Complete and detailed information is available in the Specifications Manual located on QualityNet (www.QualityNet.org) under the Hospital Inpatient Tab.

Medication Tables & Miscellaneous Charts

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Inpatient Quality Reporting

Quick Reference Guide

Clinical Measures Education
AMI ● HF ● PN ● IMM ● ST ● VTE ● PC ● SCIP

CMS Quality Measures with Tips to Excel

2014

Measure and Improve—Each Patient Every Time

This material was produced by AQAF, the Medicare Quality Improvement Organization (QIO) for Alabama, under contract with the Centers for Medicare & Medicaid (CMS), an agency of the US. Department of Health and Human Services. Contents do not necessarily reflect CMS policy.

10SOW-AL-C7-14-119
ACUTE MYOCARDIAL INFARCTION

Aspirin at Discharge: [Voluntary]
Prescribe at discharge or document reason for No aspirin at discharge.
Documentation must clearly indicate aspirin is being prescribed at discharge.
Reasons:
- Allergy
- Coumadin/warfarin or Pradaxa/dabigatran at discharge
- Other explicitly documented reason by MD/APN/PA/Pharmacist

Fibrinolytic Therapy: (Fibrinolysis/Reperfusion)
[If provided w/in 6hrs of hospital arrival & is primary reperfusion therapy]
Clear documentation is important: Applies to patients with ST-segment elevation/LBBB noted on ECG performed closest to arrival.
Give w/in 30 min of hospital arrival or *document reason for the delay.
Reasons:
- Balloon pump; Cardiopulmonary arrest; Intubation
  [Automatic - If occurred w/in 30 min after hosp arrival]
- Pt/Caregiver refusal [No further documentation needed]
- Other reasons that include BOTH the notation of delay + underlying (non-system) reason

Primary PCI: (PCI/Reperfusion/Cath/Transfer to Cath Lab)
[If performed w/in 24hrs of hospital arrival] - Clear documentation is important: Applies to patients with ST-segment elevation/LBBB noted on ECG performed closest to arrival.
Perform w/in 90 min of hospital arrival or *document reason for delay.
Reasons:
- Balloon pump; Cardiopulmonary arrest; Intubation
  [Automatic - If occurred w/in 90 min after hosp arrival]
- Pt/Caregiver refusal [No further documentation needed]
- Other reasons that include BOTH the notation of delay + underlying (non-system) reason
  *Only MD/PA/APN documentation.

Statin (or HMG CoA reductase inhibitors) Prescribed at Discharge: [Voluntary]
Prescribe at discharge or document reason for No statin at discharge.
Documentation must clearly indicate the medication (listed by name) is being prescribed at discharge.
Reasons:
- Allergy to or complication related to statins
  - Other explicitly documented reason by MD/APN/PA/Pharmacist, i.e., statins contraindicated due to:

VTE Prophylaxis Options for Surgery — 2008 American College of Chest Physicians

Intracranial Neurosurgery
Any of the following:
- Intermittent pneumatic compression devices (IPC) with or without graduated compression stockings (GCS)
- Low-dose unfractionated heparin (LDUH)
- Low molecular weight heparin (LMWH)
- LDUH or LMWH combined with IPC or GCS

General Surgery
Any of the following:
- Low-dose unfractionated heparin (LDUH)
- Low molecular weight heparin (LMWH)
- Factor Xa Inhibitor
- Intermittent pneumatic compression devices (IPC)

Gynecological Surgery
Any of the following:
- Low-dose unfractionated heparin (LDUH)
- Low molecular weight heparin (LMWH)
- Factor Xa Inhibitor
- Intermittent pneumatic compression devices (IPC)
  - LDUH or LMWH or Factor Xa Inhibitor combined with IPC or GCS

Urologic Surgery
Any of the following:
- Low-dose unfractionated heparin (LDUH)
- Low molecular weight heparin (LMWH)
- Factor Xa Inhibitor
- Intermittent pneumatic compression devices
  - LDUH or LMWH or Factor Xa Inhibitor combined with IPC or GCS

Elective Total Knee / Total Hip Replacement
Any of the following within 24 hours of surgery:
- Low molecular weight heparin (LMWH)
- Factor Xa Inhibitor
- Oral Factor Xa Inhibitor
- Warfarin
- Intermittent pneumatic compression devices
- Venous foot pump (VFP)
- Low-dose unfractionated heparin (LDUH)
- Aspirin

Hip Fracture Surgery
Any of the following:
- Low-dose unfractionated heparin (LDUH)
- Low molecular weight heparin (LMWH)
- Factor Xa Inhibitor
- Warfarin
- Intermittent pneumatic compression devices (IPC)
- Aspirin

* Vancomycin is acceptable with a physician/APN/PA/pharmacist documented justification for its use (see data element Vancomycin). Documentation by an infection control practitioner is also acceptable it is specifically designated as “infection control” documentation
** For cardiac, orthopedic and vascular surgery, if the patient is allergic to beta-lactam antibiotics, Vancomycin or Clindamycin are acceptable substitutes.
*** A single dose of Ertapenem is recommended for colon procedures.
**** This combination should only be used in hospitals where surgical site infection surveillance demonstrates gram negative surgical infections resistant to first and second generation cephalosporins. It is recommended not to be used routinely.
SCIP—Inpatient Antibiotic Recommendations

The antibiotic regimens described in the table reflect the combined, published recommendations of the American Society of Health-System Pharmacists, the Medical Letter, the Infectious Disease Society of America, the Sanford Guide to Antimicrobial Therapy 2009, and the Surgical Infection Society. Information reflects the Centers for Medicare & Medicaid Services (CMS)/The Joint Commission (TJC) Specifications Manual for discharges 01/01/14 (1Q14) - 09/30/14 (3Q14).

