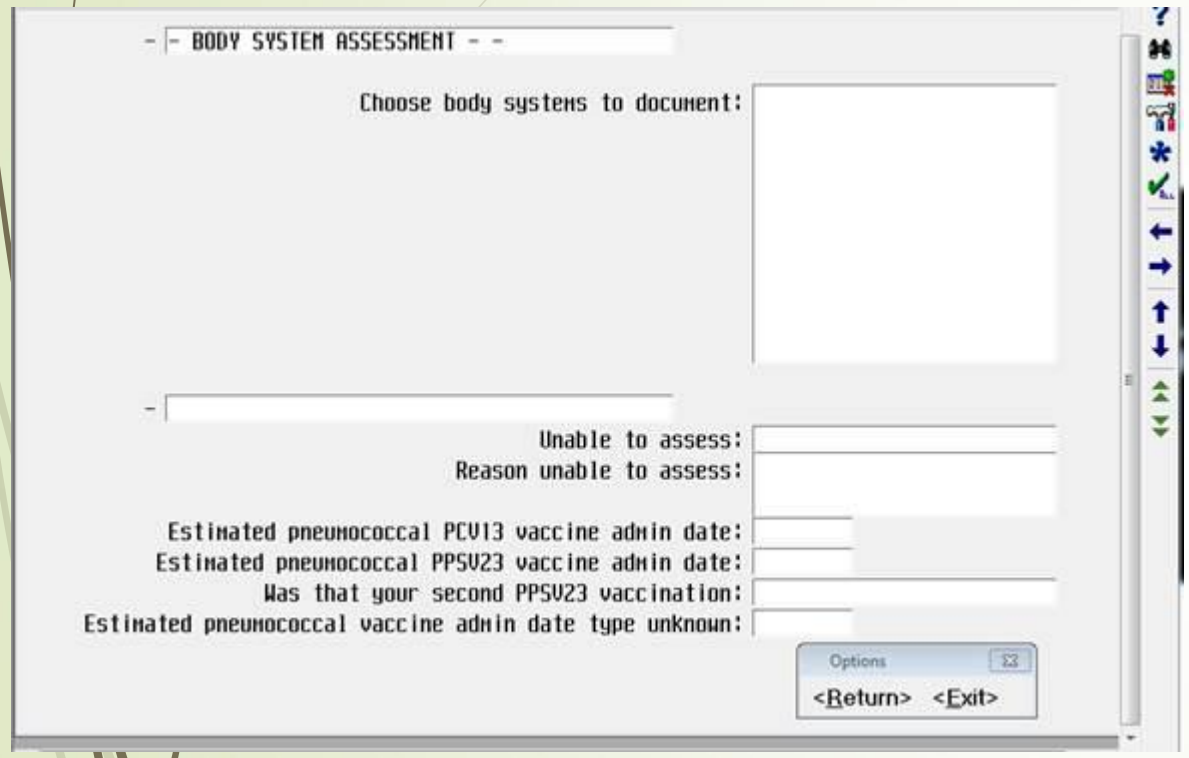
KINGWOOD
MEDICAL CENTER
An HCA Affiliated Hospital

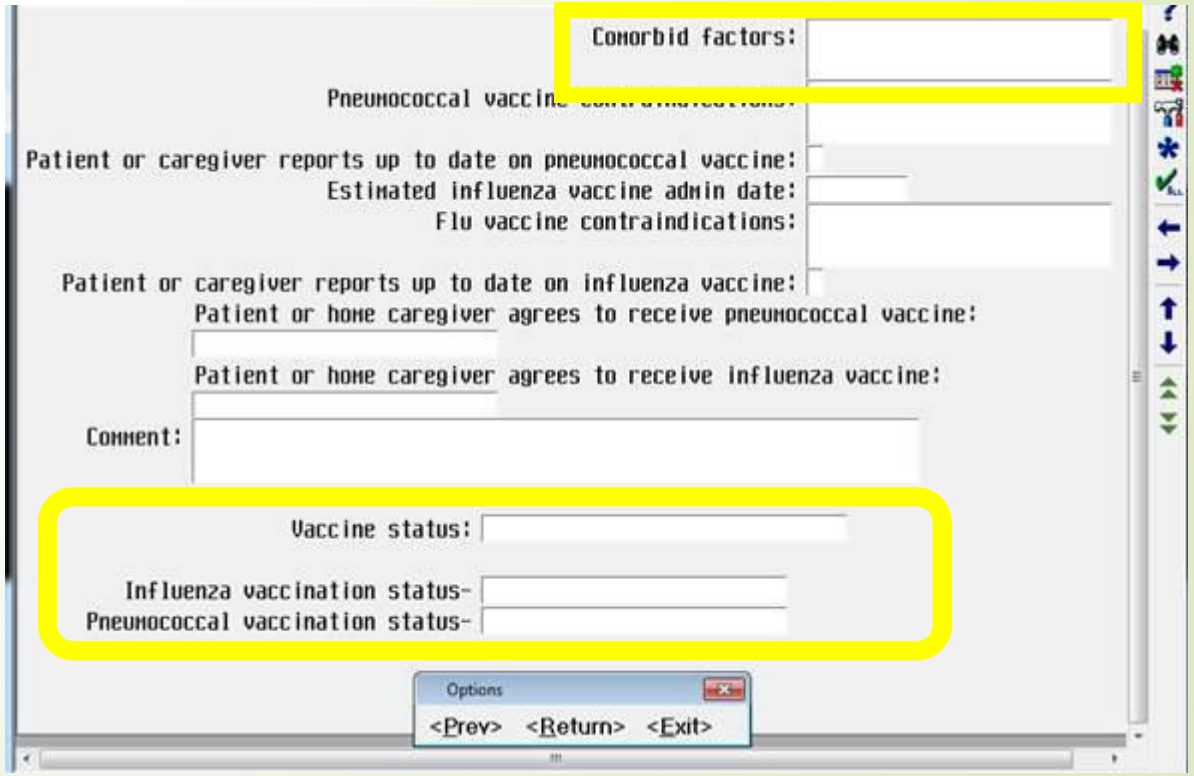
Core Measure Education

IMMUNIZATIONS

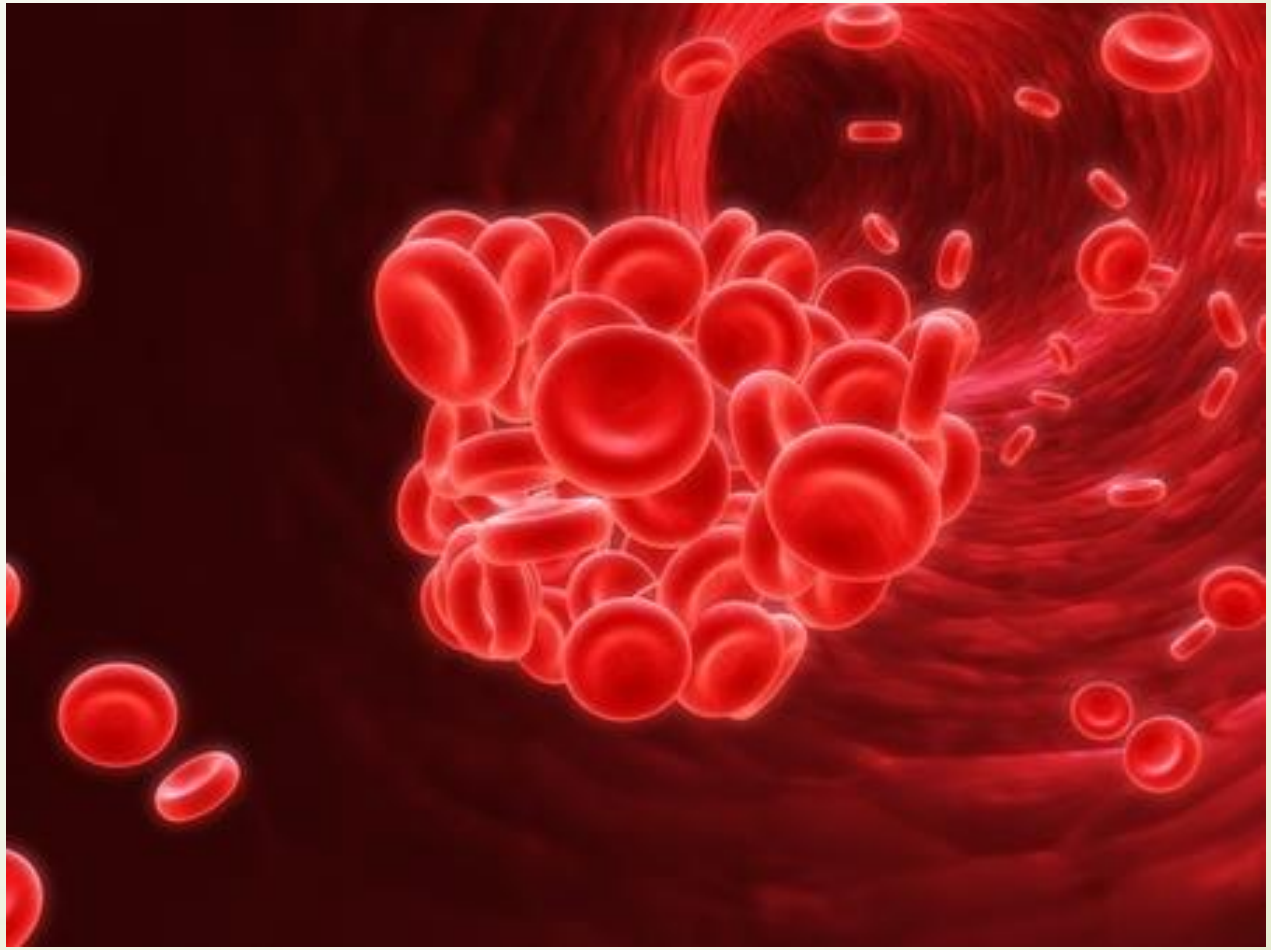
- Flu season is from October 1 at 00:01 through March 31 at 24:00.
- Every patient must be assessed for Flu and Pneumonia Vaccine
- If patient is confused, comatose or sedated, contact the patient's decision-maker.
- You must address immunizations one last time at discharge. This is your last chance 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





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.

