HQIC Community of Practice Call

Implementation and Improvement Tips of Sepsis Bundles

February 10, 2022

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Hospital Quality Improvement Contractors
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iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

Shaterra Smith
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iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
CMS

Welcome!

Who's in the Room?

Agenda

- Introduction
- Today's Topic – **Implementation and Improvement Tips of Sepsis Bundles**
- Presentations by:
  - John Lawrence, Inova Mount Vernon Hospital, Alexandria, VA
  - Jodi Griffin, Mosaic Medical Center, Maryville, Missouri
- Open Discussion/Q&A
- Closing Remarks

As You Listen, Ponder…

- What excites you the most about the information provided? What information can you leverage to help expand opportunities in your communities?
- What actions will you take as a result of the call?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- Which activities do you have underway that will allow for you to expand and push forward to build on action in the next 30 days? 90 days?

Meet Your Speakers

John Lawrence, RN, BSN, CPHQ, SCRN
Sepsis Coordinator
Inova Mount Vernon Hospital

Jodi Griffin, RN, BSN
Quality Improvement Coordinator,
Mosaic Medical Center

Health Quality Innovation Network

Implementation and Improvement Tips of Sepsis Bundles

February 10, 2022

Agenda

1. Bundle Basics
2. Raising Awareness
3. Addressing Barriers
4. Success Factors/Facilitators
5. Keeping Things in Perspective
6. Questions

Inova Mount Vernon Hospital

Founded in 1976, Inova Mount Vernon Hospital is a 237-bed community hospital in Alexandria, VA, offering patients convenience and state-of-the-art care in a unique healing environment.

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Bundle Basics

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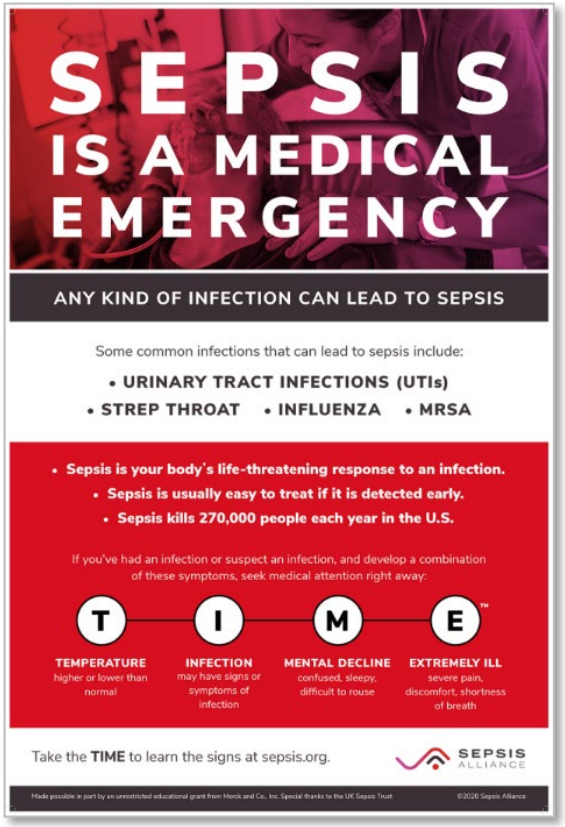
Problem

- Sepsis is a dysregulated host response to an infection and is considered a medical emergency.
- Time is of the essence. For patients with septic shock, mortality may increase by over 7% for every hour that antibiotics are delayed (Kumar et al., 2006)



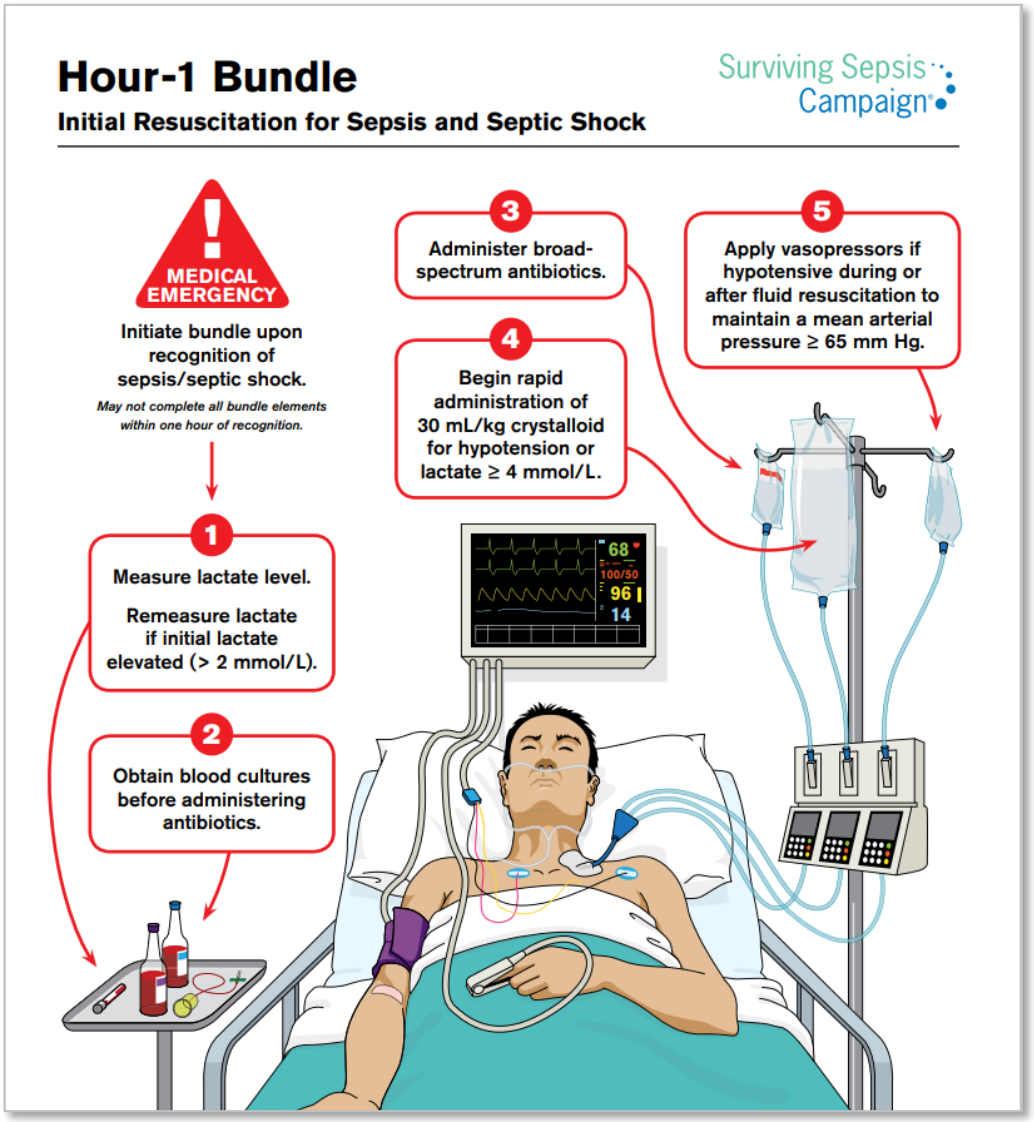
Summary of SEP-1

Within 3 Hours of Presentation:

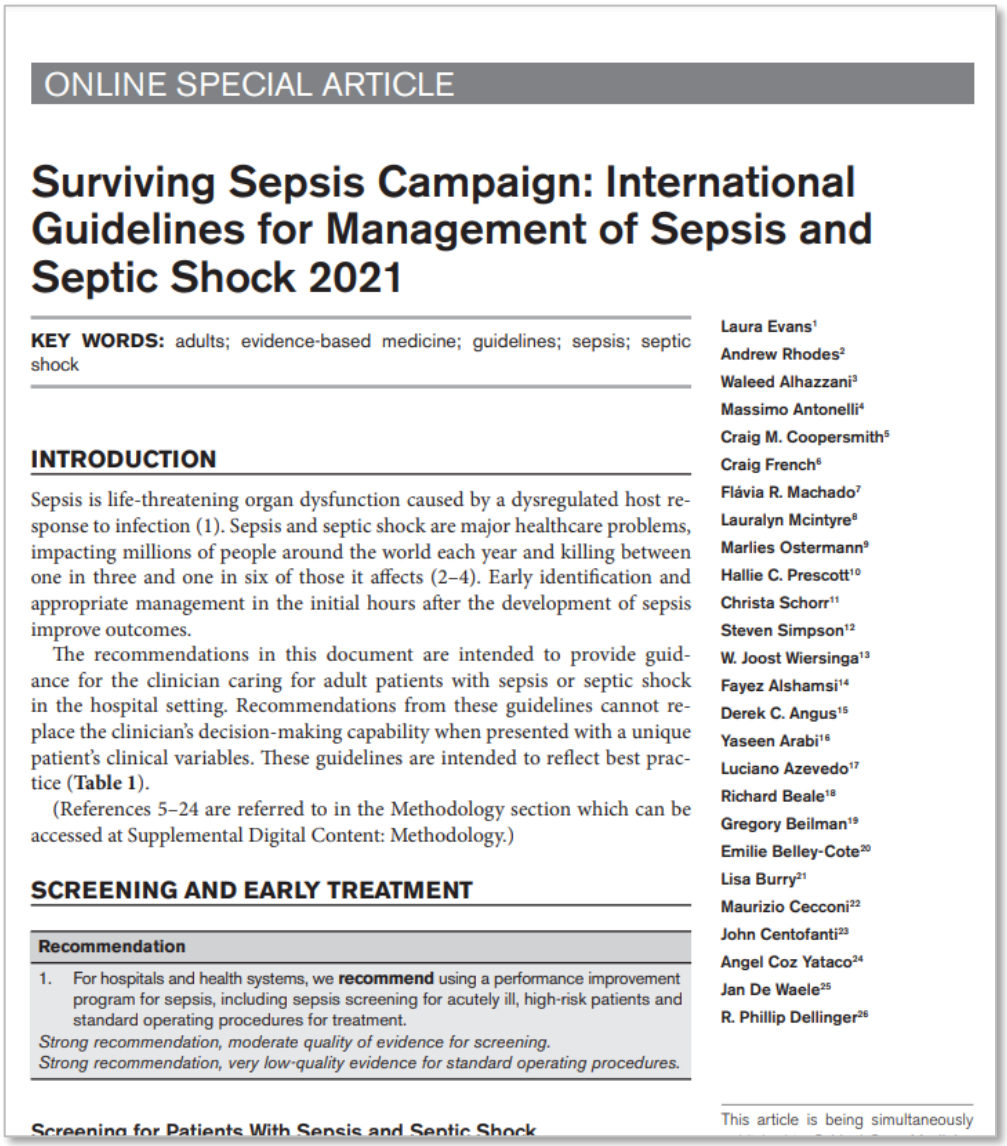
- Measure initial lactate level
- Obtain blood cultures prior to antibiotic administration
- Start broad-spectrum (or other) antibiotic(s)
- Start 30mL/kg fluid bolus for hypotension or lactate ≥4

Within 6 Hours of Presentation:

- Re-measure lactate if initial lactate >2.0
- Re-assess BP after fluids are complete
- Start vasopressors for hypotension unresponsive to fluid bolus = "septic shock"
- If persistent hypotension after fluids or lactate ≥4, provider re-assesses and documents volume status and tissue perfusion assessment



Surviving Sepsis Campaign. (2019). *Hour-1 Bundle.* Adult Patients. https://www.sccm.org/getattachment/SurvivingSepsisCampaign/Guidelines/Adult-Patients/Surviving-Sepsis-Campaign-Hour-1-Bundle.pdf?lang=en-US



ONLINE SPECIAL ARTICLE

Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021

KEY WORDS: adults; evidence-based medicine; guidelines; sepsis; septic shock

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Andrew Rhodes[2]
Waleed Alhazzani[3]
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Craig M. Coopersmith[5]
Craig French[6]
Flávia R. Machado[7]
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Christa Schorr[11]
Steven Simpson[12]
W. Joost Wiersinga[13]
Fayez Alshamsi[14]
Derek C. Angus[15]
Yaseen Arabi[16]
Luciano Azevedo[17]
Richard Beale[18]
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Emilie Belley-Cote[20]
Lisa Burry[21]
Maurizio Cecconi[22]
John Centofanti[23]
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Jan De Waele[25]
R. Phillip Dellinger[26]

INTRODUCTION

Sepsis is life-threatening organ dysfunction caused by a dysregulated host response to infection (1). Sepsis and septic shock are major healthcare problems, impacting millions of people around the world each year and killing between one in three and one in six of those it affects (2–4). Early identification and appropriate management in the initial hours after the development of sepsis improve outcomes.

