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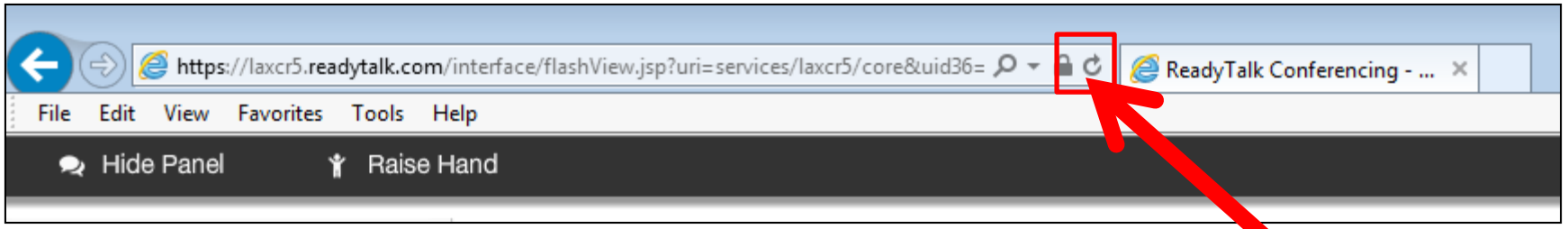

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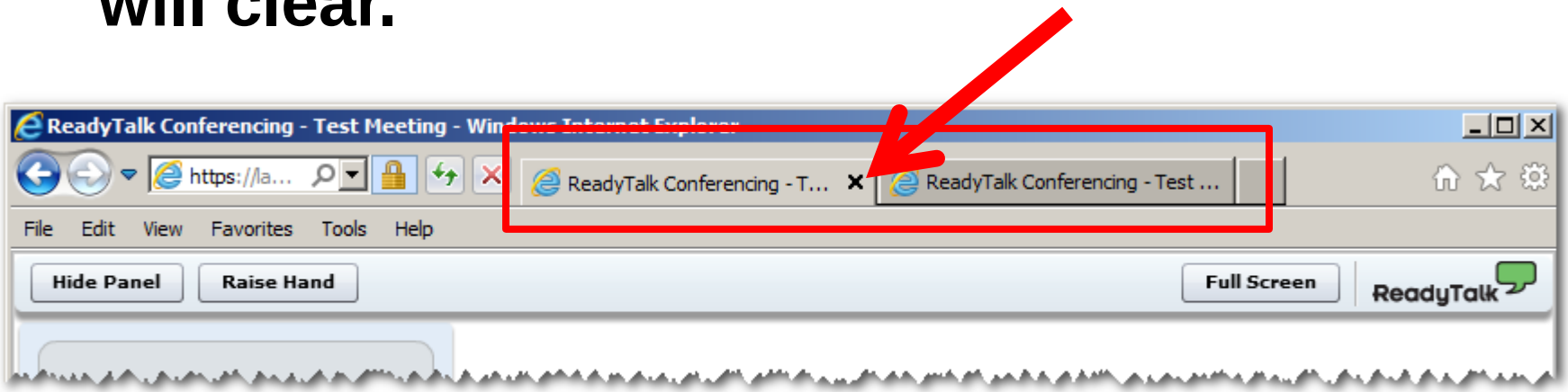

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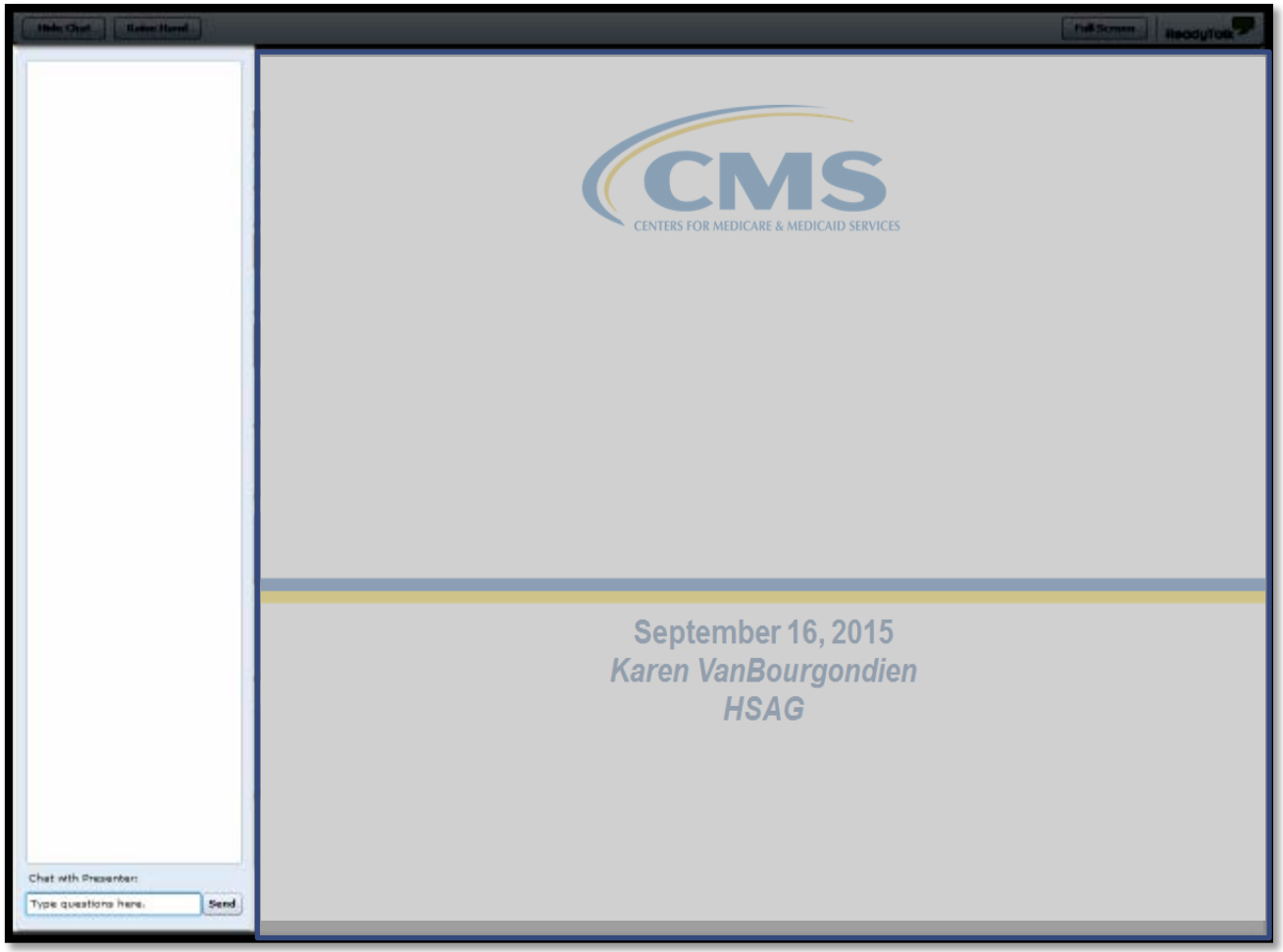

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: v5.2a Commonly Asked Questions & v5.3 Measure Updates

July 26, 2017

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Objectives

At the end of the presentation participants will be able to:

- Understand the most commonly asked questions for v5.2a.
- Identify and understand the rationale behind the guidance in the notes for abstraction (v5.2a).
- Explain the upcoming changes to the measure and guidance in v5.3.

