Dear SCQRs,
In addition to providing a chance to brush up on some definitions and hone your abstracting skills, Case Study #3 will also provide great preparation for the Certification Exam that will be released in October. Please feel free to discuss these questions and your responses on the Forum with your colleagues, and stay tuned for the ‘official’ answers in a couple weeks.

SEPSIS SCENARIO  In honor of the last few days of Sepsis Awareness Month

8/11/18:
2330: Patient presented to ED for acute abdominal pain. Pelvic abscess from a ruptured diverticulitis found on CT, and surgery scheduled for the next morning. Preoperative H&P indicates ESRD with peritoneal dialysis three times a week and creatinine levels are normally above 4 mg/dL.

8/12/18:
0400: Labs WBC 12.1, creatinine 5.2, lactate 2.0
0600: Vital signs BP 110s/70s-80s, HR 93, RR 22, T 101.2°F
0715: In room time for urgent open left hemicolectomy

8/17/18: Patient was discharged to home after an uneventful hospitalization.

8/18/18:
0730: Patient presented to ED with complaints of abdominal pain and incision redness and drainage, wound culture of incision obtained
0800-1200: Vital signs and labs included BP 110s/50s-80s, HR 90s, RR 20s, T 101.0°F; WBC 14.8, Lactate 2.4
1230: BP 88/50, HR 95, RR 26. Fluids and antibiotics administered for suspected wound infection and possible sepsis, and patient transferred to ICU
1300: in ICU, MAP 60, BP 80/48 and vasopressors were started

8/20/18: surgeon diagnosed the patient with a superficial wound infection after wound culture resulted positive

1. **What level of Sepsis should you assign to this patient? Select all that apply:**
   a) Preoperative Sepsis
   b) Preoperative Severe Sepsis
   c) Preoperative Septic Shock
   d) Postoperative Sepsis
   e) Postoperative Severe Sepsis
   f) Postoperative Septic Shock
   g) None
PRINCIPAL OPERATIVE PROCEDURE/CPT CODE/SURGICAL APPROACH

POSTOPERATIVE DIAGNOSIS:

1. History of perforated diverticulitis/severe peritonitis, status post sigmoid resection with Hartmann's pouch and colostomy (04/2018).
2. Request for reversal of colostomy.
3. Extensive pelvic adhesions.

PROCEDURE: Hand-assisted laparoscopic reversal of colostomy, takedown of splenic flexure, extensive lysis of adhesions, excision of the upper rectal stump with low colorectal pelvic anastomosis, protective diverting ileostomy.

INDICATIONS: The patient is a 60-year-old gentleman presenting for reversal of colostomy. He presented back in 04/2018 with severe sepsis secondary to perforated/gangrenous sigmoid diverticulitis/pelvic abscess. He underwent resection with colostomy and Hartmann's pouch. He wished to proceed with reversal of his colostomy.

DESCRIPTION OF PROCEDURE: Preoperatively, the patient received IV antibiotics. He was taken to the operative room, placed in supine position. Adequate general anesthesia was achieved, a Foley catheter and SCDs were placed. He was placed in Allen stirrups. Prior to surgery, I closed the colostomy with a pursestring nylon suture. Prior to making any incisions, the skin and deeper tissue were infiltrated with 0.5% Sensorcaine plain. A #11 blade was used to make a circumferential incision around the left lower quadrant colostomy along the mucocutaneous border. Blunt and sharp dissection then continued around the colostomy, freeing it from the subcutaneous tissue. The abdominal cavity was entered. The remaining peritoneal attachments were divided sharply or with cautery. The colostomy was completely freed. A finger then could be swept to take down some of the omental adhesions and clear the low midline area.

An 8 cm low midline incision was made and continued through the subcutaneous tissue and fascia with cautery. The abdominal cavity was entered. A GelPort was then placed through the midline incision. The fascia of the colostomy site was partially closed. A 12 mm port was placed through the left lower quadrant colostomy site. The abdomen was then insufflated with CO2. The 5 mm ports were placed. Initially the dissection was laparoscopic. The left colon is fairly mobile. The peritoneal reflection along the left to the splenic flexure was divided with the Harmonic scalpel. I then placed a hand through the GelPort and a 5 mm supraumbilical port was placed.