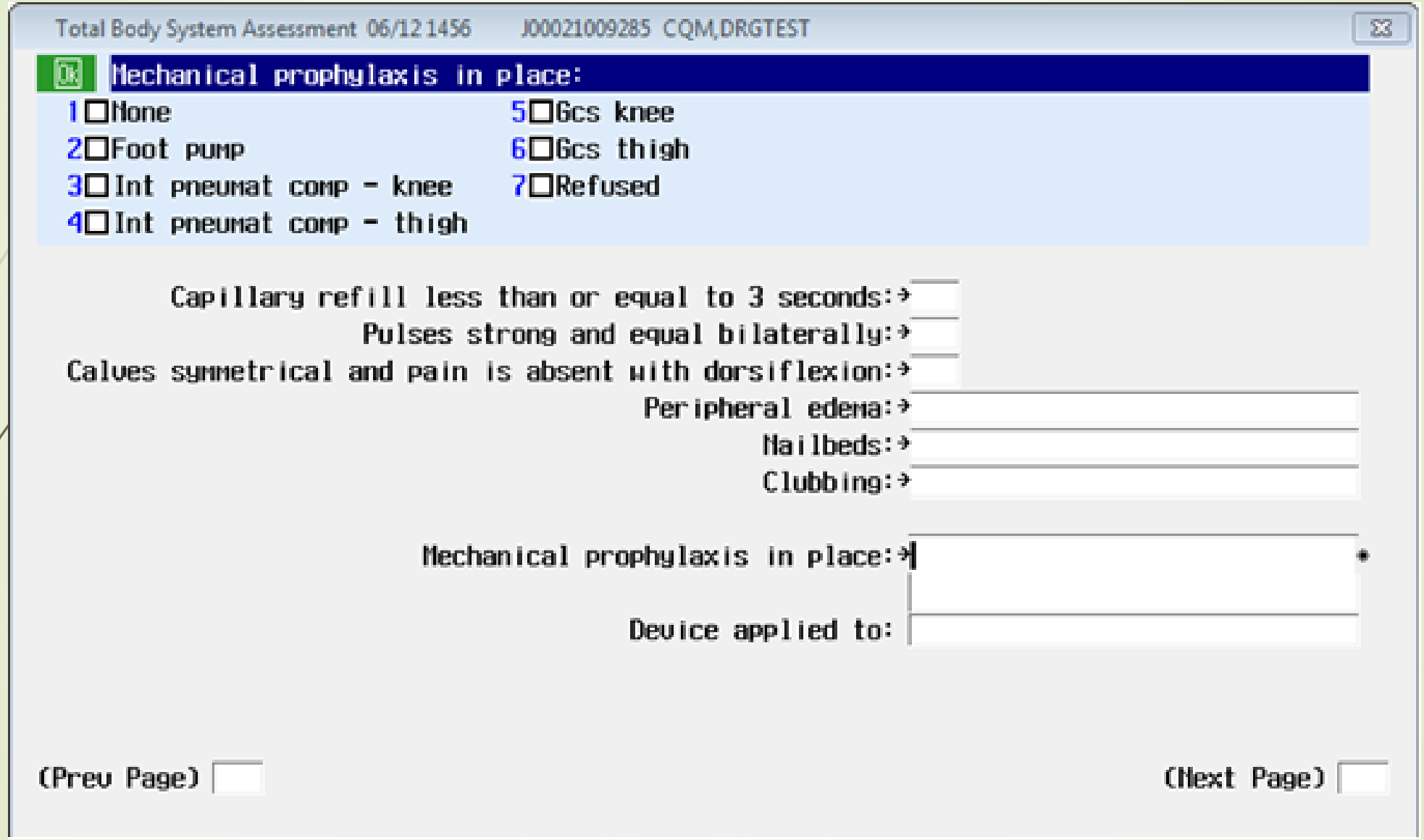
Documenting Vaccinations in CPN (For L&D, APU, and PPU nurses)

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:

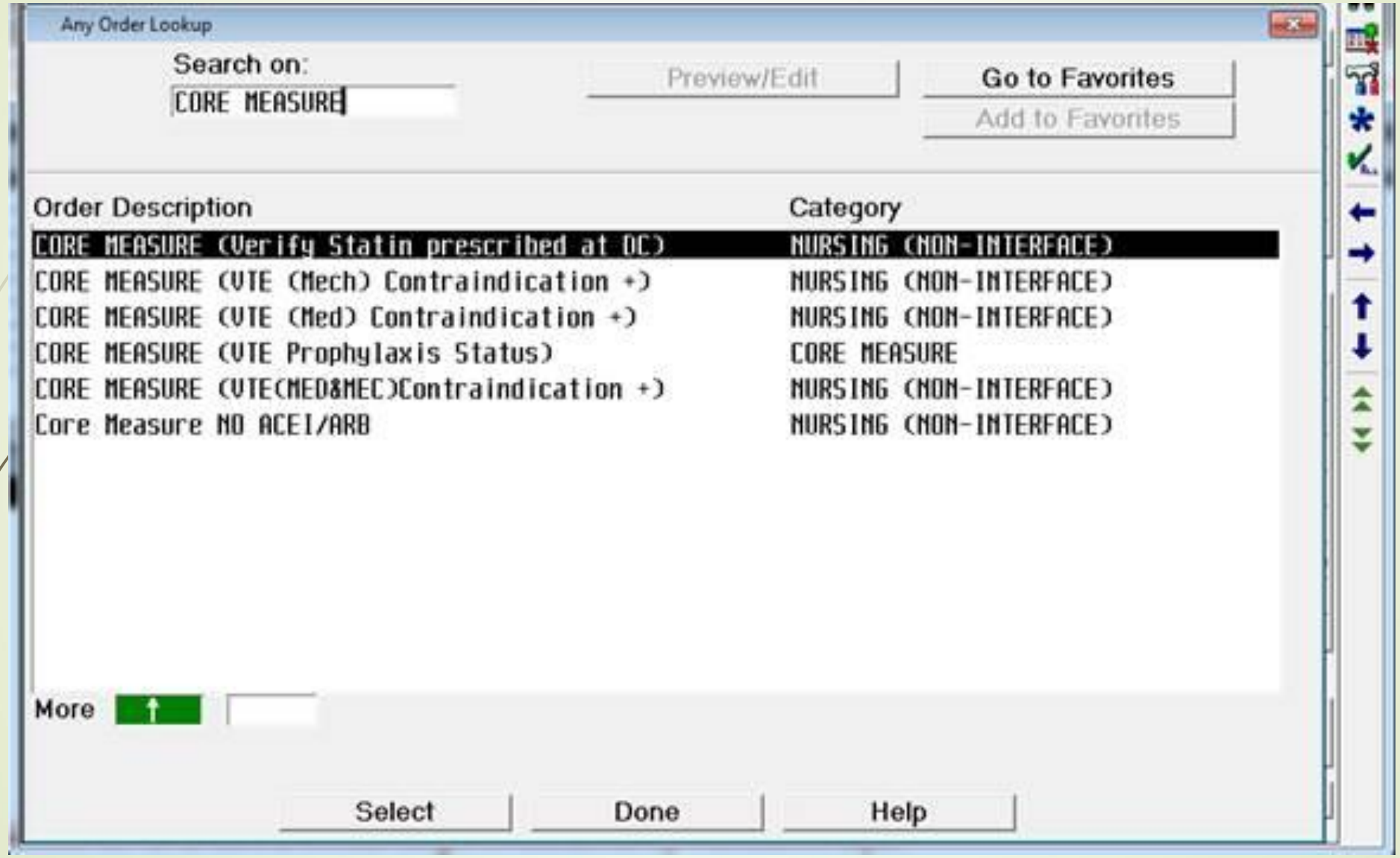
- **Adult Admission Assessment**
- **Adult Flowsheet**
- **Adult Meds/Intervention**
- **Adult Review of Systems**
- **Intraoperative Record**
- **Recovery Record**
- **PP Flowsheet**
- **PP Safety Assessment**
- **PP Review of Systems**

