Appendix A

UPMC Health System
Quality Improvement Projects vs. Research Studies
Quality Improvement Review Screening Tool

Date of Submission: June 26, 2014 - Addendum

Title of Project: Assessment of Emergency General Surgery Care Based Upon Quality Indicators

Sponsor: Dr. A. Peitzman/A. Ingraham, MD Department: Surgery

Co-Sponsors: American Associtn for the Surgery of Trauma

Facility(UPMC entity): Presbyterian

Anticipated Start Date: July 1, 2014

Anticipated End Date: ~~June 30, 2014~~ September 30, 2014

Estimated Duration of Entire Project: 1 year

Referred for QI review by IRB staff YES NO x

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1. **Goal(s) of project:**

The objectives of this proposal are:
1) to develop indicators of high-quality care for emergency general surgery patients
2) to assess compliance with these indicators in ~~both a~~ retrospective ~~and prospective~~ manner

2. **Is there a commitment to implementing a corrective plan based on the outcomes of the project (**check one**)?**
   No x Yes ▫ YES

3. **Is the project being funded by an external agency (**check one**)?**
   No ▫ **Yes x** if yes, specify agency**: American Association for the Surgery of Trauma**

4. **What is the primary intent of the project (answer one):**
   Publication or Quality Improvement X
   What improvements do you hope to implement in the local environment? Improved understanding of adherence to quality indicators in emergency general surgery care

5. **If patient data is being collected, please indicate how data is going to be collected (**check all that apply and Circle the Database being used**):**

▢ **Chart review through medical records (*i.e.,*Horizon Patient Folder(HPF) and hardcopy records)**

x Chart review through electronic medical records (*i.e,* Powerchart™,MARS, Stentor™ OR Other – please specify database):

▢ **Data collection from the UPMC Network Cancer registry database.(If using other registry database – Please specify database):**

▢ **Patient interviews/observations**

Please attach a sample data collection form. ~~The quality indicators are currently under development and thus I cannot provide you with a sample data collection form at this time.~~

Please see the data collection guide attached which details the data elements to be collected.

All patient identifiable data collected and stored for this study needs to comply with UPMC Policy HS-MR1000 Release of Protected Health Information regarding the privacy and security of clinical data.

6. **Provide a brief summary (one page) or abstract of your proposed project and attach it to this page.** Please see attached

7. **If the project involves a therapeutic intervention, is the intervention to be delivered in a blinded fashion? N/A No ▢ Yes ▢**

8. **Does the project involve "withdrawing" or holding back any needed and generally accepted treatments for the patients' condition?**

No x Yes ▢

9. **Does the project involve prospective assignment of patients to different procedures or therapies based on predetermined plans such as randomization?**

No x Yes ▢

10. **Is the project evaluating a drug, biologic or device which is not currently FDA approved (*i.e.*, off label use)? No x Yes ▢**

11. **Are patients involved in the project exposed to additional risks or burdens (i.e. other than the completion of patient satisfaction surveys) beyond standard clinical practice?**

No x Yes ▢

12. What outcomes are being evaluated? Compliance with quality indicators for emergency general surgery care

13. Describe briefly why you think this is a QI project and not a research study: This project involves developing quality indicators for emergency general surgery care~~, educating the physicians and staff on those indicators,~~ and then measuring adherence to the indicators in a retrospective and prospective fashion through chart review. It is the intent of the project to bring about improvement in healthcare delivery and does not require a rigid or fixed protocol as is applicable in a research investigation.

**** All data gathered as a result of a UPMC Quality Improvement approved project may not be published externally without review and approval by site quality director or system Chief Quality Officer.***

For completion by QI Review Committee designee: This section is for committee use only.

Date of Review: 3/12/15 **Date Approved: 3/12/15**

Approved as Quality Improvement Project - yes

Agree: X

Disagree:

Date to be presented to Total Quality Council: 4/15

Prospective date for feedback to TQC on outcomes:

Comments: This project involves developing quality indicators for emergency general surgery care, ~~-~~and then measuring adherence to the indicators in a retrospective and prospective fashion through chart review

QI Review Number:0002029

Completed by: Lakshmi P. Chelluri MD, MPH

Projects reviewed and approved by the UPMC Quality Improvement subcommittee do not meet the federal definition of research according to 45 CFR 46.102(d) and do

not require additional IRB oversight.

