



# Core Measure Education



# IMMUNIZATIONS



- ▶ Flu season is from October 1 at 00:01 through March 31 at 24:00.
- ▶ Every patient must be assessed for Flu and Pneumonia Vaccine
- ▶ If patient is confused, comatose or sedated, contact the patient's decision-maker.
- ▶ You must address immunizations one last time at discharge. This is your last chance to give your patient the flu vaccine/pneumonia vaccine.
- ▶ For those who document in CPN (L&D, APU, and PPU), vaccines must be documented in Meditech. This information will NOT flow from CPN to Meditech.

# IMM Documentation

- BODY SYSTEM ASSESSMENT - -

Choose body systems to document:

Unable to assess: \_\_\_\_\_  
Reason unable to assess: \_\_\_\_\_

Estimated pneumococcal PCV13 vaccine admin date: \_\_\_\_\_  
Estimated pneumococcal PPSV23 vaccine admin date: \_\_\_\_\_  
Was that your second PPSV23 vaccination: \_\_\_\_\_  
Estimated pneumococcal vaccine admin date type unknown: \_\_\_\_\_

Options

<Return> <Exit>

Conorbid factors: \_\_\_\_\_

Pneumococcal vaccine contraindications: \_\_\_\_\_  
Patient or caregiver reports up to date on pneumococcal vaccine: \_\_\_\_\_  
Estimated influenza vaccine admin date: \_\_\_\_\_  
Flu vaccine contraindications: \_\_\_\_\_

Patient or caregiver reports up to date on influenza vaccine: \_\_\_\_\_  
Patient or home caregiver agrees to receive pneumococcal vaccine: \_\_\_\_\_  
Patient or home caregiver agrees to receive influenza vaccine: \_\_\_\_\_

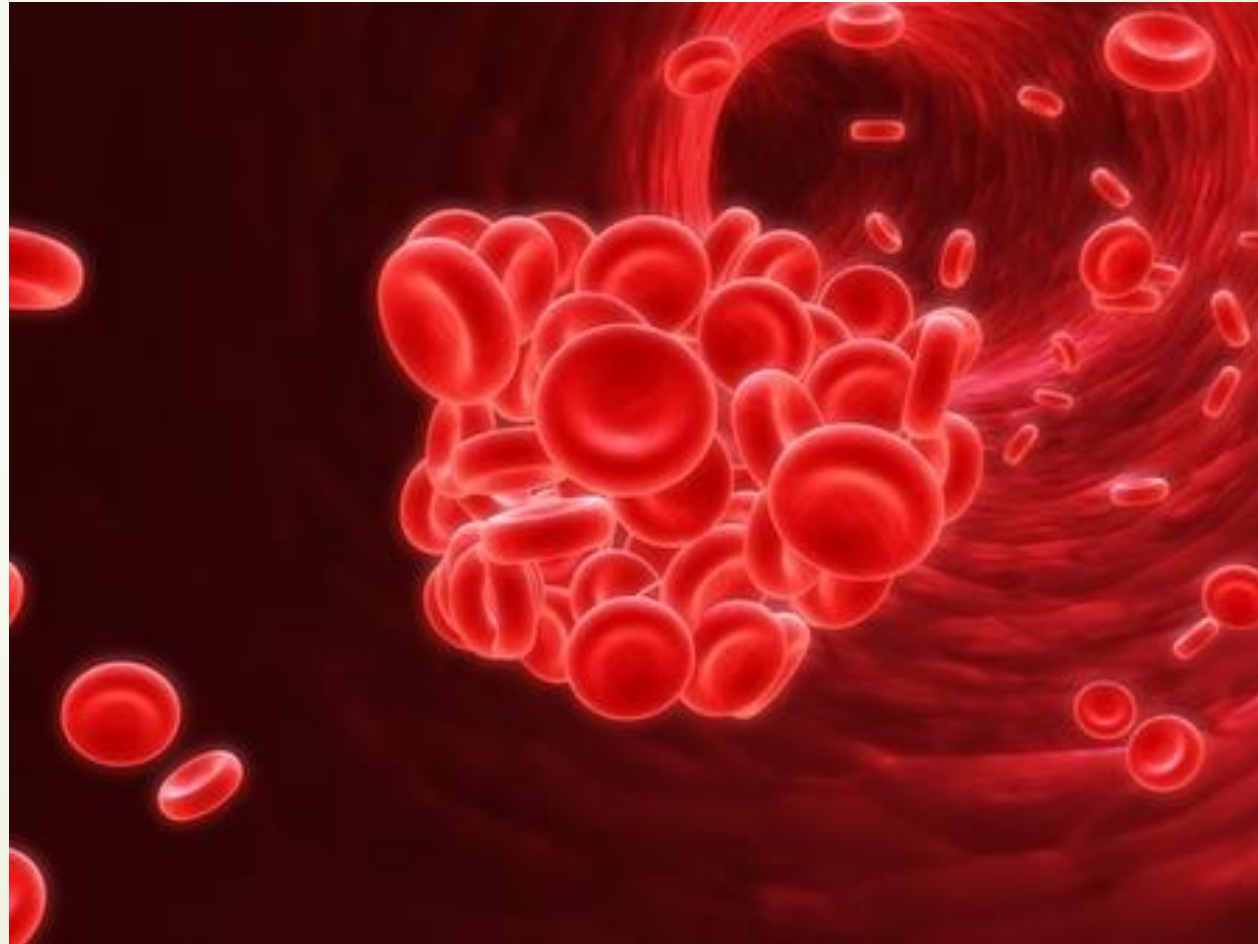
Comment: \_\_\_\_\_

Vaccine status: \_\_\_\_\_  
Influenza vaccination status- \_\_\_\_\_  
Pneumococcal vaccination status- \_\_\_\_\_

Options

<Prev> <Return> <Exit>


# VTE Core Measures



# VTE

## Venous Thromboembolism

- **All pts, including ICU pts w/ length of stay >1 day or surgery:**
- RN assesses & applies SCD's or TED's - no order needed. If pt refuses mechanical prophylaxis or if mechanical prophylaxis is contraindicated, notify MD for heparin or Lovenox order. If there is a contraindication for chemical prophylaxis, MD must document contraindication.
- Surgical and Stroke patients require the use of either SCDs or chemical VTE prophylaxis.
- For mechanical contraindication, use CPOE Order:
  - CORE MEASURE REASON FOR NO med/mech prophylaxis, or MD documents in notes or as an order in CPOE "**VTE Prophylaxis not indicated - Pt low risk for VTE**".
  - Documentation and intervention **must be** done on the day or day after Inpatient order or the day or day after surgery.
- There is no checklist for VTE. It is assessed by nurse with each Shift Assessment.



# Documenting Vaccinations in CPN (For L&D, APU, and PPU nurses)

Good news! VTE **does not** have to be double documented in CPN and in Meditech. VTE will *flow into* Meditech if documented in the places below:

- **Adult Admission Assessment**
- **Adult Flowsheet**
- **Adult Meds/Intervention**
- **Adult Review of Systems**
- **Intraoperative Record**
- **Recovery Record**
- **PP Flowsheet**
- **PP Safety Assessment**
- **PP Review of Systems**

**Documentation should occur on Arrival, Every Shift, Change in status of Mechanical Prophylaxis.**

# Shift Assessment VTE Screening

Total Body System Assessment 06/12 1456 J00021009285 CQM,DRGTEST 23

**Mechanical prophylaxis in place:**

1 <input type="checkbox"/> None	5 <input type="checkbox"/> Gcs knee
2 <input type="checkbox"/> Foot pump	6 <input type="checkbox"/> Gcs thigh
3 <input type="checkbox"/> Int pneumat comp - knee	7 <input type="checkbox"/> Refused
4 <input type="checkbox"/> Int pneumat comp - thigh	