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

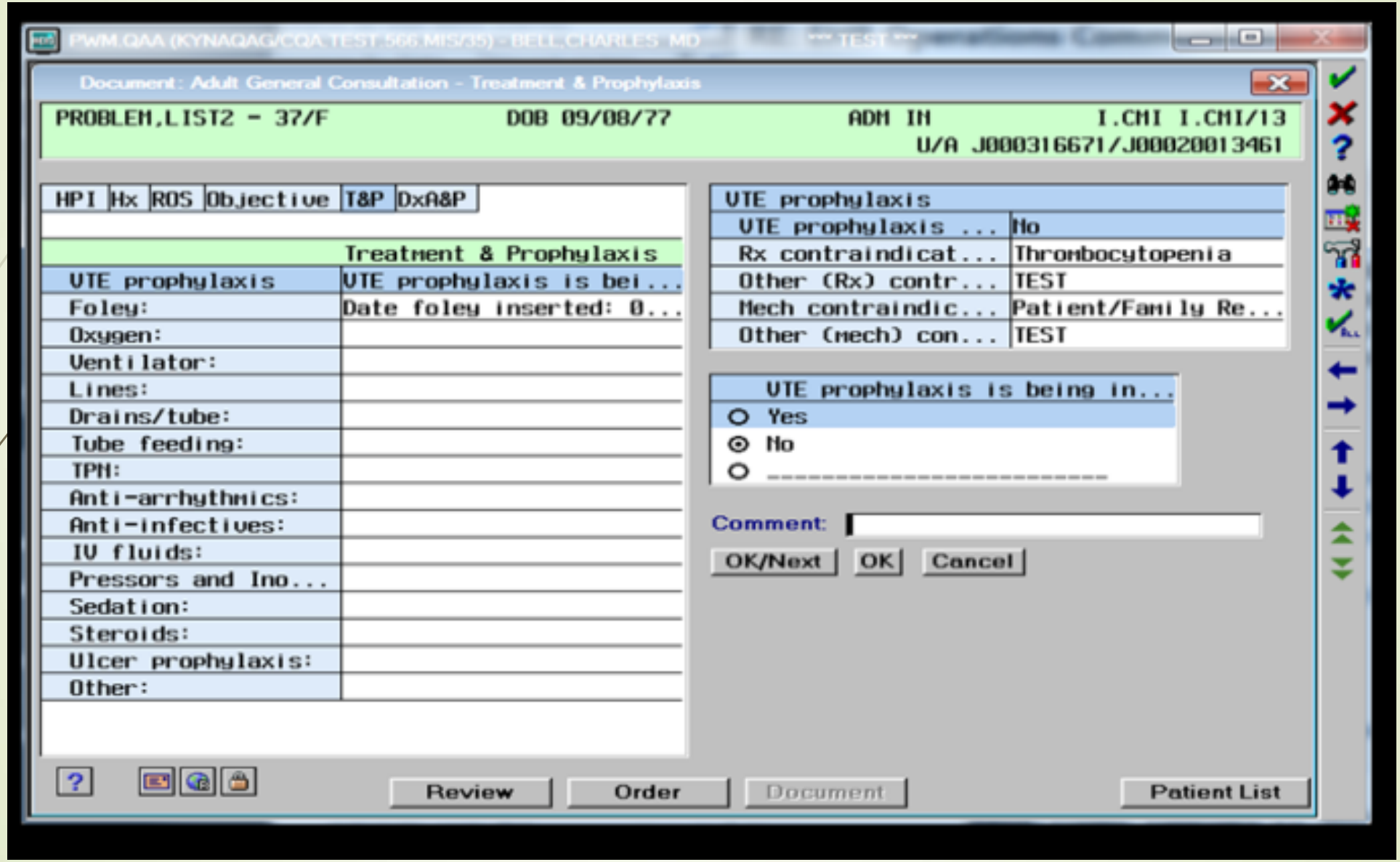
Shift Assessment VTE Screening



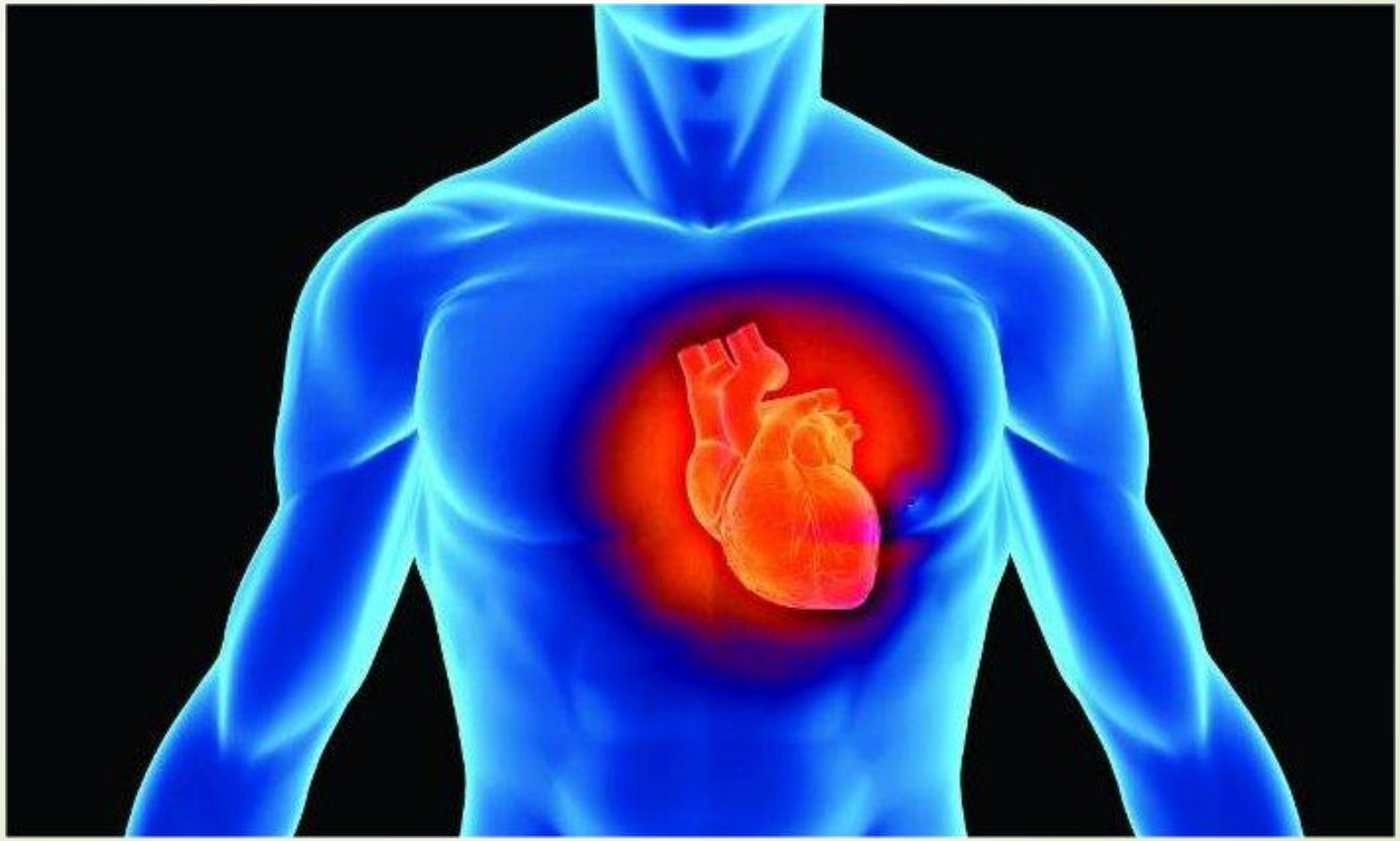
CPOE VTE Contraindication Order:

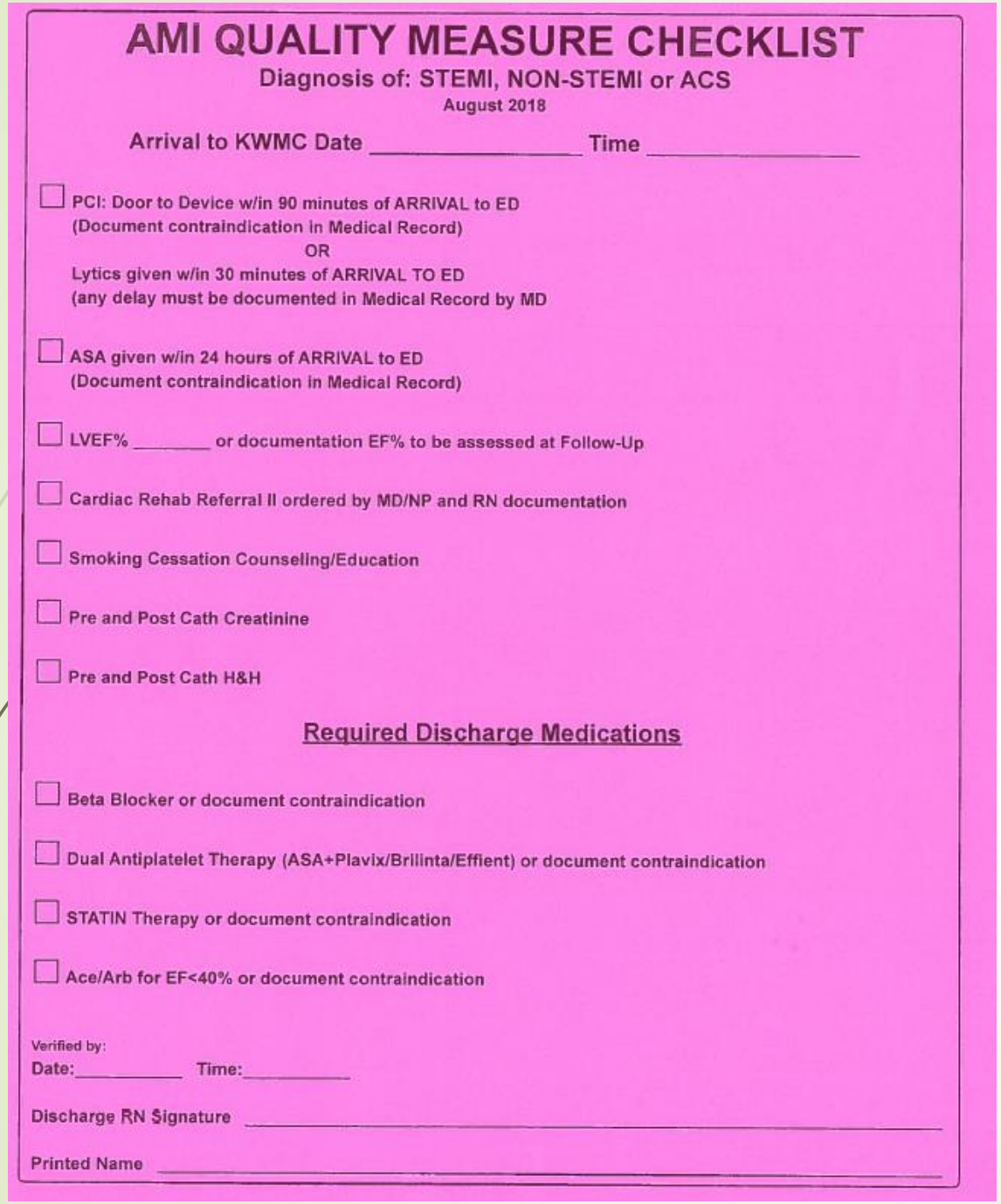


Physician VTE Contraindication note in pDOC:



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 _____

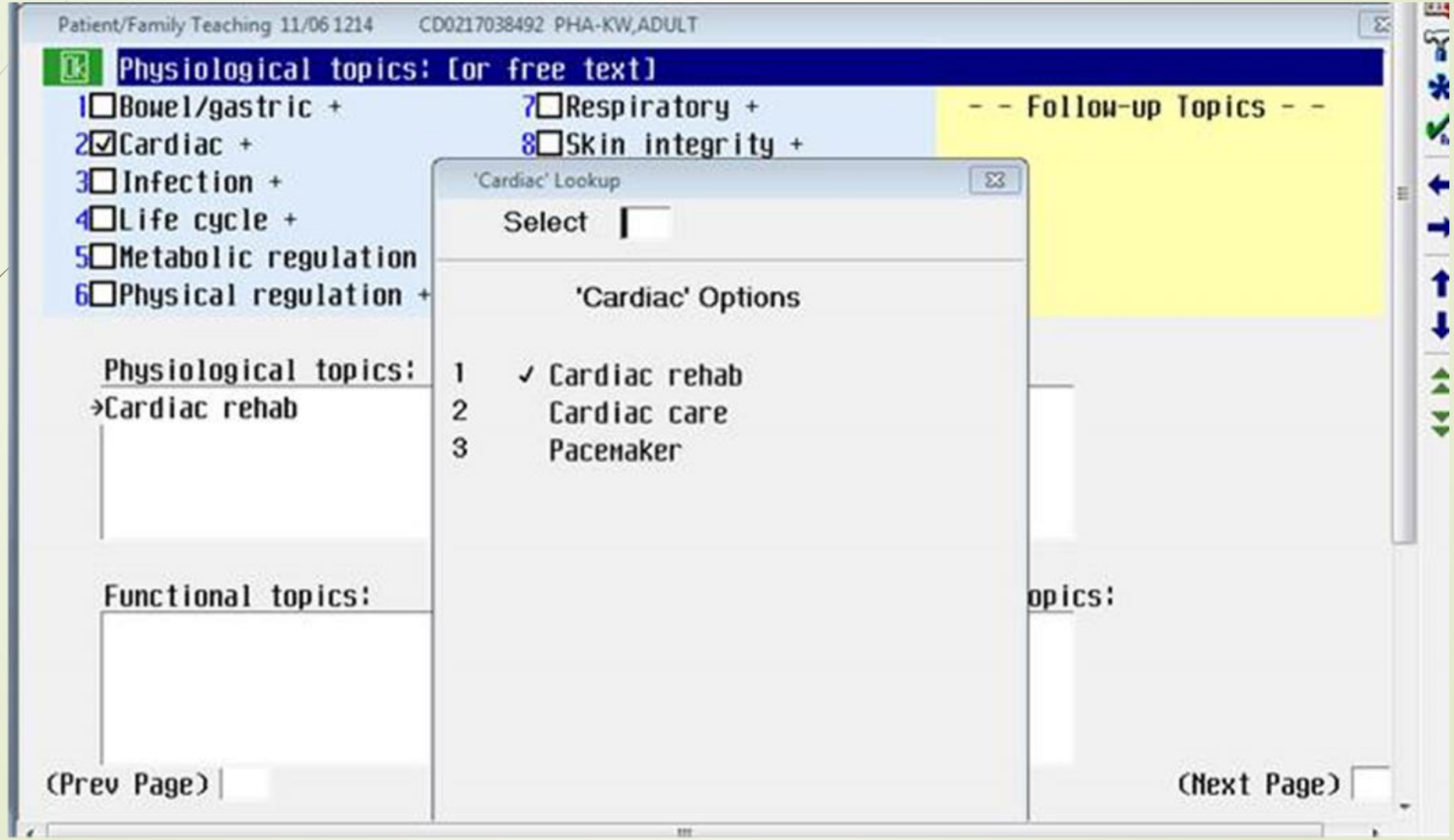
Printed Name _____

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

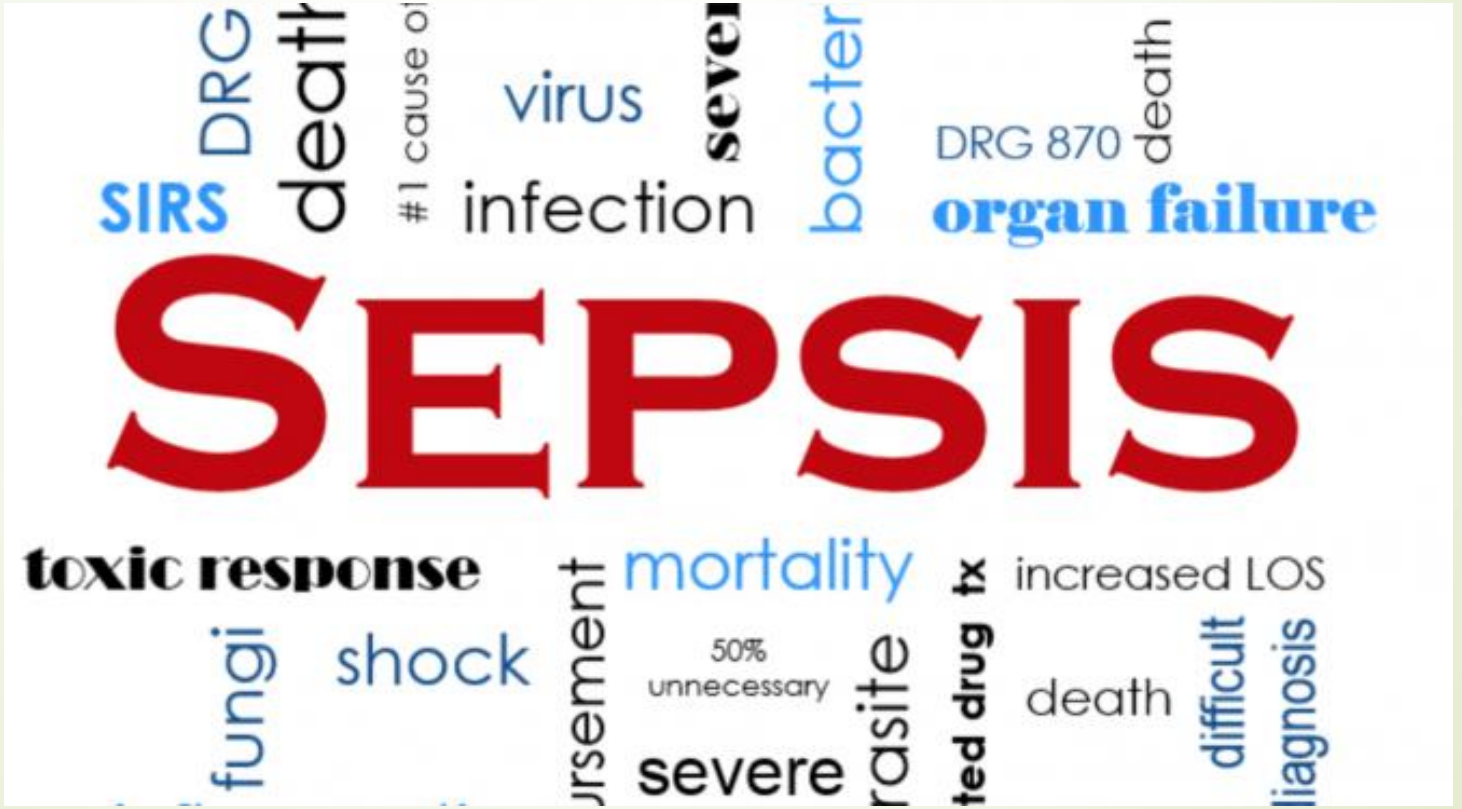
- When a patient presents to the hospital with any Dx of: STEMI/Non-STEMI/ACS, Rule Out MI, Chest Pain, Elevated Troponins, Cardiac Arrest, follow the AMI Checklist.
- LVEF% must be new post MI or physician must document plan to reassess outpatient.
- Completion of checklist will ensure a successful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

Cardiac Rehab Education

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



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 >/= 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
DATE / TIME : :

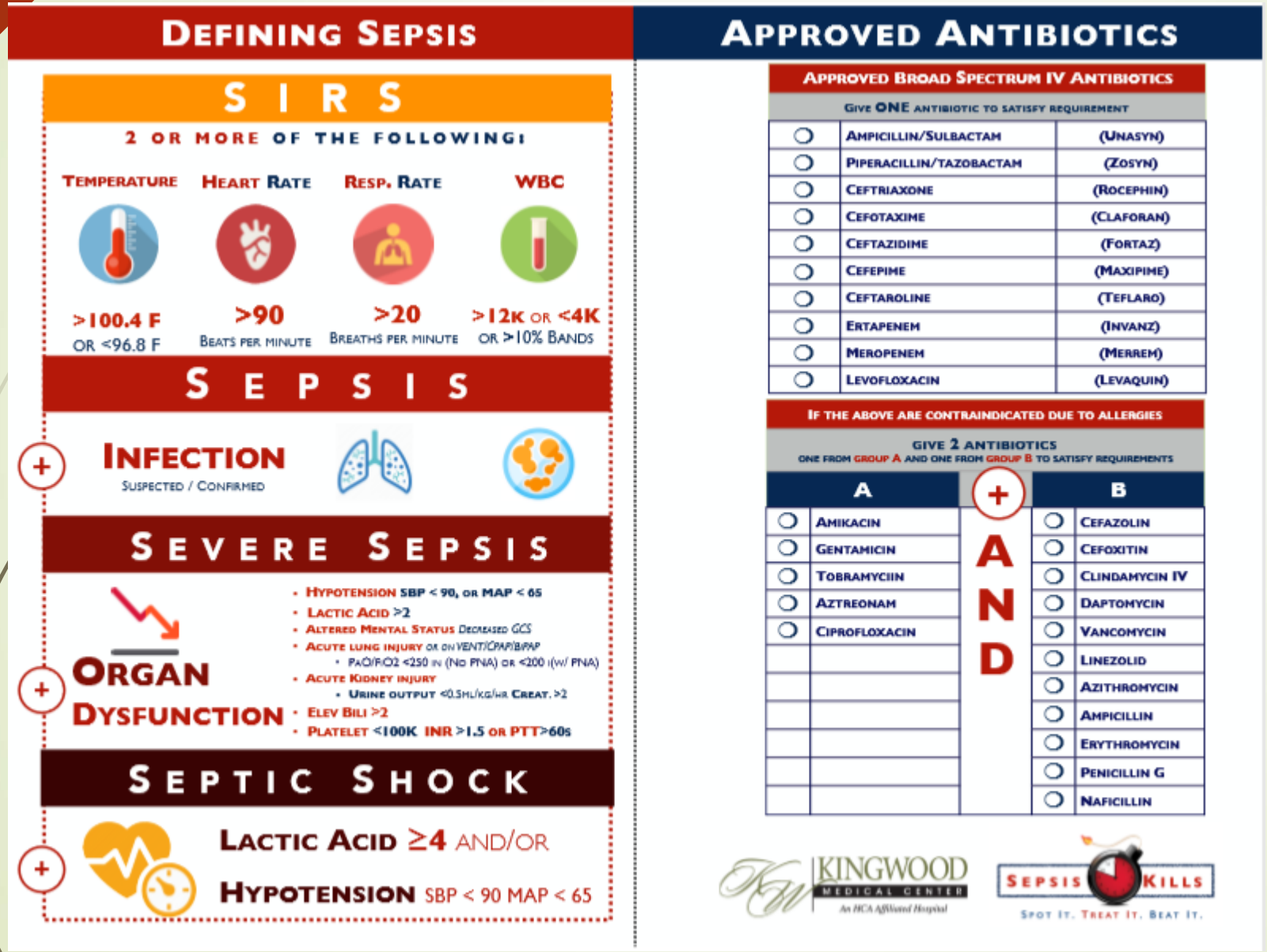
TIME ZERO IS THE EARLIEST OF 3:
1. IN ED: TRIAGE TIME
2. MD DOCUMENTS SEVERE SEPSIS/SEPTIC SHOCK
3. 2 SIRS + INFECTION + 1 ORGAN DYSFUNCTION PRESENTS.

