

National Antimicrobial PPS 2024 in Acute Hospitals Frequently Asked Questions (FAQ)

V3.0 2024

If you still have a question that needs clarification after working through this FAQ document & the protocol, the hospital PPS lead can:

- Log into the PAMS-net discussion form on [PAMS-net webpage on IIOIP.ie](#) and add a question as a comment on the [National Acute Hospital PPS 2024 thread](#). To access the discussion forum using these links you must be enrolled in the forum and logged in to your IIOIP account. Watch this [video tutorial on how to join the PAMS-net discussion forum](#). (Note: registered pharmacists can only access this forum).
- Alternatively, you can contact Ellen Martin, AMRIC senior antimicrobial pharmacist, ellen.martin@hse.ie
- If you have a question regarding data entry, the hospital PPS lead can contact AMRIC epidemiology team amricepitem@hse.ie

The following FAQs are set out under the following sections:

- **Subject details (1a-1d)**
- **Drugs given and review (2a – 2d)**
- **Diagnosis, indications, reasons (3a-3c) and surgical antibiotic prophylaxis questions (3d-3g)**
- **Currently on IV (4a-4b)**
- Other FAQs, including specific maternity and paediatric FAQs

Subject details (1a-1d)

1. Do we include patient on **PCP prophylaxis at weekends**?
 - In certain circumstances, prescribed antimicrobials may not be administered on the date of study (e.g. patient with renal impairment receiving alternate day dosing of antimicrobial therapy/medical prophylaxis or re-dosing as per results of therapeutic drug monitoring).
 - The patient is included as the antimicrobial is prescribed and scheduled to be administered.
2. If antifungals are prescribed but **held awaiting levels/counts** and may be administered later that day depending, do we not include as at the time of audit they were held?
 - The patient is included as the antimicrobial is prescribed and scheduled to be administered.
3. **Use of oral nystatin for oral candidiasis?**
 - Topical - Do not include.
4. Patient who came in query flu and had tests done but was given **oseltamivir** until results available – what diagnosis code would that come under?
 - Antivirals not included
5. **Post-op surgical patient in ICU** - Categorised as surgical or ICU?
 - Patients do not need to be sub-categorised as Medical or Surgical
6. **What happens if a patient was receiving antimicrobials at 8am, but by the time the PPS team get to the ward, the antimicrobials have been stopped?**
 - The PPS team should use the latest available information when completing the form. Therefore, the patient is counted as not on antimicrobials.

Drugs given and review (2a – 2d)

7. For 2c 'Current/ proposed /completed duration appropriate (Y/N/MP/NA/UNK)' - If the **duration isn't documented** do we answer NA here?
 - If the duration is unclear or not documented, ask the team caring for the patient what the planned duration is. If the planned review or duration remains unknown then select UNK.
 - Current duration means there will always be a current duration which can be assessed as to whether it is appropriate or not e.g. SAP appropriate D1 post op but not D2 post op.
 - An example where you would select NA might be if there is no guideline in place for the particular infection.
 - An example where you would select No (N) might be it is CAP and they are currently day 10 and your guideline states 5 days then it already falls in to a No (N) answer as it is not an appropriate duration.
8. For 2c 'Current/ proposed /completed duration appropriate (Y/N/MP/NA/UNK), **what does completed duration mean?**
 - "Completed" duration refer to surgical antibiotic prophylaxis. Detailed data is collected on patients who have received surgical antibiotic prophylaxis in the previous 24 hours, from 8am on the day before the PPS day until 8am on the day of the PPS. Therefore, the duration you are assessing may be completed in this instance.
9. **For surgical patients who get a stat dose as per anaesthetic sheet** what do I answer for 2c 'Current/ proposed/completed duration appropriate (Y/N/MP/NA)'? do we answer NA or Y?
 - If the stat dose alone is as per guidelines and therefore appropriate the answer is Yes (Y), if a stat dose is not the correct duration as per guidelines then the answer is No (N).
10. **Patients on MP – What do we fill on form 2c?**
 - In order not to skew data for questions 2c, MP may be used as an option for if Y or N are not clearly applicable.
11. How do we record **erythromycin used as a pro-kinetic agent for 2c?**
 - 2c. 'Current /proposed/completed duration appropriate as per guidelines': Not applicable (NA)

Diagnosis, indications, reasons (3a-3c)

12. For **post-op infection but the surgery was carried out in another hospital 2/52** ago, is this HI1 as it is a post-op infection or HI5 as the surgery and resultant post-op infection originated in another hospital? Patient was discharged after surgery and presented here 2/52 later with post-op infection.
 - HI1 as it was a post-op infection regardless of where the surgery was carried out initially – can be noted that operation was undertaken elsewhere
13. **Asymptomatic Bacteriuria**, what do we use for indication code?
 - CI, LI or HI4 depending on where the infection started
14. If a patient is **transferred from another hospital (HI5)**, however they had an infection on presentation to the other hospital, were there less than 24 hours, and were in ED only. Should this still be coded as HI5 or is this CI since the infection was acquired in the community.
 - If symptoms start in community then it is classed as CI

