Stopping Sepsis in Virginia Hospitals and Nursing Homes

Hospital Webinar #6 - Tuesday, December 19, 2017
I Have All This Data: What’s Next?

Tier 4 Implementation
Your Sepsis Support Team

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Objectives

- Discuss key milestones for TIER 4: Measuring Success and Continuous Improvement
- Review Core Measure changes for January, 2018
Infection Prevention

VAE (VAP) Bundle

BSI

CAUTI

Hand Washing

Early Screening with Tools and Triggers

Organizational Consensus that Severe Sepsis Must be Managed Early and Aggressively

Implementation of the Sepsis Bundles

Measuring Success CQI

Rapid Improvement

Sepsis Practice Collaborative Model
4 Tier Process for Program Implementation

Adapted from: Sepsis Solutions International

Documentation Improvement ~ Accurate Coding

1Continuous Quality Improvement
Tier IV: Measurement
Milestones and Checklist

• Define outcome and process data elements that will be collected
• Develop and implement a data collection process
• Revise and update goals and action plan as needed
• Execute implementation plan
• Continuous improvement
TO BE COMPLETED WITHIN 3 HOURS OF TIME OF PRESENTATION †:

1. Measure lactate level
2. Obtain blood cultures prior to administration of antibiotics
3. Administer broad spectrum antibiotics
4. Administer 30ml/kg crystalloid for hypotension or lactate $\geq$4mmol/L

† “time of presentation” is defined as the time of earliest chart annotation consistent with all elements severe sepsis or septic shock ascertained through chart review.
Time Zero

a. Will always be when the chart annotation suggests signs and symptoms are all present.

b. May be from nursing charting/screens, lab flow sheets, physician documentation, order sets, anything with a time stamp.

c. Will = triage time if all signs and symptoms are present at triage.

d. *It does not require MD documentation of the clock starting and relying on this alone in the ED would likely result in late clock starts.*

Sepsis coding is increasing but is accurate. More aggressive treatment seen from 2003 to 2013

TO BE COMPLETED WITHIN 6 HOURS OF TIME OF PRESENTATION:

5. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥65mmHg

6. In the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was ≥4 mmol/L, re-assess volume status and tissue perfusion and document findings according to table 1.

7. Re-measure lactate if initial lactate elevated.
DOCUMENT REASSESSMENT OF VOLUME STATUS AND TISSUE PERFUSION WITH:

Either:
• Repeat focused exam (after initial fluid resuscitation) by licensed independent practitioner including vital signs, cardiopulmonary, capillary refill, pulse and skin findings.

Or two of the following:
• Measure CVP
• Measure ScvO2
• Bedside cardiovascular ultrasound
• Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge
Data Collection

1. **Patient Log**
   1. Define how will find all patients that receive the bundles
   2. Real time data collection is optimal—then used as checklist to ensure patient receives all appropriate interventions

2. **Outcome**
   1. Mortality (ICU and Hosp)
   2. Hosp LOS
   3. Cost per case (total and direct)

3. **Process**
   1. Core Measures
   2. Data elements that measure implementation of 3 hour and 6 hour bundle
## How Your Collect Data Impacts Use

<table>
<thead>
<tr>
<th>How is Data Used</th>
<th>Prospective</th>
<th>Concurrent</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipatory review of patient record (can impact current care)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Data abstracted in real time or within 24 hours</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Serves as a prompt to execute bundle or the next phase of the bundle</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Recommended for new improvement teams</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recommended for advanced improvement teams or those that have demonstrated success with process measures</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Surviving Sepsis Campaign, Society of Critical Care Medicine, website accessed 1/26/2017
Common Challenge: Insufficient Feedback, Data and Accountability

Strategies:

**Sepsis Team (core group)**

a. Monthly multidisciplinary sepsis team meeting with consistent attendance
   - nursing and physician champions
   - lab, pharmacy, and radiology as needed

b. Accountable executive understands the role, holds team accountable and assists with problem-solving and removing barriers

c. **Timely feedback (data) to the team providing care to the sepsis patients**
Common Challenge: Insufficient Feedback, Data and Accountability

**Strategies:**

- Set goals/expectations for sepsis program
- Use examples of hospital patients in case studies for education of staff (good outcomes and bad)
- Review data at:
  - Sepsis team meeting
  - Quality meeting
  - Patient safety meeting
  - Unit based meetings
  - Medical staff/department meetings
  - Board meeting
- Provider specific data on compliance with bundle elements and patient outcomes, compared to the goal
- Individual case feedback based on case reviews
The purpose of this report is to give feedback on the below listed patient recently treated for Severe Sepsis/Septic Shock, and to emphasize the current quality improvement initiative related to Sepsis. We welcome your input and clinical expertise on opportunities that might help us improve on any of these measures.