	GOAL TIME	MEASURE	COMPLETED	REASON NOT COMPLETED	TIME	NOTE
SEVERE SEPSIS & SEPTIC SHOCK						
	0 MIN	"CODE SEPSIS" CALLED	○		:	CODE TO BE CALLED OVERHEAD AND SENT ON IMOBILE
	5 MIN	BLOOD CULTURE	○		:	DRAWN BEFORE IV ANTIBIOTIC (CMS 1-35) IF ATTEMPTED AND FAILED, DOCUMENT "BLOOD CULTURES ATTEMPTED AND FAILED." (CMS 1-139)
	5 MIN	LACTATE # 1	○	RESULT: IF >2 WILL NEED TO REPEAT	COLLECTION TIME :	IF ATTEMPTED AND FAILED, DOCUMENT "LACTATE ATTEMPTED AND FAILED." (CMS 1-139)
	10 MIN	ANTIBIOTIC START	○		EMAR SCAN TIME :	START ADMINISTRATION WITHIN 60 MINUTES SEE BACK PAGE FOR APPROVED ANTIBIOTIC CHOICES. (CMS 1-47)
	60 MIN	LACTATE # 2	○	RESULT:	COLLECTION TIME :	DRAW ASAP AFTER 1ST FLUID BOLUS (CMS 1-186)
IF SEPTIC SHOCK PRESENT CONTINUE BELOW						
	10 MIN	IV FLUID BOLUS (CONSIDER EV-1000)	○		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.** IF HEMODYNAMICS/ VOLUME OVERLOAD ARE OF CONCERN UTILIZE EV-1000 TO TAILOR FLUID MANAGEMENT (CMS 1-85)
ONE HOUR FOLLOWING IV BOLUS COMPLETION		RN REASSESSMENT: DOCUMENT 2 BPS	○	BP #1 /	:	INFORM MD IF HYPOTENSION OR ELEVATED LACTATE PERSISTS
			○	BP #2 /	:	EXAMPLE: IVF EMAR SCAN @1200 , INFUSION COMPLETES @ 1300 , PERFORM 2 BLOOD PRESSURE READINGS BETWEEN 1300-1400
		REMIND PROVIDER SEPTIC SHOCK FOCUSED EXAM	○		:	IF PATIENT HAS SEPTIC SHOCK-AND NS 30 ML/KG COMPLETED THE MD/NP/PA MUST DOCUMENT REASSESSMENT AS FOLLOWS: <DATE/TIME> "SEPSIS EXAM DONE" OR CHECK "TISSUE PERFUSION REASSESSMENT DONE" IN FLOC
		VASOPRESSORS IF PERSISTENT HYPOTENSION	○	○ NOT REQUIRED	:	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

SIRS

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

Sepsis

\+ **Infection** — Suspected / Confirmed

Severe Sepsis

\+ **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/FiO2 <250 in (No PNA) or <200 i(w/ PNA)
- Acute Kidney Injury
  - Urine output <0.5mL/kg/hr Creat. >2
- Elev Bili >2
- Platelet <100K INR >1.5 or PTT>60s

Septic Shock

\+ **Lactic Acid ≥4** and/or **Hypotension** SBP < 90 MAP < 65

Approved Antibiotics

Approved Broad Spectrum IV Antibiotics

Give ONE antibiotic to satisfy requirement

○	Ampicillin/Sulbactam	(Unasyn)
○	Piperacillin/Tazobactam	(Zosyn)
○	Ceftriaxone	(Rocephin)
○	Cefotaxime	(Claforan)
○	Ceftazidime	(Fortaz)
○	Cefepime	(Maxipime)
○	Ceftaroline	(Teflaro)
○	Ertapenem	(Invanz)
○	Meropenem	(Merrem)
○	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	
○	Amikacin	AND	○	Cefazolin
○	Gentamicin		○	Cefoxitin
○	Tobramyciin		○	Clindamycin IV
○	Aztreonam		○	Daptomycin
○	Ciprofloxacin		○	Vancomycin
			○	Linezolid
			○	Azithromycin
			○	Ampicillin
			○	Erythromycin
			○	Penicillin G
			○	Naficillin

KINGWOOD MEDICAL CENTER — An HCA Affiliated Hospital

SEPSIS KILLS — Spot It. Treat It. Beat It.

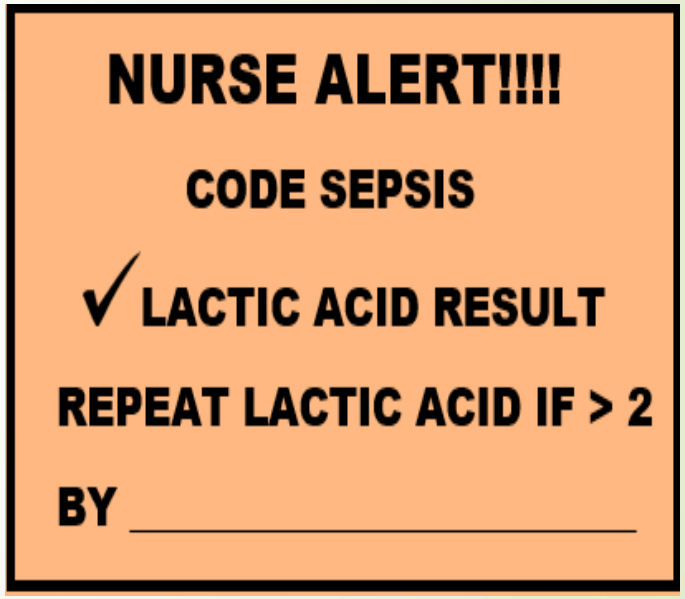
Notes:

- 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.

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 2nd LA after IVF bolus given or 1-2 hours after initial LA collected.



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

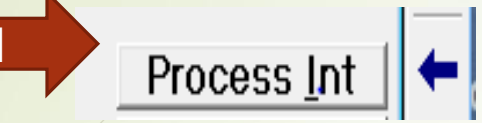
- New Orders (6)					
Code Sepsis Protocol Guideline (NUR.PH		11/12 N	New		*
LACTIC ACID (LAB)	Stat	11/12 N	New		*
CREATININE (LAB)	Stat	11/12 N	New		*
BILIRUBIN TOTAL (LAB)	Stat	11/12 N	New		*
PLATELET COUNT (LAB)	Stat	11/12 N	New		*
CULTURE BLOOD (MIC)	Stat	11/12 N	New		*

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.

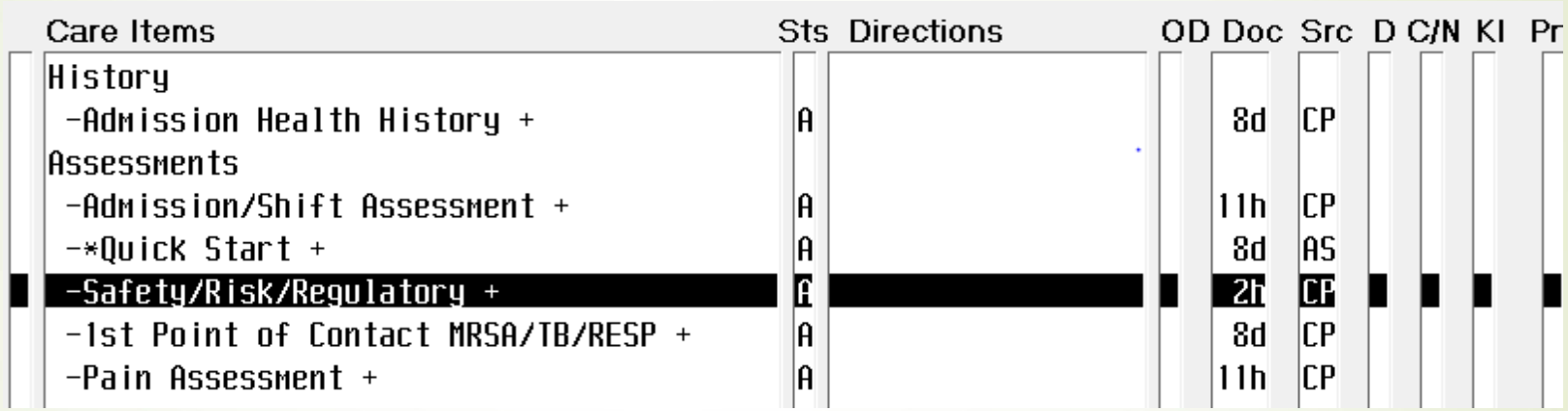
ED/In-patient Meditech Sepsis Screenings

#1

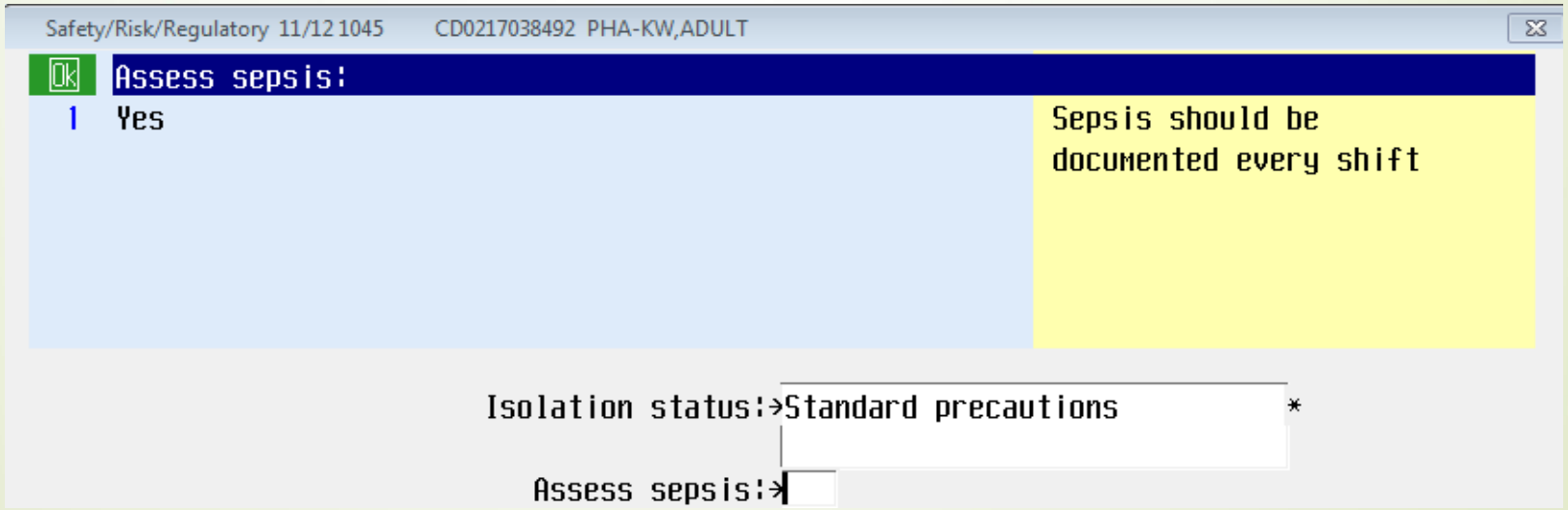


(From Nurse Status Board, Select Patient & then Process Intervention)