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: v5.2a Commonly Asked Questions & v5.3 Measure Updates

SEP-1 v5.2a Commonly Asked Questions

Blood Culture Acceptable Delay

Question

Within the *Blood Culture Acceptable Delay* data element, is there a time frame for physician/Advanced Practice Nurse (APN)/Physician Assistant (PA) documentation that delaying the antibiotic would be detrimental to the patient?

Blood Culture Acceptable Delay

- A time frame for the physician/APN/PA documentation waiting to start an IV antibiotic is not specified.
- The physician/APN/PA documentation should reflect that delaying the IV antibiotic so that a blood culture could be collected would be detrimental to the patient.
- Example of **acceptable** physician/APN/PA documentation:
  - ED Progress Note:
    - Patient condition worsening, IV Vanco ordered stat, blood and urine cultures ordered, awaiting CXR. – Dr. Smith 1/1/17 0800

Broad Spectrum or Other Antibiotic Selection

Questions

Is an explicit reference needed for physician/APN/PA documentation indicating the causative organism and susceptibility?

Does the physician/APN/PA documentation need to be within 24 hours?

Broad Spectrum or Other Antibiotic Selection

- Physician/APN/PA documentation should indicate or reference laboratory findings identifying known susceptibility via cultures collected in the period 24 hours prior to the antibiotic being started or within three hours following severe sepsis presentation.
- Examples of **acceptable** physician/APN/PA documentation:
  - Physician Progress Note:
    - 1/2/2017 0800: Culture collected at clinic 1/1/2017 at 1600, MRSA +, Vanco per confirmed sensitivity via lab.
      - MAR – Vanco start time 1/2/2017 0900
  - Physician Progress Note:
    - 4/15/2017 0600: VRE + per wound culture collected in dialysis on 4/14/2017 at 1100, Zyvox per sensitivity.
      - Severe sepsis presentation date and time 4/14/2017 at 1330
      - MAR: Zyvox started 4/14/2017 at 1400

Broad Spectrum or Other Antibiotic Selection

Examples of **unacceptable** physician/APN/PA documentation:

- Physician Progress Note:
  - 5/1/2017 1200: Culture collected at urgent care yesterday, gram - MSSA, per sensitivity cover with Zosyn.

- History and Physical Examination (H&P):
  - 3/20/2017 0800: Recent inpatient stay with positive MRSA culture of right foot wound, continued IV Vanco BID via PICC for last 9 days since discharge.

- APN Assessment Note:
  - 2/25/2017 1300: RLL wound, hx of MRSA, pharm. to dose Vanco.

Crystalloid Fluid Administration

Question

Are physician/APN/PA orders required for “prior to arrival” fluids administered by emergency medical services (EMS)?

Crystalloid Fluid Administration

- Yes, a physician/APN/PA order is required for all fluids used toward the 30 mL/kg volume.
- The order must include:
  - Type of fluid.
  - Volume of fluid.
  - Rate OR time over which the fluids are to be given.

    OR
  - Use of the terms bolus, wide-open, or open with appropriate supporting documentation.

Crystalloid Fluid Administration

- Scenario 1: ED order for prior to arrival fluids
  - Example:
    - ED physician order: NS 0.9% IV 30 mL/kg over 1 hour, 1000 mL administered via EMS.
    - EMS documentation included in the medical record identifies the start time and end time of the 1000 mL infusion.

- Scenario 2: An EMS protocol reflecting a physician's order
  - Example:
    - Standing order from EMS medical director or
      State authorized EMS orders
      - Protocols must meet the order requirements previously noted.
      - Protocols must be in the medical record.
      - Documentation of fluid administration is required (start time, end time or rate, etc.).

Crystalloid Fluid Administration

Question

Can we administer within 10% less than the 30 mL/kg volume or must the physician order a volume that is within 10% of 30 mL/kg?

Crystalloid Fluid Administration

- A fluid volume ordered that is within 10% lower than the 30 mL/kg volume is acceptable.
- Example 1:
  - The patient requires 2200 mL to equal 30 mL/kg; two physician orders:
    1) NS 0.9% IV 1000 mL at 999 mL/hr
    2) NS 0.9% IV 1000 mL at 999 mL/hr
  - Value “1” (Yes) could be selected for *Crystalloid Fluid Administration* since 2000 mL is within 10% of 30 mL/kg.
  - The completion time of the 2000 mL infusion would begin the hour to assess for *Persistent Hypotension*.

Crystalloid Fluid Administration

- Abstracting a volume that is within 10% less than the 30 mL/kg volume is not acceptable if at least 30 mL/kg is ordered.

- Example 2:
  - The patient requires 2200 mL to equal 30 mL/kg; three physician orders:
    1) 1300 - NS 0.9% IV 1000 mL at 999 mL/hr
    2) 1400 - NS 0.9% IV 1000 mL at 999 mL/hr
    3) 1500 - NS 0.9% IV 1000 mL at 999 mL/hr
  - Abstracting 1400 as the *Crystalloid Fluid Administration Time* is incorrect since more than 30 mL/kg volume was ordered.

Crystalloid Fluid Administration

- If a volume of 30 mL/kg or more is ordered, the complete 30 mL/kg volume must be infused.
- Example 3:
  - Patient requires 2200 mL to equal 30 mL/kg; three physician orders:
    1) 1300 - NS 0.9% IV 1000 mL at 999 mL/hr
    2) 1400 - NS 0.9% IV 1000 mL at 999 mL/hr
    3) 1500 - NS 0.9% IV 1000 mL at 999 mL/hr
  - Abstract 1500 as the *Crystalloid Fluid Administration Time*.
  - Assess for *Persistent Hypotension* in the hour after the completion of the 2200 mL volume.
  - In this scenario, 2200 mL completes at 1512. Assess for *Persistent Hypotension* between 1512 to 1612.

Focused Exam

Question

Can the section heading “Physical Exam” found on the H&P be used as physician/APN/PA documentation of having performed a physical exam?

Focused Exam

- The title or heading “Physical Exam” alone would not suffice as physician/APN/PA documentation of having performed a physical exam.

- Examples of **acceptable** documentation:
  - Physician/APN/PA narratively documents “physical exam performed.”
  - Physician/APN/PA selects an option in the EMR stating their performance of a physical exam, focused exam, etc. that includes a time stamp.