<table>
<thead>
<tr>
<th>Surgical Procedure</th>
<th>Prophylactic Antibiotic Regimens</th>
<th>Antibiotics for β-lactam Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG, Other Cardiac or Vascular</td>
<td>Cefazolin or Cefuroxime or Vancomycin*</td>
<td>Vancomycin** or Clindamycin**</td>
</tr>
<tr>
<td>Hip/Knee Arthroplasty</td>
<td>Cefazolin or Cefuroxime Or Vancomycin</td>
<td>Vancomycin or Clindamycin</td>
</tr>
<tr>
<td>Colon</td>
<td>Cefotetan, or Cefoxitin, Ampicillin/Sulbactam or Ertapenem*** or Metronidazole + Cefazolin or Metronidazole + Cefuroxime Metronidazole*** + Ceftriazone</td>
<td>Clindamycin + Aminoglycoside or Clindamycin + Quinolone or Clindamycin + Aztreonam or Metronidazole + Aminoglycoside or Metronidazole + Quinolone</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Cefotetan or Cefazolin, or Cefoxitin or Cefuroxime or Ampicillin/Sulbactam</td>
<td>Clindamycin + Aminoglycoside or Clindamycin + Quinolone or Clindamycin + Aztreonam or Metronidazole + Aminoglycoside or Metronidazole + Quinolone</td>
</tr>
<tr>
<td>Principal Procedure Code of Abdominal Hysterectomy with an Other Procedure Code of Colon Surgery Or Vaginal Hysterectomy with an Other Procedure Code of Colon Surgery</td>
<td>Cefotetan or Cefazolin or Cefoxitin or Cefuroxime or Ampicillin/Sulbactam OR Ertapenem***</td>
<td>Clindamycin + Aminoglycoside or Clindamycin + Quinolone or Clindamycin + Aztreonam or Metronidazole + Aminoglycoside or Metronidazole + Quinolone or Vancomycin + Aminoglycoside or Vancomycin + Aztreonam or Vancomycin + Quinolone</td>
</tr>
</tbody>
</table>

**More common reasons. Must be linked to no statins prescribed.**

**Excludes:** Patients with an LDL < 100 mg/dL [either direct or calculated] within 24 hours after hospital arrival or 30 days prior to hospital arrival and not discharged on a statin.

**Special Note:** Comfort Measures Only excludes cases from all measures except lytic and PCI.

**Aspirin at Arrival: [Voluntary]**

Give within 24 hours before or after arrival or document reason for No aspirin on arrival.

Note regarding 24 hrs. prior to arrival: For patients received as transfers, documentation must be clear that ASA was received within 24 hours of arrival or was a current medication at the transferring facility.

Reasons: • Allergy
  • Pre-arrival Coumadin/warfarin or Pradaxa/dabigatran
  • Other explicitly documented reason by MD/PA/APN/Pharmacist

**ACEI/ARB at Discharge for LVSD: [Voluntary]**

Prescribe EITHER at discharge for patients with < 40% EF or moderate/severe LVSD; or document reason for No ACEI AND No ARB at discharge.

Documentation must clearly indicate the medication (listed by name) is being prescribed at discharge.

Reasons: • Allergy
  • Moderate or severe aortic stenosis [Counts for BOTH]
  • Other explicitly documented reason by MD/APN/PA/Pharmacist
  • MD/APN/PA/Pharmacist documentation that either an ACEI or an ARB was not given due to one of the following 5 conditions [Counts for BOTH]:
    1. Angioedema
    2. Hyperkalemia
    3. Hypotension
    4. Renal artery stenosis
    5. Worsening renal function/renal disease/dysfunction

A Conditional Hold with parameters (re: BP) counts as a reason IF there is documentation that the ACEI/ARB was held due to the specified parameters.
Beta-Blocker at Discharge: [Voluntary]

Prescribe at discharge or document reason for No beta-blocker at discharge. Documentation must clearly indicate the medication (listed by name) is being prescribed at discharge.

Reasons:
- Allergy
- 2nd or 3rd degree heart block on ECG on arrival or during stay w/o pacemaker
- Other explicitly documented reason [including Bradycardia] by MD/APN/PN/Pharmacist
- A Conditional Hold with parameters (re: HR or BP) counts as a reason IF there is documentation that the beta-blocker held due to the specified parameters.

HEART FAILURE

Discharge Instructions: [Voluntary]

(For patients discharged to home/homecare/court or law enforcement)

Must Address All Components:
1. Activity
2. Diet
3. F/U Appointments (no PRN)
4. Weight Monitoring
5. HF Symptoms Worsening
6. Discharge Medications

Important: All discharge medications should be noted clearly and accurately in the chart and listed in the Discharge Instructions.

Give discharge instructions to patient/caregiver. (Documentation must verify)

Evaluation of LVS Function:
* Evaluate LVS function prior to arrival (no time limit), during stay, or definitively plan evaluation after discharge.
Otherwise, **document a reason for Not evaluating.
* Includes documentation of LVSF. Note: Document clearly.
**MD/APN/PA documentation only.

ACEI/ARB at Discharge for LVSD: [Voluntary]

Prescribe EITHER at discharge for patients with < 40% EF or moderate/severe LVSD; or document reason for No ACEI AND No ARB at discharge. See ACEI/ARB Table 1 & 2 in appendix.

Documentation must clearly indicate the medication (listed by name) is being prescribed at discharge.

VTE Prophylaxis Inclusion Table (Continued)