Using the hand, the splenic flexure was freed up with a Harmonic scalpel. This added quite a bit of extra length. It appeared there was more than enough length to fall into the pelvis without difficulty. He also had quite a bit of his omentum adhered up in the left upper abdomen. With blunt hand dissection and sharp dissection and also using the Harmonic scalpel, the omentum was freed up completely from the left upper abdomen. He has only a few scattered diverticula along the left colon. Several loops of small bowel are tightly adhered down into the pelvis. Attention was then directed to the pelvis.

As much of the small bowel was freed as possible with blunt dissection and sharp dissection with the EndoShears. Quite some time was spent carefully freeing the small bowel from the rectal stump. He had 2 Prolene sutures which had been placed during the initial surgery on each side of the rectal stump. These were removed. The small bowel has some superficial serosal tears where it was taken off of the rectal stump, but nothing of significance. During the removal of the small bowel, a small enterotomy was made along this upper rectal stump. This upper rectum was obviously abnormal, thickened and dark and scarred. This thickened scar needed to be removed and the rectal stump mobilized in order for the anastomosis to be performed.

The rectal dissection/mobilization then proceeded through the open GelPort. Ultimately the GelPort was removed and the incision was extended inferiorly 3 or 4 cm and a Bookwalter retractor was placed. Dissection here was very tedious. All in all, it took certainly well over 2 hours to free up the rectum enough in order to excise the upper abnormal rectal tissue. The ureters were visualized and protected. 2-0 Vicryl sutures in interrupted fashion were placed on each side of the rectal stump ultimately in order to elevate this thickened abnormal portion up out of the pelvis for it to be excised. The contour stapler was then able to be advanced into the pelvis. He has a small pelvis. The contour stapler was brought down as deeply as possible and this upper abnormal rectum was then excised. The area where the
perforation occurred also was included in this excised segment. The upper portion of the rectum was sent to pathology. The remaining rectum appears normal pink and well vascularized.

A 28 mm rectal sizer was lubricated and advanced to the end of the rectal stump without difficulty. The left colon was then prepared for placement of the anvil in the end of the colon. The distal 3 to 4 cm of the colostomy was excised. A 2-0 Prolene was placed in a pursestring fashion circumferentially. A lubricated anvil was inserted and the suture was tied. The bowel looks healthy and well vascularized. Care was taken to make sure there was no twist in the descending colon on the left. The 29 mm EEA was inserted transanally and advanced without difficulty. The spike came out through the staple line. A standard end to end 29 mm stapled anastomosis was performed between the descending colon and the rectum. I then inspected both rings. Both rings are full thickness.

The pelvis was irrigated and aspirated. The pelvis was then filled again with irrigation fluid. The bowel was clamped proximal to the anastomosis, from below air was insufflated and the bowel and anastomosis distended out nicely. There is no leak. The air was then aspirated. The fluid was aspirated. There is no tension of any significance on the anastomosis. The anastomosis appears well vascularized. This is a low anterior type anastomosis. I could not add any additional sutures due to its deep position.

Due to the extensive dissection/adhesiolysis/prolonged surgery time and as this anastomosis is quite low, a protective ileostomy was performed. Without this ileostomy if there was any type of complication or leak and he required a return to surgery he would never be able to have another anastomosis in the future. Placing the ileostomy was felt to be a safer alternative. A right lower quadrant ileostomy site was created. A loop ileostomy was performed in standard fashion.

The counts were all correct. The peritoneum was then closed with 0 Vicryl in a running fashion. The fascia was closed with #1 PDS in a running fashion. The skin edges of the low midline incision and the colostomy site and 5 mm port site were all closed with staples. An ostomy appliance was placed in the right lower abdomen. Sterile dressings were applied. He tolerated the procedure well, no complications. He was taken to the recovery room in stable condition.

2. What CPT/Principal Operative Procedure should be assigned to this case?
   a) 44208
   b) 44227
   c) 44625
   d) 44626

3. What Surgical Approach should be assigned to this case?
   a) Laparoscopic, converted to Open
   b) Laparoscopic, hand-assisted
   c) Laparoscopic, hand-assisted converted to Open
   d) Open, lap-assisted

4. What Other Procedure(s) Performed should be captured?
   a) LOA
   b) Colon/Small Bowel resection for ileostomy
   c) Splenic flexure mobilization
   d) Organ repair
   e) Other procedure(s)
HOSPITAL ADMISSION DATE
5. Patient presented to ED on 2/17 at 0300. Placed in observation the same day. Officially admitted to Inpatient on 2/20 at 1300. Surgery on 2/21 at 0700. Discharged on 2/24 at 1400. What should you capture as the Hospital Admission Date?
   a) 2/17
   b) 2/18
   c) 2/20
   d) 2/21

