Challenging Questions

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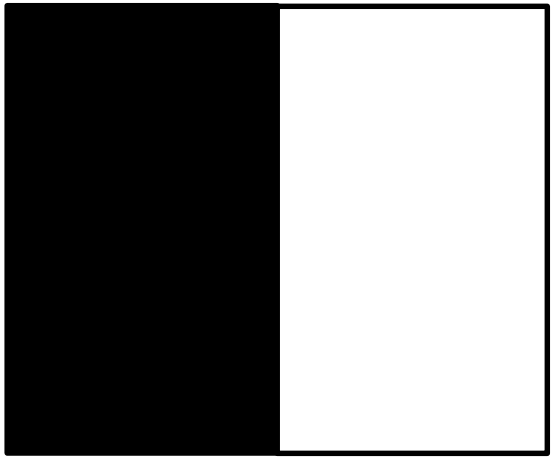
2:30

Instructions

- Show questions you submitted to MTQIP
- Definition
- Your response
- MTQIP-provided response
- Commentary

Challenges



Question

Should patients with NSTEMI or a type II MI while inpatient have the complication MI captured?

Definition

MYOCARDIAL INFARCTION

An acute myocardial infarction must be noted with documentation of any of the following:

Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

OR

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

OR

Physician diagnosis of myocardial infarction

MTQIP Response

Yes, please capture if the criteria is met.

I also found an email from the ACS that you may find helpful though. Let me forward that email to you in a separate message.

TQIP Response

To answer your question, if during their initial stay at your hospital, the documentation stated that patient experienced an NSTEMI Type II and met one of the criteria of the NTDS definition, then you should report "MI" as a Hospital Complication to TQIP.

Question

Recording the Antibiotic Use for Open Fracture type/date/time only applies to open fractures, correct?

I came across an open dislocation of an ankle joint, ligament damage, etc...but no associated fracture.

Definition

ANTIBIOTIC 1 TYPE

- Enter the first antibiotic class administered to patient at your hospital.
- Must be given, not just ordered.
- Antibiotic reference available at www.mtqip.org > Resources > Education > Antibiotic Reference

0. None
1. Penicillin
2. Monobactam
3. Carbapenem
4. Macrolide
5. Lincosamide
6. Aminoglycoside
7. Quinolone
8. Sulfonamide
9. Tetracycline
10. Cephalosporin
11. Other

Collection Criterion: Collect on all patients with open fractures.

MTQIP Response

As long as there are no injuries coded as an open fracture you're all set and don't need to enter the antibiotic.

Here's a link to the codes that are open fracture both AIS and ICD 10 that qualify. Scroll down to "Open Fracture Codes."

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Question

We had a pt transferred in from another hospital where she was admitted for over a week. While there she had a Foley placed. We cx her urine a day after she arrived and it was +.

1) Do we capture CAUTI since Foley had been in for a week and was placed at the outside hospital?
2) The definition of CAUTI says bacteria >100,000CFU/ml. So if a bacteria comes back 50,000-100,000 CFU/ml do we count that since it is not technically over 100,000?

Definition

CATHETER-ASSOCIATED URINARY TRACT INFECTION
(Consistent with the January 2016 CDC defined CAUTI). A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, and 3 below:

1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    - Fever (>38C)
    - Suprapubic tenderness with no other recognized cause
    - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria $>10^5$ CFU/ml.

Def. Source: CDC, NTDS

MTQIP Response

I've attached an excerpt from the CDC definition on the **transfer rule.**

Please don't forget to check the OSH record to see if any criterion was present prior to transfer.

Lastly, the **CFU/mL does need to be over 100,000.**

Date of Event (Event Date):

The Date of Event (DOE) is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period (Table 3 and Table 4).

Location of Attribution (LOA):

The inpatient location where the patient was assigned on the date of event is the location of attribution (see Date of Event definition). Non-bedded patient locations, (for example Operating Room (OR) or Interventional Radiology (IR) are not eligible for assignment of location of attribution for HAI events. Location of attribution must be assigned to a location where denominator data (for example, patient days, device days) can be collected.

Exception to Location of Attribution:

Transfer Rule: If the date of event is on the date of transfer or discharge, or the next day, the infection is attributed to the transferring/discharging location. This is called the Transfer Rule. If the patient was in multiple locations within the transfer rule time frame, attribute the infection to the **first** location in which the patient was housed the **day before** the infection's date of event. Receiving locations or facilities should share information about such HAIs with the transferring location or facility to enable accurate reporting. See examples below.

Question

Pt who was being treated for "superficial cellulitis of hip at incision" with Kefzol and presents with fevers, tenderness, erythema and swelling from left hip incision to thigh up to lumbar region but then ID consult notes "minimal yellow drainage" (no cultures done) would you consider this true cellulitis or a SSSI?

Would "minimal yellow drainage" count as purulent?

Definition

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION
Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)
AND
Involves only skin and subcutaneous tissue of the incision
AND
Patient has at least one of the following:

a. Purulent drainage from the superficial incision.
b. Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
c. Superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.
AND patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

Reporting Instructions for Superficial SSI

The following do not qualify as criteria for meeting the NHSN definition of superficial SSI:

1. Diagnosis/treatment of cellulitis (redness/warmth/swelling), by itself, does not meet criterion d for superficial incisional SSI. An incision that is draining or that has organisms identified by culture or non-culture based testing is not considered a cellulitis.
2. A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration)
3. A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this module.

MTQIP Response

Short answer: No, the below alone does not meet criteria.

Long answer: Based on the below, there is not enough info to confirm purulence since serous (thin, clear, yellow) drainage can also be described in that manner. We'd suggest confirming that the RN did not describe the yellow drainage as creamy, opaque, thick or viscous in the wound flowsheets. We'd also suggest confirming the surgeon did not diagnosis this as an SSI which can also be used to meet criteria.

MTQIP Response

From the CDC SSI criterion: Does NHSN have a definition for purulence?

NHSN does not define purulent drainage as there is no standard, clinically agreed upon definition. Generally, thick/viscous, creamy/opaque fluid discharge with or without blood seen at the site or document of pus/purulence by a medical professional would be accepted evidence of purulent drainage. At this time NHSN does not use any gram stain results such as WBCs or PMN's to define purulence for the SSI protocol.

Question

If patient does not have a head injury or they do have a head injury with no anticoagulant should we leave boxes NA or blank for the anticoagulant reversal variables such as First ED/Hospital INR?

Also, since I am asking this could you clarify what is Anti-Xa Activity is?

Definition

FIRST ED/HOSPITAL ANTI-XA ACTIVITY

Enter the first anti-Xa activity laboratory value obtained within 24 hours of admission to the index hospital, where the index hospital is the hospital abstracting the data.

Collection Criterion: Collect on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Def. Source: MTQIP

Data Base Column Name: MTQIP_TBI_ANTI_XA
Type of Field: Custom, Numeric
Format: X.XX
Default: Blank
Length:

MTQIP Response

You can simply leave the defaults in place if the patient does not meet criteria (read: no additional clicks). NA and blank have the same meaning in the analysis since we use logic to create the groupings.

Anti-Xa activity is a lab test for monitoring the blood coagulation cascade function or monitoring blood clotting. It is usually used to measure the impact of certain blood thinning drugs.