Focused Exam

- Examples of **acceptable** documentation**:**
  - Physician/APN/PA documents**:**
    - “I did the sepsis reassessment.”
    - “Patient's septic shock focused exam was repeated.”
    - “A focused exam was performed after fluid resuscitation.”
    - Flowsheet question: “Sepsis focused exam performed?” and selection of “Yes.”
    - “Septic shock perfusion assessment completed.”
    - “I have reassessed tissue perfusion after bolus given.”
    - “Sepsis re-evaluation, repeat focused exam demonstrates:”
    - “Sepsis re-evaluation was performed.”
    - “Review of systems completed.”
    - “12 point systems review pertinent positives as documented.”
  - Quick reference under Specifications Manual Fact Sheets on *QualityNet:* Physician/APN/PA Documentation of Performing or Attestation to Performing a Focused Exam

Focused Exam

- Examples of **unacceptable** documentation:
  - H&P section “Physical Exam” tab with four focused exam elements documented by the physician/APN/PA
  - Physician documents “focus exam reviewed”
  - PA documents, “I performed a skin assessment and peripheral pulse evaluation.”

Persistent Hypotension

Question

How do we more accurately select the correct value for persistent hypotension?

Persistent Hypotension

In the hour following the completion of 30 mL/kg of crystalloid fluids, the following blood pressure(s) are documented:

- Scenario 1: 85/58 – Select Value “3”
- Scenario 2: 95/60 – Select Value “2”
- Scenario 3: 88/50 and 86/48 – Select Value “1”
- Scenario 4: 85/58, 88/59, 82/55, 84/50, 92/57 – Select Value “2”
- Scenario 5: 95/60, 82/54, 90/68, 87/59, 92/64, 88/63 – Select Value “2”
- Scenario 6: 78/45, 92/55, 86/51, 93/60, 84/53, 88/57 – Select Value “1”

Persistent Hypotension

Question

How is the 30 mL/kg crystalloid fluid volume completion time calculated when multiple liters are infusing simultaneously?

Persistent Hypotension

- Calculation Example 1:
  - Patient requires 1800 mL (30 mL/kg)
    - Order 1: NS 0.9% 1000 mL @ 1000 mL/hr
      - Started time: 0800, Stop time: 0900
    - Order 2: NS 0.9% 1000 mL @ 1000 mL/hr
      - Started time: 0816, Stop time: 0916
  - Infusion 1: 1000 mL ÷ 60 minutes = 16.67 mL per minute
  - Infusion 2: 1000 mL ÷ 60 minutes = 16.67 mL per minute

Persistent Hypotension

- From 0800 to 0815
  - 15 minutes x 16.67 mL per minute = 250 mL
- From 0816 to 0900
  - 44 minutes x 33.33 mL per minute = 1467 mL
- Add: 250 mL + 1467 mL = 1717 mL completed at 0900
- Subtract: 1800 mL (30 mL/kg volume) - 1717 mL = 83 mL
- From 0901 to 0915
  - 83 mL (final mL needed) ÷ 16.67 mL per minute = 5 minutes
- Add: 0900 + 5 minutes = 0905
- Add: 1717 mL + 83 mL = 1800 mL (30 mL/kg) completed at 0905
- Assess for persistent hypotension – 0905 to 1005

Persistent Hypotension

- Calculation Example 2:
  - Patient requires 1,395 mL (30 mL/kg)
    - Order 1: NS 0.9% 1000 mL bolus
      - Start time: 1754, Stop time: 0008
    - Order 2: NS 0.9% 1395 mL @ 1000 mL/hr
      - Start time: 1852, Stop time: 0008
    - Order 3: NS 0.9% 1000mL @ 1000 mL/hr
      - Start time: 2010, Stop time: 21:10
  - Infusion 1: 1754 to 00:08 = 6 hours and 14 minutes
    = 374 minutes
  - Infusion 2: 1853 to 00:08 = 5 hours and 15 minutes
    = 315 minutes
  - Infusion 3: 2010 to 2110 = 60 minutes

Persistent Hypotension

- Infusion 1: 1000 mL ÷ 374 minutes = 2.7 mL per minute
- Infusion 2: 1395 mL ÷ 315 minutes = 4.4 mL per minute
- Infusion 3: 1000 mL ÷ 60 minutes = 16.7 mL per minute
- From 1754 to 1852 = 58 minutes at 2.7 mL per minute = 157 mL infused
- From 1853 to 2009 = 76 minutes at 7.1 (includes 2.7 + 4.4) mL per minute
  = 540 mL infused
- Add: 157 mL + 540 mL = 697 mL infused from 1754 to 2009
- Subtract: 1395 mL - 697 mL = 698 mL needed to meet 30 mL/kg
- 698 mL ÷ 23.8 (includes 2.7 + 4.4 + 16.7) mL per minute = 29 minutes
- Add: 2010 + 29 minutes = (30 mL/kg) completed at 20:39
- Assess for persistent hypotension – 20:39 to 21:39

Severe Sepsis Presentation Date/Time

Question

How do I better interpret which time should be abstracted when severe sepsis is documented as Present on Admission?

Answer

Use the earliest documented date and time that the patient was admitted to the hospital.

Severe Sepsis Present

- Physician/APN/PA documentation that systemic inflammatory response syndrome (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 should be documented prior to or within 24 hours after severe sepsis presentation.

- Physician/APN/PA documentation
  - SIRS criteria or a sign of organ dysfunction:
    - Is normal
    - Is due to a chronic condition
    - Is due to an acute condition that is not an infection
    - Is due to a medication

Severe Sepsis Present

- The documentation must also include either the abnormal value or reference the abnormal value under consideration.
  If the value or reference to the value is not included in the documentation, inferences should not be made that the documentation pertains to the abnormal value.

- Physician/APN/PA documentation
  - SIRS criteria or a sign of organ dysfunction
    or
  - Reference to SIRS criteria or a sign of organ dysfunction
  - If the SIRS criteria or a sign of organ dysfunction or reference is not included in the documentation, do not infer or assume the SIRS criteria or a sign of organ dysfunction is due to the chronic condition, acute condition that is not an infection, or medication.

Severe Sepsis Present

- If the abnormal value or reference to it, and the condition or medication are documented in the same note, the value should not be used. Explicit documentation stating the abnormal value is specifically due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication is NOT required.
  - Example of explicit documentation:
    “Lactate of 3.5 is due to a seizure.”
- The physician/APN/PA is still required to document the SIRS criteria or sign of organ dysfunction is due to the chronic condition, medication, etc. in a way that does not require an inference by the abstractor.

