Inpatient Quality Reporting (IQR) Program

Support Contractor

SEP-1 Early Management Bundle, Severe Sepsis/ Septic Shock: v5.1 Measure Updates

Questions and Answers

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Hypotension

Question 1: **Are we still taking a Map of < 65 as an indicator of persistent hypotension or is that no longer an indicator?**

Yes, a mean arterial pressure (MAP) less than 65 is still one of the criteria for determining that persistent hypotension is present.

Question 2: **Do you need documentation in the chart that the decrease in SBP is related to a medication?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicates the following: If there is physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required.

Question 3: **Do you still need two consecutive low B/P in the one hour after the conclusion of the fluid resuscitation to say yes to persistent hypotension? Also, do you need only one low B/P to say yes to an organ dysfunction for meeting the criteria for severe sepsis?**

Yes, two or more consecutive blood pressure readings in the one hour following conclusion of administration of crystalloid fluids are needed to select Allowable Value "1 (Yes)" for Persistent Hypotension. There is not a specified number of low blood pressure (BP) readings for organ dysfunction, therefore one is acceptable.

Question 4: **Does the decrease in BP of > than 40, have to be documented by the MD, etc. w/in the six hours' time frame?**

Yes, for the Severe Sepsis Present data element, if a decrease of greater than 40 millimeters of mercury (mmHg) in systolic blood pressure (SBP) has occurred and is being used to meet the organ dysfunction criteria all three criteria must be met within six hours of each other. Additionally, Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) documentation must be present in the medical record indicating a greater than 40 mmHg decrease in SBP has occurred and is related to infection, severe sepsis or septic shock, and no other causes.

Question 5: **Does the MD/APN/PA have to document the value ">40mm/HG" drop in BP or can they state drop in BP necessitating cont'd fluid bolus or vasopressors?**

Physician/APN/PA documentation must be present in the medical record indicating a greater than 40 mmHg decrease in SBP has occurred and is related to the infection, severe sepsis or septic shock and no other causes.

Question 6: **Does there have to be at least two episodes of low b/p to determine persistent hypertension?**

Yes, two or more consecutive blood pressure readings in the one hour following conclusion of administration of crystalloid fluids are needed in order to select Allow Value "1 (Yes)" for the Persistent Hypotension data element.

Question 7: **For initial hypotension - If there is only one SBP < 90, and the rest of the BP's are higher in the same time period - does that single BP still mean that crystalloid fluids need to be administered? Does there need to be specific documentation to exclude that BP?**

Initial Hypotension data element Notes for Abstraction indicate that, if hypotension was present within six hours prior to or within six hours following Severe Sepsis Presentation Date and Time, to then select Value "1." The SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"A single blood pressure reading that meets criteria for initial hypotension is acceptable."*

Regarding documentation to exclude a low BP for initial hypotension the 5.1 Additional Notes for Abstraction indicate:

- *"If there is physician/APN/PA documentation indicating a SBP less than 90 mmHg or MAP less than 65 mmHg is normal for the patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."*
- *"If there is physician/APN/PA documentation or nursing documentation indicating a low blood pressure reading is invalid, erroneous, or questionable, disregard that reading when determining the presence of initial hypotension."*

Question 8: **For Initial Hypotension, if the crystalloids are given and completed and the SBP was > 90 and afterwards within six hours after severe sepsis there is one SBP< 90 do we answer Yes to Initial Hypotension?**

No, you would not answer "Yes" to Initial Hypotension. To differentiate Initial Hypotension from Persistent Hypotension. Keep in mind Persistent Hypotension can only be evaluated after the 30 milliliters per kilogram (mL/kg) of crystalloid fluids has been completely infused. There is no such requirement associated with the Initial Hypotension data element. Initial Hypotension would, therefore, be hypotension present prior to 30 mL/kg of crystalloid fluids being completely infused. This means Initial Hypotension can be present before the 30 mL/kg is started, or after it is started but before it is completely infused. Once the crystalloid fluids are completely infused, you are done with the Initial Hypotension data element. You would then be looking at the Persistent Hypotension data element to determine if persistent

or new hypotension was present within one hour of the conclusion of the crystalloid fluids.

Question 9: **For persistent hypotension, the manual says we can use MD/APN/PA and nursing documentation that says a BP is erroneous. Can we accept documentation for initial hypotension that the BP was erroneous?**

Yes, the SEP-1 Additional Notes for Abstraction for Version 5.1 for Initial Hypotension indicates:

- *"If there is physician/APN/PA documentation or nursing documentation indicating a low blood pressure reading is invalid, erroneous, or questionable, disregard that reading when determining the presence of initial hypotension."*

Question 10: **For Persistent Hypotension, does two CONSECUTIVE readings means the BP's need to be recorded back to back, or is it any more than two within the hour following fluids?**

Consecutive is defined as one after the other in a series, as in following each other without interruption.

Question 11: **For the criteria Initial Hypotension: is a single BP al that is needed to say yes or does there needed to be 2 BPs readings that meet the criteria?**

The SEP-1 Additional Notes for Abstraction for Version 5.1 indicate a single blood pressure reading that meets criteria for initial hypotension is acceptable.

Question 12: **For the term "new hypotension" under the Persistent hypotension data element, does there still need to be two consecutive low BP/MAPs to answer yes to new hypotension thus requiring vasopressors?**

Yes, the criteria are the same for persistent hypotension and new hypotension. In the one hour following administration of the 30 mL/kg of crystalloid fluids there must be two or more consecutive blood pressure reading of either a SBP less than 90 mmHg, a MAP less than 65 mmHg, or a decrease in SBP by greater than 40 mmHg.

Question 13: **If a patient meets all severe sepsis components but the one low BP was taken in the PACU, should that be included to meet criteria?**

A blood pressure taken in the Post Anesthesia Care Unit (PACU) can be used. However, if there is documentation linking the low BP to another condition or medication, then it should not be used.

Question 14: **If initial hypotension is present and the patient does not receive 30ml/kg of crystalloid fluids, how do you determine persistent hypotension without the documentation of septic shock/lactate greater than four?**

If the patient did not receive the full 30 mL/kg of crystalloid fluids, then the presence of persistent hypotension cannot be determined. Based on the algorithm (SEP-1-14), if Initial Hypotension is present and 30 mL/kg of crystalloid fluids were not ordered and administered, the case fails the measure and abstraction is done.

Question 15: **If severe sepsis is present and there is a single reported episode of hypotension then the patient rules into the septic shock component of the measure?**

If the patient has severe sepsis and also initial hypotension crystalloid fluids are required. The presence of septic shock cannot be determined until the 30 mL/kg of crystalloid fluids have been infused and the presence of persistent hypotension is identified.

Question 16: **If the physician documents "persistent hypotension, vasopressors started", but there are not two blood pressure readings in that period, will the physician documentation result in a "Yes" to the presence of persistent hypotension following fluids?**

No, physician documentation of "persistent hypotension, vasopressors started" in place of documentation for the two or more consecutive blood pressure readings would not be acceptable.

Question 17: **If there is new hypotension within the hour following fluid resuscitation, does the provider have to document that it is due to severe sepsis or septic shock, or does the new hypotension alone count as persistent**

hypotension.

No, the provider does not have to document that the new hypotension is due to severe sepsis or septic shock. The presence of two consecutive low BP readings in the hour following the 30 mL/kg fluid completion is sufficient.

Question 18: **If you have severe sepsis, when would septic shock be present with an initial SBP less than 90 or when there is persistent hypotension SBP less than 90 after fluid resuscitation?**

In order to have septic shock based upon a SBP less than 90 mmHg, severe sepsis must be present and there must be two or more consecutive blood pressure readings less than 90 mmHg in the hour after the conclusion of the 30 mL/kg of Crystalloid Fluid Administration.

Question 19: **In regards to the persistent hypotension and new hypotension – the definition is the same which says "following the administration of the crystalloids fluids. However, did I understand you to say that new hypotension was PRIOR to conclusion of the fluids?**

Initial Hypotension is hypotension present prior to the conclusion of the 30 mL/kg of crystalloid fluids. "New hypotension" is within the context of the Persistent Hypotension data element and represents two or more consecutive low BP readings present after the 30 mL/kg of crystalloid fluids that was not present prior to completion of the fluids.

Question 20: **Initial Hypotension: If a patient has a known disorder, such as heart failure, with a base line MAP < 65 mmHg or Systolic Blood Pressure less than 90, can I exclude those readings for organ failure?**

The SEP-1 Additional Notes for Abstraction for Version 5.1 for Initial Hypotension indicates the following:

- *"If there is physician/APN/PA documentation indicating a SBP less than 90 mmHg or MAP less than 65 mmHg is normal for the patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."*

Question 21: **Just to clarify – if a pt. has severe sepsis and has only one SBP less than 90, does this qualify the pt. as septic shock?**

No, this doesn't qualify as septic shock. In order to have septic shock based upon a SBP less than 90 mmHg, severe sepsis must be present and there must be two or more consecutive blood pressure readings less than 90 mmHg in the hour after the conclusion of the 30 mL/kg of Crystalloid Fluid Administration.

Question 22: **Just to clarify, there is no time limit between initial hypotension and when crystalloid fluids are initiated for patients who do not have a lactate of four or greater or physician documentation of septic shock? If this is the case and the fluids are given but not completed within six hours of severe sepsis, can we answer no to septic shock?**

Correct, there is not a specified time period. If septic shock is present more than six hours after severe sepsis, you would select Value "2 (No)" for the Septic Shock Present data element.

Question 23: **Please clarify that initial hypotension: is defined by SBP less than 90 OR MAP less than 65 AND OR decrease in SBP by less than 40 mmHg. Is the last (new) option an OR also or 1 of 2 first options AND the new element?**

The Initial Hypotension data element Notes for Abstraction indicate that the criteria for determining that hypotension was present is based on only one of the criteria and not a combination of the criteria. Either six hours prior to or within six hours following severe sepsis presentation there must be one of the following blood pressure readings:

- *systolic blood pressure less than 90, or*
- *mean arterial pressure (MAP) less than 65, or*
- *a decrease in systolic blood pressure by greater than 40 mm/Hg.*

Physician/APN/PA documentation must be present in the medical record indicating a greater than 40 mmHg decrease in SBP has occurred and is related to infection or severe sepsis and no other causes.

Question 24: **If a patient is on B/P meds or has hypertension history, does the new initial hypotension requirement apply?**

Based on the information provided, the Initial Hypotension data element would apply. The BP would not be used if there is physician/APN/PA documentation indicating a SBP less than 90 mmHg or MAP less than 65 mmHg is normal for the patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication. Inferences should not be made; physician/APN/PA documentation is required.

Question 25: **Question: Is a MAP to only be taken from an arterial line? For example, if the electronic medical record shows a MAP from a non-invasive blood pressure cuff do we use that?**

Non-Invasive Blood Pressure (NIBP) mean reflects that the mean pressure was obtained non-invasively and would be acceptable.

Question 26: **Since the addition of new hypotension following the admin of 30ml/kg of crystalloid fluids, so we still need only one episode of hypotension as stated earlier? Because persistent hypotension requires at least 2 BPs.**

The term new hypotension is used within the context of persistent hypotension in the Persistent Hypotension data element. It represents hypotension that is present after the 30 mL/kg crystalloid infusion was completed and was not present prior to completion of the infusion. It is identified the same way as persistent hypotension, requiring two or more consecutive low BP readings in the hour following conclusion of the 30 mL/kg crystalloid infusion.

