable documentation:</p> <ul style="list-style-type: none"> • Documentation to hold all meds or to hold all PO meds, alone, is not acceptable. <p>Refer to TJC Appendix C, Table 1.3 for a comprehensive list of Beta-Blockers</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				Suggested data sources: Consultation notes, history and physical, medication administration record, nursing notes, physician orders, progress notes, vital signs record
		Enable Medication Reconciliation; if age >= 65, enable Delirium Risk; go to Informed Consent.		