Sepsis Management Webinar
"Lessons Learned from Sepsis Simulation & Balancing Core Measure Compliance with Improved Mortality"

August 17, 2016
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## 2016 PSF Statewide Webinars—You’re Invited!

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<th>JAN: 2016 PSF Kick-off Webinar: Overview, Data Measures, &amp; Submission Process</th>
<th>ACCESS RECORDING HERE</th>
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<tr>
<td>WEBINAR</td>
<td>WEDNESDAY, APRIL 6, 2016 • 12:15PM–1:15PM (PDT)</td>
<td>Reducing First Birth (NTSV) Cesareans in California Presented by CMQCC, Holly Smith, MPH, MSN, CNM and Kim Werkmeister, RN, BA, CPHO. Review of the CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans and the CMQCC Hospital Collaborative. REGISTER HERE</td>
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<tr>
<td>WEBINAR</td>
<td>THURSDAY, APRIL 21, 2016 • 9AM-10AM (PDT)</td>
<td>Sepsis Core Measures: Communication is the Key to Success Presented by Christen Grelling, MSN, FNP, PHN, and the Chino Valley Medical Center Team. REGISTER HERE</td>
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<td>WEBINAR</td>
<td>TUESDAY, APRIL 26, 2016 • 9AM-10AM (PDT)</td>
<td>Checklists: The Good, The Bad and the Ugly Presented by Dr. Della Lin—Are checklists the end all? Let’s discuss how they might help us, and might harm us, albeit unintentionally. REGISTER HERE</td>
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<td>WEBINAR</td>
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<td>Transfusion Support for OB Hemorrhage Presented by Dr. Kopiko a Clinical Professor of Pathology at UC San Diego, where she is Director of Transfusion Medicine and Associate Director of the Immunogenetics and Transplantation Laboratory. REGISTER HERE</td>
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<td>WEBINAR</td>
<td>WEDNESDAY, AUGUST 17, 2016 • 9AM-10AM (PDT)</td>
<td>Sepsis Management Webinar (Title TBD) Discuss and share barriers, strategies, and resources that facilitate progress towards decreasing sepsis mortality. REGISTER HERE</td>
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<td>WEBINAR</td>
<td>THURSDAY, AUGUST 25, 2016 • 9AM-10AM (PDT)</td>
<td>Getting Out in Front of Report Cards Presented by Juliane Morath, RN, MS, CPPS, President/CEO of the Hospital Quality Institute (HQI), a collaboration of the California Hospital Association and the Regional Associations. REGISTER HERE</td>
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<td>WEBINAR</td>
<td>THURSDAY, OCTOBER 6, 2016 • 12:15PM–1:15PM (PDT)</td>
<td>Perinatal Safety Webinar (Title TBD) Discuss and share barriers, strategies, and resources that facilitate progress towards eliminating early elective delivery and lowering C-Section rate, and managing post-partum hemorrhage. REGISTER HERE</td>
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<td>WEBINAR</td>
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<td>Sepsis Management Webinar (Title TBD) Discuss and share barriers, strategies, and resources that facilitate progress towards decreasing sepsis mortality. REGISTER HERE</td>
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<td>WEBINAR</td>
<td>TUESDAY, OCTOBER 18, 2016 • 9AM-10AM (PDT)</td>
<td>Data Sanitization and the Business Case for Improvement Presented by Helen Macfie, Pharm.D, Chief Transformation Officer, MemorialCare Health System; and Gayle Sandhu, MS, FACHE, Corporate Senior Director, Quality Assurance, Scripps Health. REGISTER HERE</td>
</tr>
</tbody>
</table>

Contact: Dominique Diaz | ddiaz@hasc.org | (213) 538-0732

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**Statewide Webinars**

Flyer w/registration links will be provided in a follow up email . . .
How to participate in today’s Webinar presentation

- At the telephone prompt, please be sure to enter your unique audio pin located in your Webinar audio pane.
- We will have time for Q&A at the end of the presentation.
- Submit your text question using the Questions pane.
Meet Today’s Presenters
Redlands Community Hospital

