OHIO HOSPITAL ASSOCIATION

A RECEIVING HOSPITAL'S PERSPECTIVE ON HOSPITAL TRANSFERS OF SEPSIS PATIENTS

August 19, 2020

CONTINUING EDUCATION

- The link for the evaluation of today's program is: https://www.surveymonkey.com/r/Sepsis-8-19-2020

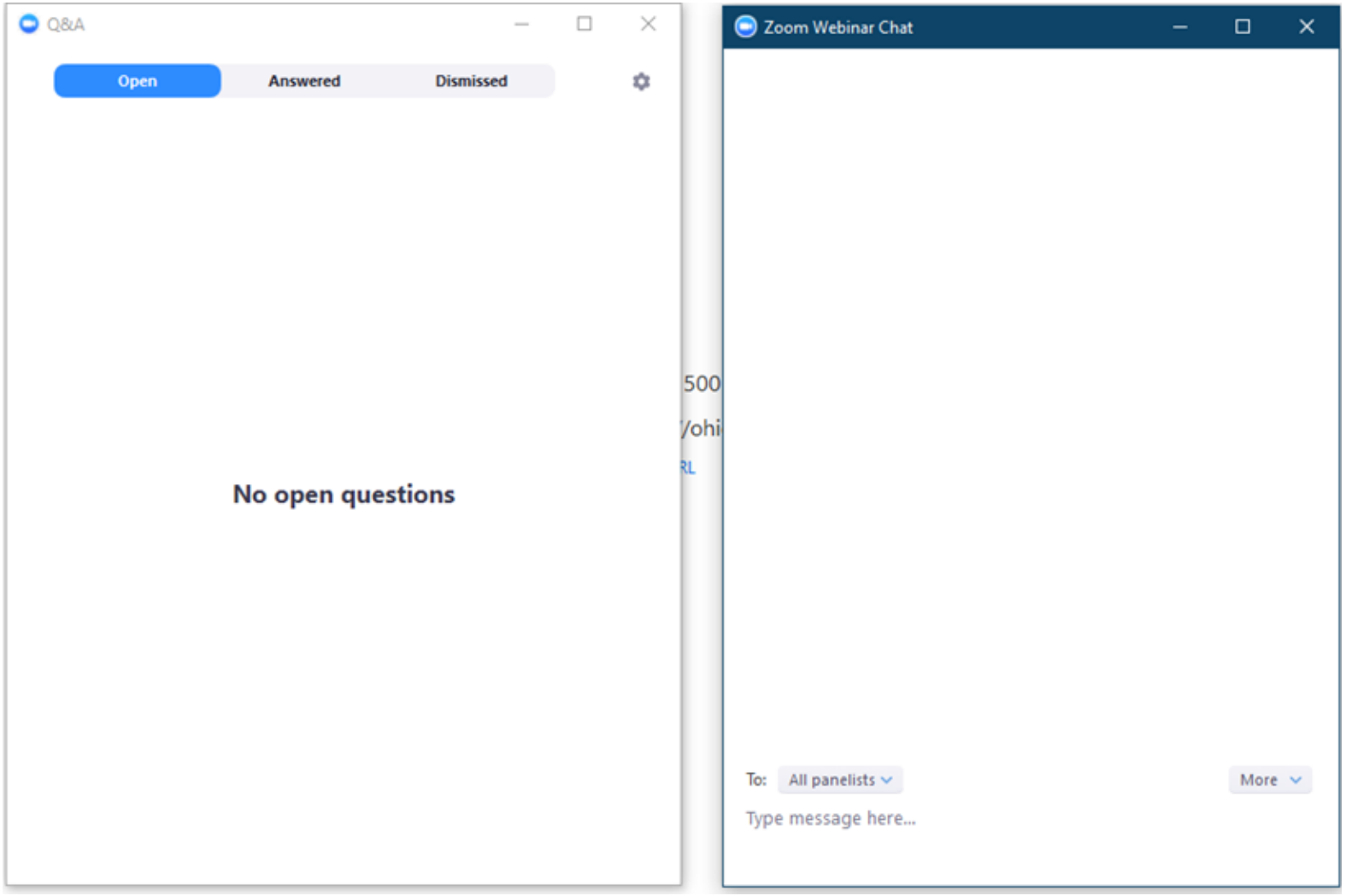
- Please be sure to access the link, complete the evaluation form, and request your certificate. The evaluation process will remain open **two weeks** following the webcast. Your certificate will be emailed to you when the evaluation process closes **after** the 2 week process.