Performing all the elements within the resuscitation bundles listed below in a timely manner can significantly reduce mortality of our Severe Sepsis and Septic Shock patients. Thank you for your dedication and care for these patients. If you have any questions, please contact Dr. __________________, MICU Sepsis Champion.

### Patient Information
- **Patient Name:** [Insert Patient Name]
- **FIN:** [Insert FIN]
- **ED Arrival Date & Time:** [Insert Date & Time]
- **ED RN:** [Insert ED RN]
- **ED Physician:** [Insert ED Physician]
- **ED Resident:** [Insert ED Resident]
- **Floor Arrival Date & Time & Unit:** [Insert Date & Time & Unit]
- **Pt Transferred From:** [Insert Information]
- **ICU Arrival Date & Time:** [Insert Date & Time]
- **Attending:** [Insert Attending's Name]
- **RN:** [Insert RN]
- **PRISM Score:** [Insert Score]
- **Severe Sepsis:** [Insert Information]
- **Septic Shock Time (Time Zero):** [Insert Information]
- **Severe Sepsis/Septic Shock Clinical Pathway:** [Insert Information]
- **Code Sepsis Paged:** [Insert Information]
- **Date/Time Criteria Infection:** [Insert Information]
- **Date/Time Criteria SIRS:** [Insert Information]
- **Date/Time Criteria Organ Dysf:** [Insert Information]

### Sepsis Quality Indicators

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Result</th>
<th>Goal Met (Y/N)</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3 Hour Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactic Acid</td>
<td></td>
<td></td>
<td>Drawn within 3h of Severe Sepsis (Look 66gs Prior)</td>
</tr>
<tr>
<td>Blood Cultures before Antibiotics</td>
<td></td>
<td></td>
<td>Drawn before ABX (Look 66gs Prior)</td>
</tr>
<tr>
<td>Broad-Spectrum Antibiotics</td>
<td></td>
<td></td>
<td>Hung within 3h of Severe Sepsis (Look 24hs Prior)</td>
</tr>
<tr>
<td>3mL/kg Fluid Bolus</td>
<td></td>
<td></td>
<td>As Fast As Possible. Infused within 3h of Severe Sepsis</td>
</tr>
<tr>
<td>Weight in kg:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Line Placed</td>
<td></td>
<td></td>
<td>Placed within 3h of Vasopressor Start</td>
</tr>
<tr>
<td>Requires Vasopressor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **6 Hour Measures** | | | |
| Vasopressor Started for SBP < 90 or MAP ≤ 60mmHg After Fluid Bolus | | | Started 1hr of Persistent Hypotension After Initial Fluid Bolus |
| CMS Requirement: Vasopressor Started for SBP < 90 or MAP ≤ 60mmHg After Fluid Bolus | | | CMS Requirement: Started within 6h of Septic Shock |
| Repeat Focused Exam by MD/AP (V/S, CD x 2, CVP, PA, Labs, Skin Findings, OR, X rays, KV, swCt, WBC, CBC, complete platelet, patients, PO volume, PO Optimization with Fluid Challenges/Every 8-12 hrs) | | | Documented within 6h of Septic Shock |
| Repeat Lactic Acid | | | Repeat within 6h of Time Zero ≥ 2 |

**Comments:** [Insert Comments]
LET’S BREAK IT DOWN!!!
Understand your Volume of Sepsis, Severe Sepsis and Septic Shock

Stratify your data by:
- POA, non-POA,
- Medical versus surgical,
- Discharge disposition
- Sepsis severity
Outcome
Mortality

a. Mortality by sepsis severity, POA vs non-POA

b. Look at volume of each sepsis severity
Outcome Data: LOS

Severity filter does not apply to mortality graphs (already stratified by severity or severity distribution).

Severity filter will only apply to LOS.

