Project Name:	Infection Data - General Statements

FAQ	Date Recorded
If patient's CAB is Robotic and he/she is extubated in the OR. Do you still want these patients entered into REDcap software project? Answer - Yes	29-Apr-16

Project Name:	Infection Data - Administrative		
Section Name	**Long Name**	**Definition**	**FAQs**
Administrative	Infection Record ID	Unique identifier	This is generated by REDCap System automatically.
	STS Record ID	RecordID is the same value of RecordID in STS data submission, which is unique value generated by the software that permanently identifies each record.	Please enter without error. Used for matching with the STS Record.
	Surgery Date	The date of Cardiac Surgical Procedure.	Date is the same date of STS date of surgery.
	Weight	Kg	STS Definition. Enter same value as for the STS Record.
	Height	cm	STS Definition. Enter same value as for the STS Record.

Project Name:	Infection Data - Pre-operative			
Section Name	**Long Name**	**Integer /Text Value**	**Definition**	**FAQs**
Oral Preparation	Oral preparation	1 = No 2 = Yes 3 = Not Applicable 4 = Unknown	Did the patient receive oral preparation (e.g. Peridex/Chlorhexidine Gluconate) pre-operatively?	1. If every patient gets the mouth prep even if there is a negative culture, select "Yes". 2. If the culture is negative and did not receive mouth prep, select "Not Applicable".
Nasal preparation	Nasal Culture	1 = No 2 = Yes 3 = Unknown	Did the patient receive a nasal culture pre-operatively?	1. How far in advance of OR can culture be done? ***Answer:*** Use your local site practices, since practice varies among hospitals.
	If "Yes" is selected go to next question.			
	Culture Positive	*1 = No* *2 = Yes* *3 = Unknown*	If nasal culture done is yes, was culture positive?	Culture can be positive for MRSA or MSSA
	Mupirocin	1 = No 2 = Yes 3 = Unknown	Was patient treated with Mupirocin preoperatively?	If a patient did not get Mupirocin pre-op but was started on it post-op, select "No". If the patient had no culture, but was still treated, select "Yes".
	If "No" or "Unknown" is selected go to next question.			
	Different Nasal Treatment	*1 = No* *2 = Yes* *3 = Unknown*	If the answer to "treated with Mupirocin" is No or Unknown, did the patient receive a different nasal treatment?	

Project Name:	Infection Data - Intra-operative			
Section Name	**Long Name**	**Integer/Text Value**	**Definition**	**FAQs**
Intra-operative Lung Protective Ventilation	Highest Tidal Volume (mL) *Tidal Volume = TV*	The suggested data value of Highest Tidal Volume: **>200 and <800.**	What was the highest tidal volume (ml) the last hour before the end of surgery (i.e., patient would have been off bypass)? Data likely in the anesthesia bypass record (suggested value: >200 and <800).	When both an inspiratory and expiratory tidal volume (TV) is reported, use the highest **inspiratory** TV for this field.
	Positive End-Expiratory Pressure	The suggested data value of Positive End-Expiratory Pressure (PEEP): **>0 and <25**	What was the highest positive end expiratory pressure during the last hour before the end of surgery? End of surgery defined as SKIN INCISION STOP (Seq #2270 of the STS manual) (i.e., patient would have been off bypass). Data likely in the anesthesia bypass record (suggested value: >0 and <25).	

Project Name:	Infection Data - Post-operative 1			
Section Name	**Long Name**	**Integer / Text Value**	**Definition**	**FAQs**
Lung Protective Ventilation	Post-op Highest Tidal Volume	The suggested data value of Highest Tidal Volume: **>200 and <800.**	What was the highest tidal volume (ml) between the 2nd hour after admission to the ICU up through the 1st hour before extubation? (suggested value: >200 and <800). Use returned tidal volume.	In the case there are 2 or 3 values for post-operative tidal volume choose the tidal volume closest to extubation time. In the case of patients in fast track (patient extubated under 2 hours post-surgery or also called immediate extubation), choose the highest post-operative tidal volume in chart.
	Post-op Peak Inspiratory Pressure	The suggested data value of Peak Inspiratory Pressure: **<60**	What was the highest peak inspiratory pressure during the 2nd hour after admission to the ICU up through the 1st hour before extubation?	
Post-Operative Pneumonia	Had Postop Pneumonia	1 = No 2 = Yes		Use STS criteria for establishing this definition.
	If "Yes", indicate the diagnosis date.			
	Diagnosis Date	mm/dd/yyyy	Indicate the date (mm/dd/20yy) when the patient met criteria for STS diagnosis of pneumonia.	If a patient is started on Prophylactic antibiotics for suspected or possible Pneumonia in the early PO course, but the diagnosis of Pneumonia is not concluded until later in the postop course, use this later date, and not the date when the prophylactic antibiotics were initiated.
ICU care	Intubation Date	mm/dd/yyyy	The initial date ventilatory support was started	Use STS definition criteria.
	OR Exit Time	hh:mm - 24 hr clock	Enter the time the patient exited the OR from the Operative procedure.	Use STS definition criteria. If the time is not known, leave this field blank.
	Intubated More Than 24hr	1 = No 2 = Yes	Was the patient intubated for more than 24 hours?	Is Intubation Time intended to include OR time too? Answer: No
	If "Yes", document the extent of compliance with the components of ICU care: i.e. Oral Care, SAT & SBT Trials			
	Daily Assessment of Oral Care with CHG	1 = All of the time 2 = Some of the time 3 = Not always documented 4 = Not Applicable	Was there compliance with daily oral care with chlorhexidine?	***Some of the time*** **-** Pertains to compliance. There was documentation of this measure every day the patient was intubated. (includes all reintubated days) ***Not always documented*** **-** i.e. if there isn't documentation of this measure every day the patient was intubated. (includes all reintubated days) ***Not Applicable*** **-** For Example: An allergy or clinical contraindication to Peridex. If no MD order for CHG, what do you choose? Answer: Not always document