Question 27: **So I am clear, is the hypotension after the Vasopressors only for persistent hypotension or can it be a new hypotension?**

Vasopressors are indicated for persistent hypotension, where two or more consecutive low BP readings within the hour following conclusion of the 30 mL/kg crystalloid infusion. The term "new hypotension" is used within the context of the Persistent Hypotension data element. Because of this, new hypotension follows the same criteria as that required for determining the presence of persistent hypotension.

Question 28: **So, if there is a SBP < 90 you must also have physician documentation stating that the reason the SBP is < 90 is due to infection? Am I correct?**

Physician documentation is only required if the low BP is not due to an infection. If the low BP is due to an infection, severe sepsis, or septic shock, then separate physician documentation confirming this is not required.

Question 29: **So the MD must actually document link of drop in blood pressure due to infection or severe sepsis?**

For a decrease in SBP greater than 40 mmHg physician/APN/PA documentation must be present in the medical record indicating the decrease is related to infection, severe sepsis, or septic shock and no other causes. For other low BP readings (e.g., SBP less than 90 mmHg and MAP less than 65 mmHg) physician documentation stating that it is due to infection, severe sepsis, or septic shock is not required.

Question 30: **Will the initial hypotension be excluded if not related to severe sepsis presentation?**

This data element limits the time frame within which initial hypotension occurs to the six hours prior to or within six hours following severe sepsis presentation. Per the Additional Notes for Abstraction v5.1 for Initial Hypotension, if there is physician/APN/PA documentation indicating a SBP less than 90 mmHg or MAP less than 65 mmHg is normal for the patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required.

Question 31: **Would Lasix be considered a blood pressure medication since it's administration and the resulting fluid loss can result in a drop in blood pressure?**

If the physician/APN/PA documents the low BP is due to the patient being on Lasix it could be used. Assumptions cannot be made that a drop in BP for a patient on Lasix is due to the Lasix.

Question 32: **Would the criteria for initial hypotension be the same as the criteria for persistent hypotension? Specifically, would this mean two occurrences**

within a one hour timeframe?

The blood pressure parameter criteria for determining the presence of Initial Hypotension does not specify a minimum number of low BP readings, but does specify a time frame within which the low BP reading must occur. One low BP reading is acceptable, if it meets the parameters in the Initial Hypotension data element that occurs within six hours before through six hours after the presentation of severe sepsis.

Organ Dysfunction

Question 33: **With BiPAP for organ dysfunction, do we also need "acute respiratory failure" documented? Or just respiratory distress?**

For acute respiratory failure as a sign of organ dysfunction, there must also be documentation of "acute respiratory failure." Respiratory distress is not sufficient.

Question 34: **Is the organ dysfunction the same as before? If it's due to one of the issues mentioned in the specifications manual (INR due to warfarin, elevated create due to ESRD, or low BP due to medication) we don't need documentation of a link from physician/APN/PA? But, if it's another condition (elevated bilirubin due to liver failure, for example) we would need documentation by a physician/APN/PA?**

This has changed slightly. The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that, if there is physician/APN/PA documentation that a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required.

Question 35: **Organ dysfunction - due to chronic condition or medication. Are the (now 3) examples given the ONLY reasons we should ignore the abnormal labs? So, if a patient has an elevated INR and is on Pradaxa or Eliquis, should we not use the elevated INR? Or is it ONLY when a patient is on Warfarin? Thank you.**

This has changed slightly. The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that, if there is physician/APN/PA documentation that a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, then it should not be used. Inferences should not be made; physician/APN/PA documentation is required.

Question 36: **Regarding lab values for SIRS and organ dysfunction, if a result time is not available, is it acceptable to use draw time? If the answer is "no" are these values to be excluded?**

For any given laboratory value, use the earliest time that a value is reported, not the draw time. If a reported time is not available, it cannot be confirmed that it was reported within the six hour time frame within which all criteria for severe sepsis must occur; therefore, it should not be used.

Question 37: **Do physicians need to make "linkage" statements, such as "elevated lactate level due to MI" to not use these labs? What about elevated lactic acid or creatinine related to Rhabdomyolysis, Overdose/toxin ingestion etc. that would make these labs abnormal and not related to septic conditions?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"If there is physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."*

Question 38: **Can chronic conditions or medications other than blood pressure medication be used to exclude organ dysfunction OR SIRS criteria? i.e.: elevated WBC d/t chronic steroid use, hypothermia induced s/p arrest, Or hypotension d/t sedation upon intubation?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"If there is physician/APN/PA documentation that SIRS criteria or a*

sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."

Question 39: **For evidence of organ dysfunction due to chronic condition or medication: specifically, what type of documentation is required as evidence that the condition is chronic? If patient has ESRD in medical history, is that sufficient? Or must there be a note, "Elevated creatinine is due to ESRD" to satisfy the measure? Also, is physician documentation the only acceptable source? Thanks.**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"If there is physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."*

Question 40: **For the patient with CKD, if the MD documents the baseline Creatinine level and the current Creatinine is greater than this; is the Creatinine level to be ignored or taken into consideration?**

Inferences should not be made; physician/APN/PA documentation is required. If the physician documents that the baseline elevated creatinine is due to the Chronic Kidney Disease (CKD) it should not be used. There would also need to be physician documentation indicating the level greater than baseline is due to the CKD to not use it.

Question 41: **The specifications exclude organ dysfunction elements that can be contributed to pre-existing conditions; example decrease in BP secondary to BP medications. Can the abstractor also assume that some of the SIRS criteria are due to pre-existing conditions, such as elevated RR secondary to asthma or elevated HR due to dehydration?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"If there is physician/APN/PA documentation that SIRS criteria or a*

sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."

Question 42: **You say we are not to assume elevated labs or due to chronic conditions. If patient has Coumadin on home med list, can we not use the INR without specific documentation stating the connection?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate inferences should not be made; physician/APN/PA documentation is required.

Question 43: **Does there have to be MD/APN/PA documentation that links the elevated INR with the home medication of Coumadin to exclude this for organ dysfunction? The example of this in the manual does not say there has to be documented linkage.**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that inferences should not be made; physician/APN/PA documentation is required.

Question 44: **The guidelines read that abnormal values related to medication should not be used, but still cite an example of INR > 1.5 for a patient on Coumadin. Can you confirm that even in this instance we still need the MD to document the link between the medication and value? In other words, we are to assume that abnormal values ARE related to sepsis unless MD specifies otherwise? In the absence of MD stating that elevated INR is related to Coumadin we can use it as organ dysfunction?**

Yes, The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that inferences should not be made; physician/APN/PA documentation is required.

Question 45: **If the patient is on Xarelto or Eliquis as an active Home medication and INR was > 2.0 on ED Presentation, will it still be considered as "organ dysfunction related to anticoagulant" and should be considered as a chronic condition?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"If there is physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, it should not be used. Inferences should not be made; physician/APN/PA documentation is required."*

Question 46: **If there is documentation of Hepatic steatosis and patient has an elevated bilirubin, can this be considered a chronic condition, if patient has a history of cirrhosis?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that inferences should not be made; physician/APN/PA documentation is required.

Question 47: **When looking for organ dysfunction. If a value is felt to be due to a chronic condition or medication, is it required that the MD document a link between the two? Or, is the abstractor able to make that determination?**

The Severe Sepsis Present data element SEP-1 Additional Notes for Abstraction for Version 5.1 indicate that inferences should not be made; physician/APN/PA documentation is required.

Administrative Contraindications for Care

Question 48: **Administrative Contraindications – Can you use RN or Lab documentation of refusal in the Record?**

For these data elements refusal must be documented by a physician/APN/PA OR documented on a witness signed consent form. Registered Nurse (RN) or lab documentation of refusal that is not on a witness signed consent form is not acceptable.

Question 49: **What if the physician documents administrative contraindication on the progress note and not on a form?**

Physician documentation for an administrative contraindication is not limited to consent forms. Any physician documentation is acceptable.

Question 50: **Administrative Contraindications – Can you use RN or Lab documentation of refusal in the Record?**

Thank you for your question and comment. This will be shared and discussed with the measure steward for future consideration.

Question 51: **Does the palliative care have to be ordered within 6 hours of septic shock DX?**

For the data element Directive for Comfort Care or Palliative Care, Septic Shock, an inclusion term (palliative care) must be documented prior to or within six hours of presentation of septic shock to be able to select value "1 (Yes)."

Question 52: **If the physician recommends palliative or comfort care, and it is documented that the discussion occurred, but the family refuses, can this be counted as a directive for palliative/comfort care?**

Given that the family refused comfort measures. This would be more consistent with conditional documentation and would be abstracted as Value "2 (No)."

Question 53: **What do we abstract if the provider says "may consider palliative care or comfort care, but no order written or no referral written, or if after discussion with family, it is decided to address more fully later?**

If this is the only documentation of an inclusion term, it appears to be consistent with being described as negative or conditional.

Question 54: **If our facility uses the term "palliative care" to reference care our facility provides to help patients with a chronic disease process and to optimize comfort and healing and not for comfort measure or hospice patients. Would I still be required to exclude all of those cases with a palliative care consult?**

If palliative care is documented by a physician/APN/PA within the

appropriate time frame, it could be used as directive for comfort care or palliative care.

Question 55: **Is physician documentation of "no Blood draw" equivalent to refusal?**

The documentation provided would not be acceptable as physician/APN/PA documentation of refusal because it does not necessarily reflect the patient is refusing blood draw.

Question 56: **All those questions re: palliative care still have to be within three hrs. After presentation of severe sepsis, correct?**

Documentation of an inclusion term must be documented prior to or within three hours of the presentation of severe sepsis to be able to select value "1 (Yes)" for data element Directive for Comfort Care or Palliative Care, Severe Sepsis.

Question 57: **Administrative Contraindications – Can you use RN or Lab documentation of refusal in the Record?**

No, the only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused."

Question 58: **what about case that state no escalation of care or if the patient is DNR/DNI**

Assuming your question is regarding the data element Directive for Comfort Care or Palliative Care. There is no documentation of an inclusion term and selecting "No" would be appropriate.

Question 59: **What if a patient refuses to have vital signs taken?**

It is not clear which data element this question is referring to. Without knowing the data element, we cannot provide a response.

Question 60: **What is the patient refuses to the lab tech for the lactate. Does this count?**

The only acceptable sources for the data element Administrative Contraindication to Care are physician/APN/PA documentation or a witness- signed consent form marked "refused."

Question 61: **Just to clarify: The refusal of IV fluids, all labs or antibiotics have to be documented within the 1st 6 hrs. to exclude the patient?**

Yes, the refusal of intravenous (IV) fluids, blood draws or IV antibiotics must be documented prior to or within six hours following presentation of severe sepsis.

Question 62: **If a physician orders a palliative care consult would that suffice? Or if a physician says "may consider palliative care" would that be enough for the directive for comfort or palliative care?**

Both examples provided could be used, if documented within the appropriate time frame.

Question 63: **Do I understand correctly that an RN can mark refused on the MAR if the pt. refuses an IV antibiotic, and it will count as EXCLUDED?**

No, the only acceptable sources for the data element Administrative Contraindication to Care are physician/APN/PA documentation or a witness-signed consent form marked "refused."

Question 64: **We do not require consents for fluid administration, antibiotics, it is only noted in nsg notes/ maybe phy progress note, there would be no refusal noted on a consent form? What do we do?**

The only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused." Physician documentation of a refusal in a progress note could be used; however, nursing documentation of refusal in a nursing note is not acceptable.

Question 65: **Physician /RN documentation of a patient's refusal of meds/labs/etc. is not sufficient unless on an actual consent form. Is this correct? We are not to use progress notes or nurse narratives?**

The only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused." Physician documentation of a refusal in a progress note could be used; however, nursing documentation of refusal in a nursing note is not acceptable.