Severity:
- Severe
- Shock
- Simple
Overall SEP-1 Bundle Compliance

Initial Abx within 3 hrs
Hospital Measures: Comparison of Baseline to Re-Measurement

- All Sepsis Mortality: Baseline 14.7, Re-Measurement 14.1
- Sepsis Admissions: Baseline 12.0, Re-Measurement 12.5
- Sepsis Readmission Rate: Baseline 20.1, Re-Measurement 19.6
Hospital Self-Reported Measures

% of Total Recruited Hospital Sepsis Patients For Whom All Elements of the 3-Hr Sepsis Bundle Were Completed on Time

Jan-17  Feb-17  Mar-17  Apr-17  May-17  Jun-17  Jul-17  Aug-17  Sep-17
62.2%  67.6%  60.5%  66.7%  70.1%  66.9%  69.3%  82.7%  78.4%
# Hospital Self-Reported Measures

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Culture Rate</td>
<td>83.3%</td>
<td>86.8%</td>
<td>74.1%</td>
<td>81.0%</td>
<td>82.9%</td>
<td>86.0%</td>
<td>84.2%</td>
<td>89.0%</td>
<td>87.9%</td>
</tr>
<tr>
<td>Broad Spectrum Antibiotics Rate</td>
<td>86.8%</td>
<td>90.8%</td>
<td>79.8%</td>
<td>80.4%</td>
<td>86.6%</td>
<td>93.0%</td>
<td>87.7%</td>
<td>89.8%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Lactate Measure Rate</td>
<td>84.8%</td>
<td>80.8%</td>
<td>78.2%</td>
<td>92.3%</td>
<td>89.3%</td>
<td>89.8%</td>
<td>87.7%</td>
<td>92.9%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Second Lactate Completion Rate</td>
<td>77.3%</td>
<td>79.0%</td>
<td>81.3%</td>
<td>86.0%</td>
<td>79.8%</td>
<td>88.0%</td>
<td>87.9%</td>
<td>95.3%</td>
<td>88.3%</td>
</tr>
</tbody>
</table>

% of Total Recruited Hospital Sepsis Patients Completing 3-Hr Sepsis Bundle by Process Measure

- Blood Culture Rate: 83.3% to 87.9%
- Broad Spectrum Antibiotics Rate: 86.8% to 90.5%
- Lactate Measure Rate: 84.8% to 92.2%
- Second Lactate Completion Rate: 77.3% to 88.3%
Where is the Challenge?

With evidence of 3hr bundle completion in the high 80’s, why is mortality not changing?
Identify Gaps in Application of Evidence

a. Set performance targets
   a. IE: 90% compliance with obtaining lactates in 3 hours
   b. 100% screening in triage and nurses shift assessments

b. Prioritize area to work on first
   a. Focus on screening and the 3 hour bundle first then move to the 6 hour bundle

c. Understand the ‘why’ there are gaps
   a. “go and see”—walk the process, talk with front line staff
   b. Cause and effect—Fishbone

d. Define action plan—
   a. Can use IHI Model for Improvement
   b. PDCA—tests of change
Determining the Gaps: Understanding Why

- Success relies on a complex set of tasks being completed in a limited amount of time
- Requires data collection and analysis to determine the bottleneck(s)
- Must analyze the workflow for patients arriving in the ED as well as those who become septic after hospitalization
- QI/PI teams are a great resource when available
- Multiple tools have proven successful
- Some examples of diagnostic tools used for analysis, and the “therapeutic” tools developed out of the analysis
Go & See Walk...
Go & See Walk…

Purpose:
• Share experiences and learn from each other on site.
• Use as input to creating a Current State Map

Objectives:
• Provide a format to continue to collaborate during and after the redesign effort
• Understand a “system perspective” in care associated with sepsis
• Visualize the work and see problems that can be documented on a value stream map
• Complete a value stream map for sepsis identification and care
• Receive constructive feedback from people outside your department
What You Need to Begin the “Go See”

- Representative colleagues from your department
- Copies of your current state map template
- A proposed “tour” which illustrates the patient flow regarding sepsis care
- “Front line” colleagues who can speak to problems they are seeing and the challenges they are facing
Suggested Agenda

• Start at the beginning of the process where patients are introduced to the ED
• Walk the value stream in terms of the patient path for sepsis care
  • Allow the visitors to absorb “what they see”
  • Engage the identified colleagues to tell their view of the “story” of the journey that they are sharing
  • Share any visuals or specific tools/bundles you are using
• Allow the visitors to absorb what they see and hear, take notes.
Suggested Agenda

• Fill out the Current State Map as you proceed through the tour
• As you see or hear about work which appears to be wasteful, jot down the example you see.
• Proceed from the ED to the ICU and continue the tour with the same tasks
• Have everyone summarize what they are seeing to begin a discussion of:
  • What they have seen and how it relates to the problems of treating septic patients
  • How to capture thoughts on the mapping templates
Helpful Hints

• Feedback is better in the form of questions!
• Understanding how they think about solutions is more important than the solutions they come up with
• Expect “new eyes” to see things you have not. Be open to this as you can each other in the same way.
Current State Mapping Exercise

