Point Prevalence Survey of Hospital Acquired Infections & Antimicrobial Use

Frequently Asked Questions

If a question arises during the PPS, the following steps are advised:

1. **Check the protocol. All questions on the data forms are explained in detail in the PPS protocol**
2. **Check this list of Frequently Asked Questions**
3. **Discuss with the local PPS team leader**
4. **Queries on determining HAI should be discussed with the consultant microbiologist and queries on determining the reason for changes in treatment antimicrobials should be discussed with the consultant microbiologist and/or antimicrobial pharmacist**
5. **If the question cannot be answered following the above actions, e-mail the PPS dedicated address: pps2017@hpsc.ie briefly stating the nature of the query in the title field. Please also provide a contact telephone number – Your query will be answered as soon as possible**

Ward List A1 – Assigning Ward Specialty

REFER TO PROTOCOL P11 & P48 APPENDIX A TABLE 1 'WARD SPECIALTY CODE LIST'

What ward specialty should be assigned to the maternity ward, where half the patients are mothers and half the patients are babies?

The maternity ward specialty is coded as 'gynaecology/obstetrics' = GO

What ward specialty should be assigned to a special care baby unit (SCBU)?

Use the ward specialty 'neonatology' = NEO

What ward specialty should be assigned to a coronary care unit (CCU)?

Use the ward specialty = MED

What ward specialty should be assigned to a ward where >80% of patients are admitted under the care of radiation oncology?

Use the ward specialty 'medical' = MED

What ward specialty should be assigned to a ward where there is a mixture of general medical and general surgical patients; e.g. mixed <u>non-specialised</u> 5-day ward?

Use the ward specialty 'other' = OTHER

What ward specialty should be assigned to a ward where there is a mixture of <u>specialised</u> patients; e.g. mixed haematology-oncology ward (50:50)?

Use the ward specialty 'mixed' = MIXED

What ward specialty should be assigned for the admitted patients in the ED or in the event that the day ward is temporarily opened for admitted patients?

Use the ward specialty 'other' = OTHER

A ward specialty is assigned in advance as 'surgery' based on the usual admission pattern to the ward. However, on the date of PPS for the ward, the PPS team discover that general medical patients account for the majority of patients on the ward. How should the ward specialty be recorded?

It is a good idea to review the printed ward census upon arrival to the ward as this will often have the name of the admitting consultant beside the patient's name. If the PPS team discover upon arrival to the ward that the pre-assigned ward specialty 'surgery' does not

accurately reflect the situation on the day, the PPS team can reassign the ward specialty as 'medicine' MED on ward list A1

Ward List A1 – Deciding on bed numbers

If the day ward is normally used to accommodate day patients, but some beds are used as overflow to accommodate admitted patients for ED, how many beds are in the day ward for the purposes of completing a Ward list A1?

Day beds used as day beds are not counted in the PPS. For example, If there are four beds in a 15 bedded day ward typically used for ED overflow, the total number of beds in the day ward (ward specialty = OTHER) will be recorded as four on Ward List A1

Patient Form C – Assigning Admitting Consultant's Specialty

How is the admitting consultant's specialty assigned to neonates?

- Consultant specialty for a healthy neonate on the maternity ward is GOBAB
- Consultant specialty for a healthy neonate on the paediatric ward is PEDBAB
- If the infant was unwell and is specifically under care of neonatology (e.g., in SCBU or paediatric ward) = PEDNEO
- For infants born and admitted to NICU, the admitting consultant's specialty is coded as ICUNEO
- For infant discharged from NICU to SCBU/HDU the admitting consultant's specialty is coded as ICUNEO
- For infant admitted directly to HDU/SCBU, the admitting consultant's specialty is coded as ICUNEO, provided the hospital has designated neonatologist(s). In a general hospital, where there might not be a neonatologist, the admitting consultant's specialty is coded as PEDNEO
- If the infant is discharged from NICU/SCBU/HDU to ward OR admitted directly to the ward, the admitting consultant's specialty is coded as PEDNEO/PEDGEN, depending on the type of consultant specialty normally caring for neonates in the hospital

Ward List A2 – General Questions

If a patient is electronically-admitted to the ward, but not yet physically admitted to the ward yet, is the patient included on the Ward List A2 as an eligible patient?