Assessment of Emergency General Surgery Care Based Upon Quality Indicators

Please do not hesitate to contact the surgeon liaison at your local hospital or Dr. Angela Ingraham (email: angieingraham@gmail.com; cell: 513-833-5205) with any questions.

Patient population to collect data on:
Patients who have undergone the following procedures in a non-elective fashion (defined as urgent or emergent; not scheduled prior to admission) at your hospital between October 1, 2014 and March 31, 2015:

- cholecystectomy (laparoscopic or open with or without an intraoperative cholangiogram)
- appendectomy (laparoscopic or open)
- colectomy (laparoscopic or open partial or total abdominal colectomy with or without creation of an ostomy)
- small bowel resection (laparoscopic or open with or without creation of an ostomy)

General considerations:

- We will be entering data into an American Association for the Surgery of Trauma (AAST) multi-institutional web based tool which is currently in the process of being developed. In the mean time, we will begin data collection using the data collection tool found within the attached excel spreadsheet which can be printed out (one page, double sided) to make a collection form for each patient.
- If a patient had two operations separated by time (i.e., underwent an appendectomy and then underwent a small bowel resection at a later time) during the study period, please enter the patient into the database twice and consider each operation a separate event. Please also email Dr. Ingraham with the patient's identification number.
- Please note that all fields, except the Secondary Procedure field, are required. Unless otherwise stated, one response is permitted per question.
- Please complete data collection by May 30, 2015.

Data items to collect (numbers correlate with Collection tool):
1) Patient's medical record number (MRN)
-Instructions to the abstractor:

- As we will be using the AAST multi-institutional study data collection tool, per AAST policy, MRN will not be entered into the database. The AAST multi-institutional study data collection tool will generate a patient identification number. When the AAST tool has been completed, please maintain an excel file to be kept at the level of your individual institution that lists the MRN as well as the corresponding patient identification number. Please note that this file will NOT be forwarded to Dr. Ingraham and is for reference should a patient's chart need to be re-reviewed for additional information or clarification.

2) Date of Surgery

-Instructions to the abstractor:

- Please record the date of surgery in MM/DD/YYY format on the data collection form and in the aforementioned institution-based excel spreadsheet that contains the MRN and AAST generated patient identification numbers. This will assist us in identifying patients who have had multiple of the index operations during the six month time frame.

3) Primary Procedure performed

-Instructions to the abstractor:

- This is the main procedure performed during the operation and the primary indication for the patient undergoing surgery. This procedure frequently correlates with the pre-operative diagnosis (i.e., preoperative diagnosis: ischemic colitis; procedure performed: left colectomy).
- If the patient had two or more of the listed procedures performed, please record the procedure that most closely relates to the pre-operative diagnosis. Please contact Dr. Ingraham or your surgeon liaison if it is not clear which procedure is the primary procedure.

4) Secondary Procedures performed

-Instructions to the abstractor:

- More than one procedure may be selected.
- This is one or more additional index procedures performed NOT including the primary procedure. For example, a patient undergoing a colectomy for ischemic colitis may also have small bowel resection performed during the same operation due to an iatrogenic injury while lysing adhesions. The primary indication for the surgery was the ischemic colitis, so the colectomy would be the primary procedure; the small bowel resection would be a secondary procedure.

5) Primary Surgeon

-Instructions to the abstractor:

- Please list in Last name, First name format.

Compliance or non-compliance with the quality indicators listed below:

6) IF a hospital provides emergency general surgery care, THEN the time from a computerized tomography scan or ultrasound being ordered STAT to the performance of the study should be no more than four hours.

-Possible responses: Compliant, Non-compliant, Not applicable

-Instructions to the abstractor:

- If the patient did not have a computerized tomography scan or ultrasound during their hospitalization or had the study at a different hospital, indicate “Not applicable.”
- If the study was not ordered STAT, indicate “Not applicable.”
- The time the order was placed represents the time the study was requested.
- The time the study was performed can be found on images themselves within the image viewing software at your institution. If the time the study was performed is not available, please use the time of the preliminary report, if available, or lastly the time of the final report. If the time the study was performed is not available at your hospital, please contact Dr. Ingraham so this can be noted when comparing compliance between centers.

7) IF a patient has undergone an emergency general surgery procedure and was subsequently found to have cancer, THEN post-operative care should include appropriate guideline directed oncologic follow-up and surveillance (as detailed by the National Comprehensive Cancer Network).