6. Patient presented to ED on 2/17 at 0300. Placed in observation the same day. Surgery on 2/20 at 0700. Officially admitted to Inpatient on 2/20 at 1300 after surgery. Discharged on 2/24 at 1400. Your data integration captured 2/20 for the Admission Date. What should you capture as the Hospital Admission Date?
   a) 2/17
   b) 2/18
   c) 2/20

7. Patient presented to hospital for outpatient colonoscopy on the morning of 2/17 and has laparoscopic bowel surgery 2/18 for obstructive mass, but never left the hospital between the colonoscopy and surgery. Per the hospital billing record, 2/17 and 2/18 are considered outpatient and patient was officially admitted to inpatient on 2/19. What should you capture as the Hospital Admission Date?
   a) 2/17
   b) 2/18
   c) 2/19

PROPHYLACTIC ABX
Patient had elective colectomy for extensive metastasis from colorectal cancer and there was no exception to giving prophylactic abx. Below are the times from the anesthesia record:

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0645</td>
<td>Ancef 2g started in preop holding</td>
</tr>
<tr>
<td>0658</td>
<td>In room time</td>
</tr>
<tr>
<td>0715</td>
<td>Surgery start time</td>
</tr>
<tr>
<td>0716</td>
<td>Flagyl 500mg</td>
</tr>
<tr>
<td>1144</td>
<td>Ancef 1g</td>
</tr>
<tr>
<td>1515</td>
<td>Flagyl 500mg</td>
</tr>
<tr>
<td>1558</td>
<td>Surgery End time</td>
</tr>
<tr>
<td>1600</td>
<td>Ancef 1g</td>
</tr>
<tr>
<td>1610</td>
<td>Out of Room time</td>
</tr>
</tbody>
</table>

8. How would you capture prophylactic antibiotics in the Workstation?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
</table>
| a)     | Ancef 2gm@0645
Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? Flagyl 500mg Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? |
| b)     | Ancef 2gm@0645
Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? Flagyl 500mg Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? |
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Ancef 1gm@1144 Flagyl 500mg@1515 |
| d)     | Ancef 2gm@ 0645
Ancef 1gm@1144 Flagyl 500mg@1515 |
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| g)     | Ancef 2gm@ 0645
Ancef 1gm@1144 Flagyl 500mg@1600 Flagyl 500mg@0716 Flagyl 500mg@1515 |
Thanks so much to all who looked at Case Study #3, whether you participated in the discussion, or not. Below is the key and rationale, please let me know if you have any questions.

Also, thank you for your feedback about the usefulness of this type of learning opportunity, we are glad it is helpful. You can look for the next case study in early December. 😊

Cheryl

**SEPSIS SCENARIO**

8/11/18:
2330: Patient presented to ED for acute abdominal pain. Pelvic abscess from a ruptured diverticulitis found on CT, and surgery scheduled for the next morning. Preoperative H&P indicates ESRD with peritoneal dialysis three times a week and creatinine levels are normally above 4 mg/dL.

8/12/18:
0400: Labs WBC 12.1, creatinine 5.2, lactate 2.0
0600: Vital signs BP 110s/70s-80s, HR 93, RR 22, T 101.2 °F
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8/17/18: Patient was discharged to home after an uneventful hospitalization.

8/18/18:
0730: Patient presented to ED with complaints of abdominal pain and incision redness and drainage, wound culture of incision obtained
0800-1200: Vital signs and labs included BP 110s/50s-80s, HR 90s, RR 20s, T 101.0°F; WBC 14.8, Lactate 2.4
1230: BP 88/50, HR 95, RR 26. Fluids and antibiotics administered for suspected wound infection and possible sepsis, and patient transferred to ICU
1300: in ICU, MAP 60, BP 80/48 and vasopressors were started.

8/20/18: surgeon diagnosed the patient with a superficial wound infection after wound culture resulted positive

1. **What level(s) of Sepsis should you assign to this patient? Select all that apply:**
   a) Preoperative Sepsis
   b) Preoperative Severe Sepsis
   c) Preoperative Septic Shock
   d) Postoperative Sepsis
   e) Postoperative Severe Sepsis
   f) Postoperative Septic Shock on 8/18/18
   g) None
Using the Sepsis Decision Tool available on the website...

