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Guidelines for Validation of Selected AHRQ Quality Indicators

PSI 14: Postoperative Wound Dehiscence (version 2.1, 12/2007)

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PSI 14: Postoperative Wound Dehiscence

Table of Contents

Getting started

Prior to starting data abstraction, familiarize yourself with the medical record, pertinent health information policies and procedures specific for your medical center, as well as the specific Patient Safety Indicator (PSI) abstraction guideline and instrument.

Review the "Getting Started" document (AHRQ_Pilot_Getting_Started.doc).

The abstraction Instrument is provided as Appendix A of this document.

General Instructions for Completing the AHRQ Study Record

Please complete all data fields: All data fields must be completed to enable submission of a Patient Record to the AHRQ Patient Safety Indicator (PSI) Database. If you do not have the information for a given field, check the "Not Documented" box. Except as noted below, avoid leaving any questions blank. Most questions that relate to specific findings or data elements default to "no" if left unchecked.

We assume that if a finding is not documented in the records that it does not occur. Questions that relate to specific times, physical findings or laboratory values generally can be answered with"9", "99", "999", "99:99" etc., if the necessary information is missing or uninterpretable. If you believe that a question should be answered in this manner, but the computer entry system does not allow it, contact your supervisor.

Use leading "zeros" to complete a number string **EXCEPT** for DRG and/or procedure codes. For example, if given a double digit entry and the number of events to be entered is less than 10, precede the entry with a zero (e.g., 07 for 7). ENTER all DRG and procedure codes as written with careful consideration of the decimal point. Do not right or left margin adjust and do not add any additional digits including "zeros". For example, 38.9 should be entered as [_ 3 8.9 _].

Date/time: All dates are recorded in the [MM/DD/YYYY] format. All times are recorded using a 24-hour clock (or military time) [_ _ : _ _]. To convert clock time to military time, with the exception of midnight and noon, add 12 to any time after noon. For example, 1:15 pm corresponds to a 24-hour time of 13:15. For estimating time, use time anchors such as important events, television shows or other references to narrow the time window.

Information sources: All information entered into the database must be gleaned from the medical record. Many hospitals are in the process of converting from paper to an electronic medical record (EMR or eMR). It is acceptable to use a combination of sources, as long as the record retrieved was

an approved component of the record system at the time care was rendered. It is permissible to obtain missing reports. For example, if the patient had a MRI but the final MRI report is missing. It is acceptable to access the report on-line or to obtain a copy from the radiology department. Electronic generated reports used for diagnoses should contain an electronic signature.

Conflicting information: For conflicting information in the record, document the finding of the most senior member of the patient care team. The hierarchy from most senior to junior is as follows:

- ❑ Primary, attending or consulting physician
- ❑ Chief or senior resident (e.g., generally 3rd or 4th year or higher depending on specialty)
- ❑ Junior resident (e.g. 2nd year or PG2)
- ❑ Intern (e.g., 1st year or PG1)
- ❑ Medical student (with MD signature)
- ❑ Physician extender [physician assistant (PA), Nurse Practitioner (NP), mid-wife, or advanced practice RN [clinical nurse specialists (CNS), certified registered nurse anesthetists (CRNA) or other]
- ❑ PA student or NP student (with physician signature)
- ❑ RN (registered nurse with or without further certifications regardless of level of entry into practice such as ASN, BSN, MSN, etc).
- ❑ Other licensed and applied healthcare professionals such as a licensed practical nurse (LPN), vocational nurse (LVN) nurse, physical therapist (PT), dietician, etc.
- ❑ Unlicensed assistive personnel (e.g., physical therapy aid, nutritional aid, laboratory assistant, nursing assistant or nursing aid).

Notes completed by students should not be used for review unless cosigned by a physician or other appropriate level staff. Medical student notes are often labeled MS3, MSIII, MS4, MSIV, or AI (acting intern). Residents notes may be labeled as R4, R3, R2, R1 or RPN" (for resident progress note with the corresponding year of training), PG4, PG3 etc., or PGY4, PGY3 respectively (for postgraduate year); or HO3, HO4, etc. (for house officer followed by the training year). The more senior resident in a leadership role may use the title "chief resident".