-Possible responses: Compliant, Non-compliant, Not applicable

-Instructions to abstractor:

- If the pathology report states no cancer or malignancy was present, indicate “Not applicable.”

- If the pathology report indicates a cancer is present, then the plan for cancer follow-up and surveillance should be documented in the discharge summary, the note from the first post-operative visit, and/or the initial note from an oncologic specialist to whom the patient was referred (if applicable).
- Appropriate guideline directed oncologic follow-up and surveillance will be based upon the National Comprehensive Cancer Network (NCCN). I have included the guidelines for cancers that are likely to be encountered in our patient population at the end of this document.
- If the procedure performed was a cholecystectomy, indicate "Not applicable." NCCN guidelines for gallbladder cancer state to "consider imaging every 6 months for 2 years" but encourage "a patient/physician discussion regarding appropriate follow-up." Due to the lack of definitive follow-up recommendations, we will not collect data on this measure for gallbladder cancer.
- Please contact Dr. Ingraham if you have any questions regarding compliance with the NCCN guidelines or if a patient has a cancer for which guidelines were not provided.
- If the patient was referred to an oncologist outside of the healthcare system where the surgery took place (and thus notes are not retrievable), please indicate "Non-compliant" and state "Referred to outside oncologist" under 7a. If "Non-compliant" for a different reason, please indicate the reason under 7b. Please send Dr. Ingraham "other" reasons for non-compliance so that they may be distributed among the data abstractors so that a consistent reporting scheme can be developed.

8) IF a patient has undergone an emergency general surgery procedure, THEN the discharge or transfer summary should indicate:
a. Medical findings and diagnoses: a summary of the care, treatment, and services provided
b. A complete list of all medications and dosages to continue on discharge, including the purpose and side effects of new medications
c. Activity restrictions
d. Diet restrictions or recommendations
e. Wound/ostomy care instructions, if applicable
f. Home health services arranged, if applicable
g. Reasons to call the responsible provider or seek emergency medical attention (signs or symptoms of complications)
h. Follow-up appointment(s)
i. Contact information for the responsible provider
-Possible responses: Compliant, Non-compliant, Not applicable

- "Not applicable" will only apply to following:
  - e. Wound/ostomy care instructions, if applicable
  - f. Home health services arranged, if applicable
- If "Non-compliant" for 8b, please list reason:
  - If a medication list (names or dosages) is not present, select "Medication list not present."
  - If the names of medications are listed but the dosages are not, select "Dosages not listed."
  - If the names and dosages of medications are listed but the purposes and side effects of new medications are not detailed, select "Purposes and side effects of new medications are not detailed."
  - If the dosages are not listed and the purposes and side effects of new medications are not detailed, select both "Dosages not listed" and "Purposes and side effects of new medications are not detailed."

-Instructions to abstractor:

- Please review the discharge or transfer summary for the information listed above.

9) IF an emergency general surgery patient is diagnosed with acute cholecystitis, THEN the patient should undergo a cholecystectomy within 72 hours of symptom onset or the reason for not doing so should be documented in the medical record.

-Possible responses: Compliant, Non-compliant, Not applicable

-Instructions to the abstractor:

- If the patient underwent a colectomy, appendectomy, or small bowel resection or the operative report indicates a preoperative diagnosis other than "acute cholecystitis" or "acute on chronic cholecystitis," indicate "Not applicable."
- If the duration of symptoms or time of symptom onset is not documented in the Surgical History and Physical or Surgical Consult note, then consider the time of presentation to the hospital to be the time of onset.
- If the duration of symptoms or time of symptom onset is not clearly stated (i.e., "two days ago"), then consider midnight of the earliest time the symptoms were present the time of onset. For example, if the patient presented to the hospital on a Friday and stated that the symptoms started two days ago, then consider Wednesday at midnight the time of symptom onset.
- The time of incision or surgical start time indicates the time the cholecystectomy was performed.
- If the cholecystectomy was not performed within 72 hours of symptom onset (i.e., non-compliance), please indicate the reason for the delay if it is documented within the "Assessment and Plan" of the Surgical History and Physical or Surgical Consult note or the "Patient presentation" or "Indication for operation" portion of the operative report.
    - If no reason is documented, then indicate "No reason documented."
    - If the patient presented to your hospital more than 72 hours after the symptoms began, then indicate "Delayed patient presentation."
    - If non-compliant due to another reason, then indicate "Other" and record the reason. Please send Dr. Ingraham "other" reasons for non-compliance so that they may be distributed among the data abstractors so that a consistent reporting scheme can be developed.