Severe Sepsis Present

- Examples of **acceptable** physician/APN/PA documentation to exclude the SIRS criteria or sign of organ dysfunction:
  - Physician/APN/PA documents**:**
    - “Creatinine 3.0, CKD, HD in am”
    - “Continue Warfarin, monitor INR”
    - “Hypotensive after pain meds”
    - “Differential Dx: ESRD – Baseline Cr. 2.5–2.8”

Severe Sepsis Present

- Examples of **unacceptable** documentation:
  - H&P: Labs Section**:** Lactate 5.5 mmol/L;
    H&P: Assessment Section: Seizures x 2 today
    - The elevated lactate would be accepted as a sign of organ dysfunction since the physician/APN/PA documentation does not link the elevated lactate to the seizures.
  - Severe sepsis presentation date and time: 4/5/2017 at 0730;
    4/5/2017 0730 – Platelet Count 74,000;
    4/9/2017 0900 – Physician Consult Note:
    "Thrombocytopenia secondary to chemo."
    - The low platelet count would be accepted as a sign of organ dysfunction since the physician documentation is greater than 24 hours after severe sepsis presentation date and time.

Severe Sepsis Present

Example of **unacceptable** documentation:

- Physician Progress Note:
  History section: Patient with a hx of CKD, ETOH abuse, COPD, MI 2 years ago, presenting to ED complaint of low back pain, weakness, fever.

Home Medications Section	**Labs Section**
– Lisinopril	WBC – 18
– Warfarin	Creatinine 3.5
– Advair	INR – 2.2

- This would not reflect physician/APN/PA documentation that the elevated labs are due to a chronic condition or medication.

Severe Sepsis Present

Question

How do I better interpret “acute condition that is not an infection and determine if the SIRS criteria or sign of organ dysfunction should be disregarded”?

Severe Sepsis Present

- If the medical resource indicates the condition is an infection or is caused by an infection, the SIRS criteria or sign of organ dysfunction should be used.
- If the medical resource indicates the condition is not an infection and not caused by an infection, the SIRS criteria or sign of organ dysfunction should not be used.
- If the medical resource indicates the condition may be or may not be an infection, or may be caused by an infection or may be caused by something other than an infection, there must be additional documentation in the medical record supporting the condition is an infection (e.g., antibiotic ordered for the condition).

Severe Sepsis Present

- Examples of **acceptable** supporting documentation:
  - Antibiotic for the condition:
    - Zoysn 3.375 g IV q6hr for diverticulitis
  - Infection support in another documentation:
    - PA documentation: Differential Dx: colitis
    - APN Note: Upon reassessment, colitis seems to have infectious etiology.
  - Infection within the same documentation as a chronic condition or medication:
    - Physician documentation: thrombocytopenia, Heparin, secondary Dx: bacterial endocarditis.
  - Condition caused by infection within the same documentation:
    - Physician documentation: gastroenteritis, likely infection (E. coli) rather than viral.

Severe Sepsis Present

- Example 1:
  - Physician documents: “Platelet count 85,000, Cystitis vs. ETOH abuse VS medication induced.”
    - Per medical resource, cystitis may or may not be caused by an infection.
    - Physician order: Levaquin 750 mg PO qd for 5 days, Indication: Cystitis.
- Example 2:
  - PA documents 5/1/2017 0800: “Lactate elevation post seizure”
  - APN documents 5/1/2017 1630: “Recent seizures r/t bacterial meningitis.”
    - The APN documentation considers the acute condition (seizure) to be due to the bacterial infection.

Severe Sepsis Present

Example 3:

- Physician Note: 6/5/2017 0730: “ED presentation patient complaint of dysuria, chest pain, dizziness, and short of breath; VS: 95/68, 98, 18, 93% on 2L, 99.8; Cr. 2.4, acute kidney injury (AKI), NSAID abuse vs. UTI, concern for sepsis, blood cultures ordered, starting Levaquin.”
  - The acute condition (AKI) and possible infection are both included in this documentation. The creatinine of 2.4 should be used as organ dysfunction.

Severe Sepsis Present

Example 4:

- PA Note: 5/20/2017 0930: “Concern for pneumonia, awaiting chest x-ray, creatinine 3.3 due to AKI.”
  - There is explicit documentation that the elevated creatinine is due to the acute condition (AKI).
  - No supportive documentation that the acute condition (AKI) is an infection or caused by an infection.
  - The creatinine of 3.3 should **not** be used as organ dysfunction.

Severe Sepsis Present

Example 5:

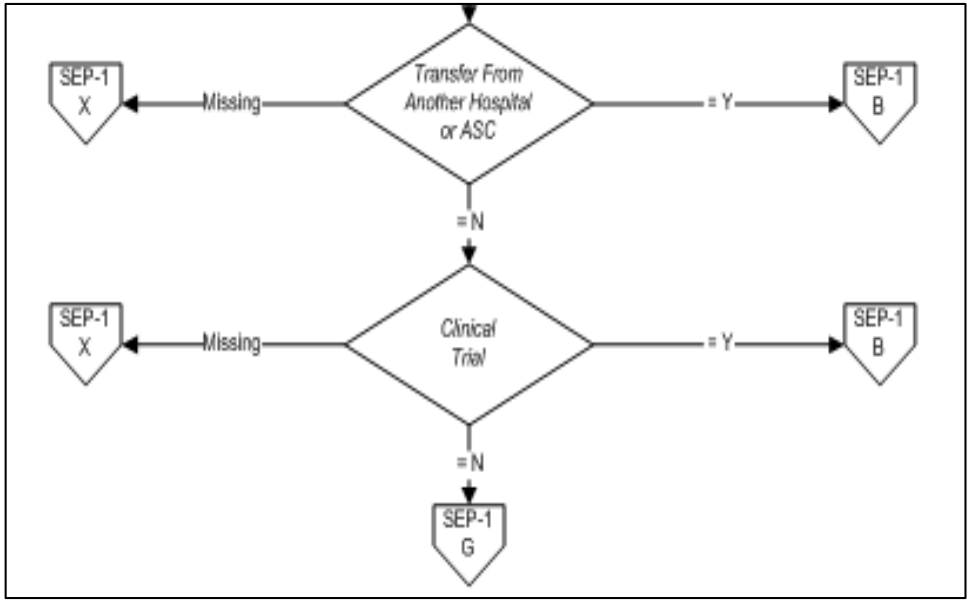
- Physician Note: 5/31/2017 1930: “Elevated lactate, congestive heart failure (CHF), pneumonia.”
  - The chronic condition (CHF) and possible infection are both included in this documentation. The elevated lactate should be used as organ dysfunction.