The recommendations in this document are intended to provide guidance for the clinician caring for adult patients with sepsis or septic shock in the hospital setting. Recommendations from these guidelines cannot replace the clinician's decision-making capability when presented with a unique patient's clinical variables. These guidelines are intended to reflect best practice (**Table 1**).

(References 5–24 are referred to in the Methodology section which can be accessed at Supplemental Digital Content: Methodology.)

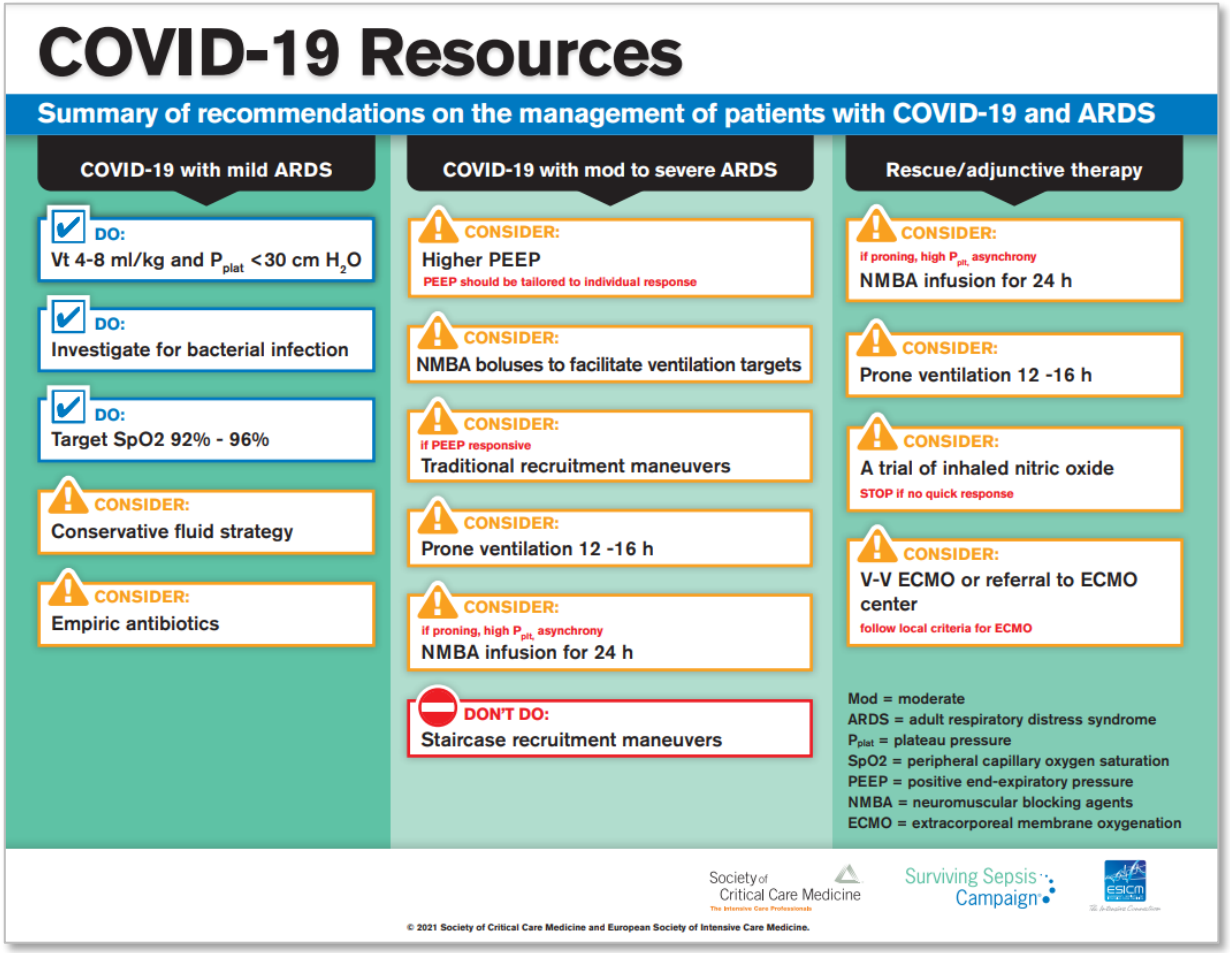
SCREENING AND EARLY TREATMENT

Recommendation
1. For hospitals and health systems, we **recommend** using a performance improvement program for sepsis, including sepsis screening for acutely ill, high-risk patients and standard operating procedures for treatment.
Strong recommendation, moderate quality of evidence for screening.
Strong recommendation, very low-quality evidence for standard operating procedures.

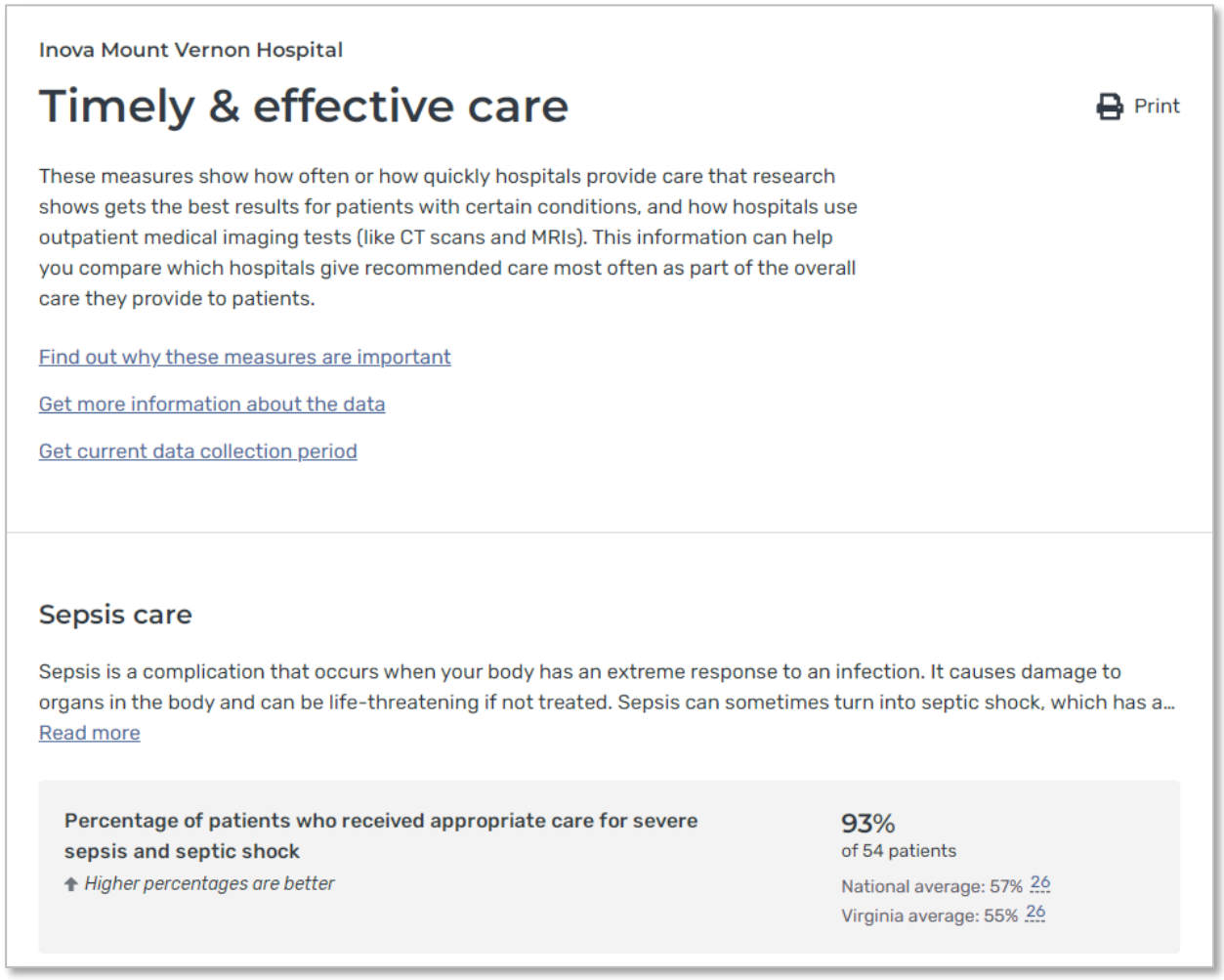
Screening for Patients With Sepsis and Septic Shock

This article is being simultaneously

Evans, L., Rhodes, A., Alhazzani, W., Antonelli, M., Coopersmith, C. M., French, C.,... & Levy, M. (2021). Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021. *Intensive Care Medicine, 47* (11), 1181-1247.