10) IF an emergency general surgery patient is diagnosed with an uncontained perforated viscus, THEN surgery should begin within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.

-Possible responses: Compliant, Non-compliant, Not applicable

-Instructions to the abstractor:

- If the patient underwent an appendectomy or cholecystectomy, please indicate "Not applicable."
- If the patient underwent a colectomy or small bowel resection but did not have imaging studies (chest x-ray, abdominal x-ray, or CT scan) preoperatively, please indicate "Not applicable."
    - Imaging studies performed at an outside hospital during a hospitalization or Emergency Room evaluation immediately prior to transfer should be considered if the formal report is available or findings from the formal report are detailed in the Surgical History and Physical or Surgical Consult note.
- Only imaging studies performed prior to the surgery need to be reviewed.
- The diagnosis of an uncontained perforated viscus is indicated by:
    - A chest x-ray or abdominal x-ray report stating that "free air" or extra-luminal air (also known as pneumoperitoneum) is present.
    - A CT scan report stating that extra-luminal air and fluid is found in an area away from the diseased bowel. If extra-luminal air and fluid is only located immediately adjacent to the diseased bowel, an uncontained perforated viscus is <u>not</u> present.
    - If it is unclear if a perforated viscus is present, please contact your surgeon liaison or Dr. Ingraham.

- If the patient underwent a colectomy or small bowel resection but findings consistent with an uncontained perforated viscus are not present on chest x-ray, abdominal x-ray, or CT scan, please indicate "Not applicable."
- Consult with the surgeon affiliated with this project at your individual hospital to determine if there is a locally derived standard regarding the time to surgery for uncontained perforated viscus at your hospital. If a standard exists, use that time frame to determine compliance. If no standard exists, then go by the three hour time window.
- The time an uncontained perforated viscus was diagnosed is the time the chest x-ray, abdominal x-ray, or CT scan was performed. Although the quality measure states three hours from the "decision to operate," it is difficult if not impossible to determine that time point retrospectively. Thus, for this study, we will rely on the time the imaging study was performed to begin the three hour window.
- The time of incision or surgical start time indicates the time the surgery was performed.
- If the time between the diagnosis and the surgical start time is longer than the hospital's standard or three hours, please indicate "Non-compliant."
- If non-compliant, please indicate the reason if documented in the "Assessment and Plan" of the Surgical History and Physical or Surgical Consult note or the "Patient presentation" or "Indication for operation" portion of the operative report.
    - If no reason is documented, then indicate "No reason documented."
    - If non-compliant due to the patient having the imaging study performed at an outside institution and then being transferred to your institution for further care, indicate "Patient transferred from outside institution" as the reason.
    - If non-compliant due to another reason, then indicate "Other" and record the reason. Please send Dr. Ingraham "other" reasons for non-compliance so that they may be distributed among the data abstractors so that a consistent reporting scheme can be developed.

11) IF an emergency general surgery patient has a small bowel obstruction and findings consistent with ischemia and/or impending perforation, THEN the patient should undergo surgical exploration within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.

-Possible responses: Compliant, Non-compliant, Not applicable

-Instructions to the abstractor:

- If the patient underwent an appendectomy, cholecystectomy, or colectomy, please indicate "Not applicable."
- If the patient underwent a small bowel resection but did not have a CT scan preoperatively during this hospitalization, please indicate "Not applicable."
    - Imaging studies performed at an outside hospital prior to transfer should be considered if the formal report is available or findings from the formal report are detailed in the Surgical History and Physical or Surgical Consult note.
- Only CT scans performed prior to the surgery need to be reviewed.
- Findings consistent with small bowel obstruction are:
    - Dilated loops of small bowel proximal to the obstruction and collapsed loops of small bowel and/or colon distal to the obstruction
    - The contents of the small bowel resembling feces (fecalization of the small bowel contents)
- Findings consistent with ischemia and/or impending perforation are:
    - Gas in the intestinal wall (pneumatosis intestinalis)
    - Gas in the portal vein or mesenteric veins (pneumatosis portalis)
    - Air within the abdomen but outside of the bowel lumen (pneumoperitoneum)
    - Lack of enhancement of the small bowel (only if intravenous contrast was given)