Several types of inconsistencies may occur in the medical record. Except as described in subsequent sections, inconsistencies should be resolved as follows:

a. If two notes are directly contradictory (e.g., one physician describes the patient's medical problem as stable but another specially states unstable), record the findings of the more senior person. If the contradictory notes are written by individuals at the same level (e.g., two attending physicians), record the findings of the person with more specialized

knowledge and expertise in the specific area (e.g. a surgeon for surgical findings and an internist or cardiologist for cardiopulmonary findings).

b. If two notes are inconsistent but not directly contradictory (e.g., one physician reports ”an accidental laceration of the bladder”, but another “does not report that any accidental laceration occurred”, record the findings of the more senior person. If the inconsistent notes are written by individuals at the same level (e.g., two attending) look for other evidence in the chart (e.g. nursing, laboratory or radiology notes) that corroborates the more specific or serious finding. If such evidence cannot be found, record the findings of the person with more specialized knowledge and expertise.

c. If two notes are inconsistent due to omission of relevant information (e.g. one physician states “deep vein thrombosis” but another does not mention deep vein thrombosis), the note that provides the most specific information relative to that data element should always be used (regardless of seniority).

Data verification: Each page of the medical record should contain at least two unique patient identifiers (e.g., medical record number, patient name, date of birth, etc.). While abstracting data, please confirm that each page of the medical record is for the index patient and associated hospital admission. It is not uncommon for portions of the record to be misfiled.

Case Ascertainment

Patients included in the AHRQ PI validation database: This is a retrospective chart review based on a computer randomized sample (without replacement) generated from Administrative Data. This sample includes patients discharged within the last 12-24 months. Data collection should occur between March 2008 and May 2008. Each hospital participating in the AHRQ PSI Validation Project will receive a computer generated list of patients for data abstraction. This list is subsequently referred to as the sampling list. The sampling list will contain an AHRQ unique patient identification code number as well as the medical record or patient control number to be used for chart identification.

It is extremely important that you include only patients listed on your sampling list. Do not substitute a patient with a like diagnosis. Patients selected for this validation project were sampled based on the following inclusion and exclusion criteria.

Inclusion criteria

It is extremely important that you include only patients listed on your sampling list. It is not okay to substitute a patient with a like diagnosis.

Selected patients should have the following criteria (denominator):

- Be at least 18 years of age or older
- Have a discharge ICD-9-CM code for reclosure of postoperative disruption of abdominal wall (54.61) in any procedure field

Exclusion criteria

Patients on your sampling list should have none of the following:

- A procedure code for re-closure of postoperative disruption of abdominal walls that occurs before or on the same day as the first abdominopelvic surgical procedure
- A length of hospital stay less than 2 days
- An immunocompromised state
- A MDC of 14 (pregnancy, childbirth, and puerperium)

For additional information on inclusion and exclusion criteria, refer to the AHRQ technical guidelines.

COMPLETING THE PATIENT RECORD

Section 1: Abstractor details

QUESTION 1.1: Date abstraction completed

Abstraction date: Enter the date of the chart abstraction using the MM/DD/YYYY format.

QUESTION 1.2: Abstractor identification number

Abstractor identification: Each abstractor will have a unique log-in identifier linked to a unique abstractor identification number. It is essential that each abstractor use their assigned identifier and password when signing into the AHRQ PSI program and in completing data abstraction.

Section 2: Record identification/validation

QUESTION 2: AHRQ Study identification number

AHRQ study identification number: Enter the AHRQ study identification code of the record you are abstracting. This number can be found on the computer generated sampling list. It is important that you have the correct chart before proceeding.

QUESTION 2.2: Medical record number/Patient control number

Medical record number (MRN, MR# or patient control number): The medical record/patient control number will be used for audit purposes and patient verification only. If the medical record/patient control number does not match the AHRQ study identification code, do not continue. If the patient has been admitted under more than one medical record number, ensure that the primary and final medical record numbers match the sampling list. If there are any questions regarding the validity of the medical record number(s), notify your supervisor and/or appropriate departments to establish the correct number for the patient. If there is a conflict in the medical record number and AHRQ study number that cannot be easily rectified or resolved, notify the coordinating center.

Preferred data source: Admission record.

QUESTION 2.3: What is the patient's date of birth?

Date of birth (DOB): Use the DOB on the admission or face sheet. Data used for analysis will contain the calculated age. Use a leading zero when entering single digit months (e.g., 03 for March).