Surviving Sepsis Campaign. (2021). *Summary of recommendations on the management of patients with COVID-19 and ARDS.* COVID-19 Guidelines. https://www.sccm.org/getattachment/SurvivingSepsisCampaign/Guidelines/COVID-19/SSC-COVID19-Infographic-Management-of-Patients-with-COVID-19-and-ARDS.pdf.aspx?lang=en-US



SEP-1 is publicly reported at Medicare.gov

Raising Awareness

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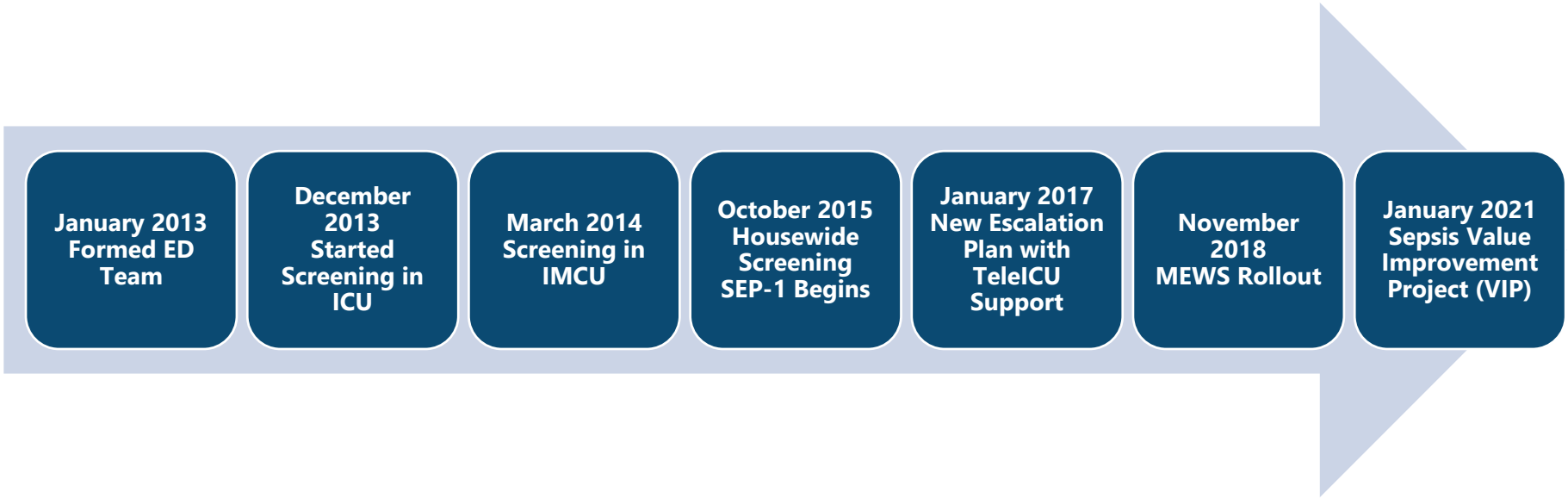
Our Journey with Sepsis



CODE SEPSIS RN + PROVIDER HUDDLE CHECKLIST 7/6/2021

Time SIRS + Infection Documented
1-HOUR GOAL
3-HOUR GOAL
6-HOUR GOAL

Patient Sticker

	Attending Initials	RN Initials
FOR SEVERE SEPSIS and SEPTIC SHOCK *SIRS + Suspected Infection + Acute (not chronic) Organ Dysfunction (Lactic > 2.0, SBP < 90 or MAP < 65, Cr > 2.0, INR > 1.5, Plt < 100,000, Bili > 2.0, Intubation/CPAP/BiPAP for acute respiratory failure)*		
DOCUMENT WEIGHT (ACTUAL) & HEIGHT		
DRAW LACTIC ACID #1 (Goal: <1 hour) Result: _____ **Is lactic 4.0 or more?** ❑ Yes: Provider must chart, "Sepsis exam done after fluids started."		
DRAW BLOOD CULTURES BEFORE ANTIBIOTICS *Collect cultures AND print label BEFORE scanning antibiotics. Do not delay antibiotics more than 45 minutes.* *Chart any barriers to obtaining cultures.*		
START IV ANTIBIOTICS (Goal: <1 hour from arrival time or first recognition) *Sepsis is a medical emergency. You may start multiple antibiotics at once: Use compatibility chart at bottom.* *PO vancomycin for suspected C. diff is acceptable.*		
DRAW LACTIC ACID #2 (Goal: <3 hours) Time Due: _____ *If first lactic 2 or less, cancel repeat lactic.* **Result:** _____ *If repeat higher than first, draw third lactic in 2 hours.*		
START FLUID BOLUS 30 ML/KG IF PATIENT MEETS TRIGGERS (<3 hours) *Fluid bolus triggers:* ***SBP <90*** *or* ***MAP <65*** *or* ***Lactic Acid ≥ 4*** *. Normal saline, lactated Ringer's or PlasmaLyte acceptable.* *Label each bag (ex. Bag 1 of 3, Bag 2 of 3, etc.). Monitor for fluid overload. May use ideal body weight if BMI >30.* *Patient is exempt ONLY IF provider charts refusal by patient/family refusal or consults palliative care.* **Patient Weight (kg):** _____ **x 30 mL = Bolus Total (mL):** _____ **Bolus Given (mL):** _____ **Bolus Remaining (mL):** _____		
BEGIN AUTO-CYCLING BP EVERY 15-30 MINUTES DURING BOLUS INFUSION AND FOR 1 HOUR AFTER BOLUS ENDS		
CHART END TIME OF FLUID BOLUS + I/O'S End Time: _____ *Chart all recorded BPs, including validating device data.*		
	Attending Initials	**RN Initials**
FOR SEPTIC SHOCK *Severe sepsis + persistent hypotension after 30 mL/kg fluid bolus ends OR lactic ≥4*		
START VASOPRESSOR (Goal: <6 hours) *Required if two consecutive readings of SBP <90 or MAP <65 during hour after 30 mL/kg amount is completely infused.*		
CHECK WITH MD THAT VOLUME STATUS/TISSUE PERFUSION ASSESSMENT CHARTED *Part of pressor order OR if initial lactic ≥ 4. Provider must chart, "Sepsis exam done after fluids started."*		**RN Initials**
FOR ALL PATIENTS		
INFORM RECEIVING RN DURING REPORT OF ANY INCOMPLETE ITEMS AND WHEN THEY ARE DUE		
BEFORE ADMISSION/TRANSFER, SCAN FORM TO IMVH SEPSIS COORDINATOR. PINK COPY STAYS WITH PATIENT.		

Provider: _____ **Receiving RN:** _____
By signing, I acknowledge that I will continue the sepsis care outlined above.

Primary RN: _____

ANTIBIOTIC COMPATIBILITY

YES = Y-site compatibility. NO = NOT Y-site compatible. Start antibiotics in ***BOLD CAPS*** *first.*

	Azithromycin	Aztreonam	CEFEPIME	CEFTRIAXONE	Clindamycin	Gentamicin	LEVOFLOXACIN	MEROPENEM	Metronidazole	PIPTAZO (ZOSYN)	Vancomycin
Azithromycin	-	NO	YES	NO	NO	NO	NO	YES	YES	NO	YES
Aztreonam	NO	-	YES	YES	YES	YES	YES	NO	NO	YES	NO
CEFEPIME	YES	YES	-	NO	NO	NO	YES	NO	YES	YES	NO
CEFTRIAXONE	NO	YES	NO	-	NO	YES	YES	NO	YES	NO	NO
Clindamycin	NO	YES	NO	NO	-	YES	YES	NO	YES	YES	YES
Gentamicin	NO	YES	NO	YES	YES	-	YES	YES	YES	NO	NO
LEVOFLOXACIN	NO	YES	YES	YES	YES	YES	-	NO	YES	NO	YES
MEROPENEM	YES	NO	NO	NO	NO	YES	NO	-	NO	NO	YES
Metronidazole	YES	NO	YES	YES	YES	YES	YES	NO	-	YES	YES
PIPTAZO (ZOSYN)	NO	YES	YES	NO	YES	NO	NO	NO	YES	-	NO
Vancomycin	YES	NO	NO	NO	YES	YES	YES	YES	YES	NO	-

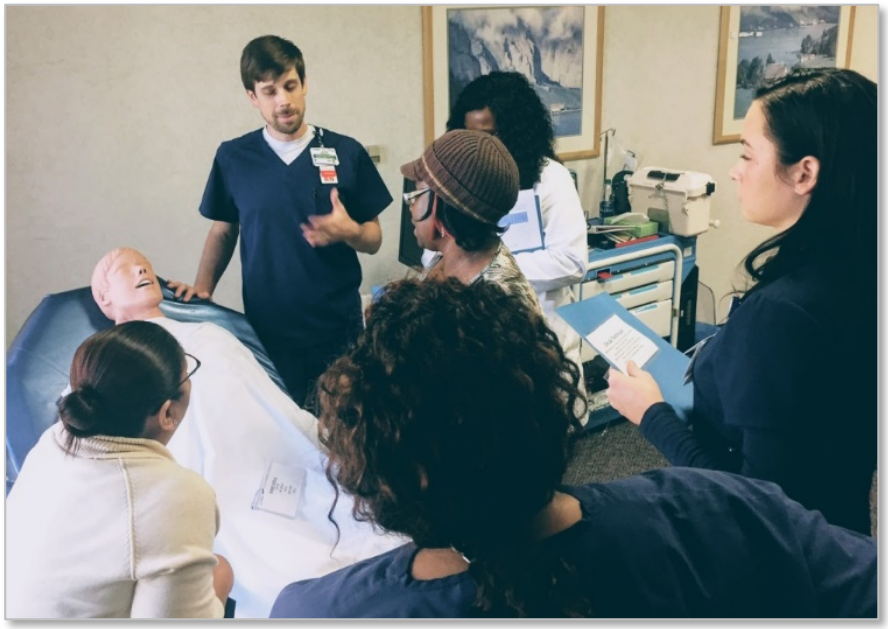
When It Comes to Sepsis: THINK PINK!

INOVA
Join the future of health.

- Checklists are in the back of the MSET notebook on the crash cart.
- Use the checklist as an SBAR tool to talk to the physician about what the patient needs.

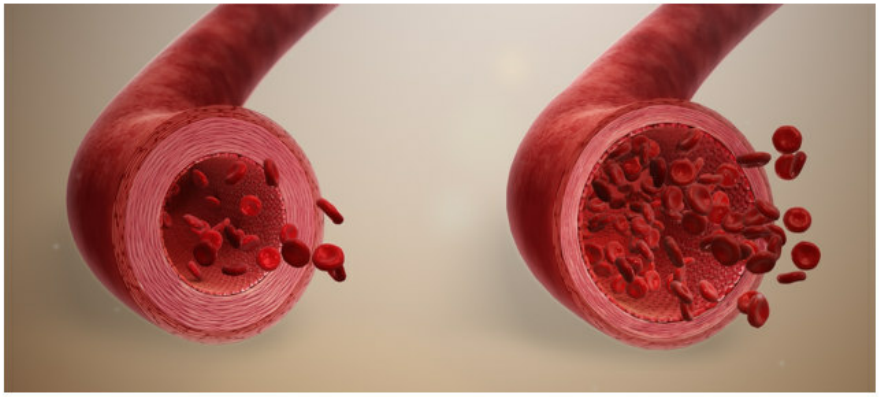
Staff Education Examples

1. Education rollout in 2017 across the entire health system for both RNs and clinical technicians
2. Annual nursing and clin tech skills fair/competency
3. 30 minutes at new employee orientation for RNs and clin techs
4. 20-minute onboarding with all new ED and hospitalist providers
5. Ongoing coaching of front-line staff