Ana Campos RN BSN CCRN
Nurse Manager Intensive Care Unit
Redlands Community Hospital

Heather M. Lent RN-BC, CPHQ
Patient Safety Supervisor
Redlands Community Hospital

Valerie Kaura, MS, RN, FNP-BC
Director of Critical Care Services
Redlands Community Hospital
Meet Today’s Presenters

Henry Mayo Newhall Hospital

Sue Trikha, RN,C CEN CPHQ
Performance Improvement Coordinator
Quality Resource Management
Henry Mayo Newhall Hospital
SEPSIS SIMULATION HOST HOSPITAL

Ana Campos BSN, RN, CCRN ICU Manager
Valerie Kaura MS, RN, FNP-BC Director of Critical Care Services
Heather Lent RN-BC, CPHQ Quality and Patient Safety Supervisor

Redlands Community Hospital
The Hospital Association of Southern California Patient Safety First Collaborative, together with Medical Simulation Corporation (MSC)

MSC’s Sepsis Immerse Program is a technology-enabled, healthcare performance improvement solution that helps hospitals advance the application of evidence-based guidelines to rapidly improve patient outcomes and measurably reduce healthcare costs.

BIG THANK YOU TO:

MSC - Tara Crockett, Coordinator and Scott Bartholomew, Trainer.
Top Notch!!

HASC - Dominique Diaz, Coordinator.
She made it so easy to get the whole class going and keep us on track!
Each three-hour hands-on simulation session included:

- Three simulation scenarios focused on the Surviving Sepsis Campaign (SSC) guidelines and SEP-1 Core Measures, presented on a high-fidelity human patient simulator
- Redlands Hospital specific Sepsis Order sets
- Critical thinking and clinical skills
- Debriefing – team feedback, applicability to everyday practice, performance improvement strategies
- Evaluation and post-session test completion
- Competence metrics and analysis
Benefits of Simulation and Being A Host Hospital

- Multidisciplinary staff participation
- Ease of on-site training
- Physician Involvement
- Hospital Order sets and protocols
- Performance Improvement Strategies
Participants demonstrated a **33% increase** in knowledge from the knowledge check to the simulation post-test. Additionally, there was a **27% decrease** in the standard deviation.

<table>
<thead>
<tr>
<th>Knowledge Check</th>
<th>Simulation Post-Test</th>
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<tbody>
<tr>
<td><strong>Participants</strong></td>
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<tr>
<th>Mean</th>
<th>62</th>
<th>85</th>
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<td>St.Dev</td>
<td>11</td>
<td>8</td>
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<td>n</td>
<td>20</td>
<td>20</td>
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“The simulation session was the glue that put it all together. I am confident that I can identify a septic patient and help our team to improve our quality of care.”

- Sepsis Program Participant, Redlands Community Hospital
RCH Sepsis Improvement Process

- Sepsis Screening incorporated to nursing assessment.
- Lactic Acid Report reviewed Rapid Assessment Team RN or ICU Charge RN will follow up on patients with Lactate levels >2.0
- ER, ICU, and Tele order sets have been developed to assist in rapid and ongoing management of septic patients.
**GOLD ALERT**

**Rapid Assessment Team**

**Situation** Reason for call, current VS, abnormal labs, symptoms, I & O's for the past 24 hours

**Background** Reason for admit, current diagnosis, comorbidities, medications

**Assessment 10 SOV** Current problem or issue

**Recommendation** Your suggested intervention

**ANY PATIENT YOU ARE SERIOUSLY CONCERNED ABOUT BUT DOES NOT MEET CRITERIA**

Call PBX ext 2000 and tell the operator to activate the RAT team & state the patient location

---

**RCH STOP SEPSIS**

Assess ALL PATIENTS Suspect new Infection?