<table>
<thead>
<tr>
<th>VTE Prophylaxis</th>
<th>Inclusion/Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Dose Unfractionated Heparin (LDUH)</strong></td>
<td>HEP; Heparin; Heparin NA; Heparin Sod; Heparin Sodium</td>
</tr>
<tr>
<td>Include only Heparin given by the subcutaneous (SQ, Subcu, SC, SubQ) route</td>
<td>Heparin Sodium Inj.; Heparin Sodium. Pork</td>
</tr>
<tr>
<td><strong>Low Molecular Weight Heparin (LMWH)</strong></td>
<td>Dalteparin</td>
</tr>
<tr>
<td></td>
<td>Enoxaparin</td>
</tr>
<tr>
<td></td>
<td>Fragmin</td>
</tr>
<tr>
<td></td>
<td>Innohep</td>
</tr>
<tr>
<td></td>
<td>Lovenox</td>
</tr>
<tr>
<td></td>
<td>Tinzaparin</td>
</tr>
<tr>
<td><strong>Intermittent Pneumatic Compression Device (IPC)</strong></td>
<td>AE pumps (anti-embolic pumps) - calf/thigh</td>
</tr>
<tr>
<td></td>
<td>DVT boots—calf/thigh</td>
</tr>
<tr>
<td></td>
<td>EPC cuffs/stockings—External pneumatic compression—calf/thigh</td>
</tr>
<tr>
<td></td>
<td>Intermittent pneumatic compression stockings</td>
</tr>
<tr>
<td></td>
<td>Intermittent pneumatic compression device (ICD)</td>
</tr>
<tr>
<td></td>
<td>Leg pumps</td>
</tr>
<tr>
<td></td>
<td>Pneumatic intermittent impulse compression device</td>
</tr>
<tr>
<td></td>
<td>Rapid inflation asymmetrical compression (RIAC) devices</td>
</tr>
<tr>
<td></td>
<td>Sequential compression device; Sequential pneumatic hose</td>
</tr>
<tr>
<td></td>
<td>Thrombus pumps—calf/thigh</td>
</tr>
<tr>
<td><strong>Venous Foot Pump</strong></td>
<td>AE pumps—foot only; Foot pump</td>
</tr>
<tr>
<td></td>
<td>Plantar Venous Plexus pump—foot only</td>
</tr>
<tr>
<td></td>
<td>SC boots—foot only; SCD boots—foot only</td>
</tr>
<tr>
<td><strong>Aspirin</strong></td>
<td>Acetylsalicylic Acid (ASA)³</td>
</tr>
<tr>
<td></td>
<td>Aspirin/caffeine³</td>
</tr>
<tr>
<td></td>
<td>Buffered aspirin³</td>
</tr>
<tr>
<td></td>
<td>Coated Aspirin³</td>
</tr>
<tr>
<td></td>
<td>Enteric coated aspirin (EC ASA)³</td>
</tr>
</tbody>
</table>

¹The USFDA has approved Eliquis (apixaban) to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
²The USFDA has approved Xarelto (rivaroxaban) to reduce the risk of blood clots, deep vein thrombosis (DVT), and pulmonary embolism (PE) following knee or hip replacement surgery only. It is additionally approved: to reduce the risk of stroke in patients with non-valvular atrial fibrillation; for treatment of DVT or PE; to reduce the risk of recurrent DVT and PE following initial treatment.
³American College of Chest Physicians Evidence-Based Clinical Practice Guidelines recommend aspirin (Grade 1b) to reduce the risk of venous thromboembolism in patients undergoing total hip or knee arthroplasty.
**Beta-Blockers**

<table>
<thead>
<tr>
<th>Acebutolol</th>
<th>InnoPran XL</th>
</tr>
</thead>
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<tr>
<td>Atenolol</td>
<td>Labetalol</td>
</tr>
<tr>
<td>Atenolol/chlorthalidone</td>
<td>Levatol</td>
</tr>
<tr>
<td>Betapace</td>
<td>Lopressor</td>
</tr>
<tr>
<td>Betapace AF</td>
<td>Lopressor HCT</td>
</tr>
<tr>
<td>Betaxolol</td>
<td>Metoprolol</td>
</tr>
<tr>
<td>Bisoprolol</td>
<td>Metoprolol/ hydrochlorothiazide</td>
</tr>
<tr>
<td>Bisoprolol fumarate</td>
<td>Metprolol Tartrate/ hydrochlorothiazide</td>
</tr>
<tr>
<td>Bisoprolol/hydrochlorothiazide</td>
<td>Nadolol</td>
</tr>
<tr>
<td>Breviboc</td>
<td>Nadolol/bendrofluemethazide</td>
</tr>
<tr>
<td>Bystolic</td>
<td>Nebivolol</td>
</tr>
<tr>
<td>Carvedilol</td>
<td>Nebivolol HCL</td>
</tr>
<tr>
<td>Coreg</td>
<td>Nebivolol Hydrochloride</td>
</tr>
<tr>
<td>Corgard</td>
<td>Penbutolol</td>
</tr>
<tr>
<td>Corzide 40/5</td>
<td>Pindolol</td>
</tr>
<tr>
<td>Corzide 80/5</td>
<td>Propranolol</td>
</tr>
<tr>
<td>Esmolol</td>
<td>Propranolol Hydrochloride</td>
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<tr>
<td>Inderal</td>
<td>Propranolol/ hydrochlorothiazide</td>
</tr>
<tr>
<td>Inderal LA</td>
<td>Sectral</td>
</tr>
<tr>
<td>Inderide</td>
<td>Sorine</td>
</tr>
<tr>
<td>Levatol</td>
<td>Sotalol</td>
</tr>
<tr>
<td>Lopressor</td>
<td>Sotalol HCL</td>
</tr>
<tr>
<td>Lopressor HCT</td>
<td>Tenoretic</td>
</tr>
<tr>
<td>Metoprolol</td>
<td>Tenormin</td>
</tr>
<tr>
<td>Metoprolol/ hydrochlorothiazide</td>
<td>Tenormin I.V.</td>
</tr>
<tr>
<td>Metprolol Tartrate/ hydrochlorothiazide</td>
<td>Timolol</td>
</tr>
<tr>
<td>Nadolol</td>
<td>Toprol</td>
</tr>
<tr>
<td>Nadolol/bendrofluemethazide</td>
<td>Toprol-XL</td>
</tr>
<tr>
<td>Nebivolol</td>
<td>Trandate</td>
</tr>
<tr>
<td>Nebivolol HCL</td>
<td>Trandate HCL</td>
</tr>
<tr>
<td>Nebivolol Hydrochloride</td>
<td>Zebeta</td>
</tr>
<tr>
<td>Penbutolol</td>
<td>Ziac</td>
</tr>
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</table>