Question 66: **If palliative care is for pain management (not CMO) then we would not exclude the case. Is this statement correct?**

No, if there is documentation of an inclusion term, such as palliative care within the appropriate time frame, it would be acceptable to use.

Question 67: **Does the palliative care have to be an order or can it be in progress note as well, and will a referral for a palliative care consult be acceptable?**

Palliative care documentation could be in an order or in a progress note. A referral for palliative care consult could be used if documented within the appropriate time frame.

Question 68: **Also if the physician orders a palliative care consult and the patient discharges or expires prior to palliative care has seen the patient, how would you abstract that scenario?**

An order for palliative care consult documented in the appropriate time could be used to select value "1 (Yes)."

Question 69: **We have an order that is usually written on admission for palliative care consult on many of our patients. This does not mean they are palliative care. Do we have to say yes to palliative care with just the order?**

An order for palliative care consult documented in the appropriate time could be used to select value "1 (Yes)."

Question 70: **On documentation of refusal for IV antibiotic, can this be just a nurse documenting on the MAR, Patient refused?**

The only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused." Nursing documentation of refusal on the Medication Administration Record (MAR) is not acceptable.

Question 71: **Does a physician order for a palliative care consult within 3 hours of severe sepsis meet the requirement to answer yes to directive for comfort care or palliative care? Often times, palliative care may not see the patient for several hours after the consult is ordered.**

An order for palliative care consult documented in the appropriate time could be used to select value "1 (Yes)."

Question 72: **For IV ABX and Lab draw refusal- it has to be documented by MD/APN/PA? RN documentation is not accepted?**

The only acceptable sources are physician/APN/PA documentation OR a witness-signed consent form marked "refused." Nursing documentation of refusal is not acceptable.

Question 73: **Administrative Contraindications: The refusal consent form has to be witnessed but not signed by the patient or family correct?**

Correct, the refusal consent form has to be witnessed, but does not have to be signed by the patient or decision-maker.

Question 74: **So an RN writing "refuses all further labs" on a consent form for Lab draws and having it witnessed by a second RN would exclude patient?**

Correct, refusal of all further labs on a consent form for labs drawn that is witnessed by a second RN would allow for value "2" to be selected.

Question 75: **If a Refusal is entered by the MD that the patient refuses the entire amount of CF, does this refusal exclude case from all measures, such as Repeat Lactate/ABX selection?**

For Administrative Contraindication to Care, Severe Sepsis, if there is physician/APN/PA documentation that the patient refuses crystalloid fluids in the appropriate time frame, selecting value "1" would be appropriate. Based on the algorithm, if value "1" is selected, the case will be excluded.

Question 76: **Palliative care does not necessarily mean comfort care, do these have to coincide to say yes to comfort care, or do we still say yes, even if only palliative care consult?**

An order for palliative care consult documented in the appropriate time frame could be used to select value "1 (Yes)."

Question 77: **Would documentation by the physician that "family has requested withdrawal of care and extubation" be acceptable for refusal of care?**

Withdrawal of care is not the same as "refusal" of care for Administrative Contraindication to Care.

Question 78: **If there is an order for Palliative care w/o referral to comfort care, will this count as stopping of care?**

An order for palliative care documented in the appropriate time frame could be used to select value "1 (Yes)."

Question 79: **If a patient has a consult for palliative care, but refuses and opts to pursue aggressive measures, does the consult for palliative care still count as documentation as an administrative contraindication to care?**

Given that the patient refused palliative care, this would be more consistent with conditional documentation and would be abstracted as Value "2 (No)."

Question 80: **The issue with Comfort Care is the timing. We had a patient that CC was ordered eight hours after presentation. We failed the measures because treatment was not continued.**

If there is not documentation of an inclusion term prior to or within six hours of presentation, selecting "2 (No)" would be appropriate.

Question 81: **Just to clarify, we could use documentation on palliative care within the specified period and it will exclude the case from the relevant measure. Does it mean we should treat "palliative care" as synonymous to Comfort measure only?**

Yes, if palliative care is documented within the appropriate time frame, it could be used as directive for comfort care or palliative care.

Question 82: **In the event that treatment for Severe Sepsis begins and then the provider orders Comfort care/ Palliative Care for the patient, as the treatment is not effective, at what time do you abstract the Directive for Comfort care – Septic Shock?**

The time frame for the data element Directive for Comfort Care or Palliative Care, Septic Shock is prior to or within six hours of the presentation of septic shock. If the documentation of an inclusion term (comfort care/palliative care) is within six hours of the presentation of septic shock, selecting value "1" would be appropriate.

Question 83: **When you say 'prior to or within six hours of' do you mean six hours before and six hours after sepsis or shock times - so that it's a 12 hr. time span to look for Admin Contra to Care?**

The time frame is prior to presentation of severe sepsis or septic shock and within six hours after presentation. It could be more than a 12 hour time frame.

Question 84: **Does a palliative care consult or physician/APN/PA recommendation of palliative care count towards Directive for Comfort Care? Thank you.**

If palliative care is documented within the appropriate time frame, it could be used as directive for comfort care or palliative care.

Question 85: **Just wish to clarify that contraindication to care does NOT include things like refusal of Central Lines or other procedures.**

Administrative Contraindication to Care, Severe Sepsis, and refusal of central line is not acceptable. In the v5.1 Additional Notes for Abstraction under Administrative Contraindication to Care, Septic Shock, refusal of a central line is acceptable.

Question 86: **Slide 13: Refusal of blood draw, etc. is that documentation by anyone, i.e., nurses or specifically the provider/PA/ANP?**

Only acceptable sources are physician/APN/PA documentation or a witness-signed consent form marked "refused." Nursing documentation of refusal would not be acceptable.

Question 87: **If the patient has a state sponsored transferable order (POLST) that declines care as part of the severe sepsis or septic shock bundle, is any further documentation by the MD required?**

Based on the Directive for Comfort Care or Palliative Care, Severe Sepsis and Directive for Comfort Care or Palliative Care, Septic Shock data elements, if an inclusion term is documented on a physician order for life-sustaining treatment (POLST) and requirements of these data elements are met, no further physician documentation is required.

Question 88: **Can a MOLST form indicating patients parameters of care serve as supporting documentation of administrative contraindication for care?**

A medical order for life-sustaining treatment (MOLST) cannot be used for the Administrative Contraindication to Care data elements because it is not considered a consent form.

Question 89: **Is a signed AMA form considered an administrative contraindication of care, as this is a refusal of all treatment including blood draws, IV antibiotics and IV fluids?**

It will depend on what documentation is present on the against medical advice (AMA) form. If there is documentation that the patient is "refusing treatment" it could be used.

Question 90: **If the physician simply documents in a progress note that the pt. refused blood draw, and this is within six hours of severe sepsis, is this acceptable to contraindication to care for severe sepsis? Or, does the documentation have to specify that the pt. refused a lactate blood draw?**

If there is physician/APN/PA documentation that the patient refused blood to be drawn, selecting value "1" would be appropriate.

Lactate-Labs

Question 91: **We are doing concurrent reviews of potential severe sepsis cases using our vendor Truven. However, we are getting errors when the lactate acid is drawn before the admission order has been put in for patients coming in through ED. This started happening with the latest update for July 1 discharges. Does the lactate acid have to be drawn after the patient is admitted as an inpatient?**

No. I would suggest you contact your vendor. Nothing has changed in the specifications that would prevent using a lactate drawn prior to arrival or admission.

Question 92: **In determining criteria for Severe Sepsis, do we take reported time or drawn time for labs?**

For the Severe Sepsis Present data element, the SEP-1 Additional Notes for Abstraction for Version 5.1 indicate for any given laboratory value, use the earliest time that value is reported, not the draw time.

Question 93: **Is lactate > four the measure or 2 or greater? I have heard both.**

A lactate level greater than two is a sign of organ dysfunction for severe sepsis criteria. An initial lactate level greater than two requires a repeat lactate be drawn. An initial lactate level greater than four indicates septic shock is present.

Question 94: **Slide 20: The lactate level you use for determining organ dysfunction may not always be the one drawn closet to the time of presentation of severe sepsis, which is what you have to abstract for the initial lactate level, is this OK to not use the same test for both items different?**

Yes. The initial lactate is defined as the one drawn closest to the presentation time of severe sepsis. If other lactates drawn were reported within the six hour time frame for determining presence of severe sepsis, they can be used to determine the presence of severe sepsis.

Question 95: **It was our understanding that, even with the changes, we needed to abstract the resulted time for the lab values. Can we use the collected time or do we need to continue to use the resulted time?**

For the Severe Sepsis Present data element, the SEP-1 Additional Notes for Abstraction for Version 5.1 indicate to use the earliest time that a lab value is reported, not the draw time.

Question 96: **On slide 20, regarding the wording of the lactate change from reported to drawn, does this change the determination of timing of the presentation of severe sepsis from using the reported time of the lactate to the time the lactate is drawn?**

No, the edits in both the Initial Lactate Level Collection Date and Time data elements were made to the first bullet point to correct a typographical error. The word "reported" was replaced with "drawn" to make these two data elements consistent with other related data elements. For any given laboratory value for the Severe Sepsis Present data element, use the earliest time that value is reported, not the draw time.

Question 97: **What time s/b abstracted for septic shock when ED presentation has a lactate > 4, which would meet septic shock criteria, but severe sepsis criteria is not met till a later time, i.e. identification of infection source is 1 hr. after ED presentation?**

The Septic Shock Presentation Time data element Notes for Abstraction indicate to use the time at which the last sign of septic shock was noted or the last laboratory value was reported. In this example, this would be reflected in the time severe sepsis criteria was met.

Question 98: **If a lab, such as creatinine, meets criteria for severe sepsis, do I abstract the time drawn or reported?**

For the Severe Sepsis Present data element, the SEP-1 Additional Notes for Abstraction for Version 5.1 indicate:

- *"For any given laboratory value, use the earliest time that value is reported, not the draw time."*

Question 99: **Please clarify: Elevated Lactate is greater than 2...not greater than or equal to two? Therefore, a Lactate = 2 is not elevated?**

For the Severe Sepsis Present data element, the Notes for Abstraction indicate an elevated lactate is a lactate greater than two millimoles per liter (mmol/L). A lactate equal to 2 mmol/L is not elevated.

Question 100: **Initial Lactate is collected and is elevated, The repeat lactate is completed. The Severe Sepsis Presentation time states use Lactic acid closest to presentation time. We end up having to use the Repeat time as the initial and then fall out for the repeat not being completed. Is this the expectation of the bullet, or should we be using the initial lactate as long as it falls in the time period?**

The first lactate drawn may not be the initial lactate, defined in the Initial Lactate data element as the lactate level drawn closest to severe sepsis presentation time. In the example, the second lactate if drawn closer to the severe sepsis presentation time than the first lactate, would be, per definition, the initial lactate. If that second lactate is elevated, another or third lactate should be drawn, representing the "repeat lactate." If that second lactate was not elevated, there is no requirement for "repeat" or third lactate draw.

Question 101: **Does lactate acid of > 4 still allow to abstract yes to septic shock?**

If there is documentation of severe sepsis being present and an Initial Lactate Level greater than or equal to four mmol/L, then selecting Allowable Value "1 (Yes)" for Septic Shock Present would be appropriate.