No, the patient is not included as an eligible patient. Only patients that are physically present on the ward at or before 8am should be included on the Ward List A2. The patient may have been physically admitted to the ward by the time that the PPS team arrive on the ward later in the day. If the name is not on the Ward List A2, the patient is not eligible for inclusion

Should we consider a patient who is documented as present on the Ward List, but who has passed away by the time the PPS team arrive on the ward, as eligible for inclusion in the PPS?

No. A patient who has died is no longer eligible for inclusion in the PPS

Sometimes there are additional stretchers or trolleys on a ward – are these included in the PPS?

The patient occupying the stretcher/trolley is included in the PPS, if the patient is present on the ward at or before 8am on the PPS date. If the stretcher is not part of the usual bed count for the ward, the stretcher is not included in the number of beds on the ward. Therefore, there will be more patients present on the ward than there are beds normally open on the ward. Suggest that the patient's on trolleys/stretchers are counted at the end of the Ward List and documented in the way that they would normally be counted/documented by the staff in the ward; e.g. 'trolley 1'/ 'corridor trolley'/ bay C stretcher, parked trolley etc..

If we exclude counting the trolleys that are not normally part of the normal bed count in the ward and we include the patients occupying those trolleys, we will have a Ward List that has more patients on it than there are beds on the ward. Is that correct?

Yes it is fine. This will highlight that in some wards the bed occupancy exceeds the number of beds normally open on the ward. All eligible patients will be counted.

How do I record the bed occupancy on the maternity/postnatal ward?

As the infant's cot would not normally be regarded as a separate bed. The infant's location should be recorded under the mother's bed number. If the baby is in the NICU/SCBU – the baby is recorded as part of the PPS on NICU/SCBU and is not recorded as being present on the maternity ward.

Bed 1 – Mary Dowe

-Baby Dowe

Bed 2 – Ann Smith

-Baby Smith (1)

-Baby Smith (2)

Should I ask the Emergency Department to complete a Ward List A2?

In Irish hospitals, patients who are admitted to the hospital may remain in the Emergency Department (ED) while awaiting transfer to a bed on the ward. The ED is not a ward and patient location within the ED may change frequently. There is no benefit to completing a Ward List A2 in ED, as there is a mix of ED attendees being evaluated, awaiting decisions on admission and admitted patients awaiting transfer to wards. It is suggested that the PPS be scheduled in ED on the final day of the hospital's PPS. On that day, the PPS team should visit ED and complete patient form C for each eligible admitted patient present in ED at the time the PPS team arrive in ED. Therefore, a Ward List A2 is not necessary for ED.

Code the ward specialty for ED on Ward List A1 as 'OTHER'

Sometimes the day ward is opened to accommodate patients admitted from the ED. Should I include the day ward in the PPS?

Treat the day ward the same as the ED. Unless the day ward is fully opened to admitted patients and not accommodating any day patients, there is no need to complete a Ward List A2. On the final scheduled day of the PPS in your hospital, you should visit the day ward at 8am and if there are admitted patients, a patient form C is completed for each of those admitted patients.

Code the ward specialty for Day ward on Ward List A1 as 'OTHER' and count the number of beds in the day ward as those used to accommodate inpatients only. Exclude the exclusive day beds from the bed count of the day ward. Patients present on the day ward as day cases are not included in the survey, because day cases are ineligible for inclusion in the PPS.

Sometimes the post-anaesthesia care unit (PACU) or theatre recovery area is used to accommodate ventilated patients when ICU is full. Should I include PACU in the PPS?

Treat the PACU the same as the ED. There is no need to complete a Ward List A2. On the final scheduled day of the PPS in your hospital, you should visit PACU at 8am. If there is a ventilated patient being cared for in PACU as overflow from ICU, a patient form C is completed for that admitted patient. Code the ward specialty for PACU on Ward List A1 as 'OTHER' and count the number of beds as those used to accommodate inpatients only. Exclude the exclusive PACU trolleys from the bed count of the PACU. Patients present in PACU at 8am who are recovering from anaesthesia and designated to return to a bed on the ward are not included in the PPS for PACU

The patient is documented as present on the Ward List A2. By the time the PPS team arrive on the ward, the morning ward round has taken place and the patient has been discharged by the team, but the patient is still present on the ward waiting for discharge letter or transport home. Is that patient eligible for inclusion in the PPS?