Capillary refill less than or equal to 3 seconds: →

Pulses strong and equal bilaterally: →

Calves symmetrical and pain is absent with dorsiflexion: →

Peripheral edema: →

Nailbeds: →

Clubbing: →

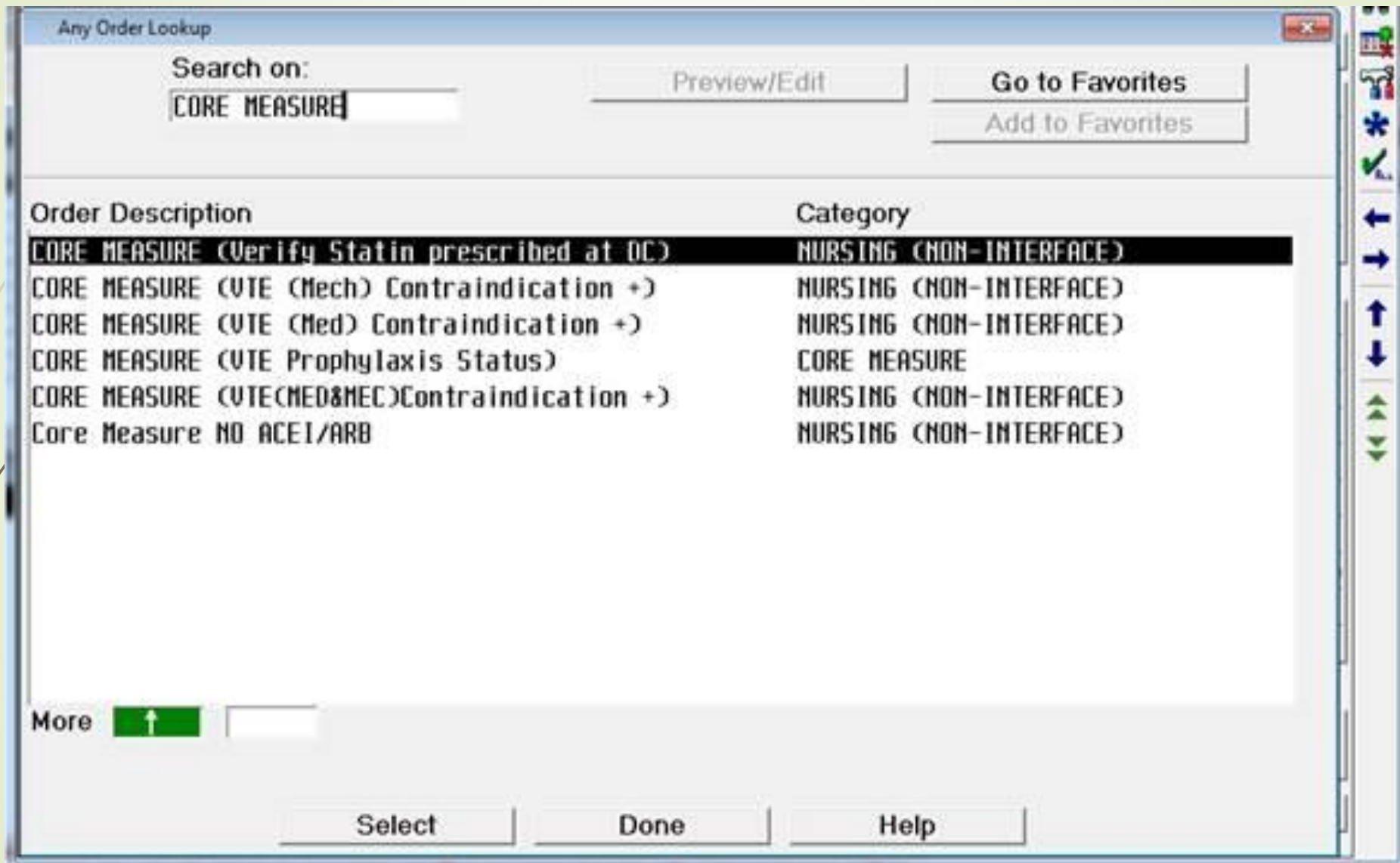
Mechanical prophylaxis in place: →

Device applied to:

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# CPOE VTE Contraindication Order:



The screenshot shows a software window titled "Any Order Lookup". At the top, there is a search bar with the text "CORE MEASURE" and two buttons: "Preview/Edit" and "Go to Favorites". Below the search bar, there are two columns: "Order Description" and "Category". The search results are as follows:

Order Description	Category
CORE MEASURE (Verify Statin prescribed at DC)	NURSING (NON-INTERFACE)
CORE MEASURE (VTE (Mech) Contraindication +)	NURSING (NON-INTERFACE)
CORE MEASURE (VTE (Med) Contraindication +)	NURSING (NON-INTERFACE)
CORE MEASURE (VTE Prophylaxis Status)	CORE MEASURE
CORE MEASURE (VTE(MED&MEC)Contraindication +)	NURSING (NON-INTERFACE)
Core Measure NO ACEI/ARB	NURSING (NON-INTERFACE)

At the bottom left, there is a "More" button with a green arrow icon. At the bottom center, there are three buttons: "Select", "Done", and "Help". On the right side of the window, there is a vertical toolbar with various icons, including a search icon, a list icon, and several arrow icons.



# Physician VTE Contraindication note in pDOC:

PWM.QAA (KYNAQAG/CQA TEST 506 MIS/35) - BELL, CHARLES MD TEST

Document: Adult General Consultation - Treatment & Prophylaxis

PROBLEM, LIST2 - 37/F DOB 09/08/77 ADM IN I.CHI I.CHI/13  
U/A J000316671/J00020013461

HPI	Hx	ROS	Objective	T&P	DxA&P
Treatment & Prophylaxis					
Ute prophylaxis	Ute prophylaxis is bei...				
Foley:	Date foley inserted: 0...				
Oxygen:					
Ventilator:					
Lines:					
Drains/tube:					
Tube feeding:					
TPN:					
Anti-arrhythmics:					
Anti-infectives:					
IV fluids:					
Pressors and Ino...					
Sedation:					
Steroids:					
Ulcer prophylaxis:					
Other:					

Ute prophylaxis	
Ute prophylaxis ...	No
Rx contraindicat...	Thrombocytopenia
Other (Rx) contr...	TEST
Mech contraindic...	Patient/Family Re...
Other (mech) con...	TEST

Ute prophylaxis is being in...

Yes

No

-----

Comment: \_\_\_\_\_

OK/Next OK Cancel

Review Order Document Patient List

# AMI

## Core Measures



# AMI QUALITY MEASURE CHECKLIST

Diagnosis of: STEMI, NON-STEMI or ACS

August 2018

Arrival to KWMC Date \_\_\_\_\_ Time \_\_\_\_\_

PCI: Door to Device w/in 90 minutes of ARRIVAL to ED  
(Document contraindication in Medical Record)  
OR  
Lytics given w/in 30 minutes of ARRIVAL TO ED  
(any delay must be documented in Medical Record by MD)

ASA given w/in 24 hours of ARRIVAL to ED  
(Document contraindication in Medical Record)

LVEF% \_\_\_\_\_ or documentation EF% to be assessed at Follow-Up

Cardiac Rehab Referral II ordered by MD/NP and RN documentation

Smoking Cessation Counseling/Education

Pre and Post Cath Creatinine

Pre and Post Cath H&H

## Required Discharge Medications

Beta Blocker or document contraindication

Dual Antiplatelet Therapy (ASA+Plavix/Brilinta/Effient) or document contraindication

STATIN Therapy or document contraindication

Ace/Arb for EF<40% or document contraindication

Verified by:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Discharge RN Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

# AMI-Pink STEMI / Non-STEMI / ACS / Chest Pain

- When a patient presents to the hospital with any Dx of: STEMI/Non-STEMI/ACS, Rule Out MI, Chest Pain, Elevated Troponins, Cardiac Arrest, follow the AMI Checklist.
- LVEF% must be new post MI or physician must document plan to reassess outpatient.
- Completion of checklist will ensure a successful discharge.