Question 102: **If your patient presents to the ER with a lactate of 6, which meets septic shock but the physician does not document infection source for 4 hours. By definition the patient does not meet severe sepsis criteria until you have an infection source. How do we abstract this chart? Does severe sepsis start when you have a lactic acid of 6? Does your septic shock automatically start at the time your lactic acid is greater than 4, even if the physician has not documented infection source yet.**

Septic shock does not automatically start when the initial lactate level is greater than four mmol/L. Documentation of severe sepsis or all three of the severe sepsis clinical criteria must also be present. The Septic Shock Presentation Time data element Notes for Abstraction indicate to use the time at which the last sign of septic shock was noted or the last laboratory value was reported. In this example, this would be reflected by the last time that the severe sepsis criteria was met.

Question 103: **How can abstractors document a reason for not obtaining a repeat lactate if the patient is in surgery at the time due?**

The measure does not allow for exceptions from obtaining a repeat lactate.

Question 104: **So, lactic acid greater than or equal to 4 is no longer an indication for the diagnosis of septic shock in the presence of SIRS and infection?**

The introduction of the new data element, Documentation of Septic Shock, does not change the criteria for determining if septic shock is present. The Septic Shock Present data element defines this. One of the criteria is the presence of severe sepsis and a lactic acid level greater than or equal to four mmol/L.

Question 105: **So, with July discharges we will no longer use the criteria of severe sepsis and a lactate > 4 to say yes to septic shock – it must be MD documentation of Septic Shock?**

No. The introduction of the new data element, Documentation of Septic Shock, does not change the criteria for determining if septic shock is present. The Septic Shock Present data element defines this. One of the ways to identify that septic shock is present is the presence of severe sepsis and an Initial Lactate Level greater than or equal to four mmol/L.

Question 106: **Does severe sepsis criteria with lactate > 4 still qualify for septic shock? Is the new data element of provider documentation of shock just an additional trigger for shock cases that might not have a lactate greater than 4 or persistent hypotension?**

Yes, if severe sepsis criteria are met within six hours of each other and the Initial Lactate Level is greater than or equal to four mmol/L then Septic Shock is present. You are correct the new data element, Documentation of Septic Shock, is an additional trigger.

Question 107: **If an initial lactate level is greater than 4.0 yet the criteria for severe sepsis is not met, including MD documentation is this still septic shock?**

No. The Septic Shock Present data element indicates severe sepsis criteria or physician documentation of severe sepsis in addition to an initial lactate greater than or equal to four is required.

Question 108: **Just for clarification Procalcitonin is not required but instead is optional for the physician. From my understanding it is not included in the 6 bundle measure.**

A Procalcitonin level is not acceptable in place of a lactate level for purposes of the SEP-1 measure.

Question 109: **Shock, can the repeat lactate be drawn before time zero?**

No, for the Repeat Lactate Level Collection data element, a repeat lactate level must be drawn in the time window beginning at Severe Sepsis Presentation Date and Time and ending six hours thereafter to choose Value "1."

Question 110: **When abstracting for severe sepsis, if a patient meets with an elevated bilirubin, does it matter if it is a direct or total bilirubin?**

The Severe Sepsis Present data element does not specify direct verses total bilirubin. Based on normal values for each (Direct bilirubin: 0 to 0.3 milligrams per deciliter (mg/dL), Total bilirubin: 0.3 to 1.9 mg/dL) a value greater than two would be reflective of a total bilirubin.

Question 111: **If a Lactate level is greater than 4 is that a trigger for Bolus, even if B/P is normal?**

Yes, crystalloid fluids should be given for the presence of severe sepsis with a lactate greater than or equal to four mmol/L, regardless of whether hypotension is present.

Question 112: **On slide 23, it says that the repeat lactate level must be drawn in the time window beginning at severe sepsis presentation date and time and ending 6 hours thereafter. The Spec Manual says that to repeat lactate level measurement, only if the initial lactate level is elevated and ONLY**

if septic shock present. So, do we need to do a repeat lactate level for Severe Sepsis, if the level is elevated, but patient is not in Septic Shock?

Yes, if the initial lactate level is elevated (greater than two mmol/L), then a repeat level must be drawn in the time window beginning at Severe Sepsis Presentation Date and Time and ending six hours thereafter.

Question 113: **Can a venous blood gas be acceptable to measure the venous oxygen level?**

There must be documentation indicating the Central Venous Oxygen Measurement (ScvO2) is from a central line. A venous blood gas may be from a peripheral sample. If from a peripheral sample, it is not acceptable for Central Venous Oxygen Measurement.

Question 114: **If the lab value is elevated and the physician documents acute-on-chronic condition, is the lab value now considered in determining severe sepsis criteria, or does it still remain excluded due to chronic condition??**

If a physician documents "an acute on chronic condition," this reflects that abnormal lab values may not be due to the chronic condition, but rather may be due to an acute episode. As such, the abnormal lab value can be used as a sign of organ dysfunction.

Question 115: **Does a lactate >=4 that occurs within 6 hours of severe sepsis presentation constitute septic shock, even though it wasn't the initial lactate?**

No, the Notes for Abstraction for the Septic Shock Present data element indicate that septic shock is based on an Initial Lactate Level greater than or equal to four mmol/L.

Fluid

Question 116: **Will there be any documentation a physician can provide to exclude a pt. from receiving the 30ml/kg fluids? (I.e. low EF, CHF, dialysis pt.)**

No, there are no exclusions or exceptions for not administering 30 mL/kg of crystalloid fluids.

Question 117: **Did you say there were some cases that could pass the measure, if they did not get the 30ml/kg of fluids. Example, 500ml bolus was given, but due to fear of overload with CHF, the 30ml/kg bolus was not given. How do would you answer this measure element?**

No, the 30 mL/kg of crystalloid fluids is required, if there is documentation of initial hypotension, initial lactate greater than or equal to four, or documentation of septic shock. There are no exclusions or exceptions for not administering 30 mL/kg of crystalloid fluids.

Question 118: **Does crystalloid fluids need to be started within 3 hours of septic shock presentation time or completed within 3 hours of septic shock presentation time?**

Based on the Crystalloid Fluid Admin Time calculation in the algorithm, the crystalloid fluids must be started within three hours of Septic Shock Presentation Time to pass the measure. Crystalloid fluids are not required to be completed within three hours of the Septic Shock Presentation Time.

Question 119: **If we are now using "bolus" for the crystalloid bolus, how are we defining the end-time to determine persistent hypotension?**

The end time of the crystalloid infusion can be determined when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order. This end time would be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 120: **How do we determine the end time for fluids ordered bolus or wide open?**

The end time of the crystalloid infusion can be determined when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order. This end time would be based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 121: **For crystalloid fluids given prior to septic shock – is there a maximum time that the fluids can be given prior? Example: what if the fluids are given at 10am but severe sepsis criteria aren't met until 1430 – could the fluids at 10 am time be used?**

Abstracting crystalloid fluids administered prior to the Septic Shock Presentation Time will be dependent on the particular triggering event of each case. Initial hypotension, or initial lactate greater than or equal to four or documentation of Septic Shock are considered triggering events. Per your example, if initial hypotension is present at 10 am, crystalloid fluids administered at that time at a rate greater than the "usual rate" are acceptable.

Question 122: **What is the time limit the 30ml/kg fluid must be completed?**

There is no time by which the crystalloid fluids must be completed to pass the measure.

Question 123: **Is I/O flow sheet documentation acceptable for crystalloid end time?**

Yes, the data element Suggested Data Sources listed within the data element is not an all-inclusive list. If the administration of crystalloid fluids is documented on the Intake and Output (I&O) flow sheet appropriately, it is acceptable to use for abstraction.

Question 124: **If you can count crystalloid fluids that were started prior to the Severe Sepsis presentation. If the fluids were started 1/1/16 at 2:00 and severe sepsis presentation is at 1/1/16 at 4:00 and the patient is given 3 Liters of fluid; two liters prior to presentation and one after presentation. Which liter of fluid do I identify as the fluid start time? The first liter prior to**

presentation or the third liter after presentation?

The Crystalloid Fluid Administration Time will be dependent on how the fluids were ordered. If there is a single physician order for crystalloid fluids, the start of the first infusion would be the appropriate time. If crystalloid fluids were ordered in multiple physician orders, the start time of the infusion that completes 30 mL/kg would be correct.

Question 125: **If a physician orders 0.9% sodium chloride at 150ml/hour, can I use it as part of my 30ml/kg?**

Crystalloid fluids administered at greater than the "usual rate" of 125 milliliters per hour (mL/hr) are acceptable.

Question 126: **In determining the presence of persistent hypotension, the previous guidelines stated that the abstractor can determine the completion of the moment the 30ml/kg fluid requirement was met by taking the volume that is required and then taking the rate and volume and time of infusion and performing a mathematical calculation. Is this still the case?**

Yes, the Additional Notes for Abstraction contain the formula for calculating the completion of 30 mL/kg.

Question 127: **Is there a timeframe prior to severe sepsis that crystalloid fluids administered can be included in the 30ml/kg? How far back can we go and include the crystalloid fluids?**

No, crystalloid fluids may be administered prior to, at the time of, or after Septic Shock Presentation Time. The basis for determining when to abstract crystalloid fluids lies in the triggering events (Initial Hypotension, Initial Lactate greater than or equal to four, or Documentation of Septic Shock). For instance, since initial hypotension may be found six hours prior to severe sepsis, crystalloid fluids administered at the time of initial hypotension are acceptable if administered at 30mL/kg.

Question 128: **In reviewing the algorithm, it looks like, with the addition of the initial hypotension data element, we are required to administer 30 ml/kg crystalloid in response to initial hypotension to pass the measure.**

That means 30 ml/kg crystalloid is required even if the pt. has not yet met the septic shock definition (lactate >=4, MD dx of septic shock, persistent hypotension following crystalloid). Is that correct? (See top of page SEP-1-16 for relevant section of algorithm.)

Yes, if initial hypotension is present, if the initial lactate is greater than or equal to 4, or if there is documentation of septic shock, 30 mL/kg of crystalloid fluids are required.

Question 129: **Septic Shock: Based on the Crystalloid Fluid Administration data element, if the physician order for crystalloid fluids is equivalent to 30 mL/kg, the type of fluid is indicated, the IV route is indicated, and a specific time over which the IV fluids are to be given or a rate is not in the order, but the terms "bolus" or wide open are included in the order, is it acceptable to select Allowable Value "1"? What about the septic shock data element? This occurs prior to the persistent hypotension data element. If I am unable to determine an hour to evaluate for hypotension because: only the terms bolus or wide open are in the fluid order without a rate or duration and a completion time for the 30 mL/kg of crystalloid fluids isn't documented in the medical record, am I to document "2 - No" for the presence of septic shock since it is unable to determine?**

The end time of the crystalloid infusion, when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If the rate or end time are not documented, the infusion end time cannot be determined. If you cannot determine the end time, then the presence of persistent hypotension cannot be determined either. If you cannot determine whether persistent hypotension is present, selecting "2 (No)" for Septic Shock Present would be appropriate, assuming septic shock is not present based on initial lactate greater than or equal to four or physician documentation of septic shock.

Question 130: **If 30 ml/kg are ordered within 3 hours of severe sepsis presentation, is there a specific time when it needs to be completed by?**

No, the Crystalloid Fluid Administration Time must be within 3 hours of Septic Shock Presentation Time. However, a time-frame to complete the 30 mL/kg fluid administration is not specified.

Question 131: **If it is documented on the pre hospital record that the patient received a volume of fluid enrooted, can this be used towards the required fluid for the measure? BPs are recorded in pre hospital record.**

Fluids administered prior to arrival are acceptable if the order and administration adheres to the data element, such as the requirement for a physician/APN/PA order for fluids.