Preferred data source: Admitting form.

QUESTION 2.4: What is the patient's gender?

Gender (sex): Enter if the patient is a male or female.

Preferred data source: Use the admission or face sheet followed by the physician's admission history and physical followed by the nurse's admission assessment.

Common Problems/ Questions: *Often there is conflicting information concerning demographic information. If the data element (e.g., gender, birth date, etc.) is recorded differently on the admission sheet and on other parts of the medical record, check several sources to verify the correct response. If an incorrect demographic is entered on admission, it will appear on all system generated reports until changed (i.e., laboratory test, diagnostic procedures, etc). Use reports that are not automatically generated to verify information (e.g. history and physical).*

QUESTION 2.5: What was the date of hospital admission?

Admission date: Verify the month, day and year the patient was admitted to the hospital. If there are conflicting times in the medical record, use the time on the face sheet followed by the admitting assessment form. If there are conflicts greater than 24-hour between the sampling list admit date and the chart date, notify the coordinating center.

Preferred data sources: Face sheet, Nursing Admission Assessment Record, History and Physical (H&P), pre-operative assessment form if admitted directly to the pre-op area.

QUESTION 2.6: What was the discharge date?

Discharge date: Enter the month, day and year the patient was discharged from the acute care hospital or index facility. This includes transfer to a non-acute care area associated within some hospital systems (e.g., a sub-acute care unit, long-term care, or rehabilitation area). For patients that expired during hospitalization, use the date the patient was pronounced.

Preferred data sources: Face sheet, Nursing Discharge Record, Ambulance transfer record, discharge summary. For patients that expired, use the death certificate or death note followed by the nursing record.

Section 3: Ascertainment of event(s), Evaluation and Treatment

QUESTION 3.1: Did the patient undergo an operation involving the abdomen or pelvis?

If No, explain in the TEXT BOX and END the abstraction here. This is an exclusion criterion.

Operation: Ensure that the patient underwent an abdominal or pelvic surgical procedure. If the procedure did not involve an operation involving either of these, provide a short description explaining why this chart was most likely flagged for review in the TEXT BOX provided and then END the abstraction.

Preferred data sources: Operative notes, coding sheet (ICD-9 CM procedure codes).

QUESTION 3.2: Was pregnancy or a condition related **to** pregnancy the patient's primary admitting diagnosis?

Pregnancy: If the patient's primary diagnosis was related to major diagnostic code 14 (pregnancy, childbirth, or the puerperium), provide an explanation of the diagnosis in the TEXT BOX provided and then END the abstraction.

Preferred data source: History and physical, progress notes, physician notes, and surgeon notes

QUESTION 3.3: Select if the patient had any of the following known immunosuppressive conditions at the time of admission. Check all that apply.

Immunosuppression: Immunosuppressive conditions are exclusions for this PSI. If the patient had any of the conditions listed, provide a brief description of why the chart was most likely flagged for review in the TEXT BOX provided and END the abstraction. A full list of immunocompromised conditions considered exclusions are listed in appendix D in the PSI technical specifications (version 3.1; March 12, 2007).

HIV/AIDS inclusions and synonyms:

- ☐ Pneumocystosis
- ☐ Pneumocystis carinii pneumonia, "PCP" pneumonia or Pneumocystic jiroveci pneumonia
- ☐ Human immunodeficiency virus or viral syndrome
- ☐ Acquired immune deficiency syndrome or disease

Severe malnutrition inclusions and synonyms:

- ☐ Kwashiorkor
- ☐ Nutritional marasmus

Chronic kidney disease inclusions and synonyms:

- ☐ End stage renal failure
- ☐ Chronic glomerulonephritis
- ☐ Benign or malignant hypertensive kidney disease with chronic kidney disease or heart failure
- ☐ Renal dialysis
- ☐ Peritoneal Dialysis

Immunoglobulin deficiency inclusions and synonyms:

- ☐ Selective IG or IGA deficiency,
- ☐ Selective IGM deficiency
- ☐ Hypoimmunoglobulonemia
- ☐ Intestinal postoperative non absorption syndrome

Transplant inclusions and synonyms:

- ☐ Any major organ transplantation and/or complication there of
- ☐ Kidney or renal transplant
- ☐ Liver transplant
- ☐ Heart transplant
- ☐ Lung transplant
- ☐ Bone marrow transplant
- ☐ Pancreas or pancreatic cell transplant
- ☐ Intestine transplant
- ☐ Operations on bone marrow and spleen

Other immunodeficiency inclusions and synonyms (see appendix D for the complete list):

- ☐ Digeorges syndrome
- ☐ Nezelofs syndrome
- ☐ Wiscott-Aldrich syndrome
- ☐ Hemophagocytic syndromes
- ☐ Panocytopenia.
- ☐ Aplastic anemia
- ☐ Myelofibrosis
- ☐ Leukocytopenia
- ☐ Hemophagocytic syndromes
- ☐ Neutropenia (include all causes such as drug, congenital, and other)
- ☐ Humoral immunity deficiency
- ☐ Automimmune disease, not elsewhere classified
- ☐ Aplastic anemia
- ☐ Lymphocytopenia
- ☐ Neutropenic splenomegaly
- ☐ ICD-9-CM code for decreased white blood cell count

Preferred data sources: History and physical, admission notes and records, physician notes, nursing notes.

QUESTION 3.4: Did the patient had any of the following conditions as listed below at the time of admission. Select all that apply.

Non-exclusions: Only include those diagnoses cited by a medical professional. Do not include conditions that a patient cites as having but is not collaborated by a licensed healthcare professional such as an RN or MD. If systemic steroids use at the admission is selected, write a brief explanation for use in the textbox provided. For all conditions selected, **continue** with the abstraction as these are not exclusions.

Sickle cell disease inclusions and synonyms:

- ☐ Sickle cell anemia
- ☐ Hemoglobin SC disease

Short gut syndrome inclusions and synonyms:

- ☐ Small intestine insufficiency
- ☐ Short bowel syndrome

Systemic steroids use inclusions and synonyms (but not limited to):

- ☐ Prednisone
- ☐ Prednisolone
- ☐ Methylprednisolone
- ☐ Betamethasone
- ☐ Dexamethasone
- ☐ Triamcinolone
- ☐ Hydrocortisone.

Preferred data sources: History and physical, admission notes and records, physician notes, nursing notes.

QUESTION 3.5: How many operations involving the abdomen or pelvis occurred during this hospital stay?

Operating Room (O.R) trips: Select the number of separate operations that the patient underwent that involved the abdomen and/or the pelvis during this hospitalization. In counting the number of operations, include the repair of the wound dehiscence as a separate operation. Do not include procedures or operations performed outside of the operating room (e.g., special procedure lab, radiology, or at the bedside). Do include the rare circumstance where the procedure was performed at the bedside because time and/or patient condition did not allow for transfer to the operating room. Only include these cases if the physician states in the record that the procedure was performed at the bedside because the patient could not be safely transferred to operating room.

Preferred data source: Operative records, surgical notes, progress note, procedure records, and discharge summary.

For each separate visit or trip to the operating room that involved the abdomen and/or pelvis, complete questions 3.6-3.16. For patients that had more than one operative trip, copy pages 4-7 and complete for each additional trip. Make sure to include the trip number at the top of each respective page (pages 4-7).

QUESTION 3.6: Specify the date and time of the procedure.

Start date and time: Use the anesthesia start time followed by operating room time.

Preferred data sources: Anesthesia record, surgical record, and surgeon's record.

QUESTION 3.7: State the primary procedure name(s) and associated ICD-9-CM code(s).

Procedure: When multiple procedures were performed, list only the salient and important procedures related to the reason for surgery. Do not include incidental or minor procedures associated with the reason for surgery (e.g., diagnostic testing, line placements, blood transfusions, etc.).

Preferred data sources: Coding sheet, operative records, surgeon's notes, and special procedure records.

QUESTION 3.8: Using physician notes or operative notes, describe in the text box the indication for the procedure.

Reason: Use the exact wording from physician or physician extender documentation that describes and/or indicates the need for the procedure.

Preferred data source: Physician notes, operative notes, and surgeon's notes

QUESTION 3.9: Indicate the type of incision used.

Incision: Select the type of incision used for the major operative procedure that the patient underwent during the respective operation. For example; a transverse(rectus transecting) incision used in colon surgery. If the name used does not correspond to those listed, select other and describe in the TEXT Box provided. An example of other would be a loin incision often used in renal surgery. The type of incision line should be specified in the surgeon's operating room records.

