ASB Data Collection FAQ

Question 2

- **Will I have access to my data later which includes these identifiers?**
    - We can provide data on an individual basis if needed after it has all been inputted.
- **What is the advantage to me of creating patient identifiers for the purposes of this research?**
    - If we have questions, you are able to identify which patient we are inquiring about. If you do not finish the questionnaire and have to go back it will let you know which patient it was for.

Question 4

- **What if I can't tell the sex at birth from my chart review, is it OK to use their presenting sex?**
    - Yes.

Question 7

- **Is this the location at the time culture is drawn or the time it is resulted?**
    - Please use the time the culture is drawn for the purposes of the study.

Question 8

- **Does it count if I found a subjective description of a fever in a chart note? What about if I found an objective fever documented as done at another institution?**
    - Subjective description of fever does not count, but an objective measure of temperature counts, no matter where it was done.

Question 9

- **Where do I look to see if a patient had an indwelling urinary catheter (IUC)?**
    - The simplest and most likely place is with other Lines, Drains, and Airways in your EHR. Another option may be the nursing flowsheets. Discontinuation/Insertion dates can be hard to determine from notes alone. Be cautious of notes copied forward in terms of IUC status.

Question 10

- **How can I tell if the patient can answer questions or not?**
    - Look in the notes, often in the nursing notes, for patients able to rate their pain, say what they wanted for a meal, or request care. If the caregiver documents that the patient answered questions around the time the culture was drawn, this is a clear yes. If the patient is unconscious at the time the culture was drawn, this is a clear no. Sometimes it is less obvious. Some patients may be intermittently confused, compare the time of the culture to the notes most closely matching that to see if the patient could answer questions at or near that time. If it is still unclear, mark unsure.
    - In cases of unsure being marked, this will be adjudicated by alert and oriented (A&O) x3

Question 11

- **Are there any other locations, aside from nursing flowsheets/assessments, where I might find signs or symptoms documented?**
    - Often nursing (and occasionally physician) notes will provide sign/symptom documentation which uses other language than the exact wording used in the definition, for example "burning on urination" is commonly understood to be dysuria and often documented that way. If you only search the EHR for "dysuria" and no one used that specific word within the IWP, you will miss what was actually documented.

Question 12

- **How will I know if the patient had another infection?**
    - Check the micro report for cultures at other sites and read the History and Physical and/or Discharge note. However, to be considered "also being treated for another infection" there must be documentation whether in a note or the antibiotic order.

Question 13b

- **What's a salt?**
    - Antibiotics are often formulated as part of a chemical salt (e.g., vancomycin HCl). The hydrogen chloride (HCl) part of the name is the second half of the salt formulation. We only need to "vancomycin" part of the name.