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: v5.2a Commonly Asked Questions & v5.3 Measure Updates

SEP-1 v5.3 Measure Updates

Clinical Trial v5.3

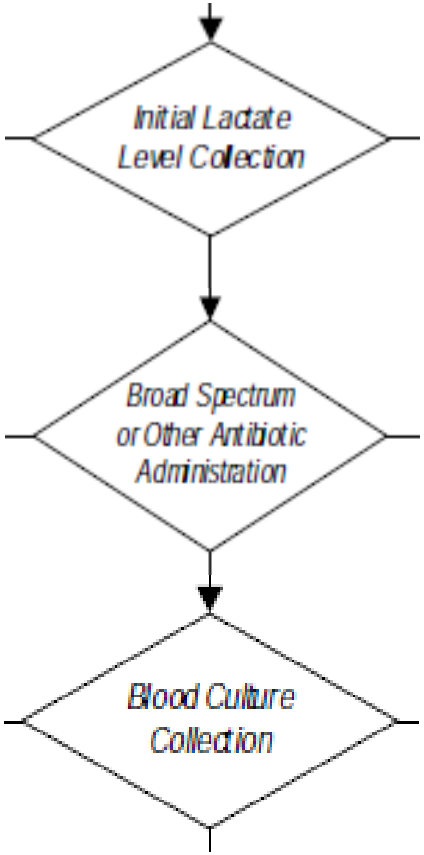
- New data element
- Provides an exclusion for patients currently enrolled in a clinical trial **related to the treatment or interventions of sepsis, severe sepsis, or septic shock.**



Algorithm Update v5.3

Previous algorithm flow:

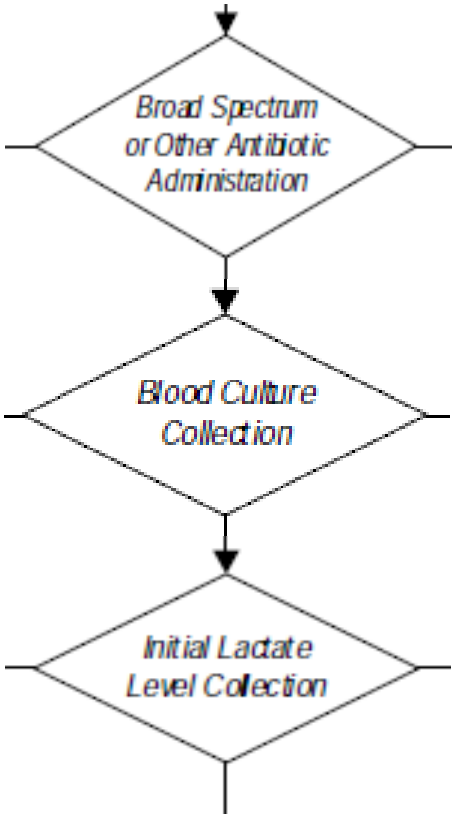
1. Initial Lactate Level Collection
2. Broad Spectrum or Other Antibiotics
3. Blood Culture Collection



Algorithm Update v5.3

New algorithm flow:

1. Broad Spectrum or Other Antibiotics
2. Blood Culture Collection
3. Initial Lactate Level Collection



Broad Spectrum or Other Antibiotic Administration v5.3

- Only IV antibiotic administered in the 24 hours prior to 3 hours after severe sepsis presentation is acceptable.

  Exception:

  - If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started in the 24 hours prior to or 3 hours after the severe sepsis presentation is acceptable to select value “1.”

- The IM or IO antibiotic would be used to determine the broad spectrum or other antibiotic date and time.

Broad Spectrum or Other Antibiotic Administration v5.3

Example:

Severe sepsis presentation time: 5/1/2017 1600

ED Nursing Note: "**Unable to obtain IV access due to dehydration**, awaiting PICC placement."

Physician Order: Rocephin 1g IM x1 now

MAR: Rocephin 1g IM
Administered: 5/1/2017 1615

Broad Spectrum or Other Antibiotic Administration Selection v5.3

- Only IV antibiotic administered 3 hours after severe sepsis presentation is acceptable.

  Exception:

  - If there is documentation indicating IV access could not be established, antibiotics administered via intramuscular (IM) or intraosseous (IO) started 3 hours after the severe sepsis presentation is acceptable to select value “1.”

Crystalloid Fluid Administration v5.3

- New Option for selecting Allowable Value “4”
  - Physician/APN/PA or nursing documentation indicating patient or authorized patient advocate has refused IV fluid administration prior to or within 6 hours following presentation of septic shock can be used to select value “4.”

Patient refused IV fluids: ✓ Value 4

Crystalloid Fluid Administration v5.3

Example:

Severe sepsis presentation time: 5/25/2017 1200

Initial hypotension: 5/25/2017 1645

- Order: 30 mL/kg NS 0.9% bolus over 3 hours
- 30 mL/kg NS 0.9% bolus start time: 5/25/2017 1700

Physician documents septic shock: 5/25/2017 1700

5/25/2017 1830 Physician Note: Fluid administration stopped. **Patient states they "don't want anymore IV fluids."**

Crystalloid Fluid Administration v5.3

- If there is **physician/APN/PA documentation identifying the patient has obesity** (defined as a Body Mass Index >30), the clinician may choose to use Ideal Body Weight (IBW) to determine the 30ml/kg crystalloid fluid volume. If the clinician prefers to use IBW, **the clinician must state that IBW will be the weight used to determine the 30 mL/kg** as the target ordered volume.

- Examples:
  - APN Order: 30 mL/kg (2190 mL) NS 0.9% 1000 mL/hr, BMI 39, IBW 73 kg.
  - PA Note: Morbidly obese, ordering sepsis fluid volume per IBW.

Crystalloid Fluid Administration v5.3

- Exception for Prior to Arrival:
  - Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) that are part of the medical record is acceptable if the documentation of fluid administration contains the type, volume, start time, and either a rate, duration, or end time of the fluid infusion. **A physician/APN/PA order for fluids administered prior to arrival is not required.**

Requirements for crystalloid fluids administered prior to arrival:

- ✓ Start time
- ✓ Type of fluid
- ✓ Volume of fluid
- ✓ Rate, duration, or end time

Crystalloid Fluid Administration v5.3

- Exception for Operating Room (OR):
  - Crystalloid fluids administered in the OR by a physician/APN/PA are acceptable without an order if a fluid type, an infusion start time, and an infusion rate or infusion end time is documented.

Requirements for crystalloid fluids administered in the OR:

- ✓ Start time
- ✓ Type of fluid
- ✓ Volume of fluid
- ✓ Rate, duration, or end time

Crystalloid Fluid Administration v5.3

- New Guidance:
  - **Isolyte** has been added to the Inclusion Guidelines as an acceptable crystalloid fluid.
  - Crystalloid fluids that are used to dilute medications are acceptable.

Crystalloid Fluid Administration v5.3

- For the presence of *Initial Hypotension*, only abstract crystalloid fluids that were started in the time frame of **6 hours** prior through **3 hours after the initial hypotension**.
  - A single order for the target ordered volume initiated within the above time frame is acceptable.
  - If crystalloid fluids are initiated via multiple physician/APN/PA orders, only abstract crystalloid fluids initiated within the above time frame.