- Acute abdominal infection
- Bloodstream/ CVL Infection
- Bone/joint infection
- Endocarditis
- ILEUS
- Meningitis
- Pneumonia
- Skin/Wound Infection
- Urinary Tract Infection

If 2 SIRS criteria:

- Temp below 36°C or above 38°C
- HR above 90/minute
- RR above 20/min
- WBC >12k or < 4K or left shift

Plus suspect new infection? Call RAT- GOLD ALERT

---

**SEPSIS SCREENING TOOL**

And 1 New Sign of Organ Dysfunction/hypoperfusion

- Acute altered mental status
- SBP below 90 mmHg
- MAP below 65 mmHg
- UOP below 0.5 ml/kg x 2hours
- Glucose above 140 mg/dl
Ten Signs of Vitality

Inclusion Criteria for Calling a RAT call

- Temp: ≤ 36°C or > 38°C
- Pulse: < 55 or > 100/min
- Pain: New or sig. increase
- RR: < 6 or ≥ 20 min
- SaO₂: < 90% or ↑ FiO₂
- BP: SBP < 90 or MAP < 60
- LOC: Anxiety to Lethargy
- CAP: > 3 seconds
- UO: < 30 cc/hr x 2 hr.*
- Lactate: Base Deficit ≥ 5 or Lactic A > 2.0

Any patient you are seriously concerned about but does not meet criteria

Call a RAT call

Any two below red line activates alert

<100 cc/4 hrs excluding renal failure

Area in gray represents decreased organ perfusion
Sepsis Order Set

**Fluid Resuscitation for Septic Shock (3 hours):**

- 0.9% NaCl intravenous bolus 30 ml/kg over 30 minutes
- 0.9% NaCl intravenous bolus administer 1,000 mL over 30 minutes
- 0.9% NaCl intravenous bolus administer 500 mL over 30 minutes
- 0.9% NaCl intravenous bolus administer 250 mL over 30 minutes
- Lactated Ringer's intravenous bolus administer 1,000 mL over 30 minutes
- Lactated Ringer's intravenous bolus administer 500 mL over 30 minutes
- Lactated Ringer's intravenous bolus administer 250 mL over 30 minutes
Labs on Admission:

- Lactic Acid Q4H for 2 tests
- Septic Patient (STAT, then every 8 hours x 6):
  - Complete Blood Count/Differential STAT, then every 8 hours for 6 tests
  - BMP (Lytes, Glu, BUN, Cre, CA) STAT, then every 8 hours for 6 tests
  - Lactic Acid STAT, then every 8 hours for 6 tests
- Urine Culture STAT
- Sputum Culture STAT
- Blood Culture: 2 sets STAT
- MRSA Screen (nasal swab) STAT
Additional Order Sets

**Antibiotics:** Per Antibiotic Stewardship Program
  - Abdominal Source
  - C. Diff
  - Necrotizing Fasciitis
  - Pneumonia CAP
  - Pneumonia Aspiration
  - Respirat Hosp/SNF
  - Skin/Soft Tissue
  - Unknown Source
  - Urosepsis

- Vasopressor Orders
- Insulin Correction NovoLOG
- Insulin Basal Bolus Correction
- Insulin Infusion Algorithm ICU
- Electrolyte Replacement ICU
Reassessment of fluid volume status

**MD Progress Notes (added fields)**

- ✔ Skin
- ✔ CAP Refill
- ✔ Pulses
- ✔ VBG
- ✔ PLR
- ✔ CV Ultrasound

**Nursing:**

Document Perfusion Status Assessment every Shift After Fluid Bolus or Change in Condition *LOC, CAP Refill, Skin, UO, CVP, MAP, SVV, VBG, PLR
Mortality Data

Sepsis Mortality (All)

<table>
<thead>
<tr>
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<tr>
<td>RCH</td>
<td>15.1%</td>
<td>14.1%</td>
<td>13.3%</td>
<td>14.9%</td>
<td>12.9%</td>
<td>13.0%</td>
<td>13.2%</td>
<td>8.9%</td>
</tr>
<tr>
<td>US Norm</td>
<td>12.0%</td>
<td>14.0%</td>
<td>13.5%</td>
<td>13.2%</td>
<td>15.0%</td>
<td>14.1%</td>
<td>12.8%</td>
<td>9.5%</td>
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</table>
Please raise your ‘hand’ icon and we will open up your line.