<table>
<thead>
<tr>
<th>Defining Criteria &amp; Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#1 New infection Source</strong> (within 72h of surgery start time or 30 days postop)</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Preop 8/11 abscess</td>
</tr>
</tbody>
</table>

| **#2 Presence of at least TWO of these signs/symptoms:** |
| Date | Time |
| Temp > 101.0°F | Preop 8/11 @ 0600 |
| HR > 90 | Preop 8/11 @ 0600 |
| RR > 20 | Preop 8/11 @ 0600 |
| WBC > 12 | Preop 8/11 @ 0400 |

| **#3 Presence of at least ONE of these organ dysfunction/tissue hypoperfusion elements:** |
| Date | Time |
| SBP < 90 | Postop 8/18 @ 1230 |
| MAP < 65 | Postop 8/18 @ 1300 (after fluids) |
| SBP decrease > 40 from baseline | |
| Creatinine > 2.0 | Cannot use if chronic condition |
| Urine output < 0.5 mL/kg/hr for at least 2h | |
| Bilirubin > 2 | |
| Platelet count < 100 | |
| INR > 1.5 or PTT > 60 | |
| Lactate/Lactic Acid > 2 | Postop 8/18 @ 0800-1200 |

| **#4 Presence of at least ONE of the following:** Lactate level ≥ 4 mmol/L (a) or persistent hypoperfusion/ hypotension elements (b or c) |
| Date | Time |
| Lactate/Lactic Acid > 4 | |
| Tissue hypoperfusion persists after fluid administration, evidenced by either: |
| SBP < 90, or MAP < 65, or SBP decrease > 40 from last recorded SBP considered normal for patient | |
| Persistent hypotension requiring vasopressors for MAP ≥65 | Postop vasopressors started 8/18 @ 1300 with MAP < 65 |

Also keep in mind the following rules since the postop sepsis is on POD 6:

**When Preop Sepsis, Severe Sepsis or Septic Shock has been assigned, or when the postop infection source is same as the preop source, or the same postop infection source was identified intraoperatively:**

- If you assigned Sepsis/Severe Sepsis/Septic Shock preop (or preop/intraop infection source was present but all criteria were not met to assign it preop), do not assign the same or a lower level sepsis when the postop infection source is the same as the preop or intraop source unless it is at least POD7
  - *Does not apply in this situation*

- If you assigned *Sepsis/Severe Sepsis preop*, you can assign postoperative sepsis of a higher level than what was assigned preop at any time when the postop infection source is the same as the preop or intraop source, if the criteria are met
  - *Preop Sepsis → Postop Septic Shock, we can assign this on POD 6 since it is a higher level*

- If you assigned *Sepsis/Severe Sepsis/Septic Shock preop*, you can assign postoperative Sepsis/Severe Sepsis/Septic Shock at any time with a different infection source postop, if the criteria are met
  - *Preop Sepsis → Postop Septic Shock, we can assign this on POD 6 since there is a new infection*
PRINCIPAL OPERATIVE PROCEDURE/CPT CODE/SURGICAL APPROACH

POSTOPERATIVE DIAGNOSIS:
1. History of perforated diverticulitis/severe peritonitis, status post sigmoid resection with Hartmann's pouch and colostomy (04/2018).
2. Request for reversal of colostomy.
3. Extensive pelvic adhesions.

PROCEDURE: Hand-assisted laparoscopic reversal of colostomy, takedown of splenic flexure, extensive lysis of adhesions, excision of the upper rectal stump with low colorectal pelvic anastomosis, protective diverting ileostomy.

INDICATIONS: The patient is a 60-year-old gentleman presenting for reversal of colostomy. He presented back in 04/2018 with severe sepsis secondary to perforated/gangrenous sigmoid diverticulitis/pelvic abscess. He underwent resection with colostomy and Hartmann's pouch. He wished to proceed with reversal of his colostomy.

DESCRIPTION OF PROCEDURE: Preoperatively, the patient received IV antibiotics. He was taken to the operative room, placed in supine position. After adequate general anesthesia was achieved, a Foley catheter and SCDs were placed. He was placed in Allen stirrups. Prior to surgery, I closed the colostomy with a pursestring nylon suture. Prior to making any incisions, the skin and deeper tissue were infiltrated with 0.5% Sensorcaine plain. A #11 blade was used to make a circumferential incision around the left lower quadrant colostomy, along the mucocutaneous border. Blunt and sharp dissection then continued around the colostomy, freeing it from the subcutaneous tissue. The abdominal cavity was entered. The remaining peritoneal attachments were divided sharply or with cautery. The colostomy was completely freed. A finger then could be swept to take down some of the omental adhesions and clear the low midline area.