• Perform a “Go See” with ED and ICU staff and draw a Current State Map for the septic patient flow
  • Include Customer & Requirements, Supplier & Inputs, major steps, technology, information flow, rework loops, delays, and data boxes with job titles

• If there is no septic patient presenting, consider:
  • Interviewing the people who would be involved in the sequence of the septic patient flow: ask them to demonstrate what they would do if they were working with a septic patient
  • Simulating a patient: choose one of the staff to “be” a septic patient and observe the simulated treatment as the patient progresses to ICU management
Sepsis Patient Flow Template: Walk Ins

1. List the process steps below each box
2. For each process step include job title of persons performing the step
3. For each queue quantify the delay time (D/T)
4. Then total each to get L/T for the overall process

Supplier Inputs:

- Triage
  - Query Pt.
  - Perform Assessment

- ER Assess
- Diagnose
- Resuscitate

ICU

Customer Requirements:

- Total L/T to admit:
- % bundle use:
  - Labs:
  - Meds:
  - IV’s:
  - Monitoring:
  - CVP:
  - MAP:
  - ScvO2:
  - SV:
  - Echo:

If bundle is not used, describe these resuscitation components
Sepsis Patient Flow Template: Ambulance

1. List the process steps below each box
2. For each process step include job title of persons performing the step
3. For each queue quantify the delay time (D/T)
4. Then total each to get L/T for the overall process

If bundle is not used, describe these resuscitation components

% pt. screened: Total L/T to diagnosis: % bundle use:
- Labs:
- Meds:
- IV’s:
- Monitoring:
- CVP:
- MAP:
- ScvO2:
- SV:
- Echo:
Sepsis Patient Flow Template: ICU

1. List the process steps below each box
2. For each process step include job title of persons performing the step
3. For each queue quantify the delay time (D/T)
4. Then total each to get L/T for the overall process

- ER
- Admit to ICU
  - ICU D/T
  - Receive Report
  - Initiate Record
- ICU Assess
  - D/T
- Resuscitate
  - D/T
- Manage
  - D/T

Total L/T to admit:

Highlight the steps with the biggest issues

% bundle use:
- Labs:
- Meds:
- IV’s:

% bundle use:
- Monitoring:
  - CVP:
  - MAP:
  - ScvO2:
  - SV:
  - Echo:

If bundle is not used, describe these resuscitation components

Customer

Supplier Inputs:

Customer Requirements:
### Current State Issues

<table>
<thead>
<tr>
<th>Process Box &amp; Issue</th>
<th>Top 2 Reasons Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1a, 1b</td>
</tr>
<tr>
<td>2</td>
<td>2a, 2b</td>
</tr>
<tr>
<td>3</td>
<td>3a, 3b</td>
</tr>
<tr>
<td>4</td>
<td>4a, 4b</td>
</tr>
</tbody>
</table>
Cause and Effect Diagram

Why is the initial 30ml/kg fluid bolus not being given

Themes:
1. Knowledge and comfort in using protocol
2. Accepting when physician doesn’t want to do protocol without going up chain of command
3. Fear of fluid in elderly, ESRD and CHF
4. Blame hypotension on other conditions
5. Unassertive RN staff

Communication
- Poor between residents and nursing staff
- Responses from physicians
- Physician aware and don’t respond and RN just accept it
- Communication breakdown RN-RN shift report
- Not sure what they received on another unit
- Takes too long for physician to come and see the patient

Policy
- Initial Fluid bolus (30ml/kg) not given in 3 hrs
- Staff busy with more than one patient
- Getting orders in and charting in MAR (should treat like a code and chart later)
- Physical support especially on shift
- Lack of documentation when fluid actually given

EMR
- New interns
- Staff not aware of sepsis protocol—doesn’t require physician order
- Unassertive RN staff—at advanced beginner stage
- Not properly using screening tool
- Fear of fluid overload of renal or CHF patients (RNs and doctors)
- Lack of education on appropriate fluid needed
- Physician not familiar with protocol and not consulting with codec
- Give fluid over long period of time or just increase IV rate

Material
- Lack of IV access
- Appropriate labs not drawn/ordered
- Appears cardiogenic not septic
- “this BP has been low before” accept low BP as normal
- Unsure of baseline BP
- Delay in identifying change in condition
- Infection not suspected—other causes pursued
- Blame hypotension on other conditions or source (e.g. sedation)
- Physician pushback
- Nurse/doctor hesitant because being diuresed
- Patient who hover or have unclear presentation

People/knowledge
- Need to elicit support of CNL and charge nurse/ nurse coordinators