# Cardiac Rehab Education

Cardiac Rehab Referral must be ordered by MD/NP and RN must document

Patient/Family Teaching 11/06 1214 CD0217038492 PHA-KW,ADULT

**Physiological topics: [or free text]**

1  Bowel/gastric +      7  Respiratory +  
2  Cardiac +      8  Skin integrity +  
3  Infection +  
4  Life cycle +  
5  Metabolic regulation  
6  Physical regulation +

--- Follow-up Topics ---

**Physiological topics:**  
→ Cardiac rehab

**Functional topics:**

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'Cardiac' Lookup

Select

'Cardiac' Options

1 ✓ Cardiac rehab  
2 Cardiac care  
3 Pacemaker

topics:



# Sepsis

## Core Measures



# Sepsis Core Measures - 2018

## What is SEPSIS?

- ▶ It is a potentially **life-threatening** complication of an infection.
- ▶ It results when an infectious insult triggers a localized inflammatory reaction that then spills over to cause systemic symptoms of **fever or hypothermia, tachycardia, tachypnea**, and either **leukocytosis** or **leukopenia**.
- ▶ This inflammation can trigger a cascade of changes that can damage **multiple organ systems**, causing them to **fail**.
- ▶ If sepsis progresses to **septic shock**, blood pressure can drop dramatically, which may lead to **death**.
- ▶ Sepsis is a **medical emergency** and should be treated aggressively & quickly just like a Code Stemi or Neuro.
- ▶ Every hour that a patient in septic shock does not receive antibiotics, the risk of death increases by 7.6%.

# Who can get Sepsis?

**Anyone can get Sepsis**, however, these populations are at increased risk:

- Adults 65 years and older
- People with weakened immune systems (d/t AIDS/HIV, chemo, organ transplants)
- People with chronic medical conditions (diabetes, cancer, kidney disease, COPD)
- Debilitated persons (bed-ridden, vent dependent)
- People with wounds (decubitus, surgical sites)
- Those with medical devices (indwelling urinary catheters, central lines)



# Stages of Sepsis

## Sepsis

2 SIRS + Infection

SIRS:

- Temp > 100.4 or < 96.8 F
- Pulse > 90
- RR > 20
- WBC > 12,000 or < 4,000 or > 10% bands

## Severe Sepsis

2 SIRS + infection + 1 Organ dysfunction

Organ dysfunction:

- **SBP** < 90 mmHg or decrease > 40 mmHg or MAP < 65
- **Acute Resp. Failure**- new: intub./CPAP/BiPAP; intermittent to continuous MV
- **Creatinine** > 2.0 (exclude if ESRD on HD)
- **Urine Output** < 0.5ml/kg/hr for 2 consec. hrs
- **Total Bili** > 2 mg/dl
- **Platelets** < 100,000
- **INR** > 1.5 or aPTT > 60 sec (exclude if on anticoagulant medication)
- **Lactate** > 2 mmol/L
- **Altered Mental Status**

## Septic Shock

2 SIRS + infection + organ dysfunct. + **Lactic Acid**  $\geq 4$  and/or **Hypotension** (SBP < 90 mmHg or decrease > 40 mmHg or MAP < 65)

# How do we monitor for Sepsis at KMC?

- 1. Sepsis Screenings** are performed on adult patients 18 yrs and older, per hospital policy:
  - Upon triage and direct admission (within 5-10 minutes of arrival)
  - **Q4** hours on in-patients & **Q2** hours on ED patients
  - Using Meditech or CPN (Women's Services)
- 2. SPOT (Sepsis Prevention Optimization Therapy) monitoring system:**
  - Provides real-time monitoring of patient labs & vitals in support of early sepsis identification.
  - When SPOT triggers an alert on a patient, the monitor tech will contact the bedside nurse to perform a sepsis screen (to be done & documented in Meditech within 60 minutes of alert).
  - To enhance patient outcomes, SPOT detection is depending on timely documentation of vital signs in Meditech (chart any Sepsis screenings and vital signs immediately)
- 3. Change in patient's condition from baseline? (Ex. AMS)**
  - Perform a sepsis screening/workup. When unsure, consult Rapid Response \*88650.

# Positive Sepsis Screening or suspect Sepsis?

## 1. Call a Code Sepsis:

- For ED patients: Initiate a Code Sepsis via i-mobile.
- For in-patients: Inform your charge nurse and call a Code Sepsis overhead.

## 2. Pull Sepsis Core Measure Checklist

- Fill in as you go.
- Stays on chart & is part of permanent medical record.

## 3. Initiate Nurse Driven Sepsis Protocol Orders







## 4. Consult/Phone the provider for antibiotics & IVFs STAT.

- Inform of Sepsis criteria: abnormal VS &/or WBCs, infection.
- Inform that a “Code Sepsis” has been called.

## 5. Initiate the Sepsis bundle within the hour of Sepsis recognition

- Important\*\* **Start the antibiotic(s) within the hour of Sepsis recognition.**

# Sepsis Core Measure Checklist - Front

SEPSIS CORE MEASURE PATIENT CHECK-LIST				TIME ZERO		<b>TIME ZERO IS THE EARLIEST OF 3:</b> 1. IN ED: TRIAGE TIME 2. MD DOCUMENTS SEVERE SEPSIS/SEPTIC SHOCK 3. 2 SIRS + INFECTION + 1 ORGAN DYSFUNCTION PRESENTS.
GOAL TIME	MEASURE	COMPLETED	REASON NOT COMPLETED	DATE /	TIME :	
<b>SEVERE SEPSIS &amp; SEPTIC SHOCK</b>						
	<b>0 MIN</b>	<b>"CODE SEPSIS" CALLED</b>	<input type="radio"/>		:	CODE TO BE CALLED OVERHEAD AND SENT ON iMOBILE
	<b>5 MIN</b>	<b>BLOOD CULTURE</b>	<input type="radio"/>		:	DRAWN BEFORE IV ANTIBIOTIC (CMS 1-35) IF ATTEMPTED AND FAILED, DOCUMENT "BLOOD CULTURES ATTEMPTED AND FAILED." (CMS 1-139)
	<b>5 MIN</b>	<b>LACTATE # 1</b>	<input type="radio"/>	RESULT: If >2 WILL NEED TO REPEAT	COLLECTION TIME :	IF ATTEMPTED AND FAILED, DOCUMENT "LACTATE ATTEMPTED AND FAILED." (CMS 1-139)
	<b>10 MIN</b>	<b>ANTIBIOTIC START</b>	<input type="radio"/>		EMAR SCAN TIME :	<b>START ADMINISTRATION WITHIN 60 MINUTES</b> SEE BACK PAGE FOR APPROVED ANTIBIOTIC CHOICES. (CMS 1-47)
	<b>60 MIN</b>	<b>LACTATE # 2</b>	<input type="radio"/>	RESULT:	COLLECTION TIME :	DRAW ASAP AFTER 1ST FLUID BOLUS (CMS 1-186)
<b>IF SEPTIC SHOCK PRESENT CONTINUE BELOW</b>						
	<b>10 MIN</b>	<b>IV FLUID BOLUS (CONSIDER EV-1000)</b>	<input type="radio"/>		INFUSE OVER 1 HR EMAR SCAN TIME :	IF SBP < 90, OR MAP < 65, OR LACTATE #1 ≥ 4, NS OR LR 30 mL/KG IV/IO BOLUS. PRESSURE BAG BOLUS PREFERRED OVER 60 MINUTES. <sup>111</sup> <b>IF HEMODYNAMICS/ VOLUME OVERLOAD ARE OF CONCERN UTILIZE EV-1000 TO TAILOR FLUID MANAGEMENT (CMS 1-85)</b>
<b>ONE HOUR FOLLOWING IV BOLUS COMPLETION</b>	<b>RN REASSESSMENT:</b> DOCUMENT 2 BPs	<input type="radio"/>	BP #1 /	:	<b>INFORM MD IF HYPOTENSION OR ELEVATED LACTATE PERSISTS</b>	
		<input type="radio"/>	BP #2 /	:	<b>EXAMPLE: IVF EMAR SCAN @ 1200 , INFUSION COMPLETES @ 1300 , PERFORM 2 BLOOD PRESSURE READINGS BETWEEN 1300-1400</b>	
	<b>REMIN PROVIDER SEPTIC SHOCK FOCUSED EXAM</b>	<input type="radio"/>		:	IF PATIENT HAS SEPTIC SHOCK-AND NS 30 ML/KG COMPLETED THE MD/NP/PA MUST DOCUMENT REASSESSMENT AS FOLLOWS: <div>Type "SEPSIS EXAM DONE" OR CHECK "TISSUE PERFUSION REASSESSMENT DONE" IN PDOC	
	<b>VASOPRESSORS</b> IF PERSISTENT HYPOTENSION	<input type="radio"/>		:	IF SEPTIC SHOCK WITH PERSISTENT HYPOTENSION : 2 DOCUMENTED SBP < 90 OR MAP < 65 OR SBP DECREASE >40MMHG START VASOPRESSORS- NOREPINEPHRINE PREFERRED.	