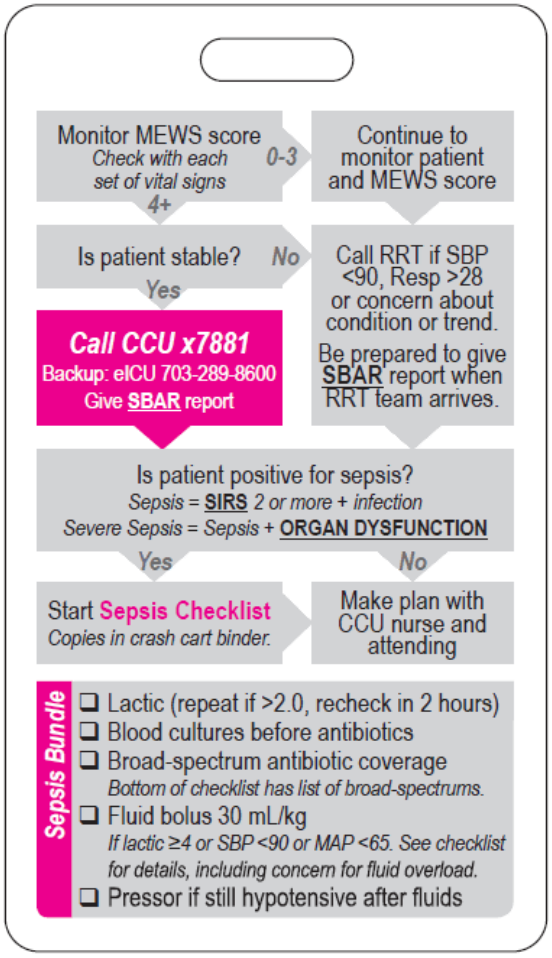


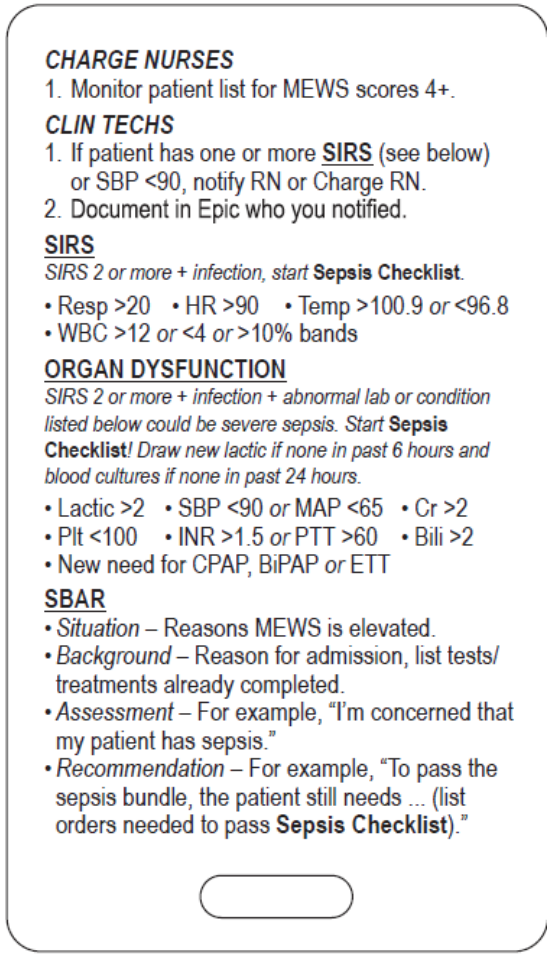
What is sepsis?

- What if whole body experiences an inflammatory response at once?
  - This is a Systemic Inflammatory Response Syndrome or “SIRS”
  - This is abnormal and bad
  - Massive vasodilation → Drop in blood pressure → Tissues don’t get oxygen → Lactic begins to go up

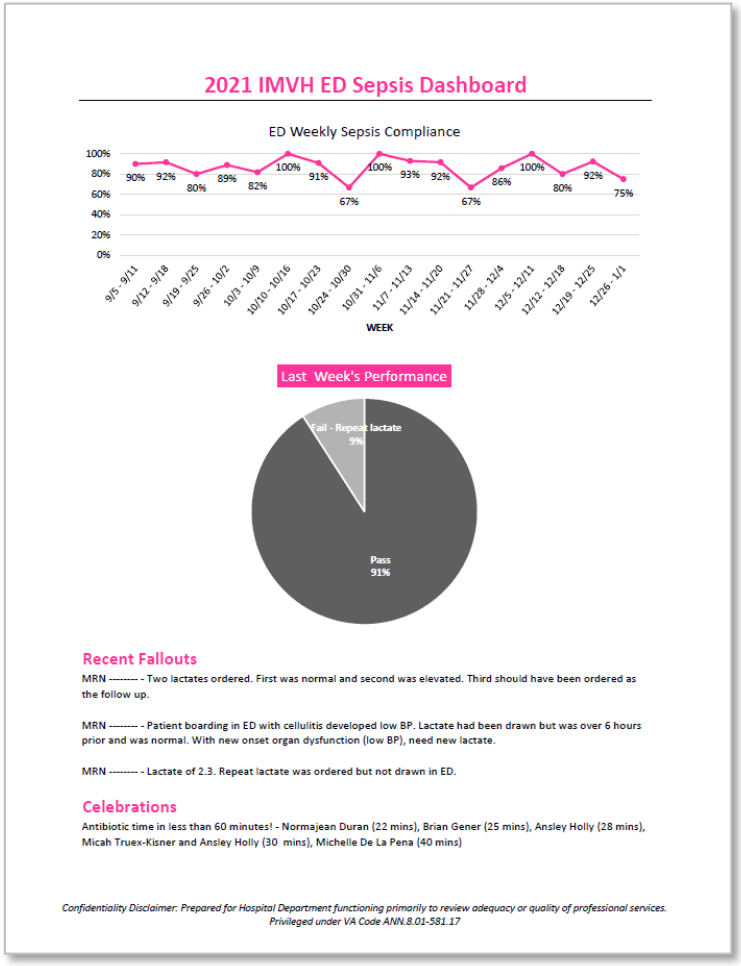


Teach the “why” behind the bundle





Sepsis badge buddy given to all nurses and clin techs



2021 IMVH ED Sepsis Dashboard

ED Weekly Sepsis Compliance

Last Week's Performance

Recent Fallouts

MRN -------- - Two lactates ordered. First was normal and second was elevated. Third should have been ordered as the follow up.

MRN -------- - Patient boarding in ED with cellulitis developed low BP. Lactate had been drawn but was over 6 hours prior and was normal. With new onset organ dysfunction (low BP), need new lactate.

MRN -------- - Lactate of 2.3. Repeat lactate was ordered but not drawn in ED.

Celebrations

Antibiotic time in less than 60 minutes! - Normajean Duran (22 mins), Brian Gener (25 mins), Ansley Holly (28 mins), Micah Truex-Kisner and Ansley Holly (30 mins), Michelle De La Pena (40 mins)

Confidentiality Disclaimer: Prepared for Hospital Department functioning primarily to review adequacy or quality of professional services. Privileged under VA Code ANN.8.01-581.17

ED sepsis compliance dashboard shared each week

Staff and students at IMVH heard from a sepsis survivor at a 2018 Sepsis Lunch & Learn

Sepsis: Keys to Success

INOVA
Join the future of health.

Detecting and treating sepsis for our inpatients can be challenging.

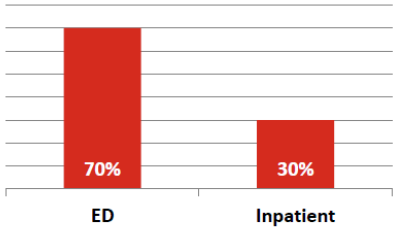
It's true – the ED and inpatient are two different worlds. But here are some elements of a successful sepsis team:

- Physician-nurse collaboration
- Careful clinical assessment ("sepsis until proven otherwise")
- Consistent use of order sets

In turn, what can we do?

- Be responsive. Nurses are required to screen for sepsis and may call requesting orders to meet the sepsis bundles.*
- For patients with infection or low-severity sepsis, be vigilant for organ dysfunction that could signal severe sepsis.
- For severe sepsis or septic shock, use one of these order sets: **SUSPECTED SEPSIS ORDERS** or **CRITICAL CARE ADMIT TO ICU**

Sepsis Bundle Compliance (May-July)



***3-HOUR BUNDLE**

- Initial lactic
- Blood cultures
- Broad spectrum antibiotic
- 30 mL/kg fluid bolus if lactic >=4 or SBP <90 (or MAP <65)

6-HOUR BUNDLE

- Repeat lactic (if initial >2)
- Septic shock exam (*.sepsiscms*), if lactic >=4 or vasopressors required
- Vasopressors, if refractory hypotension after fluid bolus

Example of focused sepsis bundle education given to providers in 2017

Addressing Barriers

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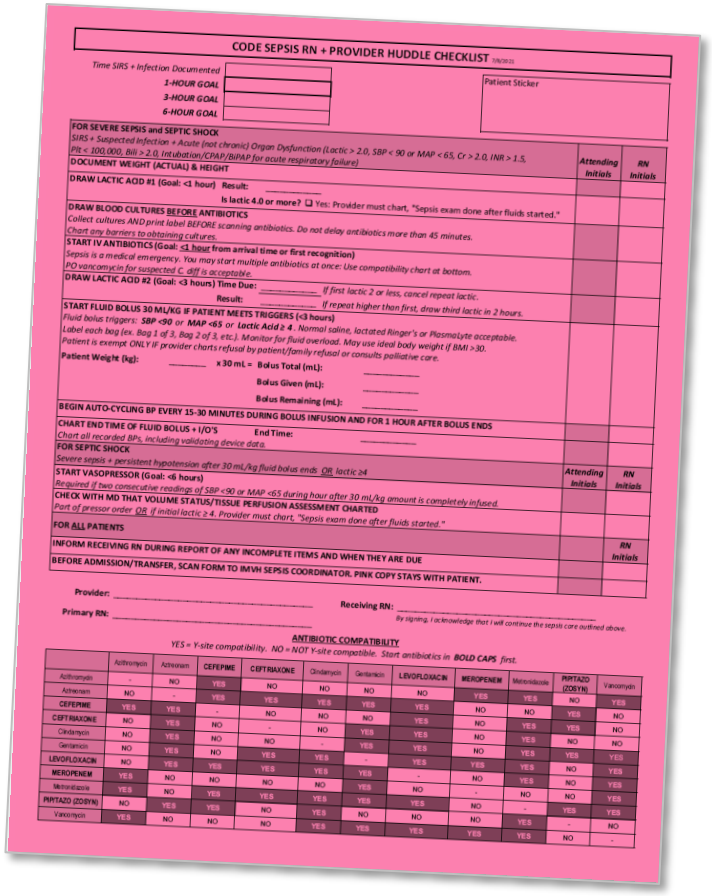
Top Bundle Barriers

Poll Results from August 2021:

1. Documentation of elements in the EHR
2. Fluids
3. Blood cultures before antibiotics
4. Physician buy-in

Barriers

- Keep bundle tools simple
- Our success with tracking bundle elements has been done almost entirely on paper for last 5+ years
- Of course order sets in EHR have been key



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Severe sepsis + persistent hypotension after 30 mL/kg fluid bolus ends OR lactic ≥4