Question 132: **Would the documentation of the physician to administer LR or NS for "Resuscitation Fluid Bolus" be enough to accept the < 40 points or Hypotension data collection element? Or, does it have to specifically be centered around the lowered B/P with the notation that the B/p Decrease is due to Severe Sepsis, Infection, etc.?**

Physician/APN/PA documentation must demonstrate that the greater than 40 mmHg decrease in SBP is due to an infection, severe sepsis, or septic shock; and, that it is not due to another cause. The documentation "resuscitation fluid bolus" alone, does not reflect the necessity to document the decrease was caused by an infection, severe sepsis, or septic shock.

Question 133: **If Fluid administration trigger not met, should that part of the abstraction be left blank?**

The triggering events for crystalloid fluid administration are Initial Hypotension, Initial Lactate greater than or equal to 4, or Documentation of Septic Shock. If none of these triggering events occur, the 30 mL/kg of crystalloid fluids will not be required. The data elements that trigger crystalloid fluid administration should not be "left blank."

Question 134: **What if our Medical Executive Committee has approved a nursing driven protocol to start 30ml/kg iv crystalloid fluid? This would fail that crystalloid fluid administration because it now needs a physician order?**

A physician/APN/PA order is required to administer IV fluids. If a standardized protocol is approved and a nurse implements the crystalloid fluid orders based on the standard protocol, this can serve the purpose of the order. To confirm there was an order for the fluids, there must documentation in the medical record reflecting the fluids were given per protocol, ordered per protocol or a physician/APN/PA approved or authenticated the fluid order.

Question 135: **The refusal of IV fluids, all labs or antibiotics have to be documented within the 1st 6 hrs. to exclude the patient?**

In order to select value "1" or "2" for the Administrative Contraindication to Care, Severe Sepsis data element, the documentation of refusal of blood draw, fluid administration, or antibiotic administration must be prior to or within six hours of Severe Sepsis Presentation Time.

Question 136: **Slide 32, if you can only abstract fluids given for presence of severe sepsis with hypotension, etc. Then can you abstract the fluids started prior to severe sepsis presentation date/time?**

This bullet point is not stating both severe sepsis with hypotension or an initial lactate greater than or equal to four must be present at the same time. It states that, if severe sepsis is present, fluids administered for one of the triggering events (Initial Hypotension, Initial Lactate greater than or equal to 4, or Documentation of Septic Shock) is sufficient to abstract crystalloid fluids administered at an appropriate rate.

Question 137: **If fluid is ordered as a bolus, how will we determine end time to look for persistent hypotension (if end time is not documented by RN?**

The end time of the crystalloid infusion, when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 138: **Do we still have to figure out exact end time for fluid? So if a pt. needs 2400 mL, and gets a liter at 10:00, 11:00, and 12:00, each ordered over an hour, can we take 13:00 for finish, or do we need to calculate the actual time 2400 is completed?**

Yes, if the end time of 30 mL/kg is not documented, you need to calculate it to identify when 30 mL/kg was infused. In the scenario provided, the end time of 13:00 identifies the completion of 3000 mL, not the completion of 2400 mL (30 mL/kg).

Question 139: **Bolus or wide open is equal to what in minutes?**

There is no time in minutes equivalent for "bolus" or "wide-open." The end time of the crystalloid infusion, when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 140: **Please clarify when to start abstracting crystalloid fluids. Must it be after the severe sepsis presentation time?**

No, crystalloid fluids may be administered prior to, at the time of, or after Septic Shock Presentation Time. The basis for determining when to abstract crystalloid fluids lies in the triggering events (Initial Hypotension, Initial Lactate greater than or equal to four, or Documentation of Septic Shock). For instance, since initial hypotension may be found six hours prior to severe sepsis, crystalloid fluids administered at the time of initial hypotension are acceptable if administered at 30mL/kg.

Question 141: **Could you clarify what should be done when the amount of fluids ordered are greater than 30mL/kg? Do we calculate time 30mL/kg are met?**

Yes, if the end time of 30 mL/kg is not documented, you must calculate it to identify when 30 mL/kg was infused and in order to evaluate for Persistent Hypotension in the hour following.

Question 142: **If provider orders 30mg/kg but during infusion stops the infusion and documents why, i.e.., patient not tolerating fluids, is this acceptable to pass the question of adequate crystalloid fluids ordered/given**

No, if the crystalloid fluid administration is stopped prior to the completion of 30 mL/kg, value "2" should be selected. At this time, no exclusions or exceptions for stopping the infusion are provided in the manual.

Question 143: **If there are several fluid bolus' ordered as 1L NS IV bolus and the total of the IVF bolus' equal 30/mL/kg is the term IV bolus acceptable or must there be a rate included in all of the orders to be considered acceptable?**

If the crystalloid fluid order is equivalent to 30 mL/kg, the IV route is indicated, and a specific time over which the IV fluids are to be given or a rate is not in the order, but the terms "bolus" or "wide open" are included in the order, this is acceptable.

Question 144: **When the physician charts "septic shock," crystalloid fluids are to be administered regardless of lab values and hypotension?**

Correct. Documentation of Septic Shock is considered a triggering event and the Crystalloid Fluid Administration data element would be addressed next.

Question 145: **If fluids were started prior to the presentation time, but are completed within the 6 hour post presentation time is that acceptable? How early prior to presentation time is OK?**

Crystalloid fluids may be administered prior to, at the time of, or after Septic Shock Presentation Time. The basis for determining when to abstract

crystalloid fluids lies in the triggering events (Initial Hypotension, Initial Lactate greater than or equal to four, or Documentation of Septic Shock). For instance, since initial hypotension may be found six hours prior to severe sepsis presentation, crystalloid fluids administered at the time of initial hypotension are acceptable if administered at 30mL/kg. A defined time frame for the completion of 30 mL/kg after septic shock presentation is not specified.

Question 146: **Can you use the maintenance rate of 125ml/hr. to complete required total volume of 30 ml/kg. EG: pt. weighs 80 kgs. 2L given wide open, 125ml/kg given and 400 ml of this infused within 3 hours from diagnosis of sepsis.**

Crystalloid fluids must be administered at a rate greater than 125 mL/hr to be acceptable. Fluid boluses may be administered at a higher rate, greater than 125 mL/hr, must be appropriately documented in order to determine the completion of 30 mL/kg.

Question 147: **Can you clarify the time requirements for fluid bolus administration for initial hypotension? Must it be initiated or completed within 3 hrs. of initial hypotension?**

No, crystalloid fluids may be administered prior to, at the time of, or after Septic Shock Presentation Time. Crystalloid fluids are not required to be initiated nor completed within a specific time-frame of Initial Hypotension. Initial Hypotension is considered a triggering event, meaning crystalloid fluids administered at the time of initial hypotension will count toward the 30 mL/kg requirement if administered appropriately.

Question 148: **IF ACTUAL WEIGHT IS DOCUMENTED BEFORE 30MLS/KG BOLUS IS ORDERED AND DOCTOR ORDERS 30MLS/KG IN A SINGLE ORDER AND DOCUMENTS A DIFFERENT WEIGHT IN THE 30MLS/KG ORDER. WHICH WEIGHT SHOULD BE USED TO MAKE SURE APPROPRIATE 30MLS/KG IS GIVEN? WEIGHT DOCUMENTED OR WEIGHT DOCTOR PLACED IN 30MLS/KG NS ORDER?**

If an actual weight is documented prior to crystalloid fluid administration, it should be used rather than an estimated weight documented in the physician/APN/PA order.

Question 149: **If hypotension resolves before the full 30ml/kg is infused, must the infusion be completed if there is evidence of volume overload?**

Yes, the presence of persistent hypotension cannot be determined until the 30 mL/kg has completely infused. If the crystalloid fluid infusion is stopped prior to completing 30 mL/kg, value "2" should be selected.

Question 150: **If the patient has an estimated weight recorded in the ED on arrival, and the pt. receives 3 liters bolus of ordered NS in the ED, but the patient is weighed on admission and the estimated weight was significantly different from the actual weight. Which weight would you use to abstract for calculating the 30mL/kg?**

If only an estimated weight is documented prior to crystalloid fluid administration, it should be used rather than an actual weight documented after the infusion.

Question 151: **Re: Crystalloid administration. Since changes will now allow for "wide open", or "bolus", what time frame will be assigned for the volume infusion time? (Ex: 500/15 minutes or 1000 ml/30 minutes) to establish an end time for fluids, since subsequent data elements are contingent on fluid completion time?**

The end time of the crystalloid infusion, when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 152: **Is there a timeframe for infusion of crystalloid fluids administered over a series, or do they need to be consecutive?**

No, crystalloid fluids may be administered prior to, at the time of, or after Septic Shock Presentation Time. The basis for determining when to abstract crystalloid fluids lies in the triggering events (Initial Hypotension, Initial Lactate, or Documentation of Septic Shock). For instance, since initial hypotension may be found six hours prior to severe sepsis, crystalloid fluids administered at the time of initial hypotension are acceptable if administered at 30mL/kg. Guidance does not state the infusions must be consecutive.

Question 153: **If a patient presents with a low BP and fluids are initiated but the 30ml/kg is not completed and the patient receives vasopressors due to BP continuing to drop, would this fail the measure since the vasopressors were started prior to septic shock presentation time?**

This case would fail the measure due to stopping the crystalloid fluid administration prior to completion of 30 mL/kg. Value "2" should be selected for the Crystalloid Fluid Administration data element, if fluids were stopped prior to the completion of 30 mL/kg.

Question 154: **For documentation of fluid reassessment, there is a change stating that actual vitals do not have to be documented. Does there have to be a comment in regards to the change in vitals (i.e. improved or not improved)?**

For the Vital Signs Review Performed data element, physician/APN/PA documentation must include all four required evaluations (Temperature, Pulse or Heart Rate, Respirations, Blood Pressure), but the actual value of each vital sign is no longer required. There is no requirement that the documentation reflect changes in vital signs.

Question 155: **Just for clarification re: Crystalloid fluid administration; if there is a second IV running at 125 ml/hour or less, we cannot use that fluid in our calculation of 30 ml/kg?**

Correct. Only crystalloid fluids administered at greater than the "usual rate," 125 mL/hr., may be applied toward the 30 mL/kg requirement. Fluids administered at 125 mL/hr or less should be disregarded.

Question 156: **With regards to the date/time of the earliest administration of crystalloids fluid, will this still follow the rule of using the fluid used prior, during or after septic shock presentation?**

Yes, crystalloid fluids may be administered prior to, at the time of, or the after Septic Shock Presentation Time. The Crystalloid Fluid Administration Time is dependent on the triggering events (Initial Hypotension, initial lactate greater than or equal to four, Documentation of Septic Shock) and how the fluids were ordered by the physician/APN/PA.

Question 157: **Does the 30ml/kg have to be given within 3hrs septic shock or just started within 3hrs of septic shock. Our physicians write multiple orders for fluids 1000ml/60 min. as long as one of the fluids were started within the 3hrs can I use the start time the first liter was started?**

The Crystalloid Fluid Administration Time must be within three hours of Septic Shock Presentation Time. Crystalloid fluids are not required to be completed within three hours of the Septic Shock Presentation Time.

Question 158: **If fluids are ordered based on an estimated weight, however an actual rate is documented later. Should the fluid amount be based on the actual weight.**

If an estimated weight is documented prior to the crystalloid fluid infusion, it should be used. If an estimated and an actual weight are documented only after the crystalloid fluid infusion, the actual weight should be used.

Question 159: **For the plasmolyte and normosol, does that include all different types of these fluids? E.g. normosol R and M?**

The data element does not distinguish between normosol R and M. Therefore, either normosol product is acceptable.