#2



#3



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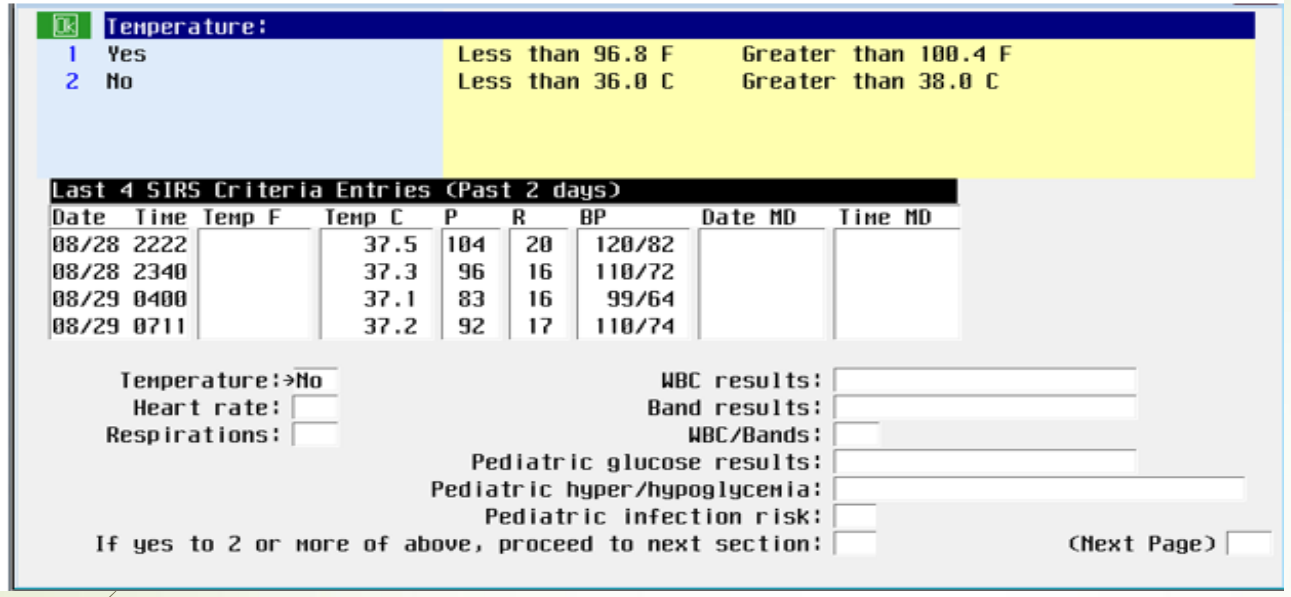
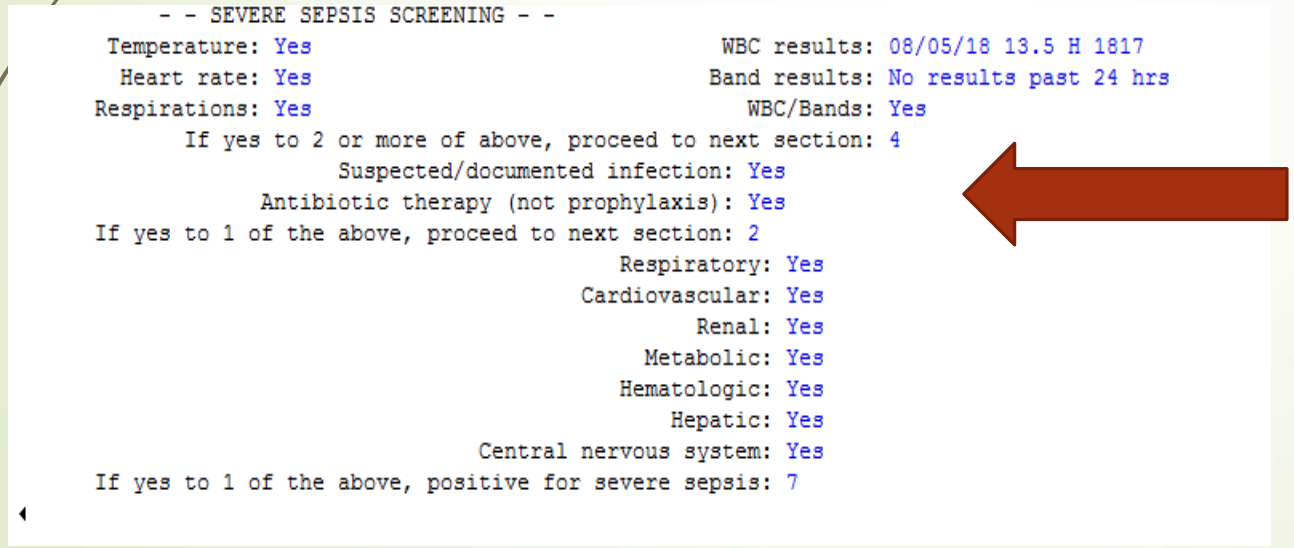
#4

Sepsis Screening:



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

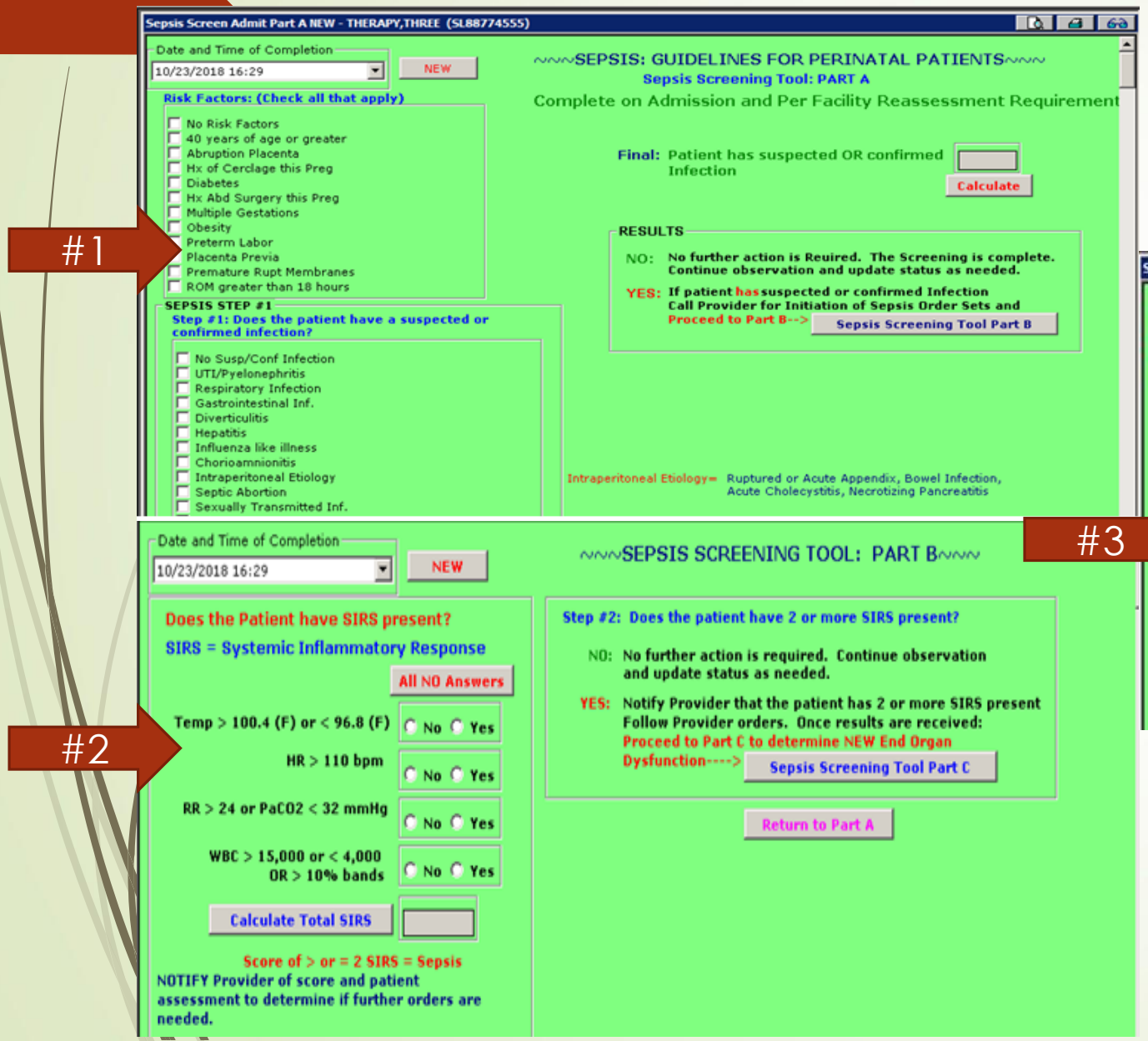
When you finish, your sepsis screening will look like this:



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.

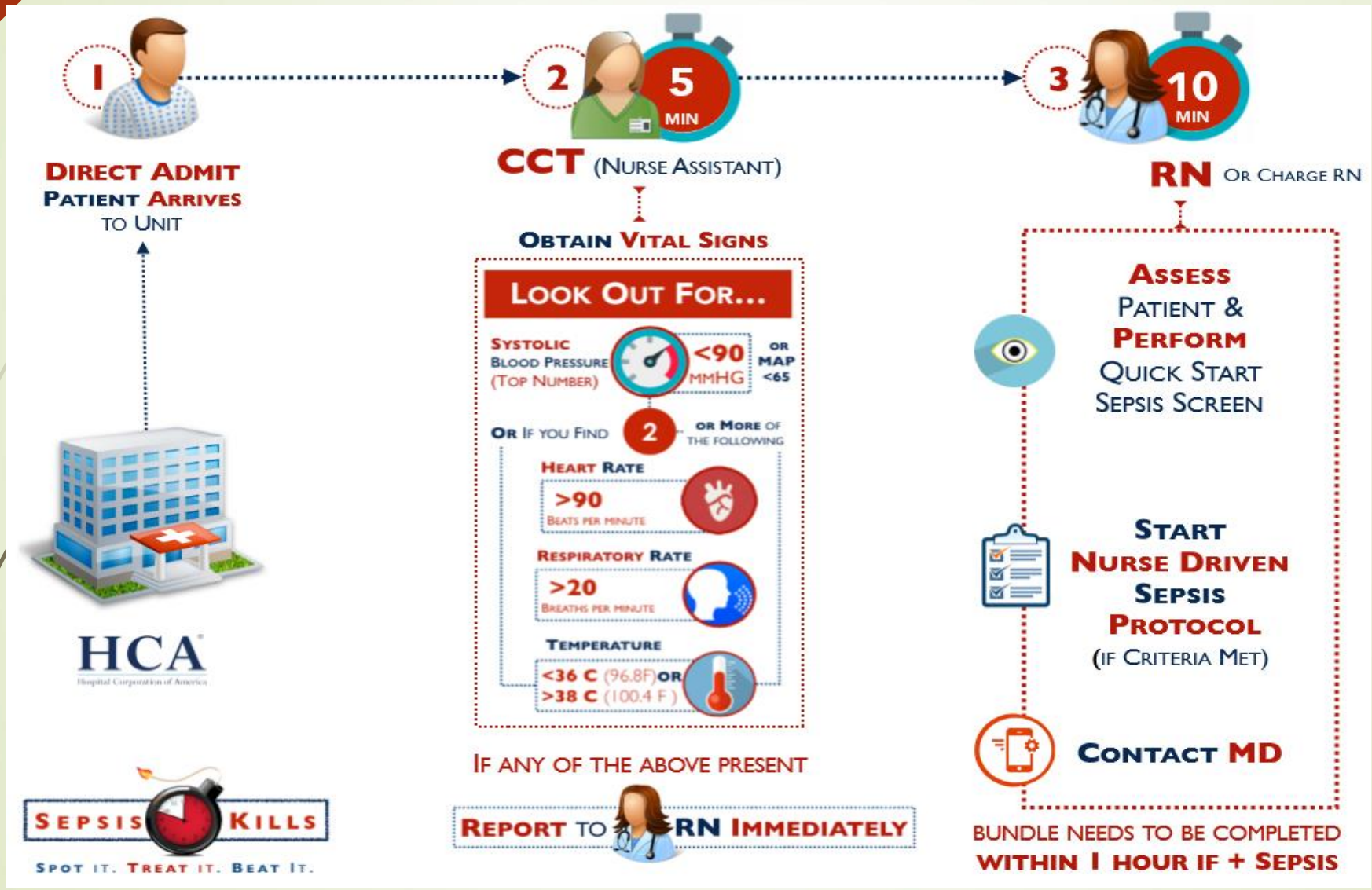
GOAL: administer **antibiotics within the hour of sepsis presentation.**