If the patient has been discharged by the team, but physically remains on the ward and there is access to the notes, the patient may be included, only if they were deemed eligible on Ward List A2. However, once the patient has left the ward, they are considered discharged and are no longer eligible

What happens if the patient on the Ward List A2 has gone to theatre by the time the PPS team arrive on the ward and the patient is scheduled to return to that ward post-operatively, but still hasn't come back by the time the PPS team leave the ward?

The patient is eligible for inclusion on the basis that the patient was present on the ward on or before 8am and is temporarily off the ward. A patient form C can be started for the patient using information available on Ward List A2. Because the patient and the notes are off the ward, they are not available for review. The information for most of section 1, 2 and 3 will be available on the Ward List A2. The PPS team can return to the ward at the end of the PPS day and if the patient has returned, the notes can be reviewed and the remaining sections of form C complete. If the patient is still not back on the ward, the remaining information is not available for review and the data collector can record 'Not known' or 'Unknown' for the relevant questions

What happens if a patient on the Ward List A2 is recorded as having a particular device *in situ,* but by the time the PPS team get to the ward, the device has been removed?

The Ward List A2 will provide the information at or before 8am and for most patients the information on the Ward List A2 will remain the same by the time the PPS team arrive on the ward. In the event that the PPS team find that information for a particular patient has changed by the time they arrive on the ward, the PPS team should use the latest available information when completing the form C for that patient. However, the PPS team is not

required to systematically review every single patient on the Ward List A2 for changes in devices. If you discover a change has occurred since the Ward List A2 has been completed, the latest information should be documented

What happens if a patient on the Ward List A2 is recorded as receiving antimicrobials, but by the time the PPS team get to the ward, the antimicrobials have been stopped?

The same principle applies. The PPS team should use the latest available information when completing the form. The form C for that patient will be completed as follows: Patient on antimicrobials = 'No'. In order to complete the patient form C for every eligible patient, the PPS team will have to review their notes and medication charts and so can access the latest available information and record that on the form C

Should normal vaginal delivery/spontaneous vaginal delivery regarded as a surgical procedure?

Normal vaginal delivery (NVD)/ spontaneous vaginal delivery (SVD) is only regarded as a surgical procedure if an episiotomy has been performed. Otherwise, NVD/SVD without episiotomy is not regarded as a surgical procedure

A patient is admitted to the hospital at 5pm on Tuesday for sleep studies and the patient will be discharged at 10am on Wednesday, should we include the patient in the PPS on Wednesday?

This patient should be included if the following criteria are met:

- The bed that the patient is admitted to is considered an acute bed in your hospital
- The patient is documented as present on the ward at or before 8am on the date of the PPS (i.e. the patient appears on the completed Ward List A2 for the ward)
- The patient is still present on the ward and admitted when the PPS team arrive on the ward:
    - If the PPS team arrive on the ward at 9am and the patient is still admitted, then the patient is included
    - If the PPS team arrive on the ward at 10:05am and the patient has been discharged since 10am, the patient is excluded

A patient is transferred to the hospital on May 5th and admitted to Ward A. The patient is transferred to Ward B on May 8th. The PPS is carried out on Ward B on May 10th. Do we record the 'date of hospital admission' as May 5th or May 8th?

The date of hospital admission is May 5th. The patient was transferred between wards on May 8th. You are asked to record date of admission to the hospital for all eligible patients in section 1 of patient form C. If the patient meets the criteria for a HAI, you will also be asked to record the date of admission to the current ward in the HAI section of patient form C.

This information will help determine whether the HAI was associated with the ward to which the patient was admitted on the PPS date

Patient Form C – Section 2 Risk Factors

A patient post laryngectomy has a laryngectomy tube (LaryTube) *in situ*. Could this be counted as intubation?

This is a device in the patient's respiratory tract, so could be counted as intubation. It is a potential portal of entry of pathogenic bacteria

A patient had a surgical procedure on their foot to repair a bunion. I can't find lower limb surgery in the list of surgical procedures in protocol Table 3 Orthopaedics – page 52

The category, **Ortho – lower limb surgery excluding open reduction #(fracture) long bones** has now been added to webforms following feedback from PPS data collectors. You can code this on your paper form C and it will be visible on webforms when the data entry is being done

Section 4 – Hospital-acquired infection (HAI)

During the current admission, a patient has completed the antimicrobial treatment course for a hospital-acquired bloodstream infection last week. I perform the PPS today. Do I count that bloodstream infection as a HAI?