Initial Hypotension v5.3

- The definition is revised from one hypotensive blood pressure to **two** hypotensive blood pressures.
- Criteria for determining initial hypotension:
  - Either 6 hours prior to or within 6 hours following severe sepsis presentation of **two low blood pressure readings.**
- Example:

  Severe sepsis presentation time 1500

  Blood Pressures documented between 0900 to 2100:

  95/70, **89/61**, 91/68, 93/65, **87/59**

  - Select Value “1” (Yes) for Initial Hypotension

Severe Sepsis Present v5.3

- Creatinine >2.0
  - If there is **physician/APN/PA documentation** the patient has **end stage renal disease (ESRD)** and is on **hemodialysis or peritoneal dialysis** all reported creatinine levels should be disregarded as signs of organ dysfunction. ESRD (on hemodialysis or peritoneal dialysis) and creatinine levels or reference to elevated creatinine levels do not need to be included in the same physician/APN/PA documentation.
  - The documentation of ESRD and hemodialysis or peritoneal dialysis are not required to be in the same documentation.

Severe Sepsis Present v5.3

- Creatinine >2.0
  - If there is **physician/APN/PA documentation** of **chronic renal disease (CKD)** (e.g., CKD I, II, or III, or "chronic renal insufficiency") and **the baseline creatinine is documented**, creatinine values elevated >0.5 above baseline should be used as organ dysfunction (e.g., baseline 2.30, creatinine now 2.81).
  - The documentation of CKD and the baseline creatinine are not required to be in the same documentation as the creatinine elevated >0.5 above baseline.

Severe Sepsis Present v5.3

- If the suggested data source shows the patient was given an anticoagulant medication in Appendix C Table 5.3, an elevated international normalized ratio (INR) or Activated Partial Thromboplastin Time (aPTT) level should not be used as organ dysfunction. Physician/APN/PA documentation is not required.

Table 5.3: Anticoagulants, Sepsis

Generic Name	Brand Name
Heparin	Heparin
Edoxaban	Savaysa
Desirudin	Iprivask
Dabigatran etexilate	Pradaxa
Rivaroxaban	Xarelto
Apixaban	Eliquis
Argatroban	Argatroban
Bivalirudin	Angiomax
Fondaparinux	Arixtra
Warfarin	Coumadin

Severe Sepsis Present v5.3

- If there is physician/APN/PA documentation prior to or within 24 hours after *Severe Sepsis Presentation Time* indicating a SIRS criterion or sign of organ dysfunction is due to the following, the following criteria values **should be used**:
  - Acute condition
  - Acute on chronic condition
- Examples:
  1. Physician documents "elevated lactate secondary to seizure."
     - Lactate should be used as organ dysfunction.
  2. APN documents "acute kidney injury, Cr 2.9."
     - Creatinine should be used as organ dysfunction.

Severe Sepsis Present v5.3

- Examples:

3. PA documents “current thrombocytopenia, medication vs. acute ITP.”
    - Platelet count should be used as organ dysfunction.

4. Physician Note: “AKI, ESRD, Cr. 2.5”
    - Creatinine should be used as organ dysfunction.

Severe Sepsis Present v5.3

- If there is physician/APN/PA documentation prior to or within 24 hours of *Severe Sepsis Presentation Time* indicating the acute condition is due to a non-infectious source/process, it should not be used. (Refer to *Severe Sepsis Present* criteria “a” to determine if a condition is an infection).

- Example:
  - Physician documents “elevated lactate secondary to seizure (acute condition) post brain injury (source).”
    - Lactate should not be used as a sign of organ dysfunction.

Source of the acute condition is required in the **same** physician/APN/PA documentation.

Severe Sepsis Present v5.3

- Example:
  - APN documents “acute kidney injury (acute condition) due to dehydration (source)” x 3 days, Cr 2.9."
    - Creatinine should not be used as a sign of organ dysfunction.

Source of the acute condition is required in the same physician/APN/PA documentation.

Severe Sepsis Present v5.3

- Determine if the source of the acute condition is an infection or caused by an infection.
  - If the medical resource indicates the source of the condition is an infection or is caused by an infection, the SIRS criteria or sign of organ dysfunction should be used.
  - If the medical resource indicates the source of the condition is **not** an infection and **not** caused by an infection, the SIRS criteria or sign of organ dysfunction should not be used.
  - If the medical resource indicates the source of the condition may be or may not be an infection, **or** may be caused by an infection or may be caused by something other than an infection, there must be additional documentation in the medical record supporting the condition is an infection (e.g., antibiotic ordered for the condition).

Severe Sepsis Present v5.3

- New Bullet Points:
  - Vital signs documented in the operating room (OR) should not be used.
  - SIRS criteria or a sign of organ dysfunction due to artificial interventions (e.g., respiratory rate is 24, vent rate set at 24) should not be used.
    - If the vent rate is 24 and the respiratory rate is 28, the respiratory rate of 28 **should be used**.

Severe Sepsis Present and Septic Shock Present

- Physician/APN/PA documentation of severe sepsis or septic shock using a qualifier will impact how the documentation is abstracted.
  - Examples:
    - "During exam in ED patient found to have severe sepsis."
      - There is no qualifier statement.
      - Severe Sepsis is abstracted as present.
    - "During exam in ED severe sepsis strongly suspected."
      - Qualifier statement for severe sepsis is "suspected."
      - Severe Sepsis is abstracted as present.
    - "During exam in ED severe sepsis not suspected."
      - Qualifier statement for severe sepsis is "not suspected."
      - Severe Sepsis is abstracted as NOT present.
- Documentation using a qualifier that indicates severe sepsis or septic shock is not suspected or not present results in the case being excluded from the measure.

Severe Sepsis Present and Septic Shock Present

- For documentation of an infection, severe sepsis, or septic shock accompanied by a qualifier, the table below should be used.
- Documentation containing a **positive qualifier should be used** to meet criteria. Documentation containing a **negative qualifier should not be used** to meet criteria.

Positive Qualifiers	Negative Qualifiers
Possible	Impending
Rule out (r/o)	Unlikely
Suspected	Doubt
Likely	Risk for
Probable	Ruled out
Differential Diagnosis	Evolving
Suspicious for	Questionable
Concern for	

Severe Sepsis Present and Septic Shock Present

- New Bullet Points**:**
  - The title or heading of an order set, protocol, checklist, alert, screening tool, etc. reflecting an infection, SIRS, sepsis, severe sepsis, or septic shock should not be used to meet criteria.
  - Documentation of an infection, sepsis, severe sepsis, or septic shock **within** an order set, protocol, checklist, alert, screening tool, etc. may be used if the following is true:
    - The documentation or value and recorded date and time are present and are the earliest date and time recorded for the criteria.

Questions?