- 15. CI versus HI1.** A lot of our patients come in day of surgery and so frequently end up on antibiotics in the next day or two for what we would call post-op infection. But if antibiotics are started <48hrs after admission my understanding is that these get classed as CI, am I correct, as instinct is to put them down as HI1.
- Yes, protocol indicates CI is what is to be recorded.
- 16.** A patient is started on broad spectrum antibiotics on admission and then undergoes a procedure/surgery. **Empirical surgical antibiotic prophylaxis is not prescribed as they are already receiving adequate antibiotic cover for the procedure/surgery.** How do you answer 3a for this patient?
- Record data as per indication for prescribed antibiotic. e.g. if antimicrobial was prescribed for community-acquired infection then record as CI.
 - The antimicrobial in this instance was not prescribed as surgical antibiotic prophylaxis and should not be recorded as SP1/SP2/SP3
- 17.** How do we record **erythromycin used as a pro-kinetic agent?**
- 3a Indication code (Table 1): O for “Other indication” as it is being used for a non-antimicrobial reason.
 - 3b Diagnostic site (Table 2): NA
- 18. Rifaxamin** for reduction in episodes of hepatic encephalopathy? Is it included?
- Yes
 - 3a Table 1: O for “Other indication”
 - 3b Table 2: NA
- 19. Patients on MP – What do we fill on form?**
- 3b. Table 2 Diagnosis site: Record NA
 - 3c. Table 3 Is the antimicrobial choice in line with local guidelines: Use “No guidelines in place (NG)” or Y or N, as applicable, if there is a local guideline in place that includes prophylaxis e.g. Haem/Onc patients
- 20. Bacteraemia (BAC) – if patient’s Blood stream infection (BSI) developed secondary to another infection site e.g. PYE - Do we document Diagnosis Site as BAC or as the contributing infection?**
- Diagnosis site will be BAC.
 - If the patient is prescribed antimicrobials for suspected UTI, the indication is PYE or CYS depending on symptom location at that time. If the patient’s blood cultures subsequently grow E. coli, the indication is upgraded to BAC, because the more severe manifestation takes precedence over the less severe manifestation and you go with the latest available information at the time you do the PPS. The source of the bacteraemia, if known, can be referred to in comments section if agreed at a local level.
- 21. Clarify PPS diagnosis category for max-fax?** e.g. cleft palate
- If it’s maxillofacial surgery – indication is SP
 - If it’s dental, mouth infection – indication is ENT
 - If it’s osteomyelitis of the jaw or skull bone – indication is BJ, which may or may not be related to surgery.
- 22.** Patient on co-amoxiclav PO - **indication not documented** but looks like they are treating possible LRTI - no symptoms /signs of infection.
- Contact team if indication not written down. If they don’t know then ‘UI’ and if they say BRON document as such.

23. PNEU vs BRON pneumonia based on CXR

- if an LRTI has reference in notes to consolidation/infiltrate on CXR (or original report can be reviewed to confirm) this is classified as PNEU
- If there is no CXR, if a CXR is reported (or can be reviewed) to confirm that no consolidation - or nothing documented, this is BRON - especially if the patient is already known to have COPD or bronchiectasis
- if they have CF, use the CF category

24. Diagnosis site code for a **pleural infection/empyema**?

- BRON

25. CYS vs PYE

- Based on clinical judgement. If the patient is systemically unwell, select PYE pending blood culture results.

26. A patient on **treatment for urosepsis** (unilateral kidney, nephrotic syndrome pt) would that be PYE or Sepsis?

- PYE if clear source is upper or complicated urinary.
- CSEP if no potential focus for infection.

27. When to use **CSEP (clinical sepsis)** e.g. we had a patient who presented with fever, hypotension and tachycardia but didn't fit in under other definitions and were unsure which diagnosis code to use?

- See Table 2 for further information - CSEP = Clinical sepsis (suspected bloodstream infection without microbiology laboratory confirmation of positive blood cultures or results are not yet available or blood cultures have not been collected or laboratory has confirmed that blood cultures are negative after five days incubation). Note CSEP excludes patients with febrile neutropenia and infection in immunocompromised hosts (See FN below).
- Patient may have at least ONE of the following clinical signs or symptoms with no other recognised cause: Fever ($>38^{\circ}$ C), hypotension (systolic blood pressure <90 mmHg) or oliguria (urine output <20 ml/hr) and blood culture not done or no micro-organisms or antigen detected in blood, no apparent infection at another site and clinician institutes treatment for sepsis. Do not use this code unless there is absolutely no other potential focus for infection.