Notes:

- For ED: if bundle started in ED, complete the entire bundle in the ED before transferring.
- Bring the checklist to the bedside & document on it as you complete the items.
- Place completed checklist on chart.

# Sepsis Core Measure Checklist - Back

## DEFINING SEPSIS

S I R S

2 OR MORE OF THE FOLLOWING:

TEMPERATURE	HEART RATE	RESP. RATE	WBC
>100.4 F OR <96.8 F	>90 BEATS PER MINUTE	>20 BREATHS PER MINUTE	>12K OR <4K OR >10% BANDS

S E P S I S

+  
**INFECTION**  
SUSPECTED / CONFIRMED

S E V E R E S E P S I S

+  
**ORGAN DYSFUNCTION**

- HYPOTENSION SBP < 90, OR MAP < 65
- LACTIC ACID >2
- ALTERED MENTAL STATUS Decreased GCS
- ACUTE LUNG INJURY OR ON VENT/CPAP/BIPAP
  - PAO<sub>2</sub>/FIO<sub>2</sub> <250 (w/ PNA) OR <200 (w/ PNA)
- ACUTE KIDNEY INJURY
  - URINE OUTPUT <0.5ML/KG/HR CREAT. >2
- ELEV BILI >2
- PLATELET <100K INR >1.5 OR PTT >60s

S E P T I C S H O C K

+

**LACTIC ACID ≥4 AND/OR**  
**HYPOTENSION SBP < 90 MAP < 65**

## APPROVED ANTIBIOTICS

APPROVED BROAD SPECTRUM IV ANTIBIOTICS

GIVE **ONE** ANTIBIOTIC TO SATISFY REQUIREMENT

<input type="checkbox"/>	AMPICILLIN/SULBACTAM	(UNASYN)
<input type="checkbox"/>	PIPERACILLIN/TAZOBACTAM	(ZOSYN)
<input type="checkbox"/>	CEFTRIAXONE	(ROCEPHIN)
<input type="checkbox"/>	CEFOTAXIME	(CLAFORAN)
<input type="checkbox"/>	CEFTAZIDIME	(FORTAZ)
<input type="checkbox"/>	CEFEPIME	(MAXIPIME)
<input type="checkbox"/>	CEFTAROLINE	(TEFLARO)
<input type="checkbox"/>	ERTAPENEM	(INVANZ)
<input type="checkbox"/>	MEROPENEM	(MERREM)
<input type="checkbox"/>	LEVOFLOXACIN	(LEVAQUIN)

IF THE ABOVE ARE CONTRAINDICATED DUE TO ALLERGIES

GIVE **2** ANTIBIOTICS  
ONE FROM **GROUP A** AND ONE FROM **GROUP B** TO SATISFY REQUIREMENTS

A	+	B
<input type="checkbox"/>	AND	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>

Notes:

- If giving 2 antibiotics (especially Vanco.) make sure you administer the shorter infusion first & then follow with the longer infusion. Both antibiotics need to be **started** within the hour to pass the core measure.




**These Sepsis Checklist Bundle Pieces will be attached to the checklist itself. Here's how to use them:**

This flyer goes into the lab bag. Lab will know to process these labs STAT.

**STAT**

**Code Sepsis Labs**

All Code Sepsis labs sent with this label **MUST** be called to the nurse at extension \_\_\_\_\_

 **SUSPECT SEPSIS.  
SAVE LIVES.™**

**Goal: Complete the Sepsis Bundle  
within 1 hour of Triage or Presentation  
Time**

Patient Label Here

If you need to draw LA #2 (because #1 was  $>2$ ), place this flyer on foot of bed or IV bolus bag to remind to collect 2<sup>nd</sup> LA after IVF bolus given or 1-2 hours after initial LA collected.

**NURSE ALERT!!!!**

**CODE SEPSIS**

✓ **LACTIC ACID RESULT**

**REPEAT LACTIC ACID IF  $> 2$**

**BY** \_\_\_\_\_

Place orange Sepsis Arm Band on patient. This signals that the patient is being treated for Sepsis.



# Ordering Nurse-Driven Sepsis Protocol Labs

To Order in Meditech:

1. Go to: Order Sets
2. Type in Sepsis or Nurse Driven Sepsis Protocol

- New Orders (6)				
Code Sepsis Protocol Guideline (NUR.PH		11/12 N	New	*
LACTIC ACID (LAB)	Stat	11/12 N	New	*
CREATININE (LAB)	Stat	11/12 N	New	*
BILIRUBIN TOTAL (LAB)	Stat	11/12 N	New	*
PLATELET COUNT (LAB)	Stat	11/12 N	New	*
CULTURE BLOOD (MIC)	Stat	11/12 N	New	*



## Nurse Driven Sepsis Protocol

1. Registered Nurse will screen patient for Sepsis in Meditech with updated VS every screening.
2. If patient screens positive for Sepsis (2 SIRS criteria with suspected or active infection), the Registered Nurse will call a Code Sepsis through the PBX operator.
3. If the patient screens positive for Sepsis, the Nurse will order blood cultures and Tier- 3 Labs (Nurse Driven Sepsis Protocol Order Set in CPOE) to rule in or rule out Severe Sepsis and Septic Shock.
  - a. Tier-3 Labs:
    - i. Lactic Acid
    - ii. Creatinine
    - iii. Total Bilirubin
    - iv. Platelets
4. If patient screens positive for Sepsis, Severe Sepsis, or Septic Shock, the Nurse must contact the physician for orders to complete the Severe Sepsis or Septic Shock Bundle.
  - a. Severe Sepsis Bundle:
    - i. Antibiotics
    - ii. Fluid bolus (1 Liter NS in 1 hour recommended)
  - b. Septic Shock Bundle:
    - i. 30ml/kg fluid bolus in 1 hour
    - ii. Vasopressors if indicated for persistent hypotension ( 2 of either: SBPs < 90 or MAP < 65) after bolus
    - iii. MD Reassessment after fluids and within 6 hours of triage/ presentation time.
5. If the initial lactic acid is > 2, obtain a repeat lactic acid (reflex order) within 1-2 hours of triage/presentation time.
6. Notify Rapid Response Team if Septic Shock criteria is present.
7. Patients that screen positive for Sepsis, Severe Sepsis or Septic Shock will have a Sep-1 (Sepsis) armband placed by the Nurse or delegate, unless there is MD documentation completely ruling out Sepsis.

# ED/In-patient Meditech Sepsis Screenings

#1

Process Int

(From Nurse Status Board, Select Patient & then Process Intervention)

#2

Care Items	Sts	Directions	OD	Doc	Src	D	C/N	KI	Pr
<b>History</b>									
-Admission Health History +	A			8d	CP				
<b>Assessments</b>									
-Admission/Shift Assessment +	A			11h	CP				
-*Quick Start +	A			8d	AS				
<b>-Safety/Risk/Regulatory +</b>	<b>A</b>			<b>2h</b>	<b>CP</b>				
-1st Point of Contact MRSA/TB/RESP +	A			8d	CP				
-Pain Assessment +	A			11h	CP				

#3

Safety/Risk/Regulatory 11/12 1045 CD0217038492 PHA-KW,ADULT

Assess sepsis:

1 Yes

Sepsis should be documented every shift

Isolation status: Standard precautions \*

Assess sepsis: >

Cont'd

Sepsis Screening:

Temperature:		Less than 96.8 F	Greater than 100.4 F
1	Yes		
2	No	Less than 36.0 C	Greater than 38.0 C

Last 4 SIRS Criteria Entries (Past 2 days)								
Date	Time	Temp F	Temp C	P	R	BP	Date MD	Time MD
08/28	2222		37.5	104	20	120/82		
08/28	2340		37.3	96	16	110/72		
08/29	0400		37.1	83	16	99/64		
08/29	0711		37.2	92	17	110/74		

Temperature:  No  
Heart rate:   
Respirations:

WBC results:   
Band results:   
WBC/Bands:   
Pediatric glucose results:   
Pediatric hyper/hypoglycemia:   
Pediatric infection risk:

If yes to 2 or more of above, proceed to next section:  (Next Page)

#4

Then continue through all of the SIRS & organ dysfunction screens.