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FOR ALL PATIENTS

RN Initials

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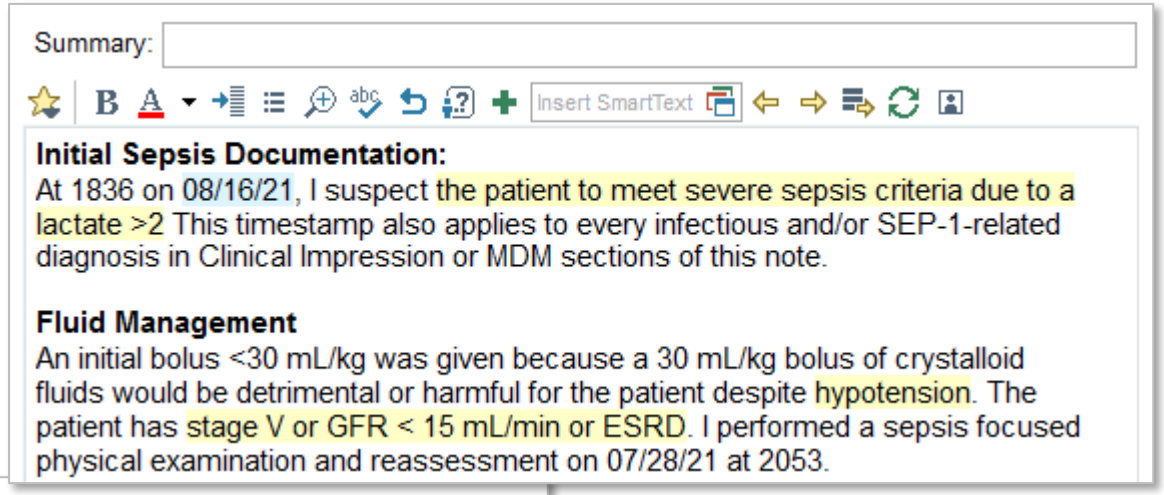
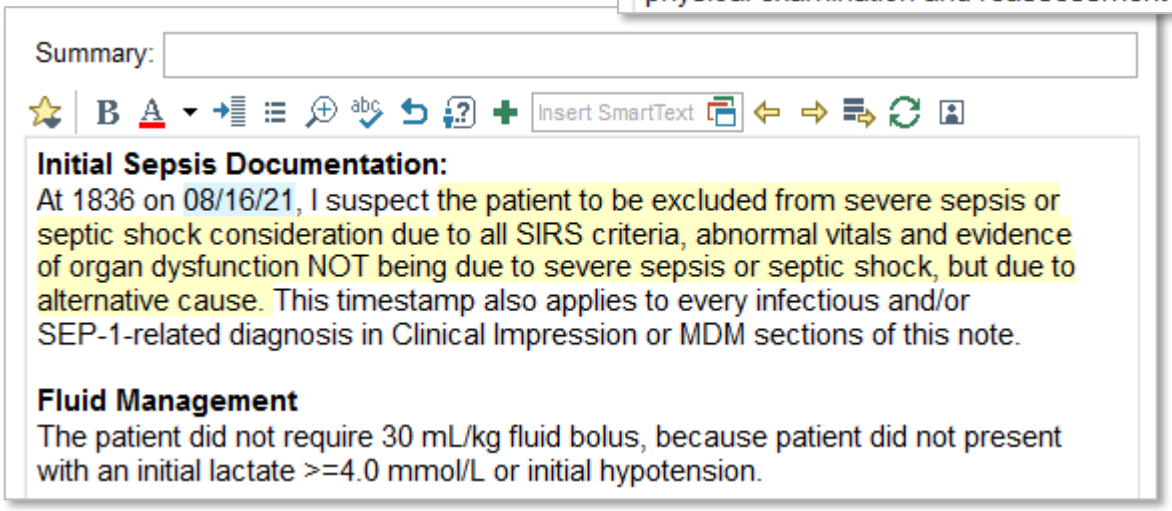
Aztreonam	NO	-	YES	YES	YES	YES	YES	NO	NO	YES	NO
CEFEPIME	YES	YES	-	NO	NO	NO	YES	NO	YES	YES	NO
CEFTRIAXONE	NO	YES	NO	-	NO	YES	YES	NO	YES	YES	NO
Clindamycin	NO	YES	NO	NO	-	YES	YES	NO	YES	NO	NO
Gentamicin	NO	YES	NO	YES	YES	-	YES	NO	YES	YES	YES
LEVOFLOXACIN	NO	YES	YES	YES	YES	YES	-	YES	YES	NO	YES
MEROPENEM	YES	NO	NO	NO	NO	YES	NO	-	YES	NO	YES
Metronidazole	YES	NO	YES	YES	YES	YES	NO	-	NO	NO	YES
PIPTAZO (ZOSYN)	NO	YES	YES	NO	YES	NO	NO	NO	-	YES	YES
Vancomycin	YES	NO	NO	NO	YES	YES	YES	YES	YES	NO	-

Barriers, continued

- A proactive approach has helped us with blood cultures
  - We do not wait for patients to meet severe sepsis criteria to start the bundle
  - We order blood cultures on every ED patient receiving IV antibiotics who will be admitted
- Patients receiving the 30 mL/kg fluid bolus has been more challenging
  - We encourage providers to order the full amount from the beginning or to clarify in documentation why another approach was taken
  - Ultimate goal is to achieve organ perfusion by maintaining MAP

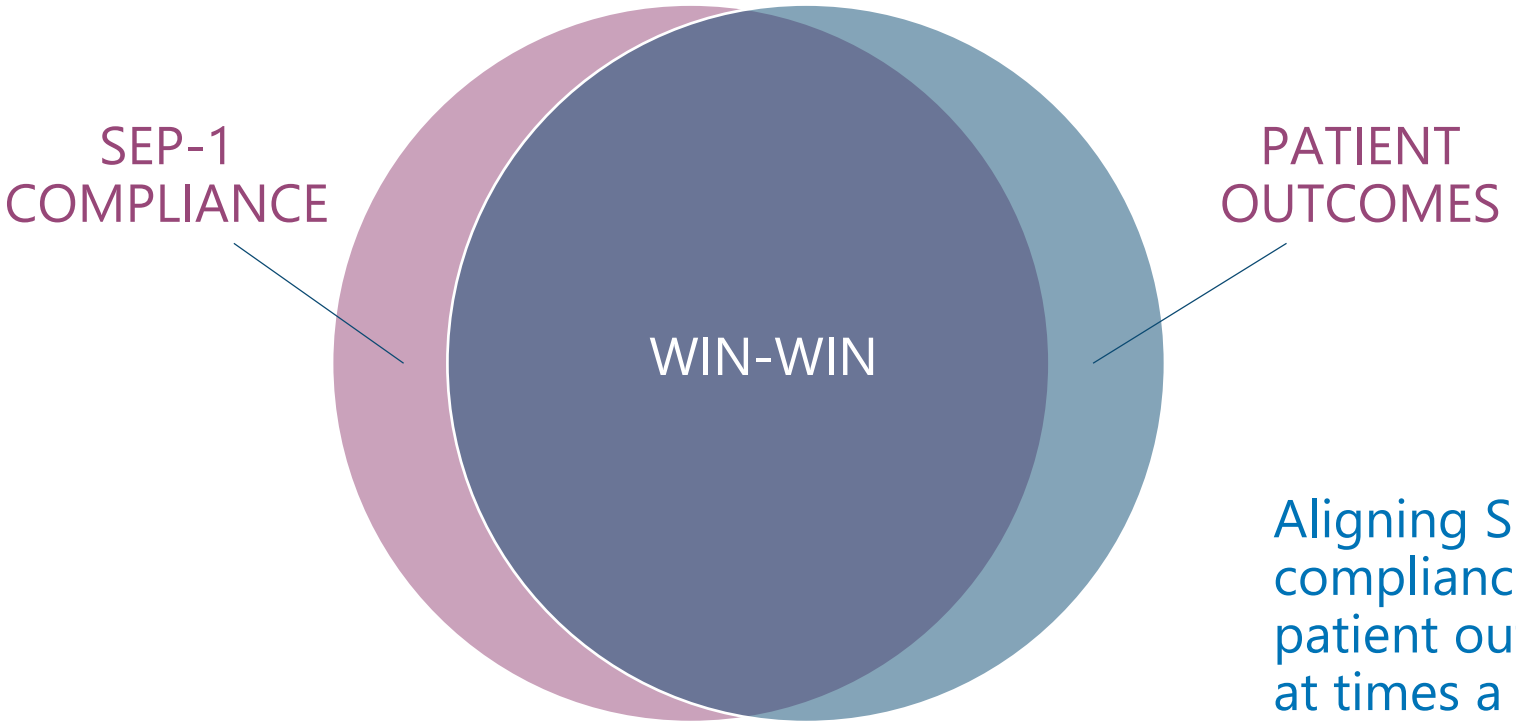
Smartphrases allow the provider to clarify diagnoses and plan of care