CPN In-patient Sepsis Screenings:



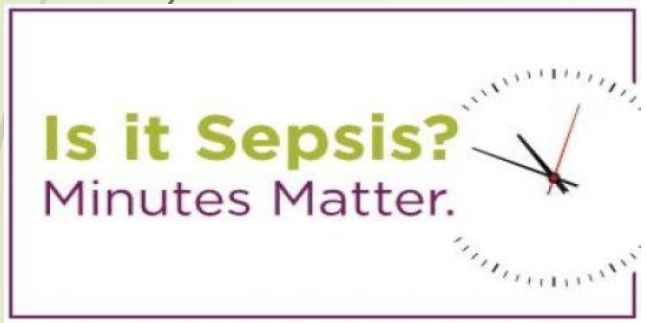
Each Screen tells you what to do next

Direct Admissions Sepsis Screen Procedure



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

Putting it all together:



Hour-1 Bundle

Surviving Sepsis Campaign

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.

1. **Measure lactate level.** Remeasure lactate if initial lactate elevated (> 2mmol/L).
2. **Obtain blood cultures before administering antibiotics.**
3. **Administer broad-spectrum antibiotics.**
4. **Begin rapid administration of 30 ml/kg crystalloid for hypotension or lactate > 4 mmol/L**
5. **Apply vasopressors if hypotensive during or after fluid resuscitation to maintain a mean arterial pressure ≥ 65 mm Hg.**

Bundle: SurvivingSepsis.org/Bundle **Complete Guidelines: SurvivingSepsis.org/Guidelines**

Society of Critical Care Medicine

ESICM

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 1st RN starts CM Checklist	YES	No	NA
ER Physician IV Alteplase **Door to Needle must be < 45 minutes**!!! 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 ***SWALLOW SCREEN BEFORE** any MEDICATIONS/Food/Fluids* 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 ***Antithrombotic by end of Hospital Day 2*** ASA, Coumadin, Plavix, Ticlid, Heparin, Lovenox			REQ REQ REQ REQ REQ
Attending MD, Day 2 Nurse: ***DVT Prophylaxis* by end of Hospital DAY 2 (SCD's!)** 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**			REQ REQ REQ REQ REQ
Attending PHYSICIAN/ NURSE (DOOR to Draw 48 hours) *Fasting NOT REQUIRED:* **Lipid Profile** *first 48 hours* or past 30 days LDL _____			REQ REQ REQ REQ
Attending MD/DISCHARGE NURSE: **REHAB Consult PT, OT, ST or REHAB Eval documented** (unless MD or NP states not eligible for rehab returned to prior level of function or unable to do rehab)			REQ REQ REQ REQ
Attending MD/ DISCHARGE NURSE: **Patient with Hx Atrial Fib/Flutter Anti-Coag Required @ Discharge** 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: **Antithrombotic @ Discharge** or contraindication/order written ASA, Coumadin, Plavix, Ticlid			REQ REQ REQ REQ REQ
DISCHARGE MD/Nurse **STATIN Required @ Discharge if; LDL ≥ 70 or Admit on Statin** **Admit on Statin = MUST discharge on Statin** *unless contraindication documented* *Intensive Statin Dosage*			REQ REQ REQ REQ REQ REQ
Attending MD/Discharge NURSE: Smoking Cessation *Smoke = 1 cigarette past* ***last year***, document cessation education			
DISCHARGE NURSE/MD: 5 Elements *Select #11 Stro/TIA* **Educate pt &/or family**: "call 911 or EMS" ***personal risk factors***, *Signs & Symptoms*, Meds, & MD f/u ***Get risk factors sheet signed** & Select TIA/Stroke on Discharge Assessment*			REQ REQ REQ REQ REQ REQ
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)

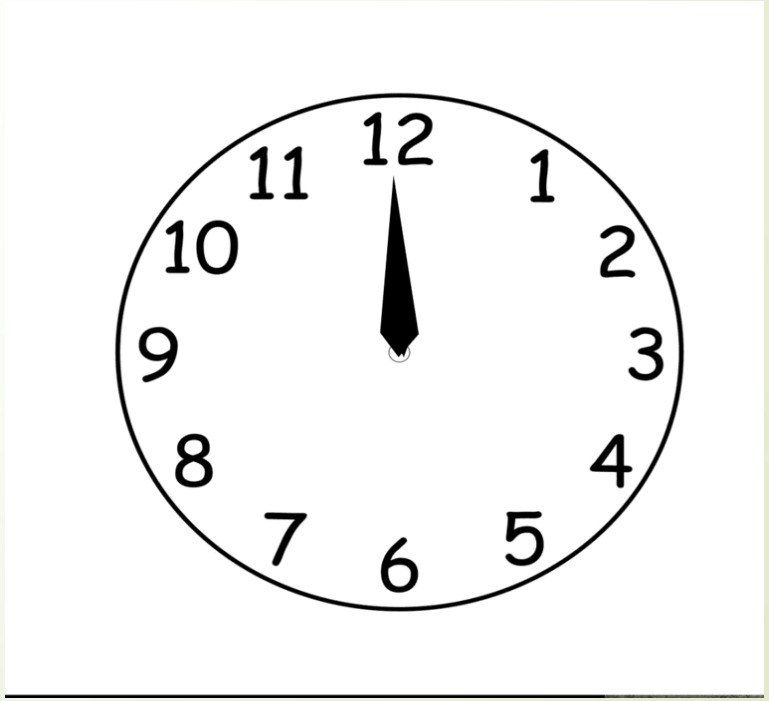
- ✓ DVT Prophylaxis by end of day 2 **(SCDs for NEURO)**
  - **Nurse must apply SCDs**
  - Anticoagulant ie, Heparin, Lovenox, Coumadin, Pradaxa
  - If the patient does not qualify for anticoagulant due to bleed, the **physician must document** rationale for holding medication.
- ✓ Lipid profile first 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

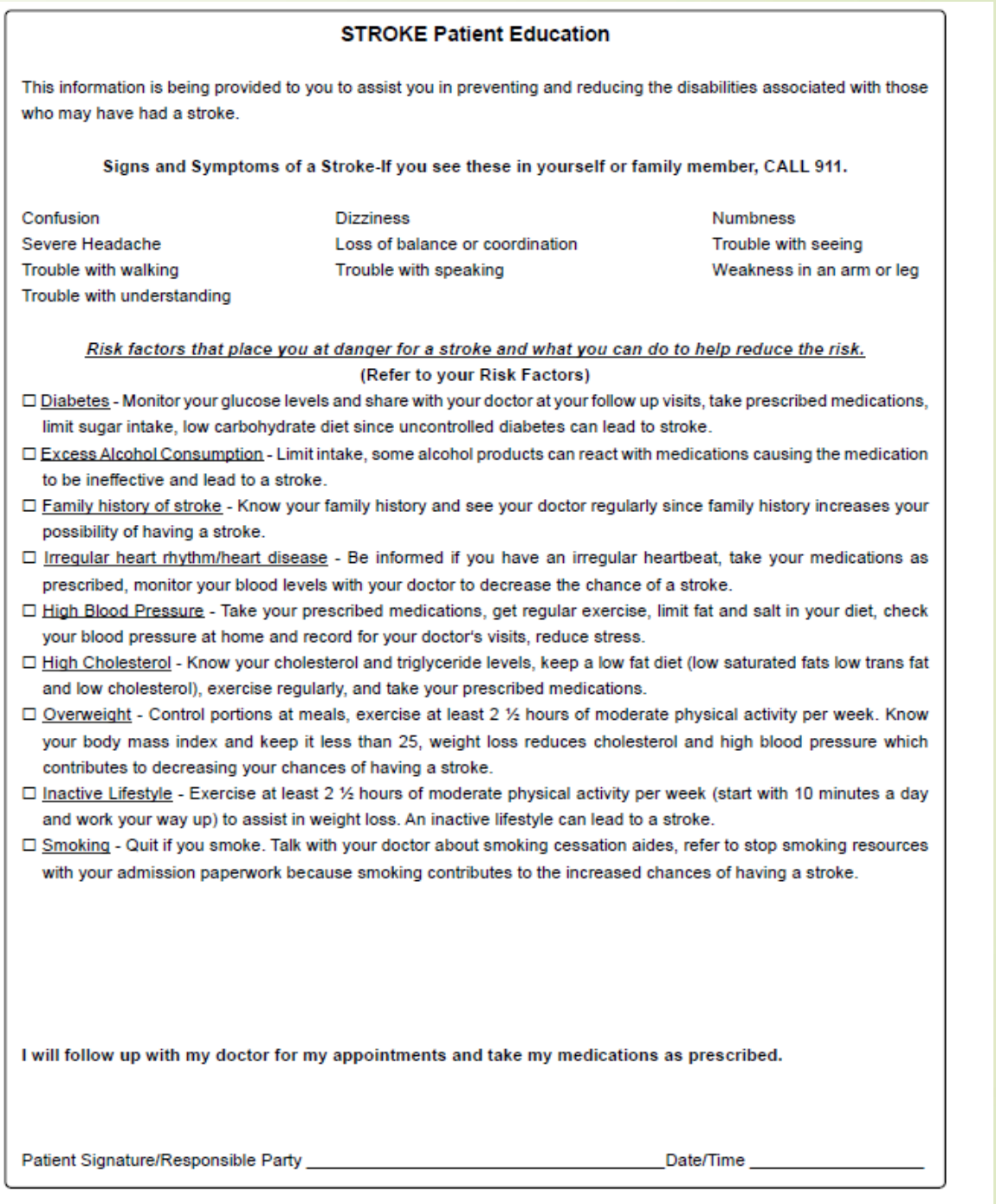
(Complete by end of hospital day 2)