Question 160: **Just wanted to be sure I am understanding Crystalloid fluid changes--if "bolus" is indicated in the order, then we don't need to look for rate or time for abstraction and it will be accepted, is that correct? Thanks!**

For the Crystalloid Fluid Administration data elements, the terms "bolus" or "wide-open" may be used to satisfy the physician/APN/PA order requirement for crystalloid fluid orders. Determination of an infusion end time is required to determine the presence of persistent hypotension. When the crystalloid infusion is ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, the end time can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined.

Question 161: **For Crystalloid Fluid Administration, are we only to use the MD order for the rate, or use the actual times noted by the nurse on the MAR, to see if the patient received the required amount of 30 ml/kg. Sometimes the order will show 1000 ml to be given in 1 hour, but the MAR shows that the 1000 ml was actually given in 2 hours.**

Documentation must demonstrate the 30 mL/kg was actually infused. The physician/APN/PA order will not suffice for the actual administration. The documentation of the administration of fluids should be used to determine the actual infusion of fluids.

Question 162: **If the crystalloids are started within 3 hours of septic shock but it is documented as completed more than 6 hours after the start, how do you answer persistent hypotension?**

Crystalloid fluids are only required to be started within three hours of Septic Shock Presentation Time. If the 30 mL/kg infusion is not complete within six hours of Severe Sepsis Presentation Time, septic shock will not be determined present based on persistent hypotension due to the infusion being completed more than six hours after Severe Sepsis Presentation Time.

Question 163: **If the patient has only one episode of hypotension within 6 hrs. of sepsis presentation time, do they have to have the entire 30 ml/kg crystalloid fluids, we usually give 500 to 1000 ml fluid for an isolated hypotensive episode, and if SBP recovers they do not get the whole bolus, will they now need this if initial hypotensive episode?**

If the patient has initial hypotension, 30 mL/kg of crystalloid fluids needs to be given to pass the measure.

Question 164: **We often have bolus fluids given, but do not have an end or stop time to these fluids. How do we answer the persistent hypotension question when we are unable to calculate the hour beyond completion of the fluid?**

The end time of the crystalloid infusion, when ordered as "bolus" or "wide-open" with no rate or infusion duration in the order, can be determined based on the rate documented in the IV flow sheet by the nurse or an end time documented in the medical record. If there is not a rate or end time documented, the infusion end time cannot be determined. Presence of persistent hypotension cannot be determined if the 30 mL/kg infusion end time cannot be determined.

Question 165: **If a patient receives fluids in the ED at the right rate but the orders were incorrect or did not order the right volume, can these fluids be counted towards the fluids once the patient leaves the ED and goes to the unit, where the fluids were ordered correctly?**

This will depend on what is incorrect about the order. If the volume ordered in the ED was not equivalent to 30 mL/kg, but all other aspects of the order

are in place, that volume can be included with fluids ordered and given after hospital admission. The entire 30 mL/kg volume does not need to be in a single order. Multiple orders that are in total equivalent to 30 mL/kg are acceptable. If the ED order does not include the name of an acceptable crystalloid fluid, it cannot be used. If the ED order does not include a rate, duration of infusion, or is not ordered as a "bolus" or "wide open" it cannot be used.

Question 166: **Does the physician need to order the specific amount of fluid equal to 30 ml/kg, e.g. 3000 ml, or is an order of "30 ml/kg" sufficient?**

An order for 30 mL/kg, or the equivalent of that volume based on the patient's weight are both acceptable.

Question 167: **Does fluid given after bolus count toward the total 30 Ml/Kg, with in the 6-hour period?**

Fluids given consistent with specifications in the Crystalloid Fluid Administration data element if administered at greater than 125 mL/hr are acceptable.

Exam Assess Vital Signs

Question 168: **Should the physician/PA/NP document physical exam within 6 hours? What if RN performs physical exam calls physician/Pa/NP and LIP doesn't document until 6 hours after?**

The physician documentation must be from the time the crystalloid fluids are started to within six hours after the presentation of septic shock.

Question 169: **With the changes to MD Vital Signs Review Performed, does the MD need to document actual vital signs or will Vital signs reviewed meet the measure?**

The Vital Signs Review Performed data element specifically states the review must include the temperature, heart rate, respiratory rate and blood pressure. Documentation of the actual values is no longer required. Documentation of "vital signs reviewed" is not sufficient, because it does not indicate which vital signs were reviewed.

Question 170: **P. 69 SUMARY OF SEP-1: VITAL SIGNS PERFORMED - "clarified that actual values are no longer required for this data element". Does this mean, for example if physician writes "patient with fever" and does not put an actual value such as Temp 38.6" this is acceptable?**

The Vital Signs Review Performed data element specifically states the review must include the temperature, heart rate, respiratory rate, and blood pressure. Documentation of the actual values is no longer required.

Question 171: **If physician documents blood pressure, temperature, resp rate and heart rate were reviewed and it is timed and dated after the 30ml/kg admin and before 6 hour end time is this sufficient? The additional information table states that values are NOT necessary. Thank you.**

Yes, this is sufficient. The requirement that the documentation must include the values has been removed.

Question 172: **Can a nurse complete the exam or is it just a MD/PA/APN?**

The Cardiopulmonary Evaluation Performed data element requires it be performed and documented by a physician/APN/PA. Other elements of the Focused Exam (Vital Signs Reviewed, Capillary Refill Examination, Peripheral Pulse Evaluation and Skin Examination) must be documented by a physician, but can be performed by a nurse.

Question 173: **What if the provider documents that "full examination was negative with the exception of items as listed" will this be acceptable?**

No. Each element of the Focused Exam must be documented. The documentation in the question does not indicate what was examined.

Question 174: **Can you please explain the difference between performed by and documented by a physician/APN/PA? Thank you.**

"Documented" reflects that someone other than the physician/APN/PA may have performed the exam or evaluation, but the physician/APN/PA documented the results of the exam. "Performed" reflects that the physician/APN/PA actually performed the exam or evaluation.

Question 175: **Can the different components of the focused exam be documented by different physicians as long as all are documented within the specific time frame?**

Yes, this is acceptable. There is nothing in the data elements to indicate that the documentation must be the same physician.

Question 176: **If the provider documents the VS within the correct timeframe but the VS were not done within the timeframe by the RN -would it be acceptable because it was documented within the proper timeframe?**

There is nothing in the Vital Signs Review data elements that indicate that this would not be acceptable. However, this is not reflective of truly evaluating the patient's response to the crystalloid fluids, which is the intent of the Focused Exam data elements.

Question 177: **So theoretically, if the MD documents the pt. is "mottled' then that would be acceptable for both the capillary refill as well as the skin exam?**

Theoretically, yes, this could fulfill requirements for both.

Question 178: **For skin examination: can MD document "consistent with ethnicity"?**

"Consistent with ethnicity" does not indicate it is in reference to skin color. There must be a reference to color or skin color must be documented.

Question 179: **We have a checklist for Focused Exam pieces. This could be performed by a nurse and later checked and signed off by a physician. Must we use the time of the physician signature or could we use time of actual assessment complete?**

The time documented must be the time the physician documented the results/findings.

Question 180: **Is "normal" skin color acceptable?**

Yes. This references that the skin color for this individual is normal.

Question 181: **Please clarify if the physician/APN/PA needs to document actual values of vital signs or if "vitals reviewed" suffices the measure? Thank you.**

Documentation of the actual values is no longer required. "Vitals reviewed" is not sufficient, because it does not indicate which vitals were reviewed. The Vital Signs Review Performed data element specifically states the review must include the temperature, heart rate, respiratory rate and blood pressure.

Question 182: **For capillary refill- "or make reference to peripheral perfusion." Does Extremities: no clubbing, cyanosis, or edema, pulses palpable bilaterally meet requirements since "no cyanosis" is in reference to peripheral perfusion? What about for "Peripheral Pulse Evaluation" since "pulses palpable bilaterally" does address peripheral pulses?**

In reference to documentation of "Extremities: no clubbing, cyanosis, or edema, pulses palpable bilaterally," given that "no cyanosis" is stated, it can be used for Skin Examination. This is acceptable because it states a color, "cyanosis," is not present. Cyanosis may or may not be reflective of peripheral perfusion, so it cannot be used for Capillary Refill Examination. The part of the statement "pulses palpable bilaterally" cannot be used for Peripheral Pulse Evaluation, because it does not indicate that the pulses palpated were peripheral pulses.

Question 183: **Can provide documentation of "peripheral circulation WNL" be taken as the evaluation of the peripheral pulses?**

Since the documentation does not make reference to peripheral pulses, it is not acceptable.

Question 184: **When collecting Vital Signs Review Performed are we to look for vital signs performed within the timeframe or are we looking for documentation of vital signs? For example there is documentation of vital signs within the timeframe that clearly states that the vital signs are from upon admission. I understand the guidelines to mean that we are looking from vital signs that were performed within the appropriate timeframe.**

The Vital Signs Review data elements are looking for physician/APN/PA documentation that the specified vital signs were reviewed within the time frame in the data element. Basing this on documentation of vital signs that were not performed within the time frame would not be reflective of truly evaluating the patient's response to the crystalloid fluids, which is the intent of the Focused Exam data elements. It would require the review and documentation be performed within the time frame designated in the data element.

Question 185: **Does physician DOCUMENTATION of the elements of the focused exam have to occur within the 6 hr. time frame after septic shock presentation?**

The time frame is starting at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

Question 186: **When does the tissue perfusion exam have to be done? After the 30ml/kg are infused or within 6 hours of the start of the 30mg/kg?**

The time frame is starting at the crystalloid fluid administration date and time and ending six hours after the presentation of septic shock date and time.

Question 187: **Does the repeat volume status and tissue perfusion assessment need to be completed by a licensed physician or LIP?**

The repeat volume status and tissue perfusion assessment consists of several data elements. Some of these must be performed by a physician/APN/PA. Some can be performed by someone other than a physician/APN/PA, but must be documented by a physician/APN/PA. Some can be documented by a physician/APN/PA or non-physician/APN/PA. Please review each data element to determine precisely who must perform and/or document.

Question 188: **For the provider reassessment of tissue perfusion and volume status element: VS review. From what I understand, actual values are no longer required. What is acceptable? Would it be acceptable, for example, to have documentation that patient is "afebrile" or "tachycardia"?**

Documentation of the actual values is no longer required. Documentation must indicate that the temperature, heart rate, respiratory rate and blood pressure were all reviewed. Documentation that the patient is afebrile or tachycardia is not acceptable.

Question 189: **Physician documentation for capillary refill, peripheral pulses etc... If performed by staff, must the documentation by physician be within a certain time frame after the exam, and would physician notification by RN be acceptable?**

The physician documentation must be from the time the crystalloid fluids are started to within six hours after the presentation of septic shock. Documentation that the nurse notified the physician is not acceptable. The physician must document the findings per the data element specifications.

Documentation

Question 190: **On slide 13, can the documentation of refusal be completed by the nurse?**

Nursing documentation must be on a witness signed consent form.

Question 191: **On, MDe 11, MD documentation linking the elevated lab to the chronic condition or the medication to the bp must be present in order to include it as a chronic condition?**

There needs to be some form of documentation in the medical record for an abstractor to "consider the value is due to a chronic condition or medication." The data element does not specify that this must be based on physician documentation.

Question 192: **Septic Shock Presentation. Is MD/NP/PA documentation of Shock the only acceptable criteria for determining shock presentation? Is the clinical criteria from v5.0b still available? Initial Hypotension: Can I use the SBP (<90)/MAP (<65) organ dysfunction to determine Severe Sepsis presentation as my initial hypotension number?**

Severe Sepsis for purposes of the Severe Sepsis Present data element can be based on clinical criteria OR physician/APN/PA documentation. This has not changed. You may be referring to the NEW data element, Documentation of Septic Shock, which is dependent upon physician/APN/PA documentation and not clinical criteria.