An 8 cm low midline incision was made and continued through the subcutaneous tissue and fascia with cautery. The abdominal cavity was entered. A GelPort was then placed through the midline incision. The fascia of the colostomy site was partially closed. A 12 mm port was placed through the left lower quadrant colostomy site. The abdomen was then insufflated with CO2. The 5 mm ports were placed. Initially the dissection was laparoscopic. The left colon is fairly mobile. The peritoneal reflection along the left to the splenic flexure was divided with the Harmonic scalpel. I then placed a hand through the GelPort and a 5 mm supraumbilical port was placed.

Using the hand, the splenic flexure was freed up with a Harmonic scalpel. This added quite a bit of extra length. It appeared there was more than enough length to fall into the pelvis without difficulty. He also had quite a bit of his omentum adhered up in the left upper abdomen. With blunt hand dissection and sharp dissection and also using the Harmonic scalpel, the omentum was freed up completely from the left upper abdomen. He has only a few scattered diverticula along the left colon. Several loops of small bowel are tightly adhered down into the pelvis. Attention was then directed to the pelvis.

As much of the small bowel was freed as possible with blunt dissection and sharp dissection with the EndoShears. Quite some time was spent carefully freeing the small bowel from the rectal stump. He had 2 Prolene sutures which had been placed during the initial surgery on each side of the rectal stump. These were removed. The small bowel has some superficial serosal tears where it was taken off of the rectal stump, but nothing of significance. During the removal of the small bowel, a small enterotomy was made along this upper rectal stump. This upper rectum was obviously abnormal, thickened and dark and scarred. This thickened scar needed to be removed and the rectal stump mobilized in order for the anastomosis to be performed.

The rectal dissection/mobilization then proceeded through the open GelPort. Ultimately the GelPort was removed and the incision was extended inferiorly 3 or 4 cm and a Bookwalter retractor was placed. Dissection here was very tedious. All in all, it took certainly well over 2 hours to free up the rectum enough in order to excise the upper abnormal rectal tissue. The ureters were visualized and protected. 2-0 Vicryl sutures in interrupted fashion were placed on each side of the rectal stump ultimately in order to elevate this thickened abnormal portion up out of the pelvis for it to be excised. The contour stapler was then able to be advanced into the pelvis. He has a small pelvis. The contour stapler was brought down as deeply as possible and this upper abnormal rectum was then excised. The area where the
perforation occurred also was included in this excised segment. The upper portion of the rectum was sent to pathology. The remaining rectum appears normal pink and well vascularized.

A 28 mm rectal sizer was lubricated and advanced to the end of the rectal stump without difficulty. The left colon was then prepared for placement of the anvil in the end of the colon. The distal 3 to 4 cm of the colostomy was excised. A 2-0 Prolene was placed in a pursestring fashion circumferentially. A lubricated anvil was inserted and the suture was tied. The bowel looks healthy and well vascularized. Care was taken to make sure there was no twist in the descending colon on the left. The 29 mm EEA was inserted transanally and advanced without difficulty. The spike came out through the staple line. A standard end to end 29 mm stapled anastomosis was performed between the descending colon and the rectum. I then inspected both rings. Both rings are full thickness.

The pelvis was irrigated and aspirated. The pelvis was then filled again with irrigation fluid. The bowel was clamped proximal to the anastomosis, from below air was insufflated and the bowel and anastomosis distended out nicely. There is no leak. The air was then aspirated. The fluid was aspirated. There is no tension of any significance on the anastomosis. The anastomosis appears well vascularized. This is a low anterior type anastomosis. I could not add any additional sutures due to its deep position.

Due to the extensive dissection/adhesiolysis/prolonged surgery time and as this anastomosis is quite low, a protective ileostomy was performed. Without this ileostomy if there was any type of complication or leak and he required a return to surgery he would never be able to have another anastomosis in the future. Placing the ileostomy was felt to be a safer alternative. A right lower quadrant ileostomy site was created. A loop ileostomy was performed in standard fashion.

The counts were all correct. The peritoneum was then closed with 0 Vicryl in a running fashion. The fascia was closed with #1 PDS in a running fashion. The skin edges of the low midline incision and the colostomy site and 5 mm port site were all closed with staples. An ostomy appliance was placed in the right lower abdomen. Sterile dressings were applied. He tolerated the procedure well, no complications. He was taken to the recovery room in stable condition.