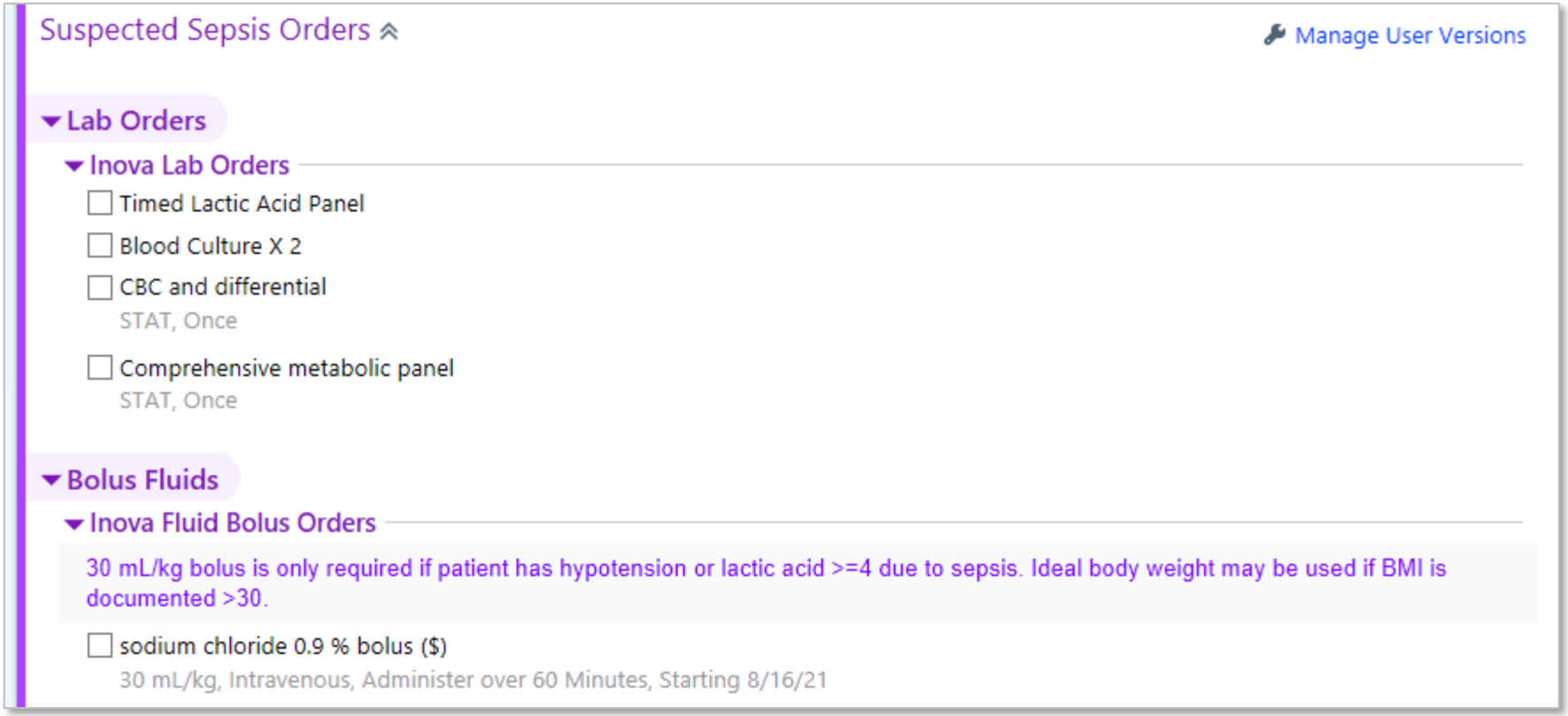


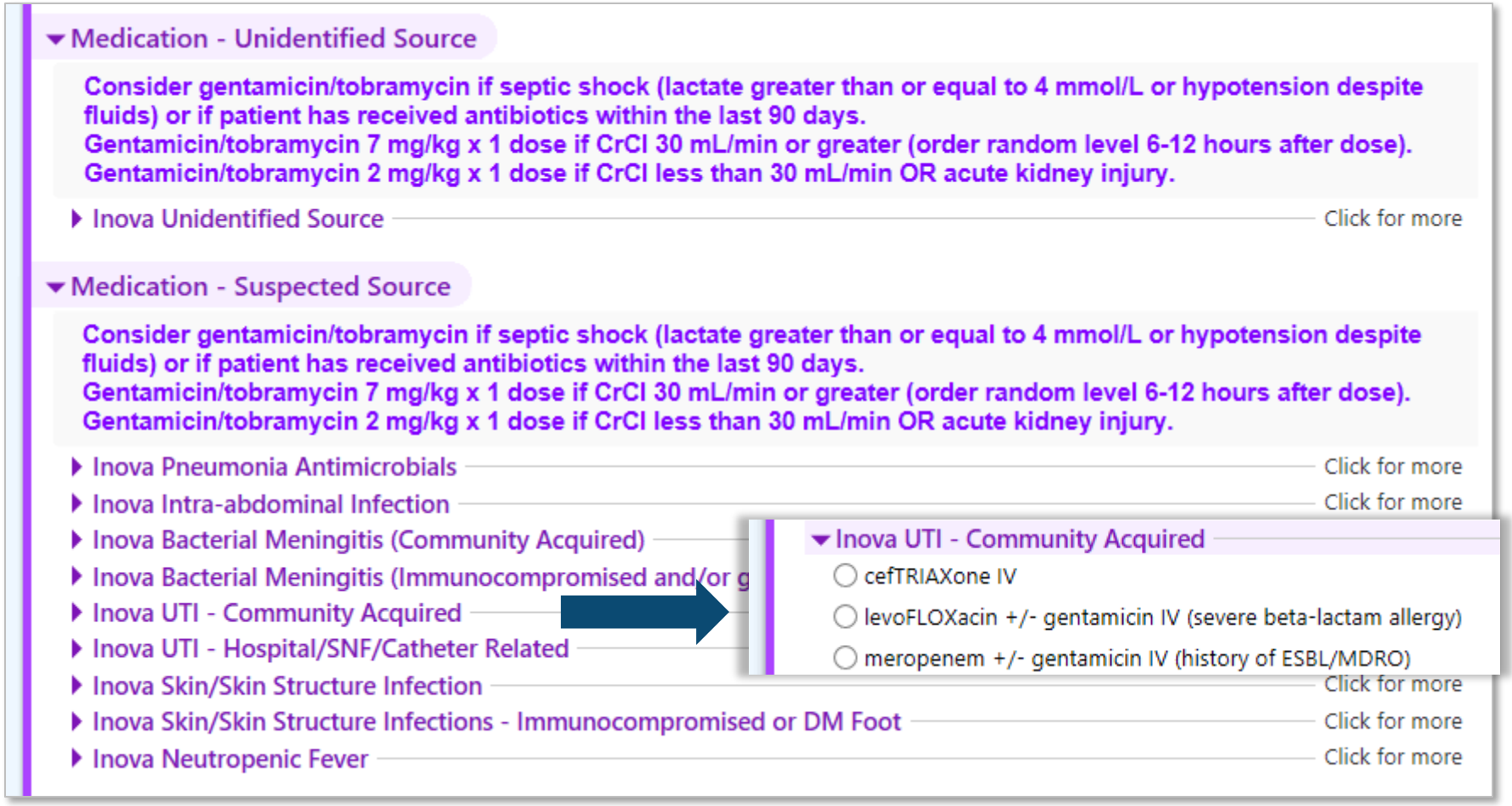
Fluid Management

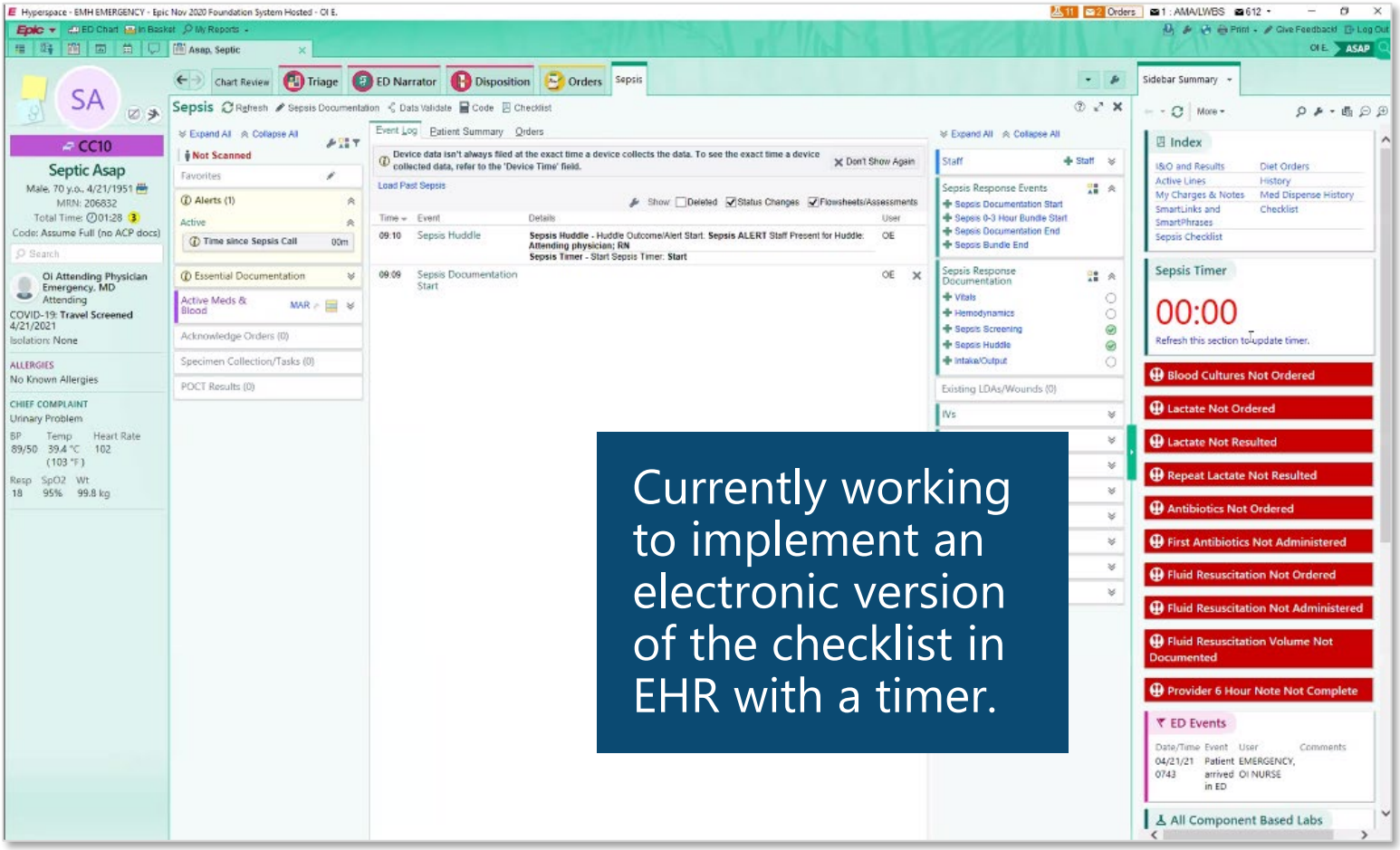
- "One of the most important principles of managing complex septic patients is the need for a **detailed initial assessment and ongoing re-evaluation of the response to treatment**."
- To avoid over- and under-resuscitation, fluid administration beyond the initial resuscitation should be guided by **careful assessment of intravascular volume status and organ perfusion**."
- "Dynamic measures have demonstrated better diagnostic accuracy at predicting fluid responsiveness compared with static techniques. Dynamic measures include passive leg raising combined with cardiac output (CO) measurement, fluid challenges against stroke volume (SV), systolic pressure or pulse pressure, and increases of SV in response to changes in intrathoracic pressure." (Evans et al., 2021, p. e1076).



Aligning SEP-1 compliance with patient outcomes is at times a matter of documentation