**VTE Prophylaxis Inclusion Table**

<table>
<thead>
<tr>
<th>VTE Prophylaxis</th>
<th>Inclusion/Synonyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coumadin/Warfarin</td>
<td>Coumadin, Jantoven, Warfarin, Warfarin Sodium</td>
</tr>
<tr>
<td>Graduated Compression Stockings (GCS)</td>
<td>Anti-embolism stockings, Anti-thrombosis stockings, Elastic support hose, Graduated compression elastic stockings, Surgical hose, White hose, Thrombosis stockings</td>
</tr>
<tr>
<td>Knee or thigh high</td>
<td>Arixtra, Fondaparinux sodium</td>
</tr>
<tr>
<td>Factor Xa Inhibitor</td>
<td>Arixtra, Fondaparinux sodium</td>
</tr>
<tr>
<td>Oral Factor Xa Inhibitor</td>
<td>Arixtra, Fondaparinux sodium, Eliquis, Rivaroxaban, Xarelto</td>
</tr>
</tbody>
</table>

**Reasons:**
- Allergy
- Moderate or severe aortic stenosis [Counts for BOTH]
- Other explicitly documented reason by MD/APN/PA/Pharmacist
- MD/APN/PA/Pharmacist documentation that either an ACEI or an ARB was not given due to one of the following five conditions [Counts for BOTH]:
  1. Angioedema
  2. Hyperkalemia
  3. Hypotension
  4. Renal artery stenosis
  5. Worsening renal function/renal disease/dysfunction
- A Conditional Hold with parameters (re: BP) counts as a reason IF there is documentation that the ACEI/ARB was held due to the specified parameters.  
  Special Note: Comfort Measures Only excludes cases from all measures.

**PNEUMONIA (CAP)**

**Blood Cultures Performed:**

1. **Patient Transferred or Admitted w/in 24hrs of Hospital Arrival to ICU** (due to PN or complications due to PN). Collect blood culture anytime from the day prior to arrival up to 24hrs after hospital arrival.
2. **ED** [Determined by clearly documented admit order]  
   *If blood culture is done, collect* blood culture prior to initial antibiotic.

**Initial Antibiotic Selection:**

Administer the initial antibiotic regimen w/in 24hrs of arrival in accordance to current antibiotic consensus recommendations.

**Must clearly document** to reflect actual administration with:

1. Antibiotic Name,  
2. Date of Administration,  
3. Time of Administration, and  
4. Route of Administration

Allowance is given when documentation reflects patient has another source of infection (w/in the 1st 24hrs of arrival), is compromised, or has healthcare associated PN.

**Note:** The only B-lactam allergy regime is for Non-ICU, pseudomonal risk patients.

**Special Note:** Comfort Measures Only excludes cases from all measures.
**ED THROUGHPUT**

**Median Time from ED Arrival to ED Departure for Admitted ED Patients:**
(Includes all patients discharged from acute care AND with a LOS less than or equal to 120 days)

*Excludes:* Patients who are not *ED patients*

Document in the **ED Record** the date and time when the patient physically left the ED. (Cannot use the time the discharge order was written, or the report called time.)

**Emphasis is placed on capturing the latest time the patient was receiving care in the ED, under ED services or awaiting transport.**

**Admit Decision Time to ED Departure Time for Admitted Patients:**
(Includes all patients discharged from acute care AND with a LOS less than or equal to 120 days)

Document in the **ED Record** the date and time the decision was made to admit the patient to the hospital as an inpatient. (The admit or disposition order date/time may be used).

Document in the **ED Record** the date and time when the patient physically left the ED. (Cannot use the time the discharge order was written, or the report called time.)

**Emphasis is placed on capturing the latest time the patient was receiving care in the ED, under ED services or awaiting transport.**

**IMMUNIZATIONS**

**Pneumococcal Immunization ("PPV23") [Voluntary]**
(Includes all patients discharged from acute care age 65 years and older AND ages 6 through 64 who are considered to have a LOS less than or equal to 120 days)

1. **Screen** patient 65 and older and 6 – 64 years of age with a high risk condition for vaccination status
2. **Vaccinate** patient prior to discharge if:
   a. Not previously vaccinated (Vaccines noted as “up-to-date” count.)
      **Do not use initial “UTD.”**
   b. No documented allergy (document exact complication)
   c. Not likely to be ineffective due to bone marrow transplant
   d. No radiation/chemotherapy currently being received as a scheduled dose, received during this stay or within two weeks prior to this stay
   e. No shingles (Zostavax) vaccination received within the past 4 weeks

---

**ACEIs**

<table>
<thead>
<tr>
<th>Accupril</th>
<th>Enalapril/hydrochlorothiazide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuretic</td>
<td>Enalaprilat</td>
</tr>
<tr>
<td>Aceon</td>
<td>Fosinopril</td>
</tr>
<tr>
<td>Altace</td>
<td>Fosinopril Sodium/hydrochlorothiazide</td>
</tr>
<tr>
<td>Benazepril</td>
<td>Lisinopril</td>
</tr>
<tr>
<td>Benazepril Hydrochloride</td>
<td>Lisinopril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Benazepril/amlodipine</td>
<td>Lotensin</td>
</tr>
<tr>
<td>Benazepril/hydrochlorothiazide</td>
<td>Lotensin HCT</td>
</tr>
<tr>
<td>Capoten</td>
<td>Lonotrol</td>
</tr>
<tr>
<td>Capozone</td>
<td>Mavik</td>
</tr>
<tr>
<td>Capozone 25/15</td>
<td>Moexipril</td>
</tr>
<tr>
<td>Capozone 25/25</td>
<td>Moexipril Hydrochloride</td>
</tr>
<tr>
<td>Capozone 50/15</td>
<td>Moexipril Hydrochloride/hydrochlorothiazide</td>
</tr>
<tr>
<td>Capozone 50/25</td>
<td>Moexipril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Captopril</td>
<td>Monopril</td>
</tr>
<tr>
<td>Captopril HCT</td>
<td>Perindopril</td>
</tr>
<tr>
<td>Captopril Hydrochlorothiazide</td>
<td>Perindopril Erbumine</td>
</tr>
<tr>
<td>Enalapril</td>
<td></td>
</tr>
<tr>
<td>Enalapril Maleate/hydrochlorothiazide</td>
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</tr>
</tbody>
</table>