Question 193: **So septic shock per the 7/1 guidelines can ONLY be present with physician documentation? It no longer is r/t lactate >4 or persistent hypotension? ONLY FROM MD DOCUMENTATION, regardless of clinical criteria?**

No, this is not correct. Presence of septic shock is determined by the Septic Shock Present data element, which is still based on clinical criteria for septic shock OR physician/APN/PA documentation of septic shock. A new data element called Documentation of Septic Shock was introduced, effective 7/1/2016. It is dependent upon physician/APN/PA documentation of septic shock. This new data element is used only for the purposes of helping to determine whether the patient should receive 30 mL/kg of crystalloid fluids.

Question 194: **If a patient is diagnosed with septic shock by the physician but never meets the criteria for severe sepsis (low lactate, few SIRS criteria) how should we proceed?**

The Severe Sepsis Present data element contains a bullet point in the Notes

for Abstraction that addresses this situation. It states: If criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, choose Value "1."

Question 195: **If dr annotates in ED list of orders, met Severe Sepsis criteria, but doesn't list as final diagnosis, do we take this as a diagnosis of Severe Sepsis?**

Keep in mind the measure is not looking for a "diagnosis" of severe sepsis. Rather it is looking for presence of severe sepsis based on clinical criteria, OR physician/APN/PA documentation of severe sepsis or that severe sepsis is possible or suspected. If there is documentation indicating the physician suspects severe sepsis is present or possible, it can be used.

Question 196: **To clarify only if there is documentation by a provider of septic shock within 6 hours following the presentation of severe sepsis will we be able to answer yes to septic shock. Does that mean if the initial lactate acid is greater than 4 then that will not be used to automatically call the case septic shock?**

No, this is not correct. Presence of septic shock is determined by the Septic Shock Present data element, which is still based on clinical criteria for septic shock OR physician/APN/PA documentation of septic shock. A new data element called Documentation of Septic Shock was introduced, effective 7/1/2016. It is dependent upon physician/APN/PA documentation of septic shock. This new data element is used only for the purposes of helping to determine whether the patient should receive 30 mL/kg of crystalloid fluids.

Question 197: **If a patient has persistent hypotension after appropriate fluid administration but there is no MD/APN/PA documentation of septic shock, do you still answer "yes" to septic shock?**

Yes. Septic Shock Present is based on either clinical criteria, OR physician/APN/PA documentation of septic shock. Both are not required.

Question 198: **How is presentation time figured when a physician documents septic shock/ severe sepsis and the patient does not meet criteria of organ failure or infection? Is presentation time considered the documentation**

time?

Yes. If the physician documented septic shock/severe sepsis presentation time would be the time of the documentation.

Question 199: **Can we assume that if the physician documented the cardiopulmonary exam then he/she performed it?**

Yes, if the physician documentation meets the requirements of the Cardiopulmonary Evaluation Performed data element, it is acceptable to assume the physician performed it.

Question 200: **Can you elaborate on the "performed" vs "documented" related to the MD documentation? Can you refer to the RN notes?**

"Documented" reflects that someone other than the physician/APN/PA may have performed the exam or evaluation, but the physician/APN/PA documented the results of the exam. "Performed" reflects that the physician/APN/PA actually performed the exam or evaluation. Nursing notes can be used to help make the determination of whether an exam was performed by a physician.

Question 201: **How can abstractors document a reason for not obtaining a repeat lactate it the patient is in surgery at the time due?**

There is no exclusion for drawing a repeat lactate.

Question 202: **How do we handle abstraction, if the ED RN Triage says yes to infection but the ED Dr says there is no infection?**

The SEP-1 Additional Notes for Abstraction for Version 5.1 include a bullet point for Severe Sepsis Present indicating that if an infection is documented as present, suspected, or possible, but within six hours following the initial documentation of the infection, there is physician/APN/PA documentation indicating the infection is not present, to disregard the documentation of the infection.

Question 203: **If patient presents with Severe Sepsis and there is no initial hypotension but physician documents SEPTIC SHOCK and no fluids given within**

the 6 hours following severe sepsis can we still say no to SEPTIC SHOCK regardless of physician documenting this?

No. If the physician has documented the patient has septic shock, you would select "1 (Yes)" to the new Documentation of Septic Shock data element. Crystalloid fluids are indicated and should be given.

Question 204: **In regards to physician documentation, can you please clarify what to do if documentation says Sever Sepsis present on admission if the [documentation] is written on Day 3?**

The SEP-1 Additional Notes for Abstraction for Version 5.1 include a bullet point for Severe Sepsis Presentation Time indicating that, if severe sepsis is in a physician note and the note states severe sepsis was present on admission, to use the earliest documented admission date and time.

Question 205: **If a patients initial Lactate is >4. Does Septic Shock need to be documented by Physician/APN/PA, as in hypotension?**

No this is not correct. Presence of septic shock is determined by the Septic Shock Present data element, which is still based on clinical criteria for septic shock OR physician/APN/PA documentation of septic shock. A new data element called Documentation of Septic Shock was introduced, effective 7/1/2016. It is dependent upon physician/APN/PA documentation of septic shock. This new data element is used only for the purposes of helping to determine whether the patient should receive 30 mL/kg of crystalloid fluids. If septic shock clinical criteria are met, select Value "1" for Septic Shock Present.

Question 206: **what if there is criteria that meet septic shock, but there is no documentation by the MD of septic shock**

Presence of septic shock is determined by the Septic Shock Present data element, which is still based on clinical criteria for septic shock OR physician/APN/PA documentation of septic shock. A new data element called Documentation of Septic Shock was introduced, effective 7/1/2016. It is dependent upon physician/APN/PA documentation of septic shock. This new data element is used only for the purposes of helping to determine whether the patient should receive 30 mL/kg of crystalloid fluids. If septic shock

clinical criteria are met, select Value "1" for Septic Shock Present.

Question 207: **If the first indication of Severe Sepsis is provider documentation of Septic Shock - does this documentation qualify to answer yes to Severe Sepsis Present?**

Yes, for septic shock to be present, severe sepsis must also be present. In some cases sepsis progresses rapidly or manifests as septic shock before severe sepsis is recognized.

Question 208: **If medical office, urgent care or pre-hospital records are available and in the medical record for practitioner's use upon hospital arrival, are those records optional in the review or MUST those earliest times to meet criteria or diagnosis be used?**

Any documentation consistent with that specified in the data elements that are considered part of the current medical record should be used in determining the presence of severe sepsis.

Question 209: **Provider time of severe sepsis is prior to documentation of severe sepsis criteria being met. Which time do you use for Severe Sepsis?**

Use the earlier of the two times.

Question 210: **If several physicians document sepsis in the chart, however it is not within 6 hrs. of the SIRS or organ dysfunction, can we use that documentation to meet the criteria for severe sepsis?**

All clinical criteria must be met within six hours of each other. Sepsis can be used as documentation of a suspected infection, but it must be within six hours of the SIRS criteria and sign of organ dysfunction.

Question 211: **Septic Shock Present data element says "There must be documentation of severe sepsis present." Does this mean the medical provider must document exactly those words, or does this mean that there is documentation in the record that supports the Severe Sepsis Present data element?**

"There must be documentation of severe sepsis present" means that there is

documentation in the medical record indicating severe sepsis is present (either clinical criteria or physician/APN/PA documentation). If you selected Value "1 (Yes)" to Severe Sepsis Present, then there is documentation of severe sepsis.

Question 212: **Please clarify: If physician documents in either PRIMARY diagnosis, SECONDARY diagnosis or DIFFERENTIAL diagnosis "severe sepsis" or "septic shock" are ANY of these THREE areas of documentation acceptable to select YES to Severe Sepsis or Septic Shock or is there exclusion for either one?**

Any physician documentation of possible/suspected severe sepsis or septic shock, or documentation that either is present or suspected is acceptable.

Question 213: **So, if a set of vital signs is only documented in the nursing flow sheet within the septic shock time frame, we cannot accept that for vs documentation, if it is not documented by an MD?**

Correct. The Vital Signs Review data element requires physician documentation that they have reviewed the vital signs specified in the data element (i.e., heart rate, respiratory rate, temperature, and blood pressure).

Question 214: **Re Septic Shock documentation: Does this new element mean that physician/APN/PA documentation of Septic Shock can only be affirmed in those patients who had already met guidelines for Severe Sepsis or had physician/APN/PA documentation of Severe Sepsis?**

The new data element Documentation of Septic Shock is simply looking for physician/APN/PA documentation of confirmed, suspected, or possible septic shock within six hours of severe sepsis presentation. This requires that either clinical criteria for severe sepsis be present or physician/APN/PA documentation of severe sepsis. Keep in mind the Severe Sepsis Present data element allows the use of physician/APN/PA documentation of septic shock for severe sepsis, if severe sepsis clinical criteria are not met or there is no physician/APN/PA documentation of severe sepsis.

Question 215: **Do the words severe sepsis and septic shock have to be included in documentation when determining if present?**

With regards to physician documentation, please refer to the Inclusion Guidelines for Abstraction for Severe Sepsis Present and Septic Shock Present.

Question 216: **If criteria for septic shock is present but is not documented as such by the MD, can this still be considered septic shock?**

Presence of septic shock is determined by the Septic Shock Present data element, which is still based on clinical criteria for septic shock OR physician/APN/PA documentation of septic shock. A new data element called Documentation of Septic Shock was introduced, effective 7/1/2016. It is dependent upon physician/APN/PA documentation of septic shock. This new data element is used only for the purposes of helping to determine whether the patient should receive 30 mL/kg of crystalloid fluids. If septic shock clinical criteria are met, select Value "1" for Septic Shock Present.

Question 217: **While the needed criteria for Severe sepsis may be present, the MD must document "Severe Sepsis" within the allotted time frame in order to become a severe sepsis case. If severe is not documented, you're dealing with an essential sepsis. Is this correct?**

No, this is not correct. Presence of severe sepsis is determined by the Severe Sepsis Present data element, which is still based on clinical criteria for severe sepsis OR physician/APN/PA documentation of severe sepsis. Both are not required.

Question 218: **How do you answer presence of Septic Shock when patient is hypotensive, crystalloid fluids were administered but not met the 30ml/kg fluid volume? Lactate is less than 4 and there is no documentation of Septic Shock by MD/NP/PA.**

For version 5.1, if the patient is hypotensive and does not receive 30 mL/kg of crystalloid fluids, the case will fail the measure before reaching Septic Shock Present.

Antibiotics

Question 219: **How should it be abstracted if the physician does not have cultures but deems that the patient has cellulitis and chooses an antibiotic that is not on the mono or combo therapy? They are concerned about giving inappropriate antibiotics which can cause other issues (c-diff.)**

Documentation of the causative organism and antibiotic susceptibility are required for ordering an antibiotic or combination not on Table 5.0 or 5.1. Documentation of cellulitis does not specify an organism. If there is not an IV antibiotic from Table 5.0 or Table 5.1 given within three hours following the presentation of severe sepsis, selecting value "2" would be appropriate.

Question 220: **Blood Cultures need to be obtained prior to antibiotics administered, does this include PO antibiotics?**

Oral antibiotics are not abstracted for SEP-1. Only IV antibiotics should be abstracted. Therefore the algorithm will calculate the timing of the blood cultures in relation to IV antibiotic administration.