Preferred data source: Surgeons operative record followed by operative records and physician progress notes.

QUESTION 3.10: Did the procedure involve **repair of a defect (or hole) in the abdominal wall fascia** that existed prior to this procedure?

Fascial defect: This question targets a repair of a defect in the abdominal wall fascia that existed prior to this procedure. This should be clearly stated in the pre-operative and/or post-operative surgeon's or physician's notes. If the patient has been transferred from an outside facility or admitted with the problem, this information may also be found in the admission history and physical. Only mark critical documentation missing if the reports needed to determine the answer to this question are not present.

Abdominal wall defect inclusions and synonyms:

- ☐ Tear
- ☐ Rip
- ☐ Puncture
- ☐ Hernia
- ☐ Opening
- ☐ Gap
- ☐ Disruption

Preferred data source: Surgeon's report, other physician notes, operative record, and admission history and physical.

Branching instructions: For YES answers continue with Q3.11. For NO answers and critical documentation missing answers, skip to Q3.12.

QUESTION 3.11a: On what date was this **defect** in the **abdominal wall fascia** first identified?

Defect date: This question pertains specifically to date that the **defect** in the abdominal wall fascia was first discovered or suspected.

Preferred data sources: Physician progress notes, operative records, surgical note, and special procedure records

QUESTION 3.11b: Using the operative note, describe the dimensions and nature **of the defect in the fascia** in the text box provided.

Dimensions: Use the exact wording of the surgeon or physician performing the operative procedure to describe the dimension and nature of the defect in the fascia.

Preferred data sources: Operative report, surgeon's progress notes, and special procedure records.

QUESTION 3.11c: Was the defect in the fascia associated with **evisceration** of the abdominal contents prior to this procedure?

Prior evisceration: Please make sure that the defect in the fascia is associated with evisceration of the abdominal contents that occurred prior to this procedure. Definition of "evisceration" implies extrusion. These exact words would need to be stated.

Evisceration inclusions and synonyms:

- ☐ Burst abdomen
- ☐ Exposed intestine
- ☐ Exposed omentum

Preferred data sources: Physician notes, operative notes, surgeon's notes, progress notes, and special procedure records.

QUESTION 3.11d: Using the physician's notes and operative notes, indicate all of the factors associated with the **defect in the fascia**. Check all that apply.

Causative factors: The operative notes may need to be read carefully. Use only physician or physician extender documentation. Only select critical documentation missing if the records needed to make this judgment are missing. For factors note listed, select other and provide a brief description in the TEXT BOX provided.

Preferred data sources: Operative records, surgeon's notes, and special procedure records.

QUESTION 3.12: Did the procedure involve **repair of a defect or hole in the abdominal skin** that existed prior to this procedure?

Synonyms and inclusions for defect or hole:

- ☐ Hernia
- ☐ Opening
- ☐ Gap
- ☐ Disruption

Preferred data sources: Physician notes, operative notes, surgeon's notes, and special procedure records.

Branching instructions: For YES answers, continue with Q 3.13.
For NO or critical information missing answers, go to Q 3.14.

QUESTION 3.13a: On what date was this defect in the abdominal skin first identified?

Date identified: Write in the date of identification or first suspicion in the space provided.

Preferred data sources: Physician notes, operative notes, surgeon's record, and special procedure records.

QUESTION 3.13b: Did the operation involve a skin graft?

Skin graft: This question only pertains to the patient who had a repair of a defect or hole in the abdominal wall (YES to Q3.12). Other terms may include autograph or skin transplant.

Preferred data sources: Physician notes, operative notes, surgeon's notes, and special procedure records.

QUESTION 3.14: Was any portion of the **fascia** closed with sutures during this visit to the operating room.

Closed fascia: Use only physician or physician extender documentation.

Preferred data sources: Surgical record, operative notes, and other physician progress notes or procedure records.

Branching instructions:

For YES answer to Q 3.14, continue with Q3.15. For NO and critical documentation answers, go to Q3.16.

QUESTION 3.15a: What suture size was used to **close the fascia** of the abdomen or pelvis?