If the treatment course has been completed, the infection is no longer active. The infection should not be counted as a HAI. A HAI is only counted if it is active (i.e., signs and symptoms present on PPS date OR were present and the patient continues to receive treatment for that infection)

How do I decide the date of onset for a HAI?

Check for evidence of the following:

- Documentation in the healthcare record or observation chart of first symptoms and signs of the HAI
- Discuss with the clinician caring for the patient – when did the first symptoms and signs develop
- Check the date that relevant recent microbiology specimens were taken (e.g. blood cultures) – Don't use the date that the positive results were reported – use the date the specimen was taken. Screening specimens should not be considered to be relevant microbiology specimens, because they are generally taken for infection

control purposes and not for infection diagnosis purposes. A positive MRSA nasal or groin screen, VRE rectal screen or CRE rectal screen may not have any relevance to the patient's underlying infection, which may be at a different site

- Check the medication chart for the dates that antimicrobials were started. Be aware of the potential for rewritten and linked antimicrobial prescriptions (e.g., escalation scenario) – go to the date the first antimicrobial was started and review the medical record for that date also

Some of the case definitions include a component of temperature of >38^{0}C. What do I do if the temperature is recorded as 38^{0}C on the observation chart?

In practice, temperature measurements tend to be recorded as a dot on the observation chart and most observation charts do not have graduations for the temperature recording between 38^{0}C and 38.5^{0}C, such as 38.1, 38.2 etc. From a practical perspective, a dot recorded on or above the line marking 38^{0}C should be regarded as a temperature >38^{0}C

How do I decide whether *Clostridium difficile* infection is a HAI if it presents on Day 1 or Day 2?

To decide if suspected CDI presenting on Day 1 or Day 2 is a HAI, the key question is whether the patient was recently discharged from hospital. If yes, the key date is the date of discharge from hospital. If the patient represents to hospital within 28 days of discharge with CDI, then the CDI can be defined as HAI on day 1 or day 2

How do I decide whether a surgical site infection (SSI) is a HAI if it presents on Day 1 or Day 2? Do I use the date of surgery or the date the patient was discharged from hospital post-operatively?

To decide if a suspected SSI is a HAI, the key dates are the date of the surgical procedure and the date of infection onset. If the surgery was non-implant surgery, any SSI type is a HAI if the onset is within 30 days of the date of surgery. If the surgery was implant surgery, the SSI is a HAI if the onset is within 90 days of the date of the surgery and a case definition for SSI-D or SSI-O is met. Please note the surveillance interval for implant related SSI-D and SSI-O was shortened from 12 months (PPS 2012) to 90 days (PPS 2017)

Can I code a superficial SSI (SSI-S) for a patient presenting more than 30 days following implant surgery?

No, the 90 day interval between date of surgery and date of infection onset does not apply to superficial SSI. The 90 day interval between date of surgery and date of infection onset does apply to deep SSI (SSI-D) and organ/space SSI (SSI-0). In order for the infection to be anatomically related to the implant, it should be deep or organ/space

A patient undergoes a hernia repair using mesh material. Is mesh regarded as an implant?

Yes. Mesh is regarded as an implant. A patient presenting within 90 days of the date of mesh insertion with a SSI meeting the case definition for SSI-D or SSI-O can be regarded as having a HAI

If a patient is attending the day oncology ward or the outpatient haemodialysis ward and the patient subsequently is admitted to the hospital with signs of an infected vascular catheter, can I call it a HAI?

Yes. Infection arising on Day 1 or Day 2 can be defined a HAI provided the patient has a relevant device *in situ*. In this case, the relevant device is a vascular catheter and in order for it to qualify as a HAI on Day 1 or Day 2, there should be clinical or microbiological evidence that the vascular catheter is the underlying source of infection. The infection should also meet a relevant vascular catheter HAI definition (See Appendix D – Page 90).

If a patient presents to the hospital with an infection that can be defined as a HAI on Day 1, can we use the information on the General Practitioner's referral letter or the transfer letter to decide the date of onset for the infection?

Strictly speaking, you are not required to record date of HAI onset if HAI onset did not occur in your hospital. If the GP letter/transfer letter provides the date of onset for the HAI, then you are welcome to record it on patient form C. You are not required to contact the GP or the referring hospital to clarify information such as date of onset.