Continuing Education Approval

This program has been approved for 1.5 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Dietetics and Nutrition Practice Council
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
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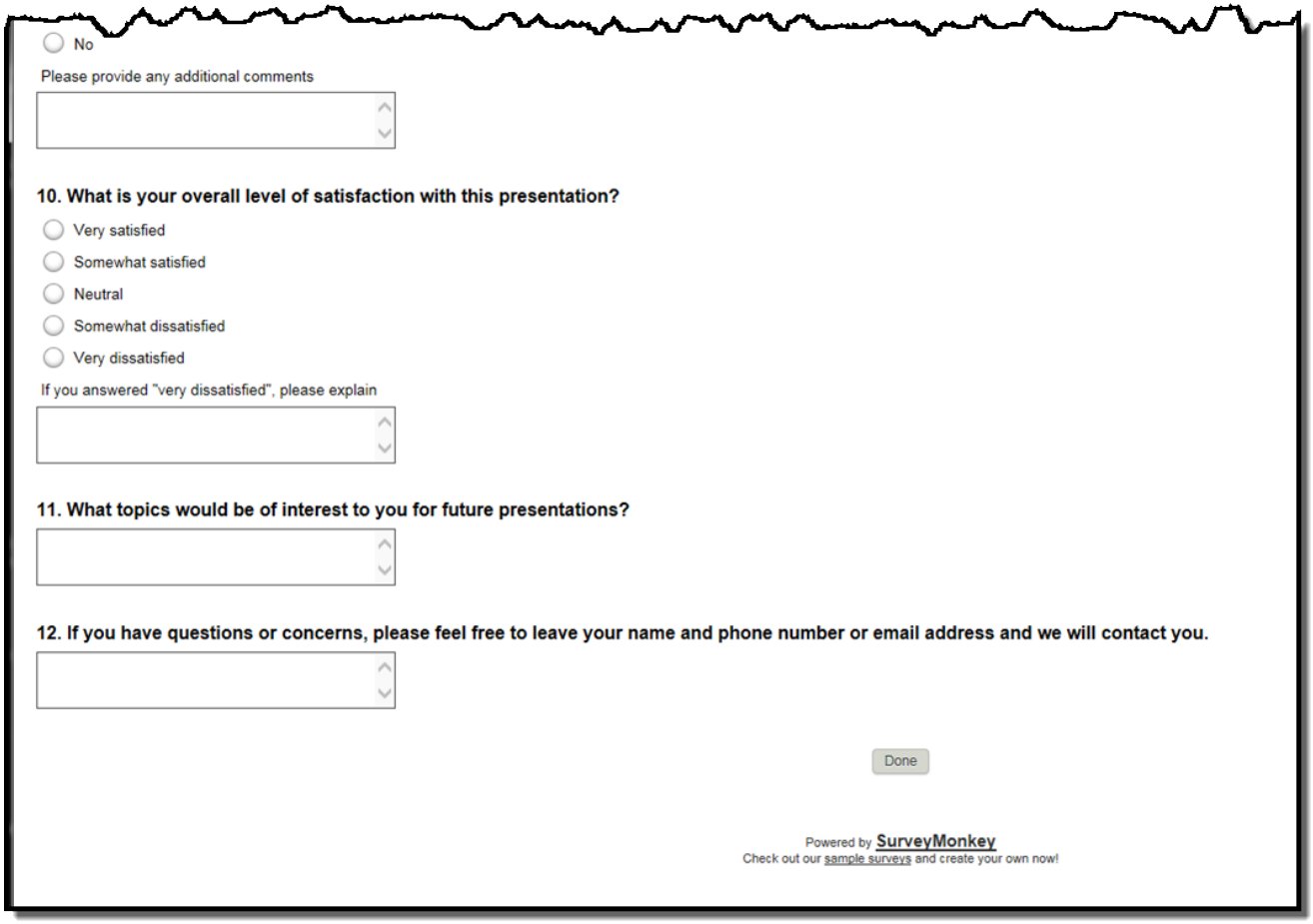

No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
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If you answered "very dissatisfied", please explain