Suture size: Sutures sized on listed in descending order from the larger size #2 and #1 to smaller the sized 2.0 and 3.0. If other than suture size listed, select other and state the size in the space provided. If the suture size is not documented, select "not specified".

Preferred data sources: Surgeon's record, post-operative note, and special procedure record.

QUESTION 3.15b: What was the primary suture type used to close the fascia of the abdomen or pelvis?

Primary suture: Often more than one type of suture may be used. We are only interested in the type of suture used to close the abdominal or pelvic fascia. If more than one suture type is used please check off the one used for the major

portion of the surgery and then describe the 2nd and 3rd suture types (if present) in the textbox provided.

Preferred data sources: Surgeon's record, post-operative note, and special procedure record.

QUESTION 3.15c: Was the **entire fascia defect** closed during this visit to the operating room?

Fascia closed: The surgical record will be the best source of information. Select no if the entire fascia defect was not repaired or closed during this operation. Only mark critical documentation missing if the surgical records are missing and cannot be retrieved.

Preferred data sources: Surgical record followed by other physician progress notes, operative reports, and special procedure records.

QUESTION 3.16: Were **retention sutures** placed during this visit to the operating room?

Retention sutures: This type of suture would be mentioned specifically in the operative notes.

Preferred data sources: Surgeon's operative report, progress notes, and procedure records.

Section 4: Risk factors

QUESTION 4.1: Height on admission.

Height: Use the most reliable height taken closest to the time of admission. Height may be entered in cm or in feet and inches.

Preferred data source: Nursing admission record, anesthesia record.

QUESTION 4.2: Weight on admission.

Weight: Use the most accurate dry weight taken at the time closest to admission and prior to surgery. If the only weight is post-operative, take the first weight available. Weight may be entered in kg (kilograms) or lbs (pounds)

Preferred data source: Nursing admission record, anesthesia record.

Section 5: Outcomes

QUESTION 5.1: Did evisceration of abdominal contents occur during this hospitalization?

Evisceration: State if the patient eviscerated abdominal contents during this hospital stay. Abdominal evisceration is the process wherein tissue or organs that usually reside within the abdominal body cavity are displaced outside that cavity through a disruption of the abdominal wall (such as that from a surgical incision). Only mark critical documentation if important reports or portions of the medical record are missing and cannot be located.

Evisceration inclusions and synonyms:

- ☐ Burst abdomen
- ☐ Exposed intestine or omentum

Preferred data sources: Physician notes, operative notes, surgeon's notes, special procedure records, and discharge summary.

QUESTION 5.2: Was an abdominal or pelvic fascial defect or hernia left un-repaired during this hospitalization?

Unrepaired: Use physician or physician extender documentation. Only mark critical documentation if important reports or portions of the medical record are missing and cannot be located. An abdominal fascial defect may also be called an abdominal wall defect.

Hernia inclusions and synonyms:

- ☐ Inguinal
- ☐ Femoral
- ☐ Paraumbilical
- ☐ Epigastric
- ☐ Incisional
- ☐ Spighelian
- ☐ Richter's
- ☐ Obturator

Preferred data sources: Physician notes, operative notes, surgeon's notes, special procedure records, and discharge summary.

QUESTION 5.3: Does the medical record suggest that the patient suffered any adverse effects or consequences from disruption of fascia that was closed during an abdominal or pelvic operation? Check all that apply.

Adverse effects: This requires judgment on the part of the abstractor. For example, the chart will rarely state that the patient stayed in the hospital an additional two days because of a wound dehiscence, but if the patient should have been discharge within 48-hours based on the type of surgery and on day 2

was taken back to the operating room because of a dehiscence and stayed several additional days in the hospital, extended length of stay should be selected. A second example would be patient that was expected to return to baseline post-operatively, but because of the complication, has residual disability or loss of function. Then this selection should be chosen.

Preferred data sources: Physician notes, operative notes, surgeon's notes, and special procedure records, discharge notes.

QUESTION 5.4: If there are special circumstances or comments related to this case that you feel are important that were not captured in the survey, please describe in the TEXT BOX.

Special circumstances: This box is only for special concerns or circumstances that the abstractor feels is important to the validation of this indicator that the form did not capture. Do not feel compelled to complete this box for each patient unless there are issues that need to be brought to our attention.

Preferred data source: All portions of the medical record reviewed.