**ARBs**

<table>
<thead>
<tr>
<th>Atacand</th>
<th>Exforge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atacand HCT</td>
<td>Exforge HCT</td>
</tr>
<tr>
<td>Avaside</td>
<td>Hyzaar</td>
</tr>
<tr>
<td>Avapro</td>
<td>Irbesartan</td>
</tr>
<tr>
<td>Azilsartan</td>
<td>Irbesartan/hydrochlorothiazide</td>
</tr>
<tr>
<td>Azilsartan/chlorothalidone</td>
<td>Losartan</td>
</tr>
<tr>
<td>Azilsartan/hydrochlorothiazide</td>
<td>Losartan/hydrochlorothiazide</td>
</tr>
<tr>
<td>Azilsartan/amlodipine</td>
<td>Micardis</td>
</tr>
<tr>
<td>Azilsartan/hydrochlorothiazide</td>
<td>Micardis HCT</td>
</tr>
<tr>
<td>Benzar</td>
<td>Olmesartan</td>
</tr>
<tr>
<td>Benicar HCT</td>
<td>Olmesartan/amloipine</td>
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<tr>
<td>Candesartan</td>
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<tr>
<td>Candesartan/hydrochlorothiazide</td>
<td>Olmesartan Medoxomil</td>
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<td>Cozaar</td>
<td>Olmesartan Medoxomil/amlodipine</td>
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<td>Diovan</td>
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<tr>
<td>Diovan HCT</td>
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<tr>
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<td>Valsartan</td>
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<tr>
<td>Edarbyclor</td>
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<tr>
<td>Eprosartan/amlodipine/hydrochlorothiazide</td>
<td>Valturna</td>
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<thead>
<tr>
<th>Tasosartan</th>
<th>Telmisartan</th>
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<tr>
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<td>Valsartan/hydrochlorothiazide</td>
<td>Valturna</td>
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</table>
Inpatient Pneumonia Antibiotic Recommendations

<table>
<thead>
<tr>
<th>ICU Patient</th>
<th>Non-ICU Patient</th>
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</thead>
<tbody>
<tr>
<td>Macrolide (IV) + either β-lactam (IV) or Antipseudomonal β-lactam (IV)</td>
<td>β-lactam (IV or IM) + Macrolide (IV or PO)</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>Antipseudomonal Quinolone (IV) + either β-lactam (IV) or Antipseudomonal β-lactam (IV)</td>
<td>Antipseudomonal Quinolone (IV) + either Antipseudomonal β-lactam (IV) or Macrolide (IV)</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>Antipseudomonal Quinolone (IV) + either β-lactam (IV) or Antipseudomonal β-lactam (IV)</td>
<td>β-lactam (IV or IM) + Doxycycline (IV or PO)</td>
</tr>
</tbody>
</table>

**β-lactam** = Ceftriaxone, Cefotaxime, Ampicillin/Sublactam, Ertapenem, Ceftefline

**Macrolide** = Erythromycin, Clarithromycin, Azithromycin

**Antipseudomonal Quinolones** = Levofloxacin, Moxifloxacin, Gemifloxacin

**Aminoglycoside** = Gentamicin, Tobramycin, Amikacin

**Tigecycline** + [Antipseudomonal Quinolone (IV)]

1. Levofloxacin should be used in 750 mg dosage when used in the management of patients with pneumonia.

2. Levofoxacin should be initiated within three hours of “time last known well.”

3. Patient/caregiver does not refuse

4. For patients six years of age or older: Did not receive a conjugate vaccine w/in the previous eight weeks

**Influenza Immunization:**

*Hospital is only responsible for immunization for discharges October through March.

1. **Screen** patients six months and older during current flu season when vaccine is available - October—March for vaccination status.

2. **Vaccinate** patient prior to discharge if:
   a. Not previously vaccinated this flu season
   b. No documented allergy to influenza vaccine; anaphylactic latex allergy or anaphylactic allergy to eggs (document exact complication)
   c. Not likely to be ineffective due to bone marrow transplant w/in the past 6 months
   d. No documented Guillian-Barre’ syndrome w/in six weeks after previous influenza vaccination
   e. Patient/caregiver does not refuse

**STROKE**

Thrombolytic Therapy for Acute Ischemic Stroke:

Thrombolytic therapy should be initiated for patients for ischemic stroke in the ED for patients who arrive at the hospital within two hours of “time last known well”. Therapy should be initiated within three hours of “time last known well.”

Clock stars with ARRIVAL date/time.

For example:

- Arrive two hours after “time last known well”, administer within one hour.
- Arrive one hour after “time last known well”, administer with two hours.

**Document clearly** and indicate the reason for not administering thrombolytic.

- Patient/family refusal;
- NIHSS score of zero;
- Initiation of IV or IA thrombolytic at a transferring hospital.

Nursing documentation of the above three reasons is acceptable.

Excludes: Patient with time “last known well” > 2 hours before ER arrival.
VTE Prophylaxis for Ischemic or Hemorrhagic Stroke:

Administer VTE prophylaxis for ischemic or hemorrhagic stroke patients on the day of admission or the day after admission;

**VTE prophylaxis includes:**
- Low dose unfractionated or low-molecular-weight heparin
- Graduated compression stockings (GCS)
- Intermittent pneumatic compression devices (IPC)
- Factor Xa inhibitors
  - Oral factor Xa inhibitors (Xarelto) requires LIP documentation of why it was administered—A Flutter, Hx of hip or knee replacement surgery, treatment of VTE
- Warfarin
- Venous Foot Pump

Stroke patients requires a documented reason for not administering another form of prophylaxis when graduated compression stockings (GCS) are the ONLY form of VTE prophylaxis administered.

For patients determined to be at risk for VTE and pharmacologic prophylaxis is contraindicated, evaluation for mechanical prophylaxis must be addressed.

Document clearly the reason for no VTE prophylaxis by the day after hospital admission; or surgery end date.

Document reason for no VTE prophylaxis such as:
- Patients low VTE risk—documented in notes or risk assessment form
- Continuous IV heparin day of or day after hospital admission
- On warfarin hold due to high INR
- Comfort measures day after arrival/admission or surgery end date
- Patient/family refusal

**Antithrombotic Therapy for Ischemic Stroke by End of Hospital Day 2:**

Administer antithrombotic therapy for patient with ischemic stroke by the end of hospital day 2.