When you finish, your sepsis screening will look like this:

```
- - SEVERE SEPSIS SCREENING - -
Temperature: Yes
Heart rate: Yes
Respirations: Yes
If yes to 2 or more of above, proceed to next section: 4
Suspected/documentated infection: Yes
Antibiotic therapy (not prophylaxis): Yes
If yes to 1 of the above, proceed to next section: 2
Respiratory: Yes
Cardiovascular: Yes
Renal: Yes
Metabolic: Yes
Hematologic: Yes
Hepatic: Yes
Central nervous system: Yes
If yes to 1 of the above, positive for severe sepsis: 7
```



If your patient has 2 SIRS & an infection (SEPSIS) = initiate the Sepsis Bundle, you don't have to wait for a positive Severe Sepsis bundle. But – continue with the screening in it's entirety.

GOAL: administer **antibiotics within the hour of sepsis presentation.**

# CPN In-patient Sepsis Screenings:

#1

Sepsis Screen Admit Part A NEW - THERAPY,THREE (SL88774555)

Date and Time of Completion: 10/23/2018 16:29

SEPSIS: GUIDELINES FOR PERINATAL PATIENTS  
Sepsis Screening Tool: PART A

Complete on Admission and Per Facility Reassessment Requirement

Risk Factors: (Check all that apply)

- No Risk Factors
- 40 years of age or greater
- Abruptio Placenta
- Hx of Cerclage this Preg
- Diabetes
- Hx Abd Surgery this Preg
- Multiple Gestations
- Obesity
- Preterm Labor
- Placenta Previa
- Premature Rupt Membranes
- ROM greater than 18 hours

SEPSIS STEP #1  
Step #1: Does the patient have a suspected or confirmed infection?

- No Susp/Conf Infection
- UTI/Pyelonephritis
- Respiratory Infection
- Gastrointestinal Inf.
- Diverticulitis
- Hepatitis
- Influenza like illness
- Chorioamnionitis
- Intraoperative Etiology
- Septic Abortion
- Sexually Transmitted Inf.

Intraperitoneal Etiology = Ruptured or Acute Appendix, Bowel Infection, Acute Cholecystitis, Necrotizing Pancreatitis

Final: Patient has suspected OR confirmed Infection

Calculate

RESULTS

NO: No further action is Required. The Screening is complete. Continue observation and update status as needed.

YES: If patient has suspected or confirmed Infection Call Provider for Initiation of Sepsis Order Sets and Proceed to Part B--> Sepsis Screening Tool Part B

#2

SEPSIS SCREENING TOOL: PART B

Date and Time of Completion: 10/23/2018 16:29

Does the Patient have SIRS present?  
SIRS = Systemic Inflammatory Response

All NO Answers

Temp > 100.4 (F) or < 96.8 (F)  No  Yes

HR > 110 bpm  No  Yes

RR > 24 or PaCO2 < 32 mmHg  No  Yes

WBC > 15,000 or < 4,000 OR > 10% bands  No  Yes

Calculate Total SIRS

Score of > or = 2 SIRS = Sepsis  
NOTIFY Provider of score and patient assessment to determine if further orders are needed.

Step #2: Does the patient have 2 or more SIRS present?

NO: No further action is required. Continue observation and update status as needed.

YES: Notify Provider that the patient has 2 or more SIRS present Follow Provider orders. Once results are received: Proceed to Part C to determine NEW End Organ Dysfunction----> Sepsis Screening Tool Part C

Return to Part A

#3

Sepsis Screen Admit Part C NEW - THERAPY,THREE (SL88774555)

Date and Time of Completion: 10/23/2018 16:30

SEPSIS SCREENING TOOL: PART C

STEP #3  
Review and Analyze Lab Results and Assess Patient Status

All NO Answers

Complete all Questions

SBP < 90, MAP < 65 or SBP decrease > 40 from baseline  No  Yes

Bilirubin > 2 mg/dL  No  Yes

Creatinine > 2 mg/dL  No  Yes

Platelet Count < 100K  No  Yes

INR > 1.5 or PTT > 60  No  Yes

Lactate > 2 mmol/L  No  Yes

New Need for Oxygen Therapy  No  Yes

Altered Mental Status  No  Yes

Calculate Total Score

Score of 1 or more = Severe Sepsis  
NOTIFY Provider of:

- Total Score and if it indicates Severe Sepsis
- Patient Assessment Status

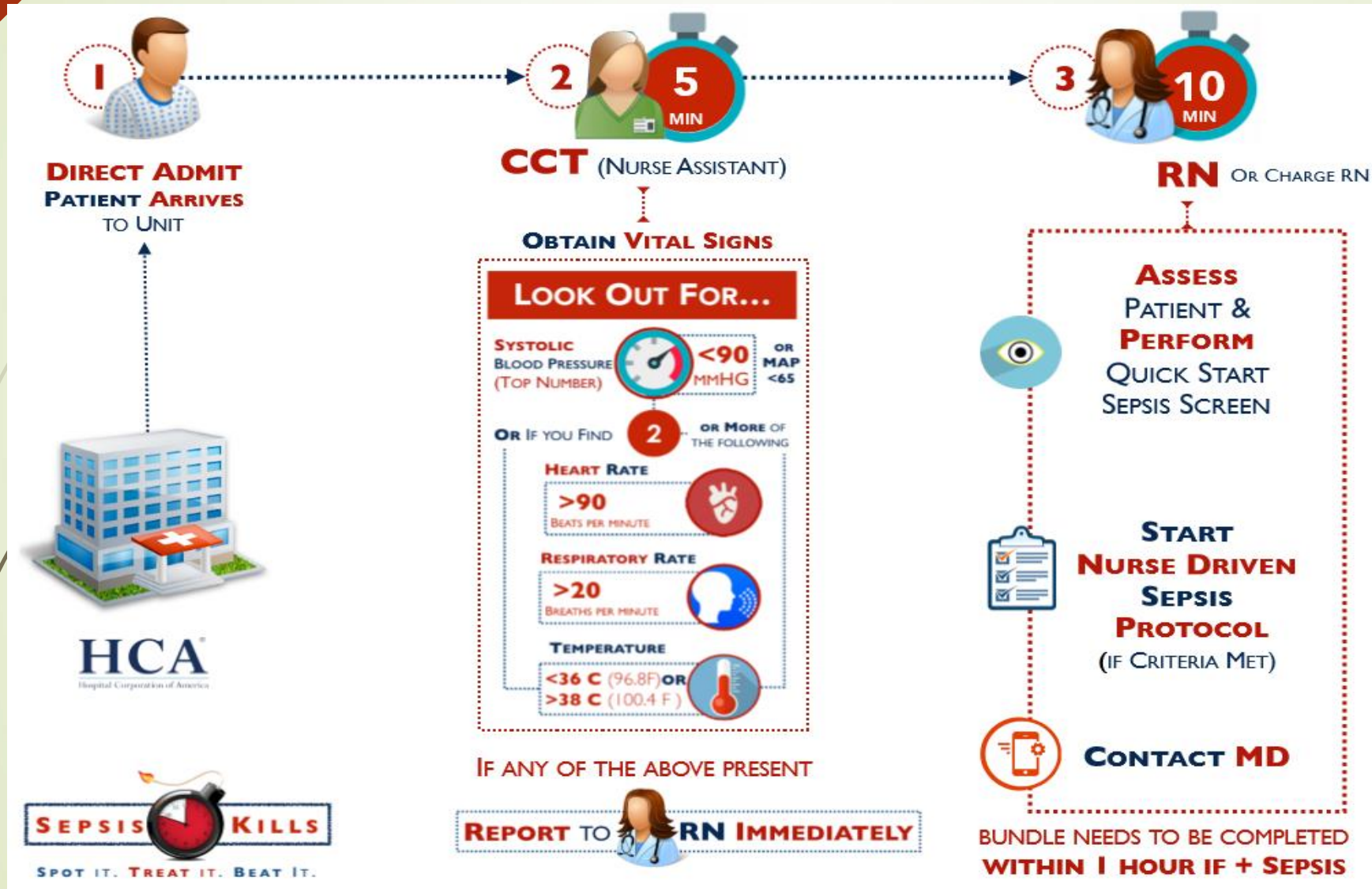
Determine if further orders are needed  
Transfer to higher level of care if indicated  
Continue Sepsis Order set until no signs of organ dysfunction are present

Return to Part A  
Return to Part B

Each Screen tells you what to do next



# Direct Admissions Sepsis Screen Procedure



GOAL: Get patient assessed for Sepsis and treated with **antibiotics within the hour of arrival.**

# Hour-1 Bundle



Initial Resuscitation for Sepsis and Septic Shock (begin immediately):

**Time Zero/Time Presentation**  
 \*\*Time zero" or "time of presentation" is defined as the time of triage in the Emergency Department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of sepsis (formerly severe sepsis) or septic shock ascertained through chart review.