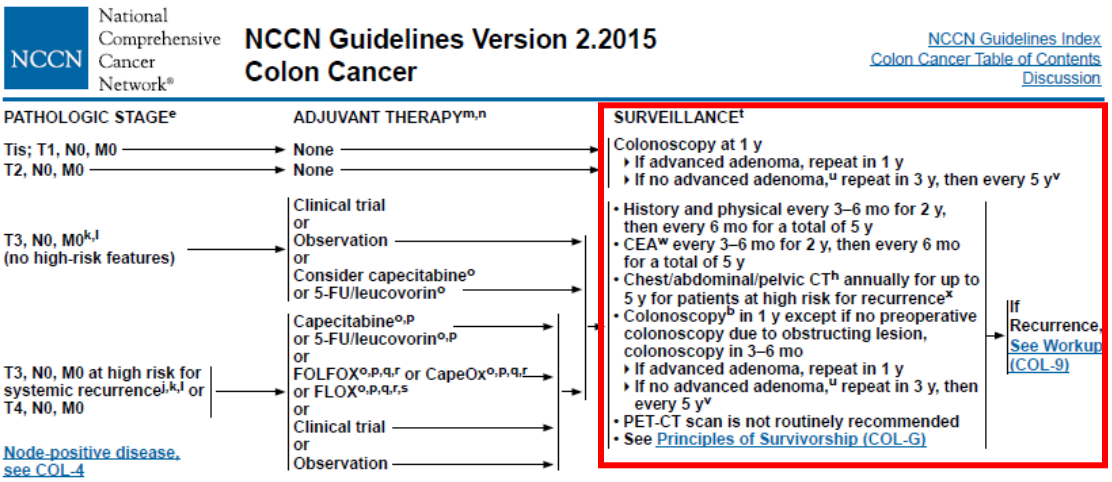
  - Bowel wall thickening or congestion
- If it is unclear if a small bowel obstruction with ischemia and/or impending perforation are present, please contact your surgeon liaison or Dr. Ingraham.
- If findings consistent with a small bowel obstruction with ischemia and/or impending perforation are not present, please indicate “Not applicable.”
- Consult with the surgeon affiliated with this project at your individual hospital to determine if there is a locally derived standard regarding the time to surgery for small bowel obstruction with findings consistent with ischemia and/or impending perforation at your hospital. If a standard exists, use that time frame to determine compliance. If no standard exists, then go by the three hour time window.
- The time a small bowel obstruction and findings consistent with ischemia and/or impending perforation was diagnosed is the time the CT scan was performed. Although the quality measure states three hours from the “decision to operate,” it is difficult if not impossible to determine that time point retrospectively. Thus, for this study, we will rely on the time the CT was performed to begin the three hour window.
- The time of incision or surgical start time indicates the time the surgery was performed.
- If the time between the diagnosis and the surgical start time is longer than the hospital’s standard or three hours, please indicate “Non-compliant.”
- If “Non-compliant,” please indicate the reason if documented in the “Assessment and Plan” of the Surgical History and Physical or Surgical Consult note or the “Patient presentation” or “Indication for operation” portion of the operative report.
  - If no reason is documented, then indicate “No reason documented.”
  - If non-compliant due to the patient having the imaging study performed at an outside institution and then being transferred to your institution for further care, indicate “Patient transferred from outside institution” as the reason.
  - If non-compliant due to another reason, then indicate “Other” and record the reason. Please send Dr. Ingraham “other” reasons for non-compliance so that they may be distributed among the data abstractors so that a consistent reporting scheme can be developed.