Question 221: **If a patient is diagnosed with UTI based on symptoms and urine dipstick, they get started on usual Cipro and flagyl, do they fail as they didn't include one from column B?**

If the Cipro and Flagyl were given intravenously, and these were the only IV antibiotics given within three hours after the presentation of severe sepsis, selecting "No" would be appropriate given that there was no acceptable combination therapy given based on the data element.

Question 222: **Re Treating known causative organism - what is the time frame for this? Example pt. has known C Diff verified microbiology on 7/1/16. Presents ED 7/8/16 with exacerbated s/s C.diff infection and sepsis criteria. Is the microbiology collected 7/1 acceptable to use as known causative organism?**

The microbiology collected on 7/1/16 would not be acceptable to use as the known causative organism. The Additional Notes for Abstraction Version 5.1 states – Exception for C. difficile: If the causative organism is identified as C. difficile, susceptibility testing is not required, and if the patient is

receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), chooses Value "1."

Question 223: **Question: Broad spectrum antibiotics. Does the organism and susceptibility need to be in the physician's progress notes or can we take it from the lab report?**

A lab report indicating the causative organism and susceptibility is acceptable.

Question 224: **Antibiotic: Our ED orders vancomycin and zosyn often. If the vancomycin is the first drug given however, zosyn is also given within the 3 hour time frame, which drug and time do I abstract? According to specifications, if I document the first drug it will be vancomycin and will fail.**

Our answer assumes this question is regarding data element Broad Spectrum or Other Antibiotic Administration Selection and that both Vancomycin and Zosyn are both given within three hours following the presentation of severe sepsis. The first bullet point under the Notes for Abstraction states: If there is one IV antibiotic started or given to the patient within three hours after presentation of severe sepsis that is on the monotherapy table in Appendix C, Table 5.0, choose Value "1." Since Zosyn is on Table 5.0, selecting value "1" for this data element would be appropriate. The order of when the antibiotics were received does not matter for this data element.

Question 225: **So, BOTH antibiotics of a combo need to be given within 3 hrs.**

There must be at least one from column A and at least one from column B administered to select Value "1." Both drugs have to be started or given within three hours of severe sepsis presentation to choose Value "1."

Question 226: **Antibiotic table 5.0 is mono therapy, if an abx from this table is used, I do not need to worry about abx from table 5.1, am I correct?**

Correct, the first bullet point under the Notes for Abstraction states that if an IV antibiotic from Table 5.0 was started or given within three hours after presentation of severe sepsis, choose value "1."

Question 227: **For the severe sepsis cases that received IV antibiotics more than 24 hours prior to severe sepsis, do we have to consider the type of antibiotics received in order for the case to be excluded? Can we only exclude this measure if a patient received monotherapy or other antibiotic therapy via IV? Or does any type of antibiotic IV, even if not in the monotherapy or other antibiotic list if received more than 24 hours prior to severe sepsis presentation will exclude the measure?**

If any IV antibiotic received in the 24 hours prior to severe sepsis presentation was also received greater than 24 hours prior to severe sepsis, the case could be excluded. Note that there is no need to review for doses greater than 72 hours prior to presentation. Monotherapy (Table 5.0) and combination therapy (Table 5.1) are only used for the data element Broad Spectrum or Other Antibiotic Administration Selection.

Question 228: **With regards to appropriate antibiotic administration. Does this only include organisms identified through blood cultures? Would it allow us to accept Flagyl/ Vanco for C-diff?**

It is in reference to the causative organism. In the Additional Notes for Abstraction Version 5.1 there is an exception for C. difficile. If the causative organism is identified as C. difficile, susceptibility testing is not required, and the patient is receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), choose Value "1."

Question 229: **If a physician documents suspect C. diff colitis, and a lab report is not back from the lab, will that suffice for the name of the pathogen and just IV vancomycin was given, will this case pass the measure?**

In the Additional Notes for Abstraction Version 5.1 there is an exception for C. difficile. If the causative organism is identified as C. difficile, susceptibility testing is not required, and the patient is receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), choose Value "1."

Question 230: **Can you please comment of the timing allowed for using antibiotics for known causative organism with susceptibility? Does 3 hours refer to the time in which you must give antibiotics or does it refer to the actual timing of the culture draw/result? For example, if a patient had a**

known culture from an outside facility or from the current facility that was drawn more than 3 hours before pt. recognized as severe sepsis or shock, can we use antibiotics for this culture or is it too old?

If an IV antibiotic was received within the three hours of presentation of severe sepsis, and the organism and susceptibility is known, and an acceptable antibiotic for that organism was given, selecting "Yes" would be appropriate. The three hour time frame is when the IV antibiotic must be given/started. The culture would need to be drawn within the time parameters identified in the Blood Culture Collection data elements.

Question 231: **Most cliff tests do not have susceptibility test, they just identify the organisms. As of now the treatment is po vanc and iv flagyl. In keeping with antibiotic stewardship we would not give additional antibiotics just to pass the measure. Do we need susceptibility for C.diff or if appropriate antibiotics are administered can we say flagyl is acceptable?**

In the Additional Notes for Abstraction Version 5.1 there is an exception for C. difficile. If the causative organism is identified as C. difficile, susceptibility testing is not required, and the patient is receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), choose Value "1."

Question 232: **Are Cephalosporins of the 3rd, 4th Generation acceptable, since the Combination antibiotic table list only 1st and 2nd Generation?**

Third and fourth Generation Cephalosporins are in the monotherapy Table 5.0 and do not need to be given in combination with another antibiotic.

Question 233: **Is it ok to collect a blood culture after giving antibiotics, if you collect the culture in a bottle with antibiotic removing device? (Charcoal in bottle - Biomerieux bottle)**

No, the blood culture must be before the IV antibiotic.

Question 234: **If "IV rocephin" is documented at a nursing home prior to arrival, but no time is documented, should we select UTD or ignore this documentation?**

If the route of an antibiotic is missing or not documented as IV, or the administration date or time are missing, disregard that dose.

Question 235: **If many attempts were made to obtain IV access and there was no IV access obtained within the first 3 hours of severe sepsis, if the MD documents to give the antibiotic IM is that acceptable?**

The data elements are only looking at IV antibiotics. An antibiotic given IM would not be acceptable.

Question 236: **If there's an MD note that states no Iv antibiotic given due to no IV access thus will be given after dialysis, would this be a valid reason?**

There currently are no acceptable reasons for an IV antibiotic to not be administered.

Question 237: **If a monotherapy antibiotic given in the 3 hours after Severe Sepsis Presentation is administered after an antibiotic that is on the dual therapy list can the antibiotic given as monotherapy be used? For example - Azithromycin is given in the first hour after time Zero and then Ceftriaxone is given after. Can I use the time that the Ceftriaxone was given instead of the Azithromycin?**

For the data element Broad Spectrum or Other Antibiotic Administration Time, the earliest dose should be used. Therefore, using the Azithromycin would be appropriate based on the information provided. For the data element Broad Spectrum or Other Antibiotic Administration Selection, if there is one IV antibiotic started or given to the patient within three hours after presentation of severe sepsis, choose Value "1," as long as that antibiotic is on the monotherapy table in Appendix C, Table 5.0. Given that Ceftriaxone is on Table 5.0, selecting value "1" for this data element would be appropriate. The order of when the antibiotics were received is irrelevant to the selection data element.

Vasopressor

Question 238: **Are you going to add "refusal of vasopressors" to contraindication to care element?**

Refusal of vasopressors is included in the Administrative Contraindications to Care, Septic Shock data element.

Question 239: **If vasopressor was started prior to septic shock can that be abstracted?**

Yes, the Vasopressor Administration Date and Time data element provides guidance regarding abstraction for septic shock.

Question 240: **Can we not abstract accepted vasopressors from the patients MAR as given?**

Documentation from the MAR indicating vasopressors are running is acceptable.

Question 241: **How do you answer the vasopressor question if the patient is already on vasopressors prior to septic shock? For example, when the doc starts them before fluids are done?**

The Vasopressor Administration Date and Time data elements provide guidance for cases such as this. If a vasopressor was infusing at the time of presentation of septic shock, demonstrated by persistent hypotension after crystalloid fluid administration, or the vasopressor was infusing at the time of septic shock and multiple doses were given, abstract the initiation time of the vasopressor that was infusing at the time of septic shock presentation.

Question 242: **For the documentation of vasopressor administration, does it need to be MD/PA/NP documentation, or can you use the medication administration record that it was infusing?**

Documentation from the MAR indicating vasopressors are running is acceptable.

Question 243: **In order to administer vasopressors for persistent hypertension does the entire 30ml/kg have to be infused?**

The measure logic takes a case to Vasopressor Administration if Persistent Hypotension is present. Determining the presence of persistent hypotension requires the full 30 mL/kg of crystalloid fluids be given. If the physician determines that it is in the patient's best interest to start vasopressors before the complete infusion of 30 ml/KG of crystalloid that would be acceptable. The Vasopressor Administration Date and Time provide abstraction guidance for these cases.

Discharge

Question 244: **Sepsis Discharge Time-A patient has blood cultures/lactic acid drawn and broad spectrum antibiotics given within 3 hours of severe sepsis. This same patient had a lactic acid of 2.1, leaves AMA 4 hours after severe sepsis and did not have a repeat lactic acid drawn prior to leaving AMA. Will this case fail the measure?**

Yes, currently, in version 5.1, if a patient leaves AMA within three hours of Severe Sepsis Presentation Time, and a repeat lactate is indicated but not drawn prior to leaving, the case will fail the measure. This is addressed in version 5.2 of the specifications manual.

Question 245: **If the patient leaves against medical advice 5 hours after Severe Sepsis Presentation time and no repeat lactate has been drawn at that time does this case fail the measure?**

Yes, currently, in version 5.1, if a patient leaves AMA within three hours of Severe Sepsis Presentation Time, and a repeat lactate is indicated but not drawn prior to leaving, the case will fail the measure. This is addressed in version 5.2 of the specifications manual.

Abstraction

Question 246: **Would order for "palliative care consult" be acceptable for abstraction?**

Yes, an order for "palliative care consult" is acceptable for abstraction.

Question 247: **Does a Consult for Palliative Care abstract as Yes to Palliative Care?**

Yes, a Consult for Palliative Care abstracts as "Yes" to Palliative Care.

Question 248: **If a physician orders a palliative care consult would that suffice? Or, if a physician says "may consider palliative care" would that be enough for the directive for comfort or palliative care?**

Yes, either an order or consideration for palliative care is acceptable.

Question 249: **If a provider orders a palliative care consult, would that exclude the chart from the measure?**

Yes, a palliative care consult excludes the chart from abstraction.

Question 250: **Is a femoral line considered a central line?**

The answer depends on the type of line insertion. Femoral refers to the location of insertion. There would need to be documentation that the tip of the catheter is centrally placed to be considered a central line.

Question 251: **On the abstract sheet If the answer to 25 is NO and my patient was never hypotensive, never met septic shock, and did not receive fluid, should I stop the abstraction?**

We are unable to provide a specific answer to this question given that it is not clear what abstract sheet is being used.

Question 252: **Can the severe sepsis presentation date and time be the same as the septic shock presentation date & time on the abstract?**

Yes, the severe sepsis and septic shock could be the same time.

Question 253: **Can "sepsis" be considered as suspicious of infection as one of the criteria to determine severe sepsis? It was added in one of the previous additional notes for abstraction, but I still see sepsis as an exclusion on the new version.**

Documentation of sepsis can be used as a sign of infection. In the Exclusion Guidelines for Abstraction under the "severe sepsis" it states that sepsis would not be acceptable for physician/APN/PA documentation for severe sepsis.