*Be sure you have entered your pin #*

-OR-

Type your question into the question pane and we will read it aloud.
Patient Safety First
HASC Collaborative

Sepsis Management:
Balancing Core Measure Compliance and Improved Mortality
August 17, 2016
Henry Mayo Newhall Hospital

- General Acute Care Hospital not for profit, stand alone
- Located in Valencia, 30 miles north of Los Angeles
- 215 licensed beds
  - 152 Unspecified general acute care
  - 15 Perinatal Beds
  - 12 ICU beds
  - 36 ED beds
  - 11 NICU beds
  - 19 Acute Rehab beds
  - 23 Acute Psych beds (IPF)
Strategies for Data Capture & Compliance

• Our Decision Support team pulls CMS defined Sepsis patient population into a “dashboard”
  • Mortality rates
  • Physician compliance with Tissue Perfusion & Fluid Volume Status exam
  • Real time Sepsis population available after the chart is coded daily
• Sepsis Review Cmte formed July 2015
  • EDMD, Critical Care MD, ID, Hospitalist, IT builders, Nsg Director/Mgr, Education & Quality
• Developed documentation tools for physicians Aug 2015
• Specifications for SEP-1 simplified into a few pages and distributed physician and nursing leaders
• Secured 2 Cheetah NICOM monitors Oct 2015 for ICU
• Quarterly nursing education targeted for M/S staff on Sepsis
• Immersive Sepsis Simulations now in-house through our education dept
• Regular presentations to all formal Medical Staff meetings
Leveraging our EHR & informatics with Decision Support

**ALL SEPSIS MORTALITY**

<table>
<thead>
<tr>
<th></th>
<th>Baseline (FY 2015)</th>
<th>Current Month</th>
<th>Current Fiscal Year</th>
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<tbody>
<tr>
<td></td>
<td>12.3%</td>
<td>5.1%</td>
<td>12.7%</td>
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</table>

**FULL CODE SEPSIS MORTALITY**

<table>
<thead>
<tr>
<th></th>
<th>Baseline (FY 2015)</th>
<th>Current Month</th>
<th>Current Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.6%</td>
<td>2.9%</td>
<td>7.7%</td>
</tr>
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</table>

* All Sepsis Mortality includes all acute inpatient sepsis patients

* Full Code Sepsis Mortality may include any acute inpatient that was admitted as a Full Code but the code status changed to DNR 24 hours or more after admission

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Document: ProgNote - Sepsis Reassessment - Sepsis

6 hour Volume/Perfusion Exam

Date of Exam

Time of Exam

Vital Signs

Cardiac Exam

- Regular Rate and Rhythm
- Irregular
- S1 Murmur
- S2 Murmur
- S3 Murmur
- S4 Murmur

Pulmonary Exam

- Clear
- Fine Crackles
- Course Crackles
- Rhonchi
- Diminished

Capillary Refill Exam

- Brisk
- Less than 2 seconds
- Greater than 2 seconds

Peripheral Pulses

- Absent (0)
- Normal (+1)
- Bounding (+3)

Skin

- Not Mottled
- Mottled
- Knee Caps Mottled

8/17/2016

Sue Trikha RN,C CEN CPHQ Quality Dept
HMNH
POM Order Rule

- From an order: A rule can trigger a **reminder** message to the Physicians

- **Rule:** Physician reminder to complete required *fluid volume/tissue perfusion* exam

  - **Rule Check: MD REMINDER**
  
  **SEPSIS ICU SET INITIATED (NUR)**

  **Rule Message**

  Physician Reminder: Please document a Fluid Volume/Tissue Perfusion reassessment after fluid resuscitation.
  