However, if the patient is presenting at or just after the 30 day post-operative threshold for diagnosis of non-implant surgical site infection or the 28 days post-discharge threshold for diagnosis of *Clostridium difficile* infection, the accurate date of infection onset may become important in helping you to decide whether or not the infection can be defined as a HAI on Day 1 or Day 2 of admission and in these two scenarios, it is advised to make every effort to determine the accurate date of onset of infection

Upon review of a patient during the PPS, it appears likely that the patient has an active HAI. However, on review of the relevant case definition, the patient does not meet the criteria for the relevant HAI. In section 3 'Condition of Interest', can we record 'Yes' for 'Patient has active HAI' and leave blank the section 5 'Hospital-acquired Infection (HAI) data?

No. In this scenario, the answer to the question 'Patient has active HAI' is recorded as 'No' – Regardless of the clinical impression or your suspicion of HAI, the patient does not have a HAI for surveillance purposes unless they meet the strict case definition for that HAI. Do not answer this question until you are sure that the patient does or does not meet a HAI case definition. If you answer this question 'Yes', you are required to record the details for each active HAI present in Section 4 of the Patient Form C

If a neonate with blood cultures which are negative on bacterial culture for a pathogen and positive on bacterial PCR for a pathogen, such as group B streptococcus, can this be coded as the neonatal case definition for laboratory-confirmed BSI (organisms other than coagulase-negative staphylococci) = NEO-LCBI?

No. The NEO-LCBI is currently defined based on a positive microbiological culture result, not a positive microbiological PCR result. It may be possible to code the infant's infection referring to the case definition of NEO-CSEP (See Appendix B: page 87)

The patient is required to have a positive blood culture to have a bloodstream infection and the number of positive blood cultures required depends upon the organism isolated from the blood. For a blood culture to be considered positive, do both of the bottles in the one blood culture set need to be positive?

No. A blood culture may considered positive if just one of the two bottles within the set is positive. The number of positive blood culture sets required depends on the organism isolated from the blood. If the organism is normally regarded as a significant pathogen (e.g. *E. coli*, *S. aureus* etc.) just one positive blood culture set is required. If the organism is considered to be a potential skin contaminant (e.g. coagulase-negative staphylococci), two different positive blood culture sets are required

In Appendix D (page 90) there is an algorithm for different vascular catheter infection scenarios. Where might the HAI – CVC VASC scenario be encountered?

The definition for CVC VASC is in Appendix B (page 76). The most likely scenario might be where a patient has a vascular catheter which is removed and then develops phlebitis after device is removed. There may be evidence of purulent drainage at the old device site and cultures may be pending – this can be coded as CVC VASC

A patient meets the case definition for UTI-B. The urine culture report from microbiology was reported as mixed growth. How do I code that microorganism in section 4 HAI?

At the end of Table 8 (page 65), there are options for coding when no specific microorganism is named on the microbiology report. This scenario of mixed growth can be coded as NONID – microorganism not identified

The final microbiology result may be pending on the hospital IT system or the lab may not have released all of the susceptibility results that I need to complete the antimicrobial resistance section of patient form C. What do I do?

For example, if a patient who meets the SSI-S case definition had a wound swab reported as MSSA, the glycopeptide susceptibility (vancomycin/teicoplanin) probably won't be released on the final report, unless the patient has a known penicillin allergy and vancomycin has been recommended to treat the infection. The PPS team should have access to a staff member who has the ability to access the laboratory information system to review

incomplete/preliminary results or susceptibility results which may not be on the electronic or printed lab report visible to ward staff. It is highly recommended to use this access to get the latest available information to complete the HAI section of the form as accurately as possible and add value to the PPS microbiology data

On the PPS date, the patient has a hospital-acquired bloodstream infection, with Gram negative bacilli reported on the Gram stain of a blood culture and the final identification is pending. How do I code the microorganism in HAI section of the form?

On Table 8, page 64, you can use the code GNBNSP – Gram negative bacilli, not specified

The patient with suspected hospital acquired pneumonia had a CXR done, but the final report is pending. What do I do?

The final radiology report is the gold standard. If this is pending, the clinician's interpretation of the CXR findings, as documented in the healthcare record or from review of the CXR on the PACS at ward level is sufficient to determine whether the radiological criteria for PN are met

A patient with underlying pulmonary fibrosis has suspected hospital-acquired pneumonia. The patient had a CT thorax six months ago and a CXR on the day of onset of pneumonia signs and symptoms. The CT thorax showed signs of pulmonary fibrosis. The CXR shows an infiltrate. Can I take the CT as prior evidence of imaging? I only have one CXR result.