**Document** reasons for not administering such as:
- Allergy to all approved medications, complications related to antithrombotic, aortic dissection, bleeding disorder, brain/CNS cancer, hemorrhagic CVA, extensive metastatic cancer, hemorrhage of any type, intracranial surgery/biopsy, patient/family refusal, peptic ulcer, planned surgery within 7 days following discharge, risk of bleeding, unrepaired intracranial aneurysm, or other documented reason by MD/

Document *Active Warming* intraoperative to maintain normothermia AND/OR at least 1 body temp ≥ 96.8F/36C 30 min prior to or 15 min after anesthesia end time; or Document **Intentional/Maintained Hypothermia** preoperatively.

**Documentation must reflect use during the perioperative period.**

**Anesthesia Start and Anesthesia End Times:** Represent the beginning and ending of Anesthesia for the principal procedure (or surgical episode if multiple procedures). It is recommended to view the Anesthesia Record as the priority source; but other sources may be used. If no inclusion terms/phrases are noted, alternative terms/phrases that best represent the time (e.g., “procedure start” or “to PACU”) may be used, starting with the Anesthesia Record.

**Medication Tables & Miscellaneous Charts**

**Fibrinolytic Agents**

<table>
<thead>
<tr>
<th>Activase</th>
<th>rPA (RPA)</th>
<th>Tissue Plasminogen Activator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alteplase</td>
<td>Streptase</td>
<td>TNKase</td>
</tr>
<tr>
<td>Retavase</td>
<td>Streptokinase</td>
<td>tPA (TPA)</td>
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<tr>
<td>Reteplase</td>
<td>Tenecteplase</td>
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**Statin Medications**

<table>
<thead>
<tr>
<th>Advicor</th>
<th>Fluvastatin</th>
<th>Lovastatin</th>
<th>Simcor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altoprev</td>
<td>Fluvastatin XL</td>
<td>Lovastatin/niacin</td>
<td>Simvastatin</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>Lescol</td>
<td>Mevacor</td>
<td>Simvastatin/ezetimibe</td>
</tr>
<tr>
<td>Atorvastatin/amlodipine</td>
<td>Lescol XL</td>
<td>Pitavastatin</td>
<td>Simvastatin/niacin</td>
</tr>
<tr>
<td>Crestor</td>
<td>Lipitor</td>
<td>Pravachol</td>
<td>Simvastatin/sitagliptin</td>
</tr>
<tr>
<td>Crestor</td>
<td>Livalo</td>
<td>Pravastatin</td>
<td>Vytorin</td>
</tr>
<tr>
<td>Crestor</td>
<td></td>
<td>Rosuvastatin</td>
<td>Zocor</td>
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**Stroke—Anticoagulants**

<table>
<thead>
<tr>
<th>Apixaban</th>
<th>Dalteparin</th>
<th>Heparin IV</th>
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<tbody>
<tr>
<td>Argatroban</td>
<td>Eliquis</td>
<td>Jantoven</td>
</tr>
<tr>
<td>Arixtra</td>
<td>Enoxaparin</td>
<td>Lepirudin</td>
</tr>
<tr>
<td>Coumadin</td>
<td>Fondaparinux</td>
<td>Lovenox</td>
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<tr>
<td>Dabigatran</td>
<td>Fragmin</td>
<td>Pradaxa</td>
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<tr>
<td>Dabigatran etexilate</td>
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<td>Refludan</td>
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<td></td>
<td></td>
<td>Rivaroxaban</td>
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<td>Warfrin</td>
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<tr>
<td></td>
<td></td>
<td>Warfarin Sodium</td>
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<tr>
<td></td>
<td></td>
<td>Xarelto</td>
</tr>
</tbody>
</table>
• Patient trauma
• Continuous IV heparin therapy within 24 hours before or after surgery

For Pharmacological Prophylaxis
• Active bleeding—GI bleeding; hemorrhagic CVA, retroperitoneal
• Bleeding risk, hemorrhage
• Thrombocytopenia
• Continuous IV heparin within 24 hours before or after surgery

Postoperative Urinary Catheter Removal
Remove indwelling urethral catheter on POD0 through POD2; or document reason on POD1 or POD2 for continuing catheter.
*POD 0 = Anesthesia End Date. POD 2 ends at midnight.

Urinary Catheter only applies to:
1. Indwelling urethral catheter
2. Inserted after arrival but prior to discharge from recovery/PACU
    And
3. Still in place upon discharge from **recovery/PACU
   (documented within 24hrs after anesthesia end time)

Acceptable reasons for not removing the urinary catheter postoperatively include:
• In ICU AND receiving diuretics; OR vasopressor/inotropics; OR paralytic therapy
   (One dose counts.)
• MD/APN/PA reason documented for continuing catheter postoperatively

Do Not Count: Physician orders alone (i.e., keep catheter); high risk of falls/any risk of falls
• A medical staff-approved facility urinary catheter protocol: There must be physician documentation on POD0, POD1 or POD2 ordering/instructing the nursing staff to follow the formal protocol AND documentation on POD1 or POD2 of a reason to continue catheterization in the protocol. The reason may be documented by a nurse.
• Patient refusal. The reason may be documented by a nurse.

Perioperative Temperature Management [Voluntary]
Consistency in temp documentation will be helpful.
• Includes ALL patients – pediatric included—regardless of age.
• Excludes patients who did not have neuraxial/general anesthesia.

APN/PA or pharmacist.

Stroke Discharge Measures

Antithrombotic Therapy at Discharge for Ischemic Stroke:
Ischemic stroke patients should be prescribed antithrombotic therapy at hospital discharge.

Excludes: patients <18 years; LOS < 2 days or >120 days, comfort measures documented the day of or day after hospital arrival; enrolled in clinical trials; admitted for elective carotid intervention; discharged to another hospital; left AMA; expired; discharged home or healthcare facility for hospice care; documented reason for not prescribing antithrombolytic.