Project Name:	Infection Data - Post-operative 1			
Section Name	**Long Name**	**Integer / Text Value**	**Definition**	**FAQs**
	Spontaneous Awakening Trials (SAT)	1 = All of the time 2 = Not always documented 3 = Some of the time 4 = Clinical contraindication 5 = Not Applicable	Perform spontaneous awakening trials daily.	***Not always documented*** **-** i.e. if there isn't documentation of this measure every day the patient was intubated. ***Some of the time*** **-** Pertains to compliance. There was documentation of this measure every day the patient was intubated when applicable. ***Clinical Contraindication*** **-** For example: Hemodyamically unstable for decreasing sedation, increased agitation upon awakening, etc. ***Not Applicable*** **-** For example: Compassionate Care, DNR Status. As you consider choices 1-5, include only days where there was not a clinical contraindication for a daily SAT.
	Spontaneous Breathing Trials (SBT)	1 = All of the time 2 = Not always documented 3 = Some of the time 4 = Clinical contraindication	Perform spontaneous breathing trials daily.	***Not always documented*** **-** i.e. if there isn't documentation of this measure every day the patient was intubated ***Some of the time*** **-** Pertains to compliance. There was documentation of this measure every day the patient was intubated when applicable.) ***Clinical Contraindication*** **-** For example**:** Recent reintubation, Hemodyamically unstable. As you consider choices 1-5, include only days where there was not a clinical contraindication for a daily SBT.
	SBT was done following an SAT trial period on a daily basis.	1 = All of the time 2 = Not always documented 3 = Some of the time	Was a spontaneous breathing trial always done following a spontaneous awakening trial to maximize vent weaning when the patient is maximally awake?	***Not always documented*** **-** i.e. if there isn't documentation of this measure every day the patient was intubated. ***Some of the time*** **-** Pertains to compliance. There was documentation of this measure every day the patient was intubated. ***Clinical Exclusion Examples:*** Recently reintubated, hemodynamically unstable, unable to tolerate sedation reduction, additional clinical issue taking precedence over weaning, etc. As you consider choices 1-5 include days without a clinical contraindication to the pairing of an SAT & SBT during the same period on a daily basis. (Exclude days with a clinical contraindication).
Subglottic Suctioning	Use of Subglottic Suctioning	1 = No 2 = Yes 3 = Not Applicable	Indicate if subglottic suctioning was performed through a subglottic port-equipped endotracheal tube	Use "**Not Applicable**" if site does not use subglottic extubation tubes.
ReIntubation (for each reintubation) Choose a new Reintubation form (# 1, 2, 3) for each repeat reintubation.	Was Reintubated	1 = No 2 = Yes 3 = Not Applicable	Was the patient reintubated?	
	If "Yes", select and complete a reintubation record.			

Project Name:	Infection Data - 1st, 2nd, 3rd Re-Intubation			
Form Name	**Long Name**	**Integer/ Text Value**	**Definition**	**FAQs**
***Select all Re-intubation reasons that apply for each of the applicable reintubation DCF's.**			Select all re-intubation reasons that apply for each of the re-intubation forms (1,2,3)	
	Reasons for Re-Intubation at 1st, 2nd and 3rd time	1 = Upper Airway Obstruction	Please select any of the reasons for re-intubation (more than one selection as needed). Re-intubation: Whether the patient was reintubated during the hospital stay after the initial extubation. This may include patients who have been extubated in the OR and require intubation in the postoperative period. Do not code reintubation if the patient self extubates and is immediately reintubated. If patient returns to the OR and intubation is required postoperatively, code Yes to reintubated.	Enter data based on which Re-Intubation selected. *1st, 2nd, and 3rd Re-Intubation data entry for Reasons
		2 = Impaired clearance of secretions		
		3 = Respiratory failure	Respiratory rate>30, or PCO2>60mmHg, or pH<7.25, or depressed conscious level, or based on judgment of the treating/managing physician.	
		4 = Acute hypoxia (P02<60) secondary *multi choice - multiple answer		
	If #4 is selected continue to next question below (multiple choice answer- ***choose all answers that apply*** *from Choices 1-4)*			These are child fields to Reason #4.
	Acute hypoxia (P02< 60) secondary 1st, 2nd and/or 3rd Re-Intubation	1 = Acute post-operative lung injury syndrome 2 = Acute post-operative fluid overload 3 = Acute post-operative pneumonia 4 = Inadequate respiratory parameters, e.g. due to pain		*1st, 2nd, and 3rd Re-Intubation data entry for Acute hypoxia (P02< 60) secondary
		5 = Insecure airway		
		6 = Cardiovascular	Tamponade, dysrhythmia with hemodynamic instability, cardiac arrest.	
		7 = Neurological impairment		
		8 = Return to the operating room		
		9 = Post-operative bleeding	>100 cc/hour for 2 consecutive hours	
		10 = Accidental extubation		
		11 = Prolonged effects of anesthesia and sedation		
		12 = Other		Complete Text Box