Remember for patients with underlying heart or lung disease, two CXR or CT films within 12 months that support the latest CXR/CT findings reflect pneumonia are required. You can take a CT and a CXR within 12 months as evidence. The patient doesn't have to have had two of the same type of scan.

Patient form C – Section 5 Antimicrobial Use – General

On the day of the PPS, a patient is identified as receiving antimicrobial treatment for pneumonia for six days. The patient is receiving oral co-amoxiclav for four days, having been previously on IV co-amoxiclav for two days. How do we decide what the start date for antimicrobials is? Is it the date oral co-amoxiclav was prescribed (four days ago) or the date IV co-amoxiclav was prescribed (six days ago)?

It is good practice for patients to be switched from intravenous to oral antimicrobials as soon as it is clinically safe and appropriate to do so. The current prescription is oral co-amoxiclav and the start date for that is four days ago. The oral co-amoxiclav does represent a change from what was originally prescribed for that indication (pneumonia), as IV co-amoxiclav was originally prescribed. The start date of the IV co-amoxiclav was six days ago and the reason for the change was an IV to oral switch

For HAI episodes, in order to determine the date of onset of the symptoms and signs of the infection, always go back to the very first date that the antimicrobials were prescribed for that episode (i.e., six days ago), because that is likely to be the date for which the patient first developed symptoms or signs of infection and the date for which the symptoms and signs are most likely to be documented

Nystatin is given as an oral suspension – how should this be considered – as topical or enteral?

Because the oral suspension will be swallowed, it should be recorded as enteral/oral route and thus included in the PPS. Agents that are topically administered are excluded in the PPS

A patient is prescribed ceftolozane-tazobactam. I can't find it in the list of antimicrobials in Appendix B - Table 4b?

Ceftolozane-tazobactam has since been added to the webforms as Ceftolozane-enzyme inhibitor (ATC5 code = J01DI54) upon feedback from PPS data collectors. You can code it on the paper patient form C and it will be available from the drop down menu when the data is being entered into webforms

If a patient is prescribed the correct antibiotic as recommended in the hospital policy but it is prescribed at the wrong dose or the wrong frequency, is that prescription non-compliant?

No. In determining compliance with hospital policy in the PPS, you are asked to assess compliance based on the choice of agent only. Compliance is not assessed on the dose, route, frequency or duration of the agent prescribed

Antimicrobial Use – Surgical prophylaxis

A patient went to theatre yesterday and had a surgical procedure which could be classified as 'dirty surgery' (e.g. surgery for a perforated viscus or surgery which took place in the setting of obviously infected tissue). The patient is still prescribed antimicrobials the following day when the PPS team arrive on the ward. What is the correct 'indication code' for this scenario?

When the patient is taken to theatre, it may or may not be known what category the surgery will fall into. When there is intraoperative evidence of active infection, a procedure is classified as 'dirty surgery', antimicrobial therapy which may have initially been administered as surgical prophylaxis would be automatically converted to ongoing treatment for infection. Therefore, rather than coding this indication as >3 doses surgical prophylaxis (SP3), it is more accurate and fairer to categorise the indication as 'treatment

intention for infection' – Depending on the clinical scenario, that infection may be community infection (CI), hospital infection (HI) or long-term care facility infection (LI)

An immunocompromised patient underwent an ERCP on the day before the PPS. The patient was given a stat dose of piperacillin/tazobactam prophylaxis just before the ERCP procedure. The patient is not on antimicrobials today on the PPS date. The patient has not undergone any other procedures or surgery on this admission. How do I code this event?

An ERCP is not regarded as a surgical procedure, so in section 2 of the patient form C – the answer to surgery since admission will be 'No'

In the antimicrobial use section 5 of patient form C, the pip/tazo can be categorised as SP1, as a prescriber indication for the pip/tazo prescription administered yesterday

Antimicrobial Use - Ophthalmology

How do we record antimicrobial use in ophthalmology patients?

Topical antimicrobials, including eye drops are excluded.

For intraocular injections of antimicrobials, route can be recorded as 'parenteral'

Antimicrobial Use – Obstetrics & Neonatology

The delivery/labour ward is excluded in this PPS, how do we capture administration of intrapartum antimicrobials?