- If you have any questions please contact Dorothy Aldridge (Dorothy.Aldridge@ohiohospitals.org)

SEPSIS WEBSITE

ohiohospitals.org/sepsis

SUBMITTING QUESTIONS



The Sepsis Alliance Summit

September 16 - 17, 2020

- **Free** virtual event
- 2 days of learning with presentations from clinicians, thought leaders, topic experts
- Nursing continuing education contact hours

Register at SepsisSummit.org

Opportunity for healthcare providers, managers, policymakers, and industry leaders to explore a range of sepsis-related topics including:

▪ *viral sepsis* ▪ *COVID-19* ▪ *healthcare inequities* ▪
▪ *antimicrobial stewardship* ▪ *SEP-1* ▪ *spiritual care* ▪

SPEAKERS

Jaclyn Carr, MSN, RN, PCCN
Director of Inpatient Nursing
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Davina Martin, MSN, BSN, RN
Adm. Nurse Manager
OhioHealth Transfer Center &
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Leigh Anne Germani, MSN, RN
Director of Emergency Services
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Emily Walker, BSN, RN
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Matthew Majzun, DO
Pulmonary & Critical Care Medicine
Physician
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Amy Wheeler, BSN, RN
Clinical Educator/Staff RN
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Dept

Kimlyn Queen-Weis, MS, MBA, CRA, FAHRA
Dir Operations, Patient Logistics Services
(Transfer Center)
Dir Operations, Virtual health & Telehealth
Srvs.

KEY CONSIDERATIONS

What are some key issues that sending hospitals and transporters of sepsis patients need to be aware of that reflect the perspective of the receiving hospital?

KEY CONSIDERATIONS

What is a “transfer center”?

KEY CONSIDERATIONS

Walk us through an example of how a transfer into the health system occurs (ex. 51 y. o. male s/p prostate biopsy 3 days ago with general malaise, elevated temp, now increasing HR and weakness, increasing lethargy)

CHALLENGES

Describe the unique challenges of a receiving hospital for sepsis patients? (bed availability, recognition of sepsis vs. other condition, location for placement – ICU, step down, gaps in handoff report as to interventions completed/attempted (labs, ATB, fluids), the simple things that don't arrive with the patient (films).

EFFECTIVE PRACTICES

Please share some effective practices that others may benefit from knowing (ED bedside handoff w/EMS present less than 3 min, etc. – example of when it worked well and example of when it did not work well – what could have been done differently to improve it) – and – (questions in the ED module that are useful for timely, accurate recognition and treatment of sepsis)

LESSONS LEARNED

Are there any lessons learned to share? (teaching opportunities, communication barriers)

TOOLS

- Vasopressor and Inotrope Infusion via Peripheral IV Administration
- CC Sepsis Card Severe Sepsis
- Sepsis BPA Follow Up
- Sepsis TL DR
- Sepsis Screen Tool CC

Sepsis Case Study:	88 y/o female transferred from out lining hospital for evaluation. Per medic report pt being transferred to ED for admission to ICU for SOB. Medic's report pt received fluids and ATB at transferring facility, unsure of when given or how long pt was in facility prior to transfer.
	Pt arrives with paperwork from outlining facility, has 1 peripheral IV, on CPAP, is alert and awake, but slightly combative.
	Vital Signs: Temp 101.6, BP: 79/51 RR: 31, HR 109 A-FIB and SPO2 is 94%
	ED perspective: patient needs additional access, when and what type of ATB did the patient receive? When and what type and how much fluid resuscitation did the patient receive. What has been the trend in VS, patients baseline versus current mental status. What other findings were found i.e. chest x-ray, ct scan, lab work. Gaps in report/clear and organized communication from provider to provider is important so delays in patients care does not occur. After looking through pt's chart if sent from outline Hospital and transfer center notes. Pt received 2g of Vancomycin and 4.5g of Zosyn completed 2 hours PTA and 2 liters of 0.9 NS. Arrives with no fluid hanging and remains hypotensive. Per evaluation of chart pt has been at outlining facility for 5 hours prior to transport. Pt is 90KG
	Pt needs CVC placement for initiation of vasopressors
	Pt per 30ml/kg needs additional fluids potentially
	Pt will be admitted to ICU, nurse to nurse bedside report completed.

OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

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