  **Use the "Prog Note - Sepsis Reassessment"**
NICOM (Non-Invasive Cardiac Output Monitor): New monitoring tool implemented in ICU for fluid responsiveness and coming soon to the Emergency Dept.

Hemodynamic Monitoring

- SP PICC LINE INSERT (SP) Today Now
- Nursing Order: Other (NUR) Today Now
  Add. Info Arterial line placement/monitoring for patients on high dose
- Initiate NICOM Monitoring (NUR) Today Now
- Monitor CO CI SV SVI via NICOM (NUR) Today Now
- Monitor Mean Art Pressure MAP (NUR) Today Now
  Add. Info Measure MAP with goal of 65 mm Hg or greater
- NICOM Passive Leg Raise PLR (NUR) Today Now

Bolus Test (PLR Contraindicated)

- NICOM Bolus Test (NUR) Today Now
  Add. Info IF Passive Leg Raise PLR Contraindicated
How the Cheetah NICOM works

An electric current of known frequency is applied across the thorax between the outer pair of sensors.

A signal is recorded between the inner pair of sensors.

The blood absorbs electrons, causing a delay in the signal. The delay is proportional to the volume of blood, and the information is updated every 60 seconds.

This time delay, called a Phase Shift, is recorded; and the figure is translated to flow.
Sepsis Bundle: All or Nothing

SEP-1 Compliance

Q4 CY15: 47%
Q1 CY16: 40%
Q2 CY16: 54%

Sue Trikha RN, C CEN CPHQ Quality Dept
HMNH
Mortality Trends

8/17/2016

Sue Trikha RN, C CEN CPHQ Quality Dept
HMNH
<table>
<thead>
<tr>
<th>Diagnostic Tests, Therapeutic Interventions and Clinical Assessments</th>
<th>CMS Requirement</th>
<th>Internal Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sepsis-1</strong> Blood Cultures prior to Antibiotic <strong>1</strong></td>
<td>&lt;3 Hours from presentation</td>
<td>&lt; 1 Hour from presentation</td>
</tr>
<tr>
<td><strong>Sepsis-2</strong> Antibiotics administered <strong>2</strong></td>
<td>&lt; 3 Hours from presentation</td>
<td>&lt; 1 Hour from presentation</td>
</tr>
<tr>
<td><strong>Sepsis-3</strong> Initial Lactate <strong>3</strong></td>
<td>&lt;3 Hours from presentation</td>
<td>&lt; 2 Hours from presentation</td>
</tr>
<tr>
<td><strong>Sepsis-4 Shock</strong> Adequate Fluids</td>
<td>&lt;3 Hours from presentation</td>
<td>&lt; 2 Hours from presentation</td>
</tr>
<tr>
<td><strong>Sepsis-5</strong> <strong>5a</strong> Repeat Volume Status and Tissue Perfusion Assessment</td>
<td>&lt;6 Hours for lactate &gt;=4 or refractory hypotension</td>
<td>Anytime after the patient receives their fluid resuscitation or &lt;5 Hours from presentation for lactate &gt;=4 or refractory hypotension</td>
</tr>
<tr>
<td><strong>Sepsis-6</strong> Repeat Lactate <strong>6</strong></td>
<td>&lt;6 hours</td>
<td>&lt; 4 hours from initial lactate</td>
</tr>
<tr>
<td><strong>Sepsis-7</strong> Shock <strong>7</strong></td>
<td>&lt;6 hours</td>
<td>&lt; 3 hours for refractory hypotension, not responding to fluids</td>
</tr>
</tbody>
</table>

**5b** Any 2 of the following 4:
1. CVP
2. CV02,
3. Cardiovascular U/S,
4. Passive Leg Raise or Fluid Challenge

**5a** Focused Exam:
- Capillary Refill
- Peripheral pulse
- Skin exam r/t Tissue Perfusion
- Cardio-Pulmonary exam and Vital Signs

< 6 hours
All 5 elements must be documented by a MD/PA after the patient receives a fluid bolus