- ✓ 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

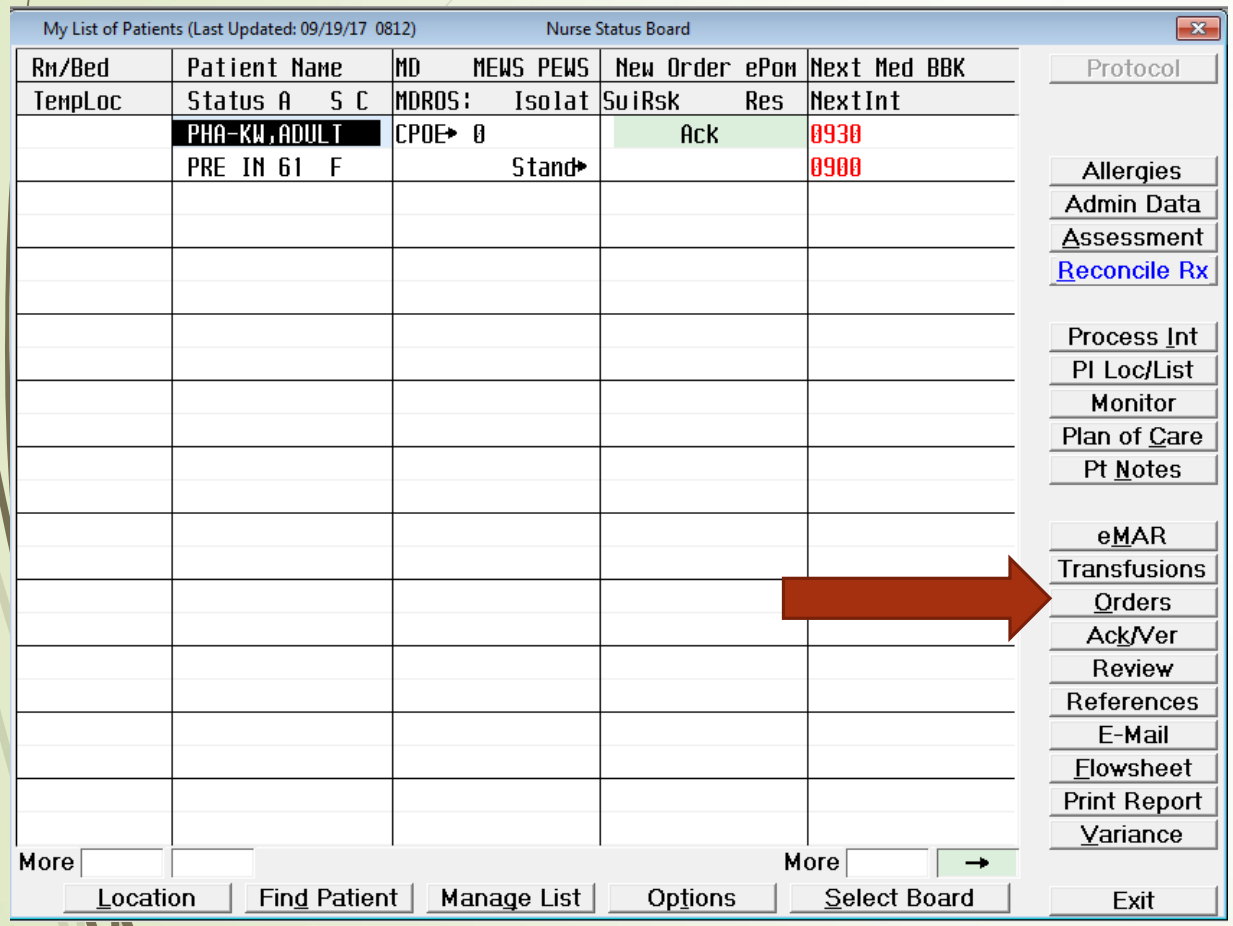
- Completed before the patient leaves the hospital
- As the nurse, all you can do is remind physicians. If they do not order the measures just document a ***nurse's note*** stating that you spoke to them so you, the nurse, are covered.
- If not ordered, physician ***MUST*** document contraindication.
  - 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.

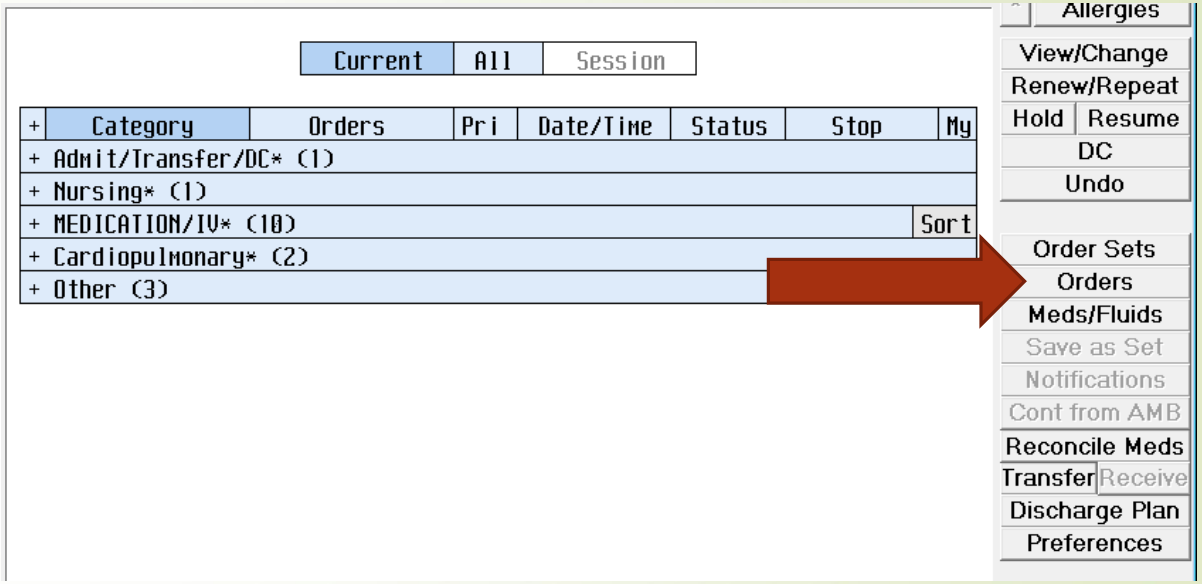
Completed at Discharge

- ✓ 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

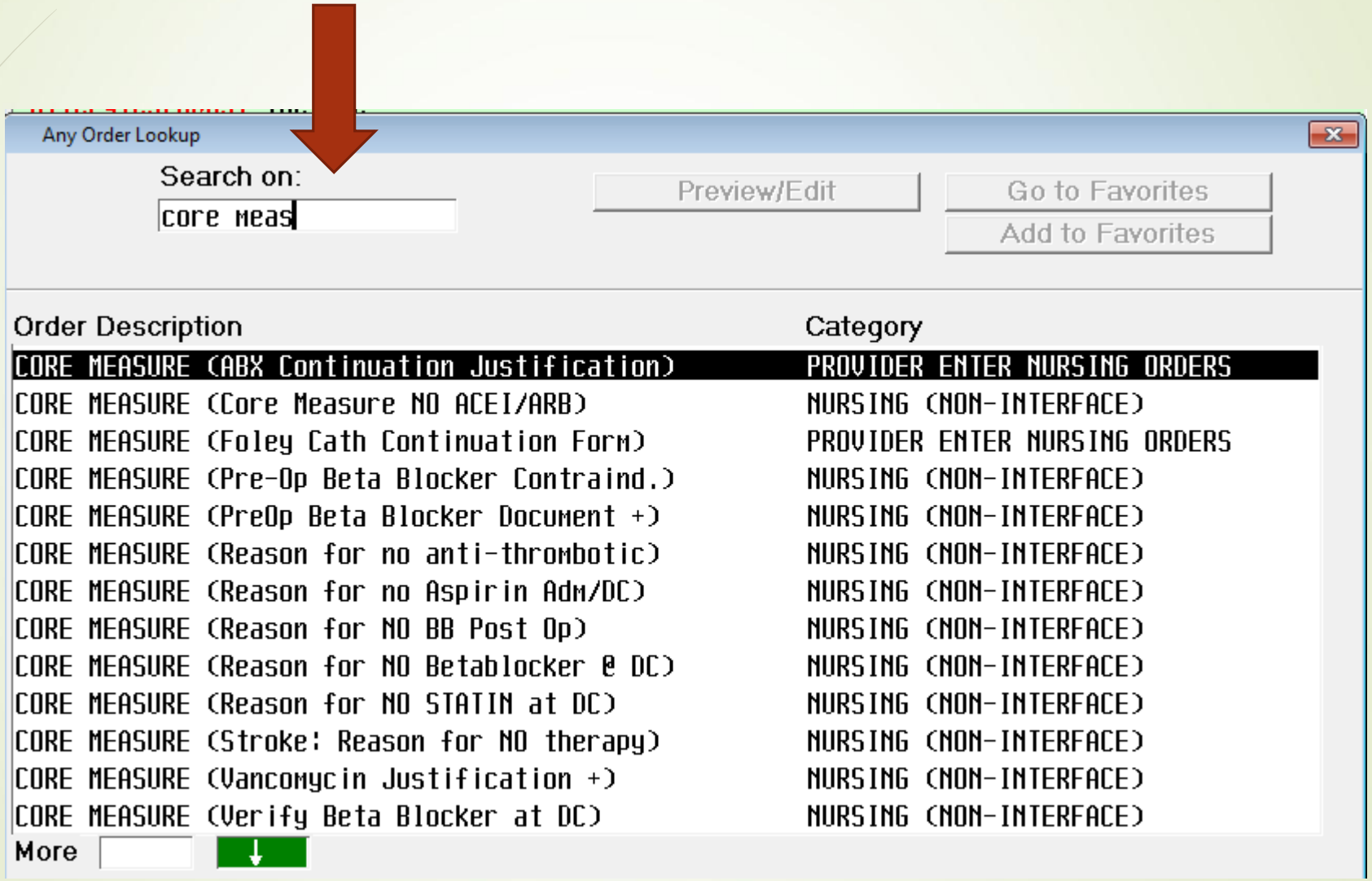
Entering CORE MEASURE CONTRAINDICATION Orders

Choose pt – click ORDERS, click ORDERS again





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



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

- 1st Core Measure Fallout: Nurse will complete Healthstream training on Core Measures.

- 2nd Fall out for same measure: Nurse will meet with CNO/ACNO.
- 3rd 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