National Comprehensive Cancer Network Guidelines

-Instructions to the abstractor:

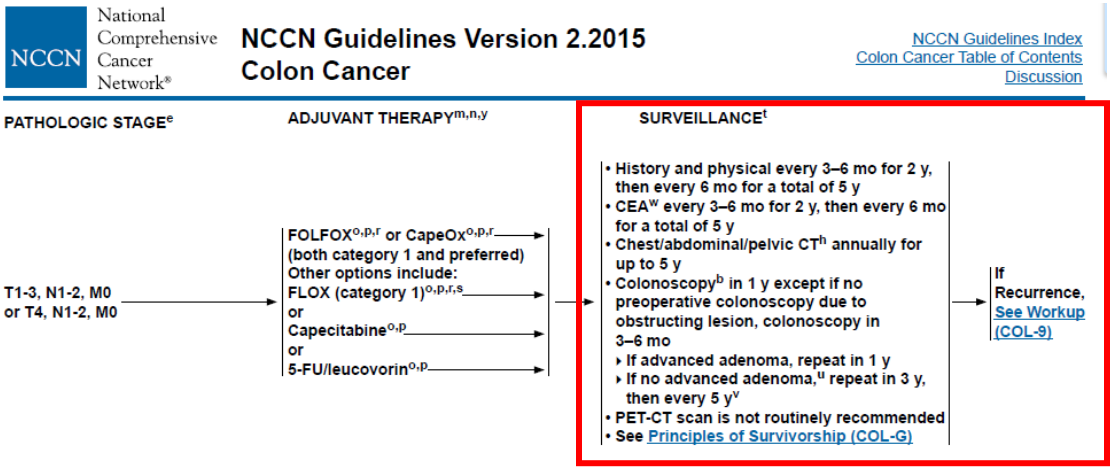
- The pathologic stage should be indicated in the patient's discharge summary or pathology report.
- Find the pathologic stage and then follow the flow diagrams as listed below.

Colon Cancer Without Positive Lymph Nodes and Without Metastatic Disease



-The patient's pathology report will indicate if the cancer is T1, T2, T3, or T4. "T" indicates how deep the tumor has spread through the tissue.
-Metastatic disease ("M") is cancer that is outside of the colon or the lymph nodes of the colon (i.e., liver, lung, etc).
-Advanced adenoma is defined as a villous polyp, a polyp > 1 cm, or the presence of high-grade dysplasia.
-Regarding follow-up imaging, the CT abdomen and pelvis should be with IV and oral contrast. The chest CT can be without contrast. An abdominal/pelvic MRI with MRI contrast plus a non-contrast chest CT can be used if the patient has a contraindication to CT with IV contrast.

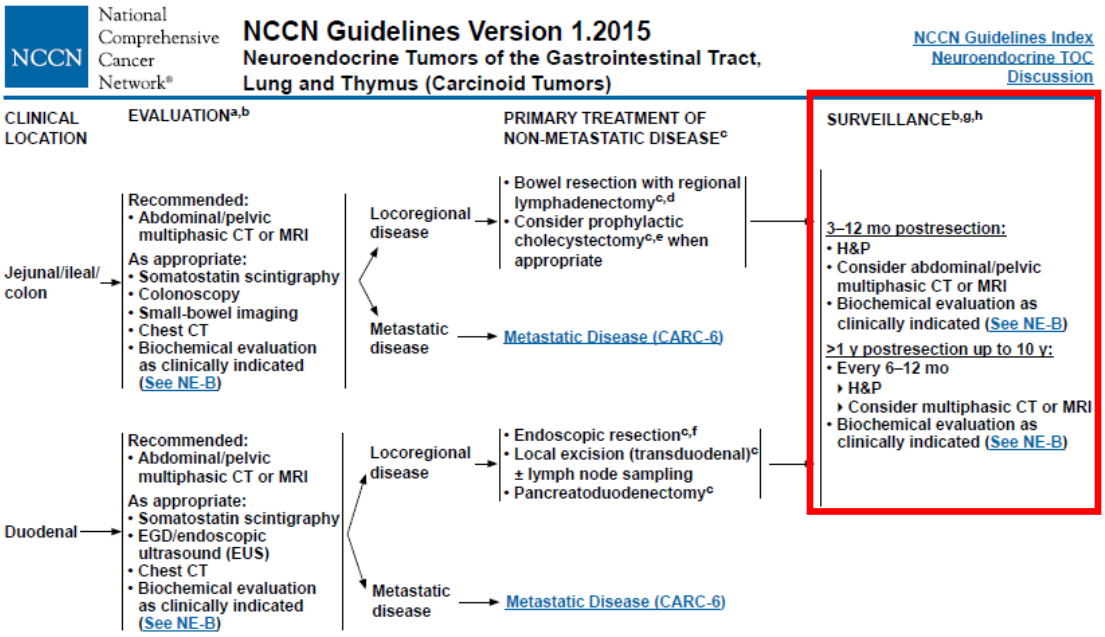
Colon Cancer With Positive Lymph Nodes



-N1 or N2 (not N0) indicates that the cancer has spread outside the colon to the lymph nodes.