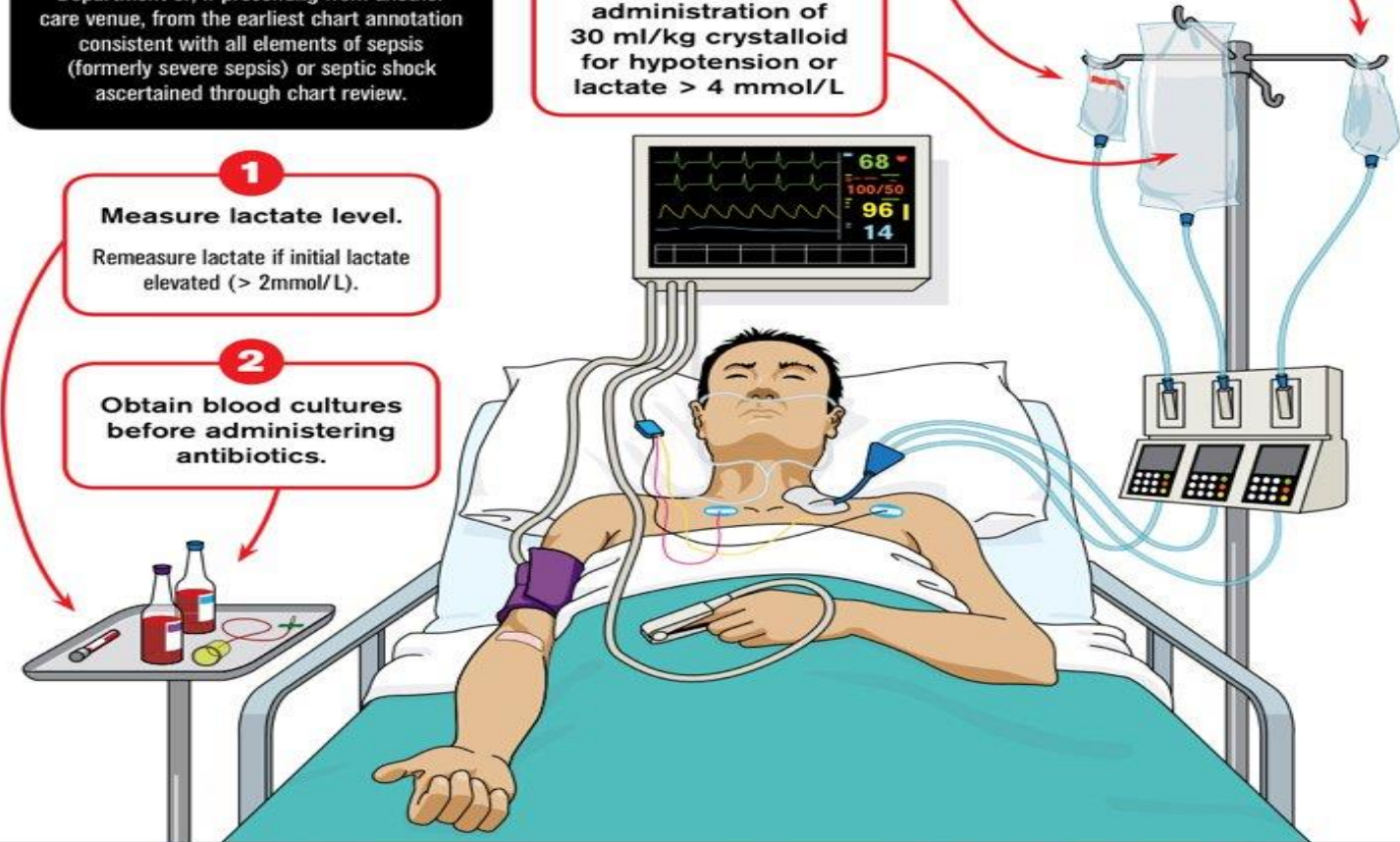
**3**  
 Administer broad-spectrum antibiotics.

**5**  
 Apply vasopressors if hypotensive during or after fluid resuscitation to maintain a mean arterial pressure  $\geq 65$  mm Hg.

**4**  
 Begin rapid administration of 30 ml/kg crystalloid for hypotension or lactate  $> 4$  mmol/L

**1**  
 Measure lactate level.  
 Remeasure lactate if initial lactate elevated ( $> 2$ mmol/L).

**2**  
 Obtain blood cultures before administering antibiotics.



Putting it all together:

**Is it Sepsis?**  
 Minutes Matter.

Bundle: [SurvivingSepsis.org/Bundle](https://www.survivingsepsis.org/Bundle)

Complete Guidelines: [SurvivingSepsis.org/Guidelines](https://www.survivingsepsis.org/Guidelines)



# Neuro (Stroke) Core Measures





# R/O TIA/Hemorrhagic or Ischemic STROKE, SAH, ICH, IVH, Carotid Stenosis or CEA

UPDATE 8/1/2018

CORE MEASURE PATIENT Treatments must be met or document contraindications in chart

Discipline/Treatment Requirements	ER NURSE or 1 <sup>st</sup> RN starts CM Checklist	YES	No	NA
<i>ER Physician IV Alteplase</i>				
<b>Door to Needle must be &lt; 45 minutes!!!</b> Order & Start STAT ED MD must document Contraindication/Exclusions/Exceptions, ANY reasons started LATE!				
ER Physician/ER/Admit NURSE: Document NIHSS on Arrival, before Alteplase, Discharge				REQ REQ REQ
1st NURSE to give any Meds/food/fluid <b>SWALLOW SCREEN BEFORE any MEDICATIONS/Food/Fluids</b> If failed get Speech therapy order, make Strict NPO Document passed swallow in medical record... Screen with Symptoms above neck				
		Date, Time & initial:	REQ REQ REQ REQ REQ	REQ REQ REQ REQ REQ
Attending MD/Day 2 NURSE <b>Antithrombotic by end of Hospital Day 2</b> ASA, Coumadin, Plavix, Ticlid, Heparin, Lovenox				
Attending MD, Day 2 Nurse: <b>DVT Prophylaxis by end of Hospital DAY 2 (SCD's!)</b> Anticoagulant ie Heparin, Lovenox, Coumadin, Pradaxa, or SCD's! (NO TEDs.. NO ASA NO Plavix) if INR too high to administer Anti-coagulant or refuses Lovenox NURSE MUST apply SCDs				
Attending PHYSICIAN/ NURSE (DOOR to Draw 48 hours) Fasting NOT REQUIRED: <b>Lipid Profile first 48 hours or past 30 days</b> LDL _____				
Attending MD/DISCHARGE NURSE: <b>REHAB Consult PT, OT, ST or REHAB Eval documented</b> (unless MD or NP states not eligible for rehab returned to prior level of function or unable to do rehab)				
Attending MD/ DISCHARGE NURSE: <b>Patient with Hx Atrial Fib/Flutter Anti-Coag Required @ Discharge</b> Coumadin, Heparin, Pradaxa, Lovenox, Xarelto, Eliquis If NOT ordered MD Documents contraindication i.e.: No Anti Coag @ risk for falls or bleeding risk				
DISCHARGE MD/ DISCHARGE NURSE: <b>Antithrombotic @ Discharge</b> or contraindication/order written ASA, Coumadin, Plavix, Ticlid				
DISCHARGE MD/Nurse <b>STATIN Required @ Discharge if; LDL ≥ 70 or Admit on Statin</b> Admit on Statin = MUST discharge on Statin unless contraindication documented Intensive Statin Dosage				
Attending MD/Discharge NURSE: Smoking Cessation Smoke = 1 cigarette past last year, document cessation education				
DISCHARGE NURSE/MD: 5 Elements Select #11 Stro/TIA <b>Educate pt &amp;/or family</b> *call 911 or EMS* personal risk factors, Signs & Symptoms, Meds, & MD WU <b>Get risk factors sheet signed &amp; Select TIA/Stroke on Discharge Assessment</b>				

ER START on All RULE OUTs TIA, Ischemic SAH, IVH, ICH, Carotid Stenosis, CEA & Stroke COMPLETE CHECKLIST @ Discharge = SUCCESS

- Start checklist for **ALL RULE OUTS**, TIA, Ischemic, SAH, IVH, ICH, **Carotid Stenosis, CEA**, & Stroke.