Document reason for not prescribing antithrombotic at discharge such as:
• Allergy to all approved medications, complications related to antithrombotics, aortic dissection, bleeding disorder, brain/CNS cancer, hemorrhagic CVA, extensive metastatic cancer, hemorrhage of any type, intracranial surgery/biopsy, patient/family refusal, peptic ulcer, planned surgery within 7 days following discharge, risk of bleeding, unrepaired intracranial aneurysm, or other documented reason by MD/APN/PA or pharmacist.

Anticoagulation Therapy for Atrial Fibrillation/Flutter at Hospital Discharge:
Stroke patients with atrial fibrillation or flutter should be discharged on anticoagulation therapy at hospital discharge.

Excludes: patients <18 years; LOS < 2 days or >120 days, comfort measures documented the day of or day after hospital arrival; enrolled in clinical trials; admitted for elective carotid intervention; discharged to another hospital; left AMA; expired; discharged home or healthcare facility for hospice care; or documented reason for not prescribing antithrombolytic.

Reason for not prescribing antithrombotic at discharge include:
• Allergy to all approved medications, complications related to antithrombotics, aortic dissection, bleeding disorder, brain/CNS cancer, hemorrhagic CVA, extensive metastatic cancer, hemorrhage of any type, intracranial surgery/biopsy, patient/family refusal, peptic ulcer, planned surgery within 7 days following discharge, risk of bleeding, unrepaired intracranial aneurysm, or other documented reason by MD/APN/PA or pharmacist.
Discharged on Statin Medication for Ischemic Stroke

Ischemic stroke patients should be prescribed on statin medication at hospital discharge if:
- LDL > 100mg/dL; LDL not measured; or patient was on lipid-lowering medication prior to hospital arrival

Excludes: patients <18 years; LOS < 2 days or > 120 days, comfort measures documented the day of or day after hospital arrival; enrolled in clinical trials; admitted for elective carotid intervention; discharged to another hospital; left AMA; expired; discharged home or healthcare facility for hospice care; or documented reason for not prescribing statin medication at discharge.

Document reason for not prescribing statin medication at discharge such as:
- Statin medication allergy; hepatic failure; hepatitis; myalgias; patient/family refusal; rhabdomyolysis; or other reasons documented by MD/APN/PA, or pharmacist.

Stroke Education—Ischemic & Hemorrhagic

Patients and/or caregivers should be given educational material during the hospital stay addressing ALL of the following:
- Activation of medical system
- Need for follow-up with MD/APN/PA after discharge
- Names of ALL medications prescribed at discharge
- Risk factors for stroke
- What to do if warning signs and symptoms of stroke occur

Excludes: patients < 18 years; LOS < 2 days or > 120 days; comfort measures only documented the day of or day after hospital arrival, enrolled in clinical trial; or admitted for elective carotid intervention.

Ischemic & Hemorrhagic Stroke Assessed for Rehabilitation

Patients should be assessed or services initiated for rehabilitation services by the MD/physical therapy/occupational therapy/speech and language pathologist/physiatrist/neuropsychologist.

Excludes: patients < 18 years, LOS < 2 days or > 120 days, comfort measures only documented the day of or day after hospital arrival; enrolled in clinical trials; admitted for elective carotid intervention; discharged to another hospital; left AMA; expired; discharged to home/health care facility for hospice care.

- Treatment of syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH) of hyponatremia with Demeclocycline

Cardiac Surgery Patients with Controlled Postoperative Blood Glucose:

Monitor and control patient’s blood glucose to ≤ 180mg/dL between 18 and 24 hours after anesthesia end time.

Suggestion: Maintain and document blood glucose levels throughout the entire postoperative period.

Excludes: Burn patients, transplant patients and patients with preop infections

Beta-Blocker Therapy Patients Receiving Beta-Blocker During Perioperative Period:

Give to patient (on daily beta-blocker therapy prior to arrival) during the perioperative period (the day prior to surgery through POD 2); or document reason for Not giving beta-blocker periop.

Two (2) categories of evaluation based on LOS:
1. Patients with a LOS postoperatively < 2 days: Looking for documentation of administration the day prior or the day of surgery
2. Patients with a LOS postoperative 2 or more days: Looking for documentation of administration the day prior to or day of surgery AND POD 1 or POD 2

Document reason for not administering beta-blocker during perioperative period such as:
- Bradycardia [HR < 50];
- Hypotension [Systolic ≤ 100 mm/Hg]
- Concurrent use of intravenous inotropic medications during perioperative period
- Other reason by MD/PA/APN/Pharmacist.

VTE Prophylaxis Ordered and Received:

Administer recommended prophylaxis w/in 24hrs prior to anesthesia start to 24hrs after anesthesia end time; or document reason for Not administering both mechanical and pharmacological prophylaxis.

Document reason for not administering such as:
- Arterial insufficiency of lower extremities
- Bilateral amputee or bilateral lower extremity trauma
**PERINATAL CARE—PC 01**

**Elective Delivery Prior to 39 Weeks**
Includes vaginal delivery, medical induction of labor, or cesarean section.
Must have at least one condition possibly justifying elective delivery prior to 39 weeks or meet one of the stated exclusions
- a. Clinical trial
- b. Prior Uterine Surgery
- c. Gestational Age <37 or > 39 weeks
- d. Other documented reason for elective delivery

**Surgical Care Improvement (SCIP)**

Principal Procedure applied: CABG, Hip/Knee Arthroplasty, Colon, Hysterectomy, Vascular and Other Major Surgery

**Prophylactic Antibiotic Received Within One Hour Prior To Surgery:**
Administer w/in 1hr [or 2hrs if receiving Vancomycin or fluoroquinolone] prior to surgical incision.
**Must clearly document to reflect** actual administration with: 1. Antibiotic Name; 2. Date of Admin; 3. Time of Admin; 4. Route of Admin.
Document suspected/diagnosed infections clearly.

**Prophylactic Antibiotic Selection:**
Administer the recommended prophylactic antibiotics for specific surgical procedures.
**Must clearly document to reflect** actual administration with: 1. ABX Name; 2. Date of Admin; 3. Time of Admin; & 4. Route of administration.
- Document suspected/diagnosed infections clearly.