-Advanced adenoma is defined as a villous polyp, a polyp > 1 cm, or the presence of high-grade dysplasia.
-Regarding follow-up imaging, the CT abdomen and pelvis should be with IV and oral contrast. The chest CT can be without contrast. An abdominal/pelvic MRI with MRI contrast plus a non-contrast chest CT can be used if the patient has a contraindication to CT with IV contrast.

Carcinoid Tumor of the Small Bowel or Colon



-Carcinoid tumor is one type of neuroendocrine tumor.
-Biochemical evaluation for carcinoid tumor includes chromogranin A and 24-hour urine 5-HIAA

Patient-Level Quality Indicators	
Medical Record Number	
Date of Operation (MM/DD/YYY)	
Primary Procedure Performed (select one)	Laparoscopic cholecyste cholangiogram
	Laparoscopic cholecyste
	Open cholecystectomy w
	Open cholecystectomy w
	Laparoscopic appendecto
	Open appendectomy
	Laparoscopic partial cole
	Laparoscopic partial cole
	Open partial colectomy w
	Open partial colectomy w
	Laparoscopic total abdom
	Laparoscopic total abdom
	Open total abdominal col
	Open total abdominal col
	Laparoscopic small bowe
	Laparoscopic small bowe
	Open small bowel resecti
	Open small bowel resecti
Secondary Procedure Performed (select none or multiple as appropriate)	Laparoscopic cholecyste cholangiogram
	Laparoscopic cholecyste
	Open cholecystectomy w
	Open cholecystectomy w
	Laparoscopic appendecto
	Open appendectomy
	Laparoscopic partial cole
	Laparoscopic partial cole
	Open partial colectomy w

	Open partial colectomy w
	Laparoscopic total abdom
	Laparoscopic total abdom
	Open total abdominal col
	Open total abdominal col
	Laparoscopic small bowe
	Laparoscopic small bowe
	Open small bowel resecti
	Open small bowel resecti
Primary Surgeon	
IF a hospital provides emergency general surgery care, THEN the time from a computerized tomography scan or ultrasound being ordered STAT to the performance of the study should be no more than four hours.	Compliant
	Non-compliant
	Not applicable
IF a patient has undergone an emergency general surgery procedure and was subsequently found to have cancer, THEN post-operative care should include appropriate guideline directed oncologic follow-up and surveillance (as detailed by the National Comprehensive Cancer Network).	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 7, please indicate reason.	Referred to outside oncol
	Other
b. If reason for "Non-compliant" for 7 is "Other," please indicate reason.	
IF a patient has undergone an emergency general surgery procedure, THEN the discharge or transfer summary should indicate:	

a. Medical findings and diagnoses: a summary of the care, treatment, and services provided	Compliant
	Non-compliant
b. A complete list of all medications and dosages to continue on discharge, including the purpose and side effects of new medications	Compliant
	Non-compliant
If "Non-compliant" for 8b, please indicate reason.	Medication list not preser
	Dosages not listed
	Purpose and side effects
	Dosages not listed AND P medications not detailed
c. Activity restrictions	Compliant
	Non-compliant
d. Diet restrictions or recommendations	Compliant
	Non-compliant
e. Wound/ostomy care instructions, if applicable	Compliant
	Non-compliant
	Not applicable
f. Home health services arranged, if applicable	Compliant
	Non-compliant
	Not applicable
g. Reasons to call the responsible provider or seek emergency medical attention (signs or symptoms of complications)	Compliant
	Non-compliant
h. Follow-up appointment(s)	Compliant
	Non-compliant
i. Contact information for the responsible provider	Compliant
	Non-compliant

IF an emergency general surgery patient is diagnosed with acute cholecystitis, THEN the patient should undergo a cholecystectomy within 72 hours of symptom onset or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 9, please indicate reason.	No reason documented
	Delayed patient presenta
	Other
b. If reason for "Non-compliant" for 9 is "Other," please indicate reason.	
IF an emergency general surgery patient is diagnosed with an uncontained perforated viscus, THEN surgery should begin within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 10, please indicate reason.	No reason documented
	Patient transferred from c
	Other
b. If reason for "Non-compliant" for 10 is "Other," please indicate reason.	