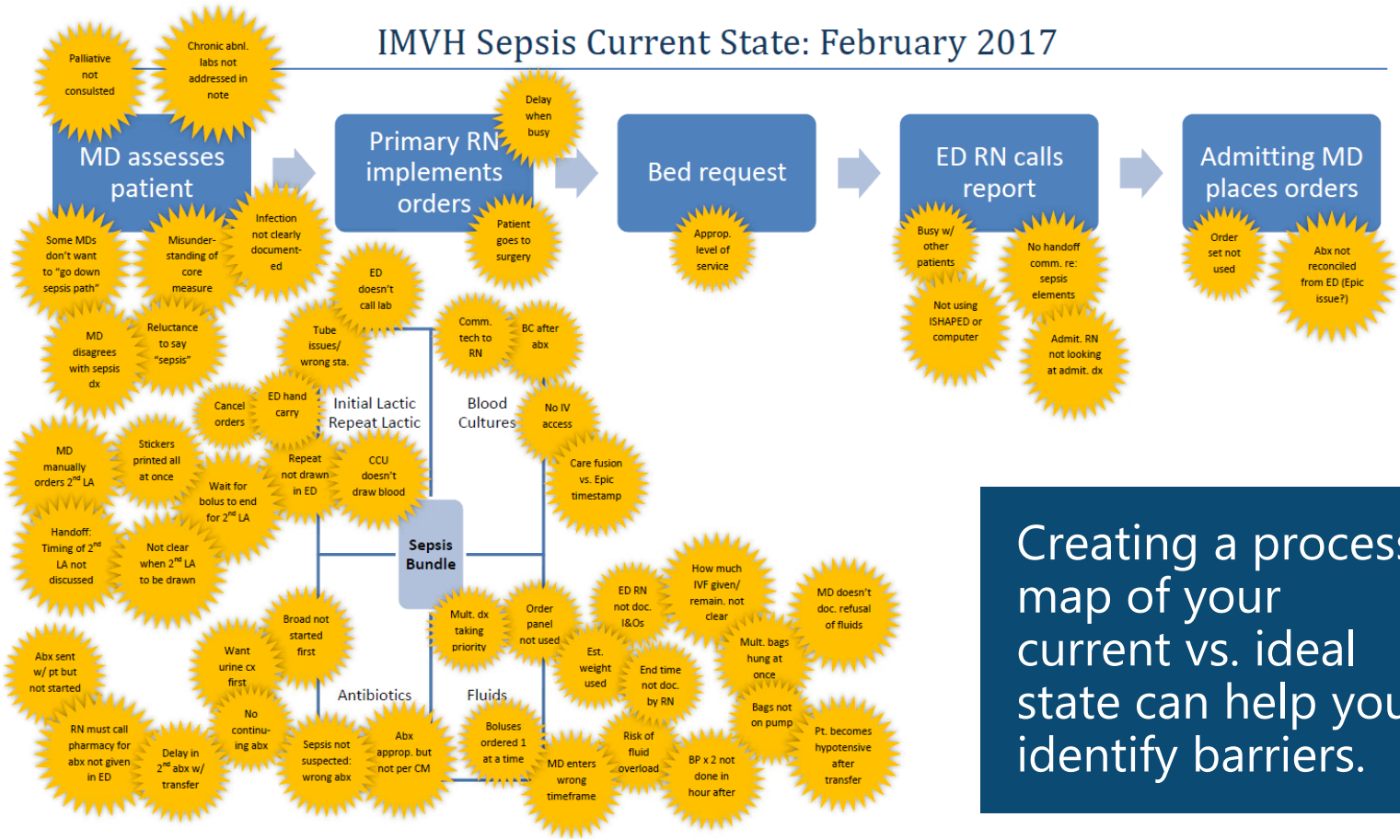

Suspected Sepsis Orders
Manage User Versions
Lab Orders
Inova Lab Orders
Timed Lactic Acid Panel
Blood Culture X 2
CBC and differential
STAT, Once
Comprehensive metabolic panel
STAT, Once
Bolus Fluids
Inova Fluid Bolus Orders
30 mL/kg bolus is only required if patient has hypotension or lactic acid >=4 due to sepsis. Ideal body weight may be used if BMI is documented >30.
sodium chloride 0.9 % bolus ($)
30 mL/kg, Intravenous, Administer over 60 Minutes, Starting 8/16/21


Medication - Unidentified Source
Consider gentamicin/tobramycin if septic shock (lactate greater than or equal to 4 mmol/L or hypotension despite fluids) or if patient has received antibiotics within the last 90 days.
Gentamicin/tobramycin 7 mg/kg x 1 dose if CrCl 30 mL/min or greater (order random level 6-12 hours after dose).
Gentamicin/tobramycin 2 mg/kg x 1 dose if CrCl less than 30 mL/min OR acute kidney injury.
Inova Unidentified Source
Click for more
Medication - Suspected Source
Consider gentamicin/tobramycin if septic shock (lactate greater than or equal to 4 mmol/L or hypotension despite fluids) or if patient has received antibiotics within the last 90 days.
Gentamicin/tobramycin 7 mg/kg x 1 dose if CrCl 30 mL/min or greater (order random level 6-12 hours after dose).
Gentamicin/tobramycin 2 mg/kg x 1 dose if CrCl less than 30 mL/min OR acute kidney injury.
Inova Pneumonia Antimicrobials
Click for more
Inova Intra-abdominal Infection
Click for more
Inova Bacterial Meningitis (Community Acquired)
Inova Bacterial Meningitis (Immunocompromised and/or g
Inova UTI - Community Acquired
Inova UTI - Hospital/SNF/Catheter Related
Inova UTI - Community Acquired
cefTRIAXone IV
levoFLOXacin +/- gentamicin IV (severe beta-lactam allergy)
meropenem +/- gentamicin IV (history of ESBL/MDRO)
Inova Skin/Skin Structure Infection
Click for more
Inova Skin/Skin Structure Infections - Immunocompromised or DM Foot
Click for more
Inova Neutropenic Fever
Click for more



Currently working to implement an electronic version of the checklist in EHR with a timer.

IMVH Sepsis Current State: February 2017



Creating a process map of your current vs. ideal state can help you identify barriers.

Success Factors/ Facilitators

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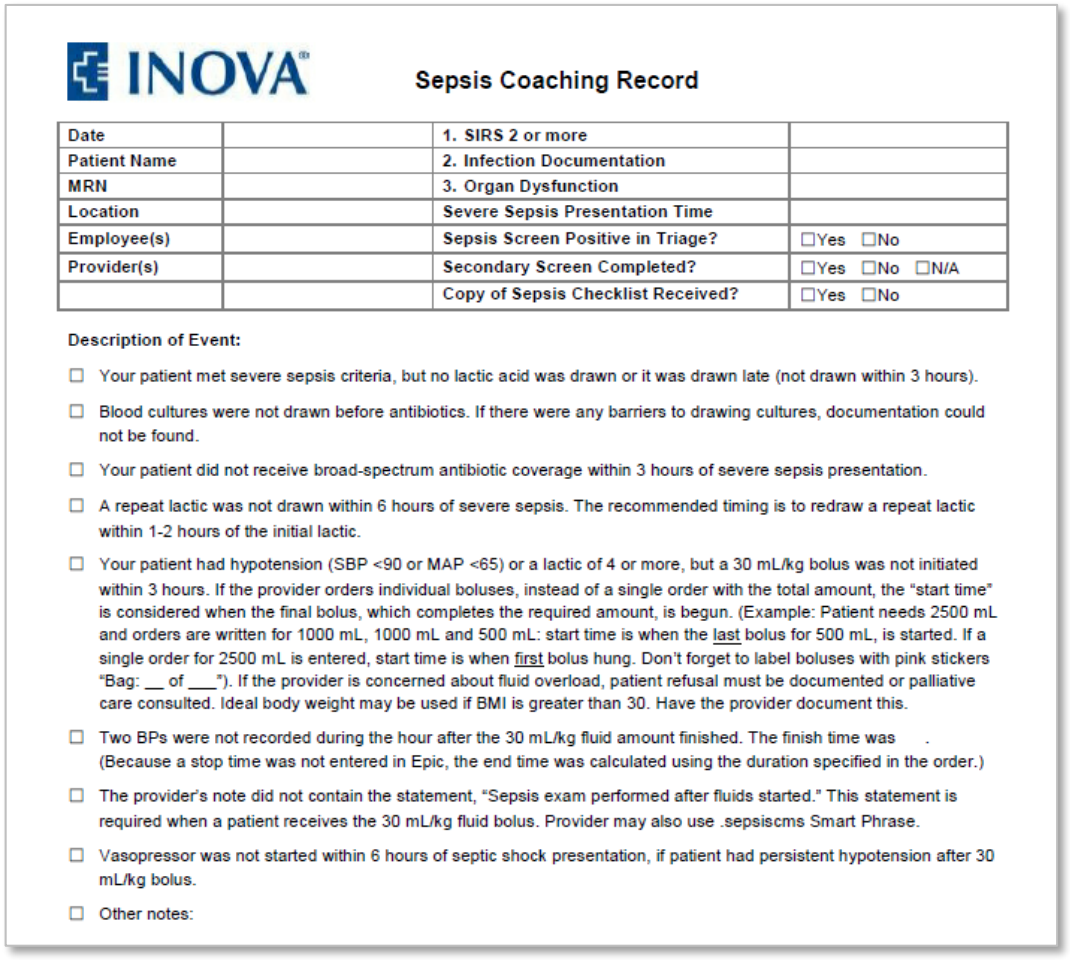
Success Factors/Facilitators

- Having a sepsis coordinator, even part-time, has been key
  - Permanent position allows for succession planning
- Short feedback cycle for fallouts and successes
  - Value of concurrent reviews
- Leadership, accountability and support of CMO and medical directors (ED, hospitalists) has been critical
  - Emergency physician group allows me to attend quarterly meetings to give updates
- Regular sepsis committee meetings for last 5+ years
  - Role of interprofessional collaboration
- 24/7 support from TeleICU for inpatient nurses on *all* units



INOVA

Sepsis Coaching Record

Date		1. SIRS 2 or more	
Patient Name		2. Infection Documentation	
MRN		3. Organ Dysfunction	
Location		Severe Sepsis Presentation Time	
Employee(s)		Sepsis Screen Positive in Triage?	☐Yes ☐No
Provider(s)		Secondary Screen Completed?	☐Yes ☐No ☐N/A
		Copy of Sepsis Checklist Received?	☐Yes ☐No

Description of Event:

- ☐ Your patient met severe sepsis criteria, but no lactic acid was drawn or it was drawn late (not drawn within 3 hours).
- ☐ Blood cultures were not drawn before antibiotics. If there were any barriers to drawing cultures, documentation could not be found.
- ☐ Your patient did not receive broad-spectrum antibiotic coverage within 3 hours of severe sepsis presentation.
- ☐ A repeat lactic was not drawn within 6 hours of severe sepsis. The recommended timing is to redraw a repeat lactic within 1-2 hours of the initial lactic.
- ☐ Your patient had hypotension (SBP <90 or MAP <65) or a lactic of 4 or more, but a 30 mL/kg bolus was not initiated within 3 hours. If the provider orders individual boluses, instead of a single order with the total amount, the "start time" is considered when the final bolus, which completes the required amount, is begun. (Example: Patient needs 2500 mL and orders are written for 1000 mL, 1000 mL and 500 mL: start time is when the last bolus for 500 mL, is started. If a single order for 2500 mL is entered, start time is when first bolus hung. Don't forget to label boluses with pink stickers "Bag: __ of ___"). If the provider is concerned about fluid overload, patient refusal must be documented or palliative care consulted. Ideal body weight may be used if BMI is greater than 30. Have the provider document this.
- ☐ Two BPs were not recorded during the hour after the 30 mL/kg fluid amount finished. The finish time was . (Because a stop time was not entered in Epic, the end time was calculated using the duration specified in the order.)
- ☐ The provider's note did not contain the statement, "Sepsis exam performed after fluids started." This statement is required when a patient receives the 30 mL/kg fluid bolus. Provider may also use .sepsiscms Smart Phrase.
- ☐ Vasopressor was not started within 6 hours of septic shock presentation, if patient had persistent hypotension after 30 mL/kg bolus.
- ☐ Other notes:

Coaching tool for fallouts

Celebrate Successes

- Each month we recognize a nursing Sepsis Star
- They receive a gold star pin

Keeping Things in Perspective

Health Quality Innovation Network

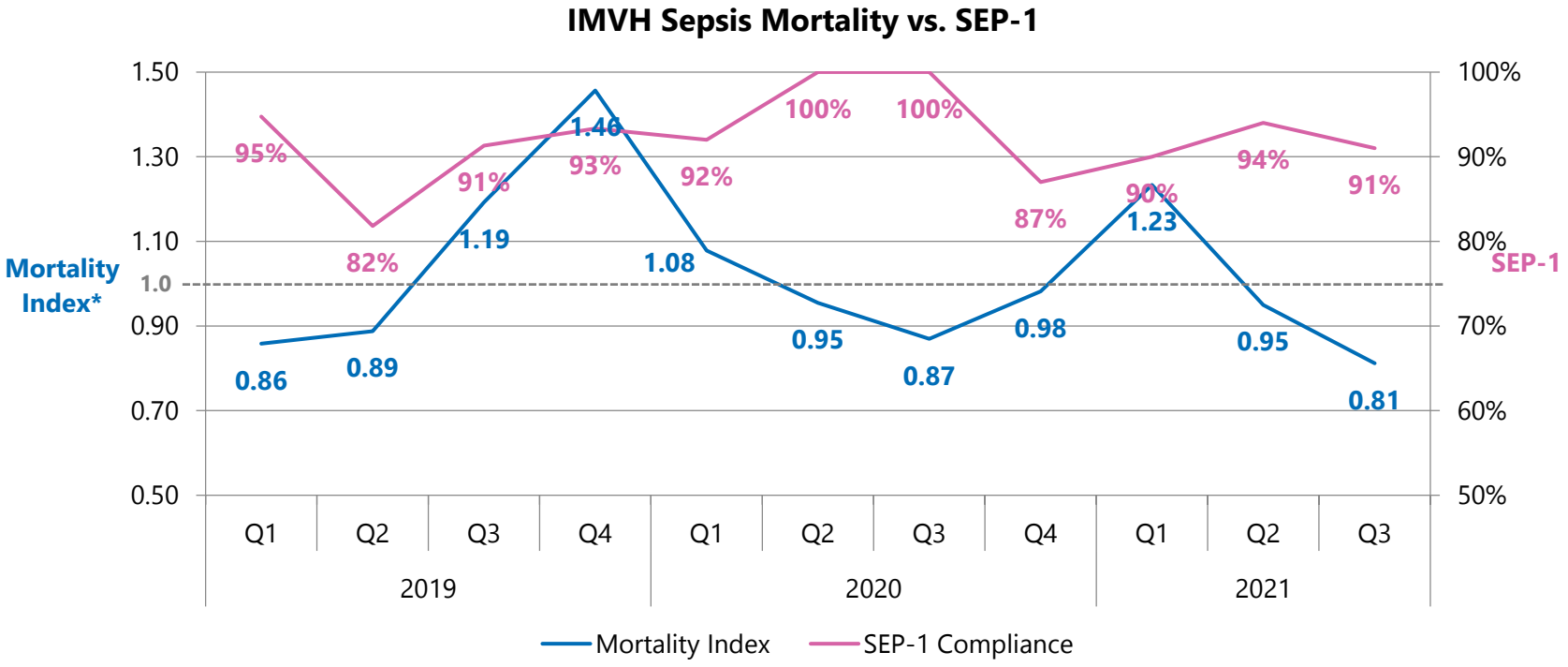
Keeping Things in Perspective

- SEP-1 is useful process measure for developing sepsis programs.
- SEP-1 serves as a catalyst for improvements in patient care – including interdisciplinary collaboration, staff education, order sets and early warning systems. (Mukherjee & Evans, 2017)

Keeping Things in Perspective, continued

- In addition to compliance with SEP-1, nursing leaders should examine other variables and processes that may impact outcomes, for example
  - More aggressive antibiotic goals (<1 hour)
  - Timely source control (surgical interventions)
  - More nuanced fluid management and assessment of fluid responsiveness, etc.
- Pay attention to near misses and harm from other causes
- What do *you* consider a fallout?

Mortality vs. SEP-1 Compliance



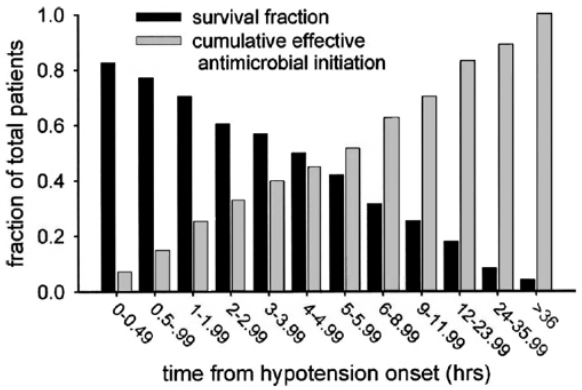
**Data from the Vizient Clinical Data Base used by permission of Vizient, Inc. All rights reserved.*

Focus on Early Antibiotic Administration

Surviving Sepsis

INOVA Join the future of health.

Don't delay: Early antibiotics improve sepsis survival!



Kumar et al., 2006, p. 1592

Process: Antibiotic Times

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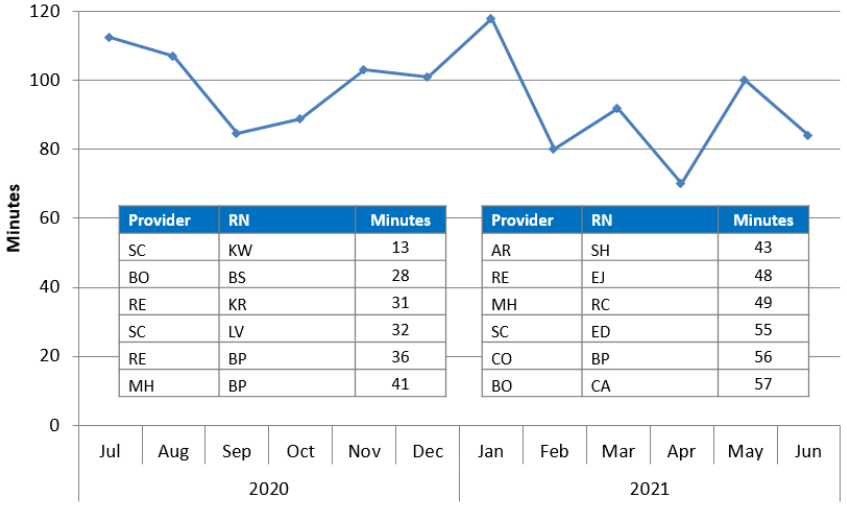
ED Median Door to Antibiotic for Severe Sepsis & Septic Shock (Inset: Best June Times)



Provider	RN	Minutes
SC	KW	13
BO	BS	28
RE	KR	31
SC	LV	32
RE	BP	36
MH	BP	41

Provider	RN	Minutes
AR	SH	43
RE	EJ	48
MH	RC	49
SC	ED	55
CO	BP	56
BO	CA	57

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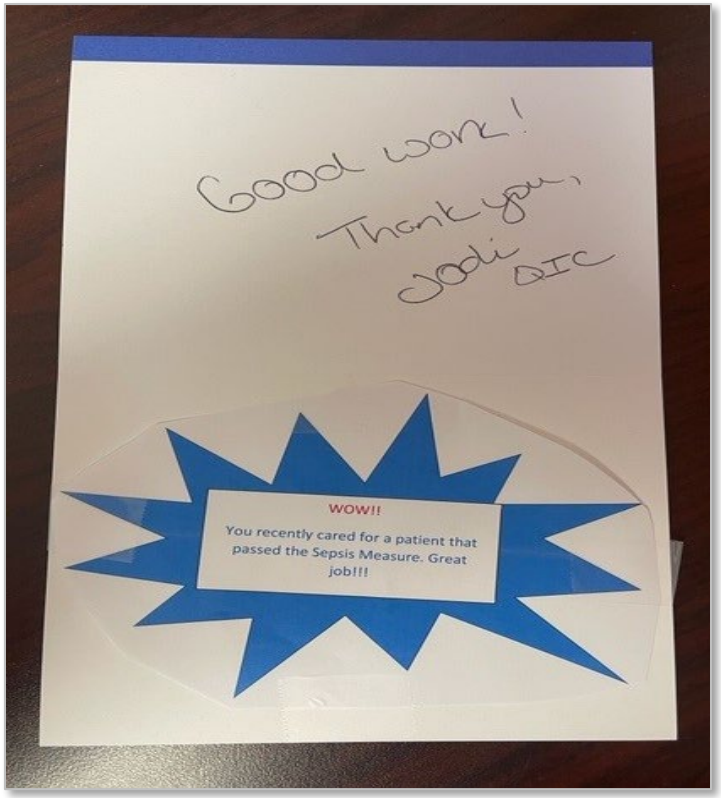
Sepsis Presentation for the February 2022 HQIC Community of Practice Call


EMERGENCY
MOSAIC
MEDICAL CENTER
MARYVILLE

Sepsis Action Items

- Monthly Sepsis Team Meeting – hospitalist, ER provider and front-line nurses having joined the team
- Reworked the Sepsis Flow Sheet (see slide #5)
- Process for documenting IV stop times on the inpt side
- Fall-outs reviewed monthly at dept staff mtgs, Nurse Practice Council and the Medical Staff Quality Affairs mtg
- Sending WOW notes to the providers and nurses whose pts pass the Sep-1 measure (see next slide)
- Real time chart reviews on Sepsis pts
- Work with providers on documentation opportunities

WOW Cards


Good work!
Thank you,
Jodi
DIC
WOW!!
You recently cared for a patient that passed the Sepsis Measure. Great job!!!

Sepsis Tracking Tool

MOSAIC

Maryville Sepsis Tracking Tool	Pt Name & Enc #	Date/Time Completed
If the provider does not suspect infection, document reason/time, complete icon(s) and turn in form.		
Sepsis = • 2 or more SIRS criteria • Suspected infection	**Severe Sepsis =** • Sepsis + • 1 or more Organ Dysfunction	
SIRS Criteria (circle) Temp > 38.3 °C or < 36°C HR > 90 Resp > 20 WBC > 12K or < 4K cells per cubic milimeter of blood or Bands > 10%	**Organ Dysfunction (circle)** SBP < 90 mmHg or MAP < 65 mmHg Plt < 100,000 per microliter INR > 1.5 or aPTT > 60 Bili > 2 mg/dl Creatinine > 2 mg/dl Need for Mechanical Ventilation - CPAP, BiPAP, or Intubation Lactate > 2 mmol/L UOP < 0.5 ml/kg/h/for 2 Hours	
Septic Shock • Lactate ≥ 4 mmol/L OR • Severe sepsis with persistent or new hypotension in the 1 hour after IVF fluid completion		
Complete within 3 Hours ☐ Place ED (or Inpt) Sepsis Treatment Order Set-Maryville ☐ Obtain patient weight (avoid stated weight) ☐ Initial lactate drawn ☐ 2 set of blood cultures. It is recommended to obtain 2 sets of blood cultures prior to antibiotic administration, however, if time constraint, the first antibiotic can be initiated after the first blood culture ☐ Antibiotics initiated ☐ Initate fluid bolus 30 mL/kg if SBP < 90 or MAP < 65, an initial lactate ≥ 4, or provider documentation of septic shock (If BMI > 30 use ideal body weight) ☐ Document accurate IVF Stop Times when bolus is completed		
Complete within 6 Hours ☐ If initial lactate >2, repeat lactate x1 within 6 hours, ideally after fluid bolus ☐ Give appropriate vasopressor for persistant hypotension following fluid resuscitation ☐ Focus Exam by MD/PA/APN OR CVP, Sv02, Echo or Fluid Challenge completed		
ED Provider	ED Nurse	
Hospitalist	Med-Surg Nurse	

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Discussion

- What excites you the most about the information provided? What information can you leverage to help expand opportunities in your communities?
- What actions will you take as a result of the call?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- Which activities do you have underway that will allow for you to expand and push forward to build on action in the next 30 days? 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on March 10, 2022
from 1:00 – 2:00 PM ET

We invite you to register at the following link:

https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post event assessment here: [post assessment 2.10.22]

We will use the information you provide to improve future events.