Intrapartum administration of benzylpenicillin to a mother colonised with Group B streptococcus is classified as medical prophylaxis. To capture this use of antimicrobials, you can apply the same timing rules to this medical prophylaxis as that used for surgical prophylaxis. Intrapartum antimicrobials administered as medical prophylaxis between 8am on the day before the PPS and 8am on the day of the PPS can be captured using this method

How do I classify antimicrobials administered to an otherwise well neonate as a result of maternal illness or pyrexia in labour?

This would be recorded as medical prophylaxis because the infant does not have signs of infection

Hospital Form (Form B)

How do I calculate the number of whole time equivalent (WTE) infection prevention and control nurses in the hospital?

Whole-time equivalent is based on the number of hours dedicated to the activity in the hospital. If an IPCN is contracted to cover two hospital sites – 0.5 WTE is allocated to each hospital. If an IPCN works half-time, the post is 0.5 WTE

How do I calculate the number of WTE infection prevention and control doctors in the hospital?

Unlike other European countries, Ireland does not have a designated infection prevention and control doctor sub-specialty. The role of infection prevention and control doctor is generally taken on by the consultant microbiologist. The PPS team leader is advised to check with the consultant microbiologist(s) to determine what proportion of the contract of employment is specifically allocated to the role of infection prevention and control. If there is no mention of specific infection prevention and control time in the contract of employment, the hospital has no infection prevention and control doctor. If 0.4 WTE is devoted to infection prevention and control and the doctor covers two hospital sites, each site is allocated 0.2 WTE infection prevention and control doctor

What is meant by the WTE registered nurses question?

For the purposes of this PPS, WTE registered nurses are deemed to be:

- Registered with NMBI (student nurses are not included, as not yet registered)
- Registered nurses and registered midwives
- Filled posts (can include permanent, temporary, agency appointments)
- The person in the post is professionally accountable to the Hospital's Director of Nursing & Midwifery
- As staffing levels can vary throughout the year, we suggest that the date of the WTE nursing and healthcare assistant census should be 31/12/16
- A qualified nurse working in a role which is not professionally accountable to the DONM would not be counted in the WTE registered nurse complement (e.g., risk manager, quality and patient safety officer)

If a 1.0 WTE post holder was on maternity leave at the time of the calculation of the WTE figures, but their post was approved only for 0.5 WTE backfill, how do I record the post?

If the backfill appointee is in post and is working 0.5 WTE, then the post is counted as 0.5 WTE.

If the backfill has not yet been appointed, then the post is vacant and not filled and should not be counted in the WTE for the hospital

Top Tips

1. If you are doing the PPS on a surgical ward, it is a good idea to review the Ward List A2 with the ward CNM and check if any of the patients are scheduled to go to theatre that day? Try to review those patients first, to ensure that you have access to their information before the patient and all the documentation are taken off the ward to theatre
2. Whenever an antimicrobial prescription is rewritten or re-prescribed at a different dose, the date that the antimicrobial commenced should be recorded on the medication chart, rather than the date that the prescription was rewritten or re-prescribed. If you find that the patient is receiving antimicrobials, but you cannot find any reason recorded in the notes on the date the antimicrobials were prescribed, check the medication chart carefully, to ensure that the chart has not recently been rewritten, with the date of rewriting the chart recorded erroneously as the date of prescribing the antimicrobials. Check for earlier crossed-off prescriptions of the same antimicrobial at different doses or frequencies, which will help to work back and decide what the actual start date was

3. Be aware that prescribers may use drug trade names rather than generic names when prescribing antimicrobials or recording information in the patient's notes. If you are not very familiar with the names of antimicrobials most commonly prescribed (See Appendix A – Table 4a & 4b, page 54) – ask your pharmacy department to provide you with a list of the generic and trade names of the most commonly prescribed antimicrobials, so you don't miss an antimicrobial prescription

4. If you find a patient is prescribed an antimicrobial that is not mentioned in the protocol Appendix B - Tables 4a or 4b, confirm that the name is not a trade name and confirm the generic name of the antimicrobial and that it is classified as an antibacterial or antifungal agent. The PPS is not collecting data on antivirals. If it is still not listed in the protocol, it can be counted on the paper form and please e-mail pps2017@hpsc.ie as soon as possible. There may be some newer antimicrobials which were not included in the PPS antimicrobial list. They can be added to webforms if necessary and the prescription can be captured.