IF an emergency general surgery patient has a small bowel obstruction and findings consistent with ischemia and/or impending perforation, THEN the patient should undergo surgical exploration within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 11, please indicate reason.	No reason documented
	Patient transferred from c
	Other
b. If reason for "Non-compliant" for 11 is "Other," please indicate reason.	
Patient-Level Quality Indicators	
Medical Record Number	
Date of Operation (MM/DD/YYY)	
Primary Procedure Performed (select one)	Laparoscopic cholecyste cholangiogram
	Laparoscopic cholecyste
	Open cholecystectomy w
	Open cholecystectomy w
	Laparoscopic appendecto
	Open appendectomy
	Laparoscopic partial cole
	Laparoscopic partial cole
	Open partial colectomy w
	Open partial colectomy w
	Laparoscopic total abdom
	Laparoscopic total abdom
	Open total abdominal col

	Open total abdominal col
	Laparoscopic small bowe
	Laparoscopic small bowe
	Open small bowel resecti
	Open small bowel resecti
Secondary Procedure Performed (select none or multiple as appropriate)	Laparoscopic cholecyste cholangiogram
	Laparoscopic cholecyste
	Open cholecystectomy w
	Open cholecystectomy w
	Laparoscopic appendecto
	Open appendectomy
	Laparoscopic partial cole
	Laparoscopic partial cole
	Open partial colectomy w
	Open partial colectomy w
	Laparoscopic total abdom
	Laparoscopic total abdom
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	Open total abdominal col
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	Open small bowel resecti
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Primary Surgeon	
IF a hospital provides emergency general surgery care, THEN the time from a computerized tomography scan or ultrasound being ordered STAT to the performance of the study should be no more than four hours.	Compliant
	Non-compliant
	Not applicable

IF a patient has undergone an emergency general surgery procedure and was subsequently found to have cancer, THEN post-operative care should include appropriate guideline directed oncologic follow-up and surveillance (as detailed by the National Comprehensive Cancer Network).	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 7, please indicate reason.	Referred to outside oncol
	Other
b. If reason for "Non-compliant" for 7 is "Other," please indicate reason.	
IF a patient has undergone an emergency general surgery procedure, THEN the discharge or transfer summary should indicate:	
a. Medical findings and diagnoses: a summary of the care, treatment, and services provided	Compliant
	Non-compliant
b. A complete list of all medications and dosages to continue on discharge, including the purpose and side effects of new medications	Compliant
	Non-compliant
If "Non-compliant" for 8b, please indicate reason.	Medication list not preser
	Dosages not listed
	Purpose and side effects
	Dosages not listed AND P medications not detailed
c. Activity restrictions	Compliant
	Non-compliant
d. Diet restrictions or recommendations	Compliant
	Non-compliant
e. Wound/ostomy care instructions, if applicable	Compliant
	Non-compliant

	Not applicable
f. Home health services arranged, if applicable	Compliant
	Non-compliant
	Not applicable
g. Reasons to call the responsible provider or seek emergency medical attention (signs or symptoms of complications)	Compliant
	Non-compliant
h. Follow-up appointment(s)	Compliant
	Non-compliant
i. Contact information for the responsible provider	Compliant
	Non-compliant
IF an emergency general surgery patient is diagnosed with acute cholecystitis, THEN the patient should undergo a cholecystectomy within 72 hours of symptom onset or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 9, please indicate reason.	No reason documented
	Delayed patient presenta
	Other
b. If reason for "Non-compliant" for 9 is "Other," please indicate reason.	
IF an emergency general surgery patient is diagnosed with an uncontained perforated viscus, THEN surgery should begin within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable

a. If "Non-compliant" for 10, please indicate reason.	No reason documented
	Patient transferred from c
	Other
b. If reason for "Non-compliant" for 10 is "Other," please indicate reason.	
IF an emergency general surgery patient has a small bowel obstruction and findings consistent with ischemia and/or impending perforation, THEN the patient should undergo surgical exploration within a time frame consistent with the locally derived standard but no longer than three hours from the decision to operate or the reason for not doing so should be documented in the medical record.	Compliant
	Non-compliant
	Not applicable
a. If "Non-compliant" for 11, please indicate reason.	No reason documented
	Patient transferred from c
	Other
b. If reason for "Non-compliant" for 11 is "Other," please indicate reason.	