- Symptoms from the **NECK UP** except seizures you must complete the Core Measure checklist

- A completed checklist @ discharge = SUCCESS**



# On Arrival

- ✓ **NIH** stroke scale must be completed within **60 minutes of arrival**
- ✓ Swallow screen **BEFORE** PO administration.
  - Example Medication at 09:30, Swallow screen at 09:29 or earlier.



# During the Stay

(completed by end of hospital day 2)

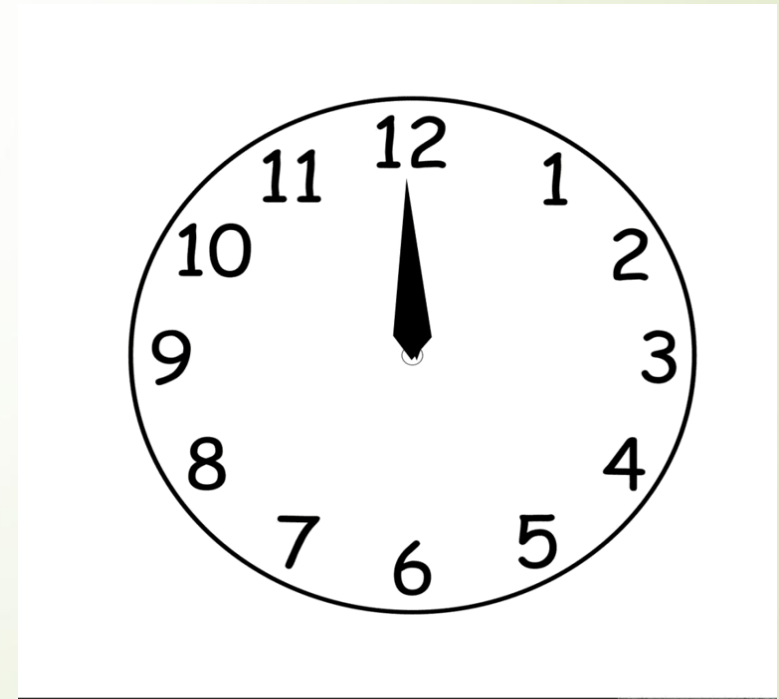
- ✓ DVT Prophylaxis by end of day 2 **(SCDs for NEURO)**
  - **Nurse must apply SCDs**
  - Anticoagulant ie, Heparin, Lovenox, Coumadin, Pradaxa
  - If the patient does not qualify for anticoagulant due to bleed, the **physician must document** rationale for holding medication.
- ✓ Lipid profile first 48 hours (Arrival to draw=48 hours) Fasting *not* required
- ✓ Antithrombotic by end of day 2
  - Examples: Aspirin, Coumadin, Plavix, Ticlid, Heparin, Lovenox, Xarelto, Eliquis
- ✓ **Complete NIH Stroke Scale if patient has a change in mental/neuro status.**



# During the Stay

(Complete by end of hospital day 2)

- ✓ Hospital day 2 is calculated by midnights not 24 hour period
- Example: if your patient arrives at 2300 (11pm), then 0000 (midnight) is end of day 1.



# Stroke Education

- **Stroke/TIA must be *patient specific*. Stroke Patient Education Sheet in Core Measure packet or in e-precision under “stroke patient education”.**
- **Must check each risk factor that pertains to that particular patient.**
- **Patient signs and dates, copy goes on the chart and a copy goes to the patient.**
- **Education is not complete if missing check marks or signature**

## STROKE Patient Education

This information is being provided to you to assist you in preventing and reducing the disabilities associated with those who may have had a stroke.

**Signs and Symptoms of a Stroke-If you see these in yourself or family member, CALL 911.**

Confusion	Dizziness	Numbness
Severe Headache	Loss of balance or coordination	Trouble with seeing
Trouble with walking	Trouble with speaking	Weakness in an arm or leg
Trouble with understanding		

**Risk factors that place you at danger for a stroke and what you can do to help reduce the risk.**

(Refer to your Risk Factors)

- Diabetes** - Monitor your glucose levels and share with your doctor at your follow up visits, take prescribed medications, limit sugar intake, low carbohydrate diet since uncontrolled diabetes can lead to stroke.
- Excess Alcohol Consumption** - Limit intake, some alcohol products can react with medications causing the medication to be ineffective and lead to a stroke.
- Family history of stroke** - Know your family history and see your doctor regularly since family history increases your possibility of having a stroke.
- Irregular heart rhythm/heart disease** - Be informed if you have an irregular heartbeat, take your medications as prescribed, monitor your blood levels with your doctor to decrease the chance of a stroke.
- High Blood Pressure** - Take your prescribed medications, get regular exercise, limit fat and salt in your diet, check your blood pressure at home and record for your doctor's visits, reduce stress.
- High Cholesterol** - Know your cholesterol and triglyceride levels, keep a low fat diet (low saturated fats low trans fat and low cholesterol), exercise regularly, and take your prescribed medications.
- Overweight** - Control portions at meals, exercise at least 2 ½ hours of moderate physical activity per week. Know your body mass index and keep it less than 25, weight loss reduces cholesterol and high blood pressure which contributes to decreasing your chances of having a stroke.
- Inactive Lifestyle** - Exercise at least 2 ½ hours of moderate physical activity per week (start with 10 minutes a day and work your way up) to assist in weight loss. An inactive lifestyle can lead to a stroke.
- Smoking** - Quit if you smoke. Talk with your doctor about smoking cessation aides, refer to stop smoking resources with your admission paperwork because smoking contributes to the increased chances of having a stroke.

**I will follow up with my doctor for my appointments and take my medications as prescribed.**

Patient Signature/Responsible Party \_\_\_\_\_ Date/Time \_\_\_\_\_



# Completed at Discharge

- Completed before the patient leaves the hospital
- As the nurse, all you can do is remind physicians. If they do not order the measures just document a **nurse's note** stating that you spoke to them so you, the nurse, are covered.
- If not ordered, physician **MUST** document contraindication.
  - Example: No anticoag @ risk for falls or bleeding risks
  - Example: no rehab consult because the patient returned to baseline with no deficits. The physician must document no rehab consult due to patient returning to baseline.