**Prophylactic Antibiotic Discontinued:**
Discontinue prophylactic antibiotics excluding Urinary Antiseptics w/in 24hrs (or 48hrs for CABG or Other Cardiac Surgery) of anesthesia end time or document reasons to extend antibiotics.

Reasons for extending antibiotics Includes as documented by MD/APN/PA:
- Treatment of Infection [currently diagnosed/suspected]
- Benign or malignant bone tumor of the same lower extremity on which the principal procedure of an original or revised arthroplasty was performed
- Use of erythromycin for increasing gastric motility
- Treatment of hepatic encephalopathy, pulmonary fibrosis, acne, or rosacea
- Prophylaxis against PCP for AIDS

**VENOUS THROMBOEMBOLISM—VTE**

**Venous Thromboembolism Prophylaxis:**
Patients should be given VTE prophylaxis the day of or the day after admission; OR the day of; or the day after surgery end date if surgery is started the day of or the day after admission or reason for no VTE prophylaxis documented.

- Documentation of the reason for no VTE prophylaxis must be written by the day after hospital admission, or surgery end date.
- For patients determined to be at risk for VTE and pharmacological prophylaxis is contraindicated, evaluation for mechanical prophylaxis must be addressed.

Reason for not administering any mechanical or pharmacologic prophylaxis include:
- Patient at low risk for VTE, explicit documentation by a MD/APN/PA or pharmacist that the patient does not need VTE prophylaxis, or patient/family refusal.

Reasons for not administering mechanical prophylaxis include:
- Bilateral amputee, bilateral lower extremity trauma, patient/family refusal, patients on IV heparin therapy

Reasons for not administering pharmacological prophylaxis include:
- Active bleeding, bleeding risk, hemorrhage, pt/family refusal, patients on IV therapy thrombocytopenia, received blood transfusion after arrival

**Excludes:** patients< 18 years, LOS > 120 days, comfort measures only on day of or day after hospital, enrolled in clinical trials, direct admission to ICU or transferred to ICU the day of or day after hospital admission with ICU LOS > 1 day, principal diagnosis of mental disorders or stroke, obstetrics or VTE, or SCIP VTE selected surgeries per specified tables.

**Intensive Care Unit VTE Prophylaxis**
Patients should be given VTE prophylaxis the day of or the day after admission (or transfer) to ICU OR the day of or the day after surgery end date if surgery is started the day of or the day after admission or reason for no VTE prophylaxis documented.

Reason for not administering any mechanical or pharmacologic prophylaxis include:
- Patient at low risk for VTE, explicit documentation by a MD/APN/PA or pharmacist that the patient does not need VTE prophylaxis, or patient/family refusal.

For patients determined to be at risk for VTE and pharmacological prophylaxis is contraindicated, evaluation for mechanical prophylaxis must be addressed.
Documentation of reason for no VTE prophylaxis must be written by the day after ICU
admission/transfer is acceptable. Patients that are transferred to ICU need documentation that the reason for no VTE prophylaxis is associated with the ICU transfer.

Excludes: patients < 18 years, LOS > 120 days, comfort measures only on day of or day after hospital, enrolled in clinical trials, patients with ICU > 1 day without VTE prophylaxis administered and documentation for no VTE prophylaxis, principal diagnosis of mental disorders or stroke, obstetrics or VTE, or SCIP VTE selected surgeries per specified tables that start the day of or the day after ICU admission or transfer.

Hospital Acquired Incidence of Potentially Preventable VTE

VTE Diagnosis—Documentation should clearly indicate if VTE diagnosis was suspected on admission by the MD/APN/PA. Patient should receive VTE prophylaxis prior to VTE diagnostic test order date. It is important that a reason for no VTE prophylaxis be documented.

VTE Patients with Anticoagulation Overlap Therapy
Patients who receive < 5 days of overlap therapy should be discharged on both medications, or have a reason for discontinuation of parenteral therapy.

Includes: patients who received both warfarin and parenteral anticoagulation on the same day at least one time.

Document reason for no overlap therapy. Reasons why parenteral anticoagulation therapy and warfarin were not administered on the same day include:
- Bleeding complications
- Patient/family refusal
- Surgical procedure
- Use of oral anticoagulants other than warfarin such as Xarelto or rivaroxaban

Patient refusal or medication during hospitalization or at discharge may be documented by a nurse.

Excludes: patients < 18 years, LOS > 120 days, comfort measures only on day of or day after hospital arrival, enrolled in clinical trials, discharged to health care facility or home for hospice care, expired, left AMA, discharged to another hospital, patients without warfarin therapy during hospitalization, patients without VTE confirmed by diagnostic testing.

VTE Patients Who Receive IV Unfractionated Heparin (UFH)
VTE patients who receive intravenous unfractionated heparin should have their dosages and platelet counts monitored using defined parameters such as a nomogram or protocol.

Pathways, orders, or documentation by a MD/APN/PA or pharmacist that state that a nomogram or protocol was used to calculate the UFH therapy dosages and platelet count are acceptable.

UFH therapy ordered per pharmacy dosing or per pharmacy protocol are acceptable if there is documentation that platelet counts were also monitored.

IV UFH managed by nomogram, but discontinued prior to monitoring platelet counts is acceptable.

Excludes: patients < 18 years, LOS > 120 days, comfort measures only on day of or day after hospital arrival, enrolled in clinical trials, discharged to health care facility, expired, left AMA, discharged to another hospital, patients without UFH therapy during hospitalization, patients without VTE confirmed by diagnostic testing.

VTE Discharge Education
For patients discharged to home, home care/court or law enforcement on warfarin, address and document ALL four criteria:

1. Compliance issues—importance of taking warfarin and monitoring warfarin with scheduled PT/INR blood draws
2. Dietary advice—that includes recommendations of “consistent amount” of foods with Vitamin K AND avoidance of major changes in dietary habits without approval from health care professional
3. Follow-up Monitoring—Must include information about plans to monitor warfarin post-discharge
4. Potential for adverse drug reactions and interactions—Must include all of the following
   a. Diet and medications that can affect the PT/INR level
   b. Instructions not take or discontinue any medication or over-the-counter medication except on the advice of the MD or pharmacist
   c. Warning that warfarin increases the risk of bleeding