2. What CPT/Principal Operative Procedure should be assigned to this case?
   a) 44208: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
   b) 44227: Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis
   c) 44625: Closure of enterostomy, large or small intestine; with resection and anastomosis other than colorectal
   d) 44626: Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

3. What Surgical Approach should be assigned to this case?
   a) Laparoscopic, converted to Open
   b) Laparoscopic, hand-assisted
   c) Laparoscopic, hand-assisted converted to Open.
      RATIONALE: placing the Bookwalter retractor indicates an open procedure, and the pneumoperitoneum was never reestablished.
   d) Open, lap-assisted

4. What Other Procedure(s) Performed should be captured?
   a) LOA
   b) Colon/Small Bowel resection for ileostomy
   c) Splenic flexure mobilization
   d) Organ repair
   e) Other procedure(s) for ileostomy this is where to capture ostomy not included in the principal CPT code
5. Patient presented to ED on 2/17 at 0300. Placed in observation the same day. Officially admitted to Inpatient on 2/20 at 1300. Surgery on 2/21 at 0700. Discharged on 2/24 at 1400. What should you capture as the Hospital Admission Date?
   a) 2/17
   b) 2/18
   c) 2/20
      RATIONALE: If the patient is officially admitted to the hospital as an Inpatient before the principal operative procedure: Use the date of inpatient admission as the Hospital Admission Date.
   d) 2/21

6. Patient presented to ED on 2/17 at 0300. Placed in observation the same day. Surgery on 2/20 at 0700. Officially admitted to Inpatient on 2/20 at 1300 after surgery. Discharged on 2/24 at 1400. Your data integration captured 2/20 for the Admission Date. What should you capture as the Hospital Admission Date?
   a) 2/17
      RATIONALE: If the patient is not officially admitted to the hospital as an Inpatient before the principal operative procedure: And patient in hospital for more than 2 consecutive midnights before surgery: Use the date of presentation to the facility as the Hospital Admission Date.
   b) 2/18
   c) 2/20

7. Patient presented to hospital for outpatient colonoscopy on the morning of 2/17 and has laparoscopic bowel surgery 2/18 for obstructive mass, but never left the hospital between the colonoscopy and surgery. Per the hospital billing record, 2/17 and 2/18 are considered outpatient and patient was officially admitted to inpatient on 2/19. What should you capture as the Hospital Admission Date?
   a) 2/17
   b) 2/18
      RATIONALE: If the patient is not officially admitted to the hospital as an Inpatient before the principal operative procedure: And patient in hospital less than 2 consecutive midnights before surgery: Use the “Patient In Room Date” as the Hospital Admission Date.
   c) 2/19
**PROPHYLACTIC ABX**

Patient had elective colectomy for extensive metastasis from colorectal cancer and there was no exception to giving prophylactic abx. Below are the times from the anesthesia record:

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
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<tr>
<td>1610</td>
<td><strong>Out of Room time</strong></td>
</tr>
</tbody>
</table>

8. **How would you capture prophylactic antibiotics in the Workstation?**

<table>
<thead>
<tr>
<th>a)</th>
<th>Ancef 2gm@0645 Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed?****</th>
</tr>
</thead>
<tbody>
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<td>Ancef 2gm@0645 Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? Flagyl 500mg Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed?</td>
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<tr>
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</tr>
<tr>
<td>d)</td>
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</tr>
<tr>
<td>e)</td>
<td>Ancef 2gm@0645 Ancef 1gm@1144 Flagyl 500mg@1515</td>
</tr>
<tr>
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</tr>
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<td>g)</td>
<td>Ancef 2gm@0645 Ancef 1gm@1144 Ancef 1gm@1600 Flagyl 500mg@0716 Flagyl 500mg@1515</td>
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</tbody>
</table>

*Only antibiotics administered beginning 2 hours prior to surgery start time and ending with surgery end time are captured. Therefore, the 1600 dose of Ancef would not be entered.

**Initial Prophylactic IV antibiotics must be started prior to incision time. Any Initial dose started after surgery start time would not be entered into the workstation. Therefore, the Flagyl would not be entered at all.

***If you are participating in the SSI QII, this is how the abx should be entered:

Ancef 2 gm@0645

Answer ‘Yes’ to Was the prophylactic IV antibiotic re-dosed? since the next dose was given within the hour that it was due

Ancef 1gm @1144

Answer ‘Exception’ to Was the prophylactic IV antibiotic re-dosed? since surgery end time was within the hour of when the next dose was due

*For more details, please see the SCQR Conference Call minutes from August 2, 2018 [here](#).*