# Completed at Discharge

- ✓ Rehab consult
- ✓ If history of Afib/Aflutter, Anti-coagulant required @ discharge
  - ✓ Coumadin, Heparin, Pradaxa, Lovenox, Xarelto, Eliquis
- ✓ Antithrombotic required @ discharge
  - Aspirin, Coumadin, Plavix, Ticlid, Eliquis
- ✓ STATIN required at discharge if:
  - ✓ LDL greater than or equal to 70 or admitted on a STATIN (home med)
- ✓ NIH stroke scale
- ✓ Stroke Education

# Entering CORE MEASURE CONTRAINDICATION Orders

Choose pt – click ORDERS, click ORDERS again

My List of Patients (Last Updated: 09/19/17 0812) Nurse Status Board

Rn/Bed	Patient Name	MD	MEWS	PEWS	New Order	ePom	Next Med	BBK	
TempLoc	Status	A	S	C	MDROS:	Isolat	SuiRsk	Res	NextInt
	PHA-KW, ADULT				CPOE	0	Ack		0930
	PRE IN 61 F						Stand		0900

Protocol

- Allergies
- Admin Data
- Assessment
- Reconcile Rx
- Process Int
- PI Loc/List
- Monitor
- Plan of Care
- Pt Notes
- eMAR
- Transfusions
- Orders
- Ack/Ver
- Review
- References
- E-Mail
- Flowsheet
- Print Report
- Variance

More [ ] More [ ] →

Location Find Patient Manage List Options Select Board Exit

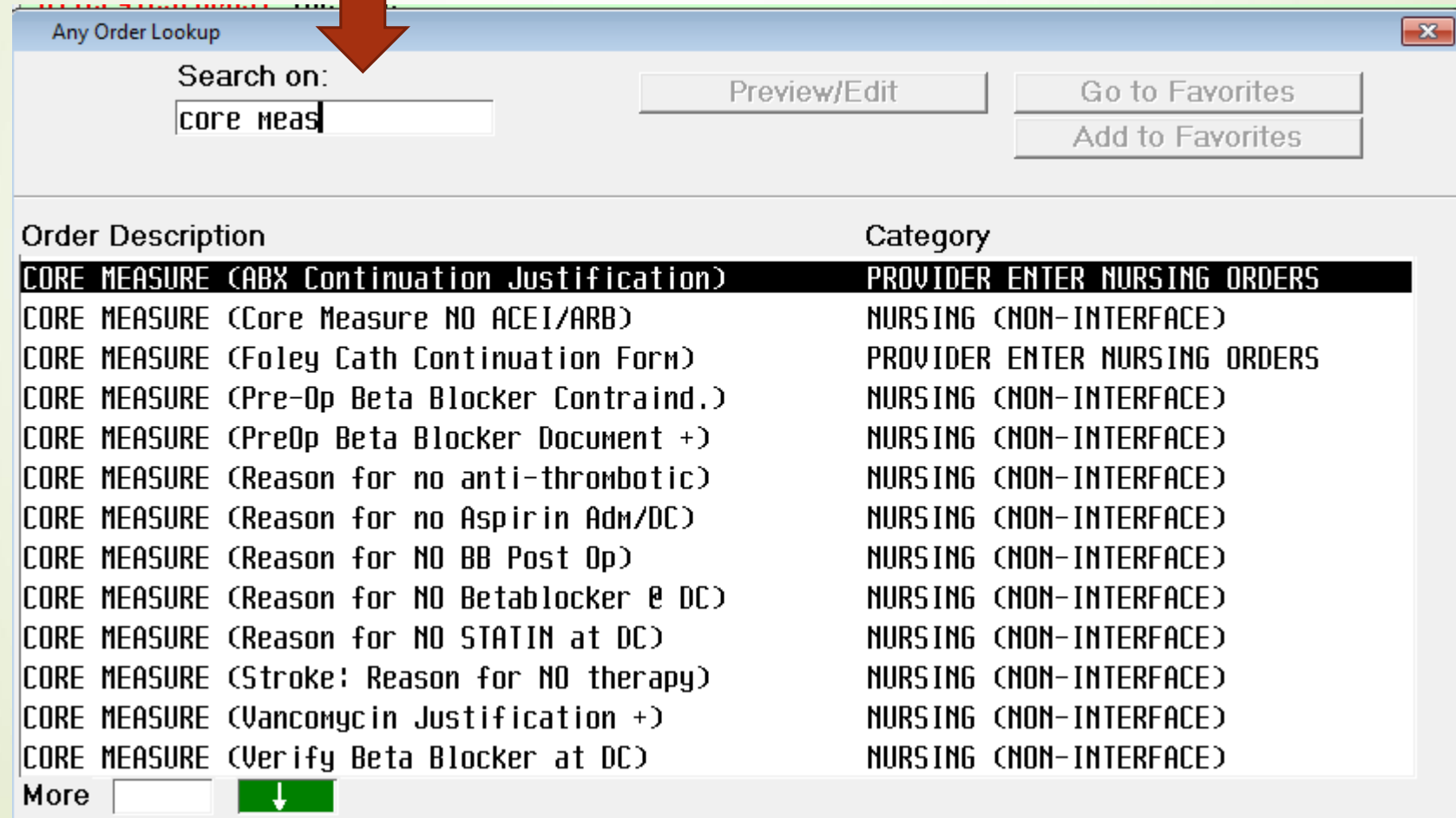
Current All Session

+	Category	Orders	Pri	Date/Time	Status	Stop	My
+	Admit/Transfer/DC* (1)						
+	Nursing* (1)						
+	MEDICATION/IV* (10) Sort						
+	Cardiopulmonary* (2)						
+	Other (3)						

Allergies

- View/Change
- Renew/Repeat
- Hold Resume
- DC
- Undo
- Order Sets
- Orders
- Meds/Fluids
- Save as Set
- Notifications
- Cont from AMB
- Reconcile Meds
- Transfer Receive
- Discharge Plan
- Preferences

Type in **CORE MEASURE** to pull up all **CORE MEASURE orders**, then choose the **REASON** based on MD reason for not ordering\_\_\_\_\_.



The screenshot shows a software window titled "Any Order Lookup". At the top, there is a search bar with the text "Search on:" and a text input field containing "core meas". To the right of the search bar are two buttons: "Preview/Edit" and "Go to Favorites". Below the search bar is another button labeled "Add to Favorites". The main area of the window displays a list of search results in a table format. The first row is highlighted in black. The table has two columns: "Order Description" and "Category".

Order Description	Category
<b>CORE MEASURE (ABX Continuation Justification)</b>	<b>PROVIDER ENTER NURSING ORDERS</b>
CORE MEASURE (Core Measure NO ACEI/ARB)	NURSING (NON-INTERFACE)
CORE MEASURE (Foley Cath Continuation Form)	PROVIDER ENTER NURSING ORDERS
CORE MEASURE (Pre-Op Beta Blocker Contraind.)	NURSING (NON-INTERFACE)
CORE MEASURE (PreOp Beta Blocker Document +)	NURSING (NON-INTERFACE)
CORE MEASURE (Reason for no anti-thrombotic)	NURSING (NON-INTERFACE)
CORE MEASURE (Reason for no Aspirin Adm/DC)	NURSING (NON-INTERFACE)
CORE MEASURE (Reason for NO BB Post Op)	NURSING (NON-INTERFACE)
CORE MEASURE (Reason for NO Betablocker @ DC)	NURSING (NON-INTERFACE)
CORE MEASURE (Reason for NO STATIN at DC)	NURSING (NON-INTERFACE)
CORE MEASURE (Stroke: Reason for NO therapy)	NURSING (NON-INTERFACE)
CORE MEASURE (Vancomycin Justification +)	NURSING (NON-INTERFACE)
CORE MEASURE (Verify Beta Blocker at DC)	NURSING (NON-INTERFACE)

At the bottom left of the window, there is a "More" label followed by a small white box and a green button with a white downward-pointing arrow.

# Core Measures – Keys to Success

- Core Measure Checklists to be used on all patients with Core Measure Dx.
- Charge Nurse on each unit to run IMM and VTE reports every shift and ensure completion.

## Outlier Process

- 1<sup>st</sup> Core Measure Fallout: Nurse will complete Healthstream training on Core Measures.
- 2<sup>nd</sup> Fall out for same measure: Nurse will meet with CNO/ACNO.
- 3<sup>rd</sup> Fall out for same measure: Nurse will be referred to Nursing Peer Review.





# FINAL TIPS

- All shift reports/hand-offs will utilize the Checklist to ensure all Core Measure elements are complete and documented
- Do not go back and fill in an empty checklist if you were not the nurse that was responsible for that element. Check off only the elements that you completed.
- Contact Information for any questions:

- **Core Measure Nurses**

Jen Caribardi, RN \*8 8893

Kilee Northrup, RN \*8 8249

- **Chest Pain Coordinator**

Teri Shaath, RN \*8 8535

- **Sepsis Coordinator**

Regina Hall, RN \*8 8242

- **Stroke Coordinator**

Elyse Lassley, RN \*8 8153

Thank  
You