Process/critical thinking
Infection Prevention

VAE (VAP) Bundle

Early Screening with Tools and Triggers

Organizational Consensus that Severe Sepsis Must be Managed Early and Aggressively

Implementation of the Sepsis Bundles

Measuring Success

CQI\(^1\)

Rapid Improvement

Hand Washing

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VAE (VAP) Bundle
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Documentation Improvement
~ Accurate Coding

Adapted from: Sepsis Solutions International

\(^1\)Continuous Quality Improvement
### Sepsis Program Action Plan

<table>
<thead>
<tr>
<th>Item</th>
<th>Responsibility</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assemble team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identify executive sponsor</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Educate team on evidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Project Charter</td>
<td></td>
<td></td>
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<tr>
<td>5. Baseline data</td>
<td></td>
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<tr>
<td>6. Define screening tool and process— for ED, ICU, Floor, RRT</td>
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<tr>
<td>7. Define screening audit process</td>
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<tr>
<td>8. Develop triggers/processes to alert staff when time to move from first 3 hrs to shock bundle</td>
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<tr>
<td>9. Develop &amp; implement an educational plan for all staff:</td>
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<tr>
<td>10. Develop an implementation plan</td>
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<tr>
<td>11. Data measurement &amp; feedback</td>
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</tbody>
</table>
Algorithm

• Data elements reordered in the algorithm to first abstract *Broad Spectrum or Other Antibiotic Administration, Blood Culture Collection, then Initial Lactate Level Collection.*

Criteria for SIRS

• *Documentation defining the abnormal value can be disregarded: Thrombocytopenia due to chemo, exclude plts. Afib with tachycardia or RVR, exclude HR.*

• *SIRS criteria or organ dysfunction due to an acute or acute on chronic condition the criteria value should be used*
Fluid

- **Crystalloid Fluid Administration-** Don’t abstract CF started more than 6 hrs prior to Initial LA result = 4 or physician documentation of septic shock. For initial hypotension, only abstract CF started 6 hrs prior and 3 hrs after initial hypotension.

- Fluid given prior to arrival (ambulance, nursing home) that is part of MR does not require an order but must have type, volume, start time, and either rate, duration or end time to count toward CF.

- OR fluids do not require order if type, start time, rate or end time.

IV Fluid Determination for Patients with Obesity

- 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.

- There must be clear documentation that the clinician stated that IBW will be the weight used to determine the 30 mL/kg as the target ordered volume.
Acceptable Fluid

- **Isolyte** added to the inclusion guidelines as acceptable for abstraction.

- The bullet point indicating to not abstract crystalloid fluids that are used to give medications such as antibiotics was removed.

- Crystalloid fluid volumes used to deliver or dilute antibiotics can be counted toward the 30 mL/kg target volume.

- Crystalloid fluids administered through intraosseous (IO) route are now acceptable for this data element.

Refusal of Fluid:

- Physician/APN/PA or nursing documentation indicating patient or decision-maker has refused IV fluid administration prior to or within 6 hours following presentation of septic shock can be used to select value “4”
Hypotension

- *Initial Hypotension - Requires 2 low readings in the timeframe, does not need to be consecutive. Do not use BP’s in OR*
- Persistent Hypotension - following target ordered volume, If more than 1 reading in the one hr after, look at only last 2 readings and use specs guidance, Do not use BP’s in OR
- Do not use hypotension or low blood pressure (SBP <90 mmHg or MAP <65 mmHg) if there is physician/APN/PA documentation prior to or within 24 hours after Severe Sepsis Presentation Time indicating it is due to the following:
  - Normal for that patient
  - Is due to a chronic condition
  - Is due to a medication
Organ Dysfunction

- Creatinine: Documentation of ESRD with HD or PD, exclude creat. Documentation of CKD and baseline creat, creat values 0.5 above baseline can be excluded.
- INR/PTT: If below documented meds, exclude INR/PTT.

Table 5.3: Anticoagulants, Sepsis

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heparin</td>
<td>Heparin</td>
</tr>
<tr>
<td>Edoxaban</td>
<td>Savaysa</td>
</tr>
<tr>
<td>Desirudin</td>
<td>Iprivask</td>
</tr>
<tr>
<td>Dabigatran etexilate</td>
<td>Pradaxa</td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>Xarelto</td>
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<tr>
<td>Apixaban</td>
<td>Eliquis</td>
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<tr>
<td>Argatroban</td>
<td>Argatroban</td>
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<tr>
<td>Bivalirudin</td>
<td>Angiomax</td>
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<tr>
<td>Fondaparinux</td>
<td>Arixtra</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Coumadin</td>
</tr>
</tbody>
</table>
Contact Information

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