28. How do we deal with situation where appropriate agent used – **but PPS team do not feel there is an infection in the first place? What if the documented diagnosis doesn't fit the clinical picture?** E.g. Patient has haematuria or urinary retention but no real signs of infection - UTI documented.

- We are not required to make a diagnosis – just compliance with guidelines. We are assessing documented diagnosis vs choice. Refer to Micro lead and treat on a case-by-case basis.

29. 3c 'Is antimicrobial choice in line with guideline'. Patient receiving SAP for a procedure, but **only received one agent (clindamycin) rather than the two that are in our guidelines** (clind plus gent). When filling out this field for the first antimicrobial (clindamycin) – this agent is in line with guidelines. However, gentamicin was not prescribed for the patient. Should answer to 3c be No for all agents?

- The assessment for that particular antibiotic is that it is appropriate and so the answer is Yes.
- If there is local agreement to capture this type of data locally then a comment could be noted to include in local feedback.

SAP questions (3d-3g)

- 30. 3d surgical category and 3e operative procedure.** How do I complete these fields?
- These fields now aligned to [PPS HCAI & Antimicrobial Use in European Acute Care Hospitals \(Irish Protocol 2023\)](#).
 - Reference: NHSN operative procedure category mappings to ICD-9-CM codes, October 2010. Available from: www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf
 - In the excel tool an option must be selected for 3d in order for the operative procedures to appear for 3e.
 - You can find the new codes with description in the “Codes” tab on the excel tool or Table 4 in the protocol (Pg 13-15).
- 31. Regarding 3f ‘If surgical prophylaxis prescribed for more than 24 hours, was there a specific documented reason?’. If the reason isn’t documented** but after speaking verbally with team and micro we can confirm the reason for prolonged duration is this classified as Yes or No?
- The answer is No – as we are particularly interested in collecting data on documentation here.
- 32. If answer to 3f is “no”** because it wasn’t documented then does this prevent us from answering 3g because it says only to answer this question if 3f was yes- which means we then can’t document the reason for the prolonged duration even though we know the reason?
- Yes answering “no” to 3f precludes you from answering 3g.
- 33. Why are surgical antibiotic prophylaxis prescriptions with a duration greater than 24 hours** examined in more detail instead of just those that are greater than 48 hours?
- In the HSE AMRIC action plan the target for 2025 is to reduce the percentage of surgical antibiotic prophylaxis that extends beyond 24 hours to 20%. Also this PPS methodology has always used the code SP3 >24 hours so historical data can be compared. It is for these reasons this specific target of 24 hours is chosen.

Currently on IV (4a-4b)

- 34. 4a Suitable for oral switch. For Surgical prophylaxis antibiotics, SP1 & SP2, should we be using N or NA**
- N/A.

Other FAQs

Neonates

35. Should all neonates on the post-natal wards be included?

- Yes they are admitted patients.

36. How did you classify your NNU patients – Paeds medical or Paed ICU?

- Paed ICU includes NICU, Special care units
- Babies receiving antibiotics who are not in special care/NICU –but only go over to receive their antibiotics (i.e. on ward with mum) would be Paeds medical.

37. What indication code should be selected for a neonate with an infection within 12 hours of life on the neonatal ICU. Is this a community acquired infection (CI) or hospital (HI 1-5) or other (O)?

- HI4 is best fit.

Maternity

38. Classify maternity and gynaecology patients as OBGYN and maternity ward as OBGYN

39. How did you classify the indication code for an antibiotic treatment post 3rd degree tear post-delivery - MP or SP?

- Surgical prophylaxis – the prophylaxis is for the surgical repair of the tear.

General

40. Does ‘total number of patients in ward included in PPS’ refer to the number of patients on antimicrobials or the total number of patients reviewed for the PPS?

- ‘Total number of patients in ward included in PPS’ refers to the total number of patients reviewed for the PPS on the ward, it is the denominator figure. i.e. patients on antimicrobials + patients not on antimicrobials.
- E.g. The total number of patients on the ward at 8am is 20 and there were no patients excluded based on selection criteria. If 10 of these patients are on antimicrobials, the fields on the ward/department data collection form would be completed as per page 3 of the protocol: Total number of patients in ward included in PPS = 20.

41. A patient is in for a procedure. You note they got the appropriate pre-op SAP etc and no further antibiotics are charted on their kardex but there’s a discontinued prescription for a further week of antibiotic therapy inside in the notes to be given to the patient on discharge. Are we just auditing retrospective prescribing?

- In the current protocol of the PPS there is no way of capturing this data. If there is local agreement to capture this type of data locally then a comment could be noted to include in local feedback. If in future years this is considered a field that requires to be added we can discuss and consider it.