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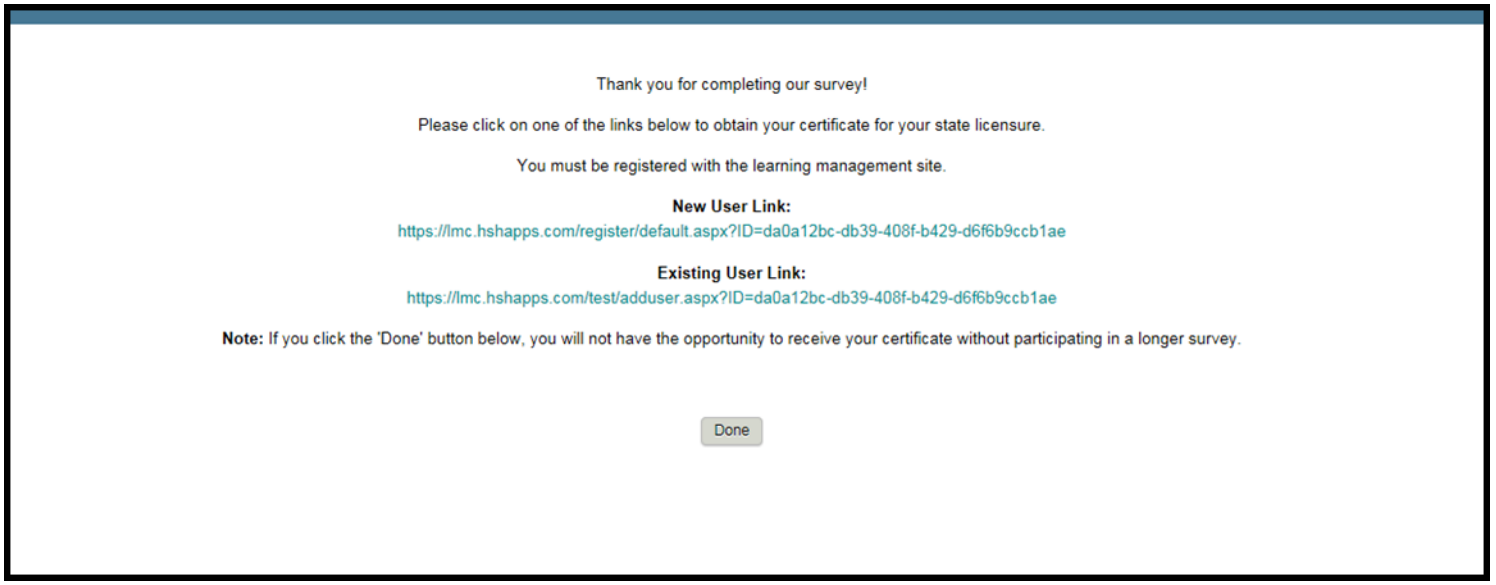
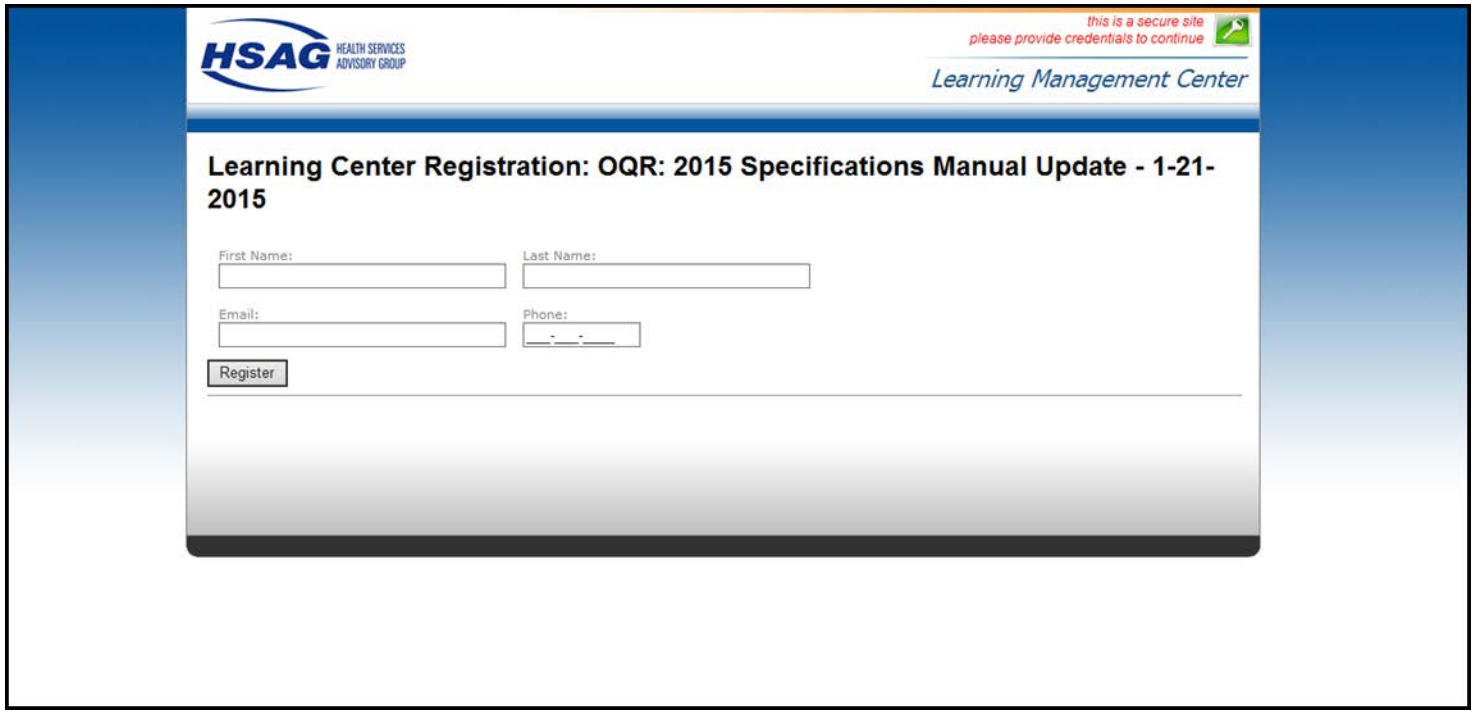
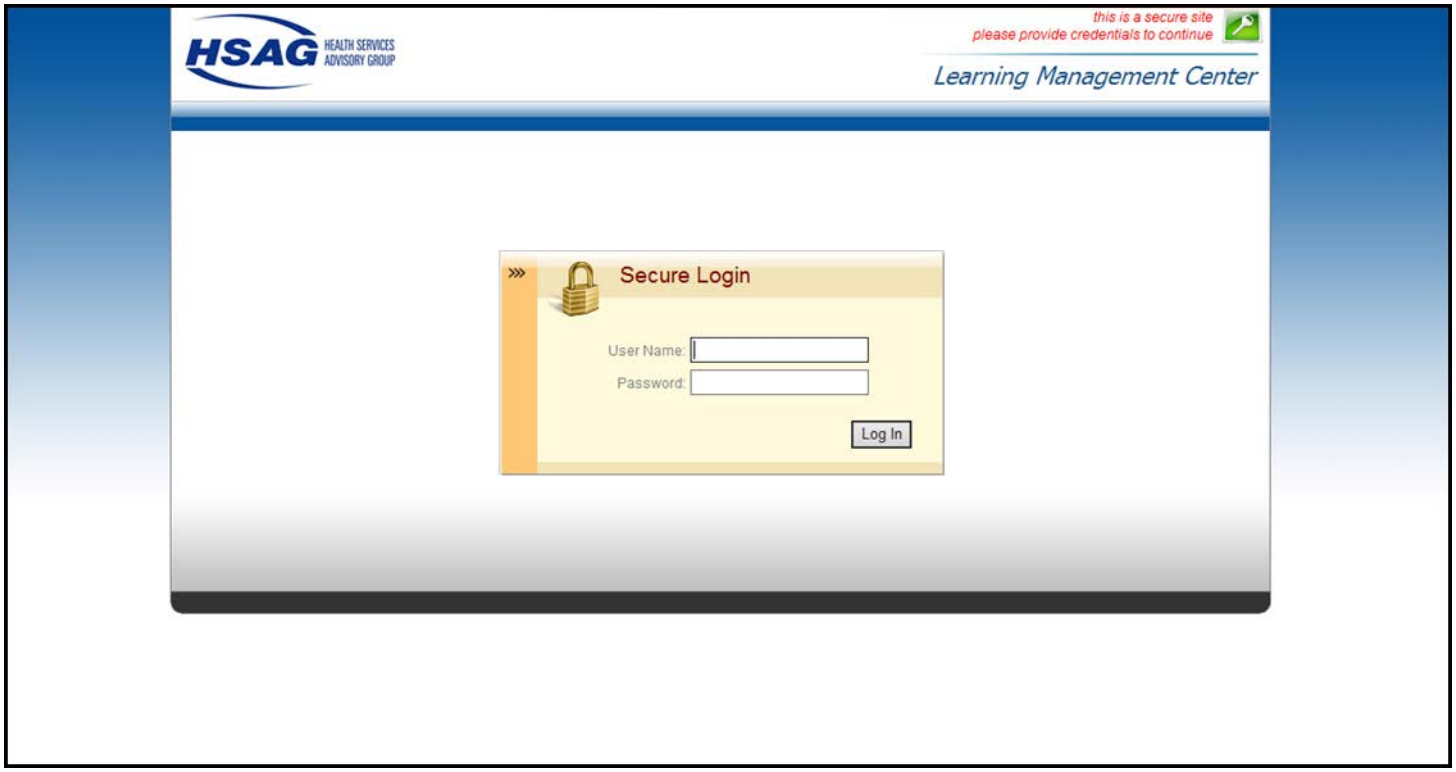


CE Credit Process: New User



CE Credit Process: Existing User



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