Project Name:	Infection Data - Post-operative 2			
Form Name	**Long Name**	**Integer / Text Value**	**Definition**	**FAQs**
Management of Post-Operative Patient **Not including Cardiac Surgery**	Formal Clinical Consult	1 = No 2 = Yes 3 = Unknown	Did the patient receive at least 1 formal clinical consult during the hospital stay? **Includes preop and post op consults**	
	If "yes" is selected, answer consult type.			
		Check all that apply		
	Consult Type	*1 = Anesthesiology* *2 = Pulmonology Critical Care* *3 = Cardiology* *4 = General Surgery* *5 = Nephrology* *6 = Internal Medicine* *7 = Neurology* *8 = Infectious Disease* *9 = Endocrinology* *10 = Gastroenterology* *11 = Intensivist* *12 = Respiratory Therapy* *13 = Speech Therapy* *14 = Physical Therapy* *15 = Other (Complete Text Field)* *16 = Hospitalist* *17 = Case Management* *18 = Cardiac Rehab*	Check all that apply	Includes preop and post op consults ***Do not include Cardiac Surgery as a consult.*** Patient is on Cardiology service from admission. Work up leads to CAB. Is Cardiology listed as a consult service if they were admitted to them initially? Answer: Do not include as a consultant unless they were requested to see patient post-op. This also includes any admitting preop service. Complete Text Field

Project Name:	Infection Data - Post-operative 2			
Form Name	**Long Name**	**Integer / Text Value**	**Definition**	**FAQs**
	All ambulation fields apply to the INITIAL Extubation episode ONLY			
Ambulation **All ambulation fields apply to the INITIAL Extubation episode ONLY.**	Ambulation to Chair	1 = Ambulation to Chair 2 = Not documented 3 = Not Applicable	Up-to-chair means standing and pivoting into a chair.	Not Applicable (e.g. patient remained in bed).
	If "Ambulation to Chair" is selected, show date to Chair and time to Chair.			
	Date to Chair	*mm/dd/yyyy*	What was the date when the patient was up to chair?	
	Time to Chair	*hh:mm - 24 hr clock*	What was the time when the patient was up to chair?	If time is not known, leave blank. Type in the colon when listing the time, as the system does not automatically populate it.
All ambulation fields apply to the INTITAL Extubation episode ONLY.	Ambulation	1 = Ambulation 2 = Not documented 3 = Not Applicable	Ambulation means the patient took more than a couple steps to meet this definition.	Not Applicable (e.g. patient remained in bed).
	If "Ambulation" is selected, show date to Ambulation and time to Ambulation.			
	Date to Ambulation	*mm/dd/yyyy*	What was the date when the patient began ambulating?	
	Time to Ambulation	*hh:mm - 24 hr clock*	What was the time when the patient began ambulating?	If time is not known, leave blank. Type in the colon when listing the time, as the system does not automatically populate it.

Project Name:	Infection Data - Post-operative 2			
Form Name	**Long Name**	**Integer / Text Value**	**Definition**	**FAQs**
All ambulation fields apply to the INITIAL Extubation episode ONLY.	Ambulation≥150ft	1 = Ambulation ≥150ft 2 = Not documented 3 = Not Applicable		Not Applicable (e.g. patient remained in bed or ambulated less than 150 ft). N/A can also mean patient was never out of bed, or transferred to another facility in bed without ever meeting criteria to be out of the bed.
	If "Ambulation ≥150ft" is selected, show date to Ambulation ≥150ft and time to Ambulation ≥150ft			
	Date to Ambulation ≥150ft	mm/dd/yyyy	What was the date when the patient began ambulating greater than 150ft?	
	Time to Ambulation ≥150ft	hh:mm - 24 hr clock	What was the time when the patient began ambulating greater than 150ft?	If time is not known, leave blank. Please type in the colon when listing the time, as the system does not automatically populate it.
Use of Bronchodilator	Use of Bronchodilator	1 = No 2 = Yes 3 = Unknown	Indicate whether oral and/or inhaled bronchodilators or inhaled (not oral or IV) steroid medications were given to the patient post-operatively.	