< 5 hours
All 5 elements must be documented by a MD/PA after the patient receives a fluid bolus
July 1, 2016 update for SEP-1 v5.1

- **New additions**
  - "Vital Signs Review Performed" data element
    - Actual values for V/S are not required
  - Focused exam and reassessment data element (Capillary Refill Exam, Peripheral Pulse Evaluation, Skin Exam, V/S review and **passive leg raise**)  
    - No longer needs to be performed by the physician/APN/PA, but **must be documented by the physician/APN/PA**
  - It is acceptable to treat with "other" antibiotics for a **known causative organism and susceptibility** within 3 hrs following the presentation of severe sepsis. This must be documented in:
    - a lab report or
    - MD/APN/PA documentation
  - Except for **c. difficile**, you do not need susceptibility testing **and**:
    - if the patient is on oral Vancomycin **only** choose value “1”, which allows the case to pass
  - **Timing of crystalloid fluids**
    - Can be given prior to, at the time of, or after initial hypotension, Lactate >4 (36mg/dL), or documentation of septic shock
    - Abstract the last time/date of fluids hung if multiple orders are used to equal 30ml/kg
    - If a single order is written for the 30ml/kg, then abstract the date/time the first liter was started

8/17/2016

Sue Trikha RN,C CEN CPHQ Quality Dept
HMNH

8/17/2016
July 1, 2016 update for SEP-1 v5.1

- To meet criteria (pass), the 30ml/kg infusion cannot be stopped prior to the entire infusion being completed
- If a crystalloid infusion is increased from a “maintenance” rate (125ml/hr), you may count that fluid toward the 30ml/kg
- PlasmaLyte and Normosol are now acceptable as crystalloid fluids along with NS and LR
- The terms “wide open” or “bolus” are acceptable orders if the crystalloid fluid order is at least 30ml/kg and the route is IV
- Persistent hypotension - drop of >40mmHg
  - Physician documentation must be present in the MR indicating the decrease has occurred and is related to infection, severe sepsis or septic shock and not other causes
- Organ failure related to a decrease in the SBP
  - “a decrease in SBP associated with administration of a blood pressure medication is not acceptable as evidence of organ dysfunction”
- Cefotetan is added to Appendix C-Table 5.1
• If placement of central line or IO is refused consider this a refusal of vasopressors
• **If there is an attempt or multiple attempts to collect the blood culture, use the earliest date/time of the first attempt regardless of whether it was successful**
• CVP/ CV02
  – Start abstracting at the crystalloid fluid start time and stop abstracting 6hrs after presentation of septic shock time
• You may count crystalloid fluids that potassium, magnesium, calcium, lactate, acetate, or gluconate have been added (they don’t have to run at a rate >125ml/hr)
• Fluid Challenge performed is a rapid administration of at least 500ml - 1000ml over 15-30 minutes
• *Severe Sepsis Present* “consider using a medical dictionary” for conditions not listed in inclusion list
• Lactate results
  – If there is physician documentation that the initial lactate value is due to a condition that is not an infection, or is due to a medication, select value”1”
July 6, 2016 “Additional Notes” v5.1

- If there is physician documentation of septic shock and within 6 hours there is conflicting physician documentation indicating the patient does not have septic shock, choose value “2”

- Lactate results
  - If there is physician documentation that the initial lactate value is due to a condition that is not an infection, or is due to a medication, select value”1”

- Organ Dysfunction
  - For acute respiratory failure there must now be physician documentation of:
    • “acute respiratory failure” and
    • the patient was placed on BiPAP (CPAP) or intubation.
Key Take Away’s

• Physicians no longer have to perform certain tasks, but they still must document them
• You no longer must have blood cultures, but you must attempt to draw them and document
• For suspected c-difficile PO Vancomycin is ok
• Other reasons for elevated lactate when documented by a physician can exclude a case
Please raise your ‘hand’ icon and we will open up your line.

Be sure you have entered your pin #

-OR-

Type your question into the question pane and we will read it aloud.