Improving ED Sepsis Bundle Compliance

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Background
• Worst performer in PSJH in sepsis mortality
• No sepsis screening = delayed recognition and diagnosis
• Non-protocolized care = High variability in treatment among providers

Actions Taken
• Identification of Sepsis Champion – ICU Medical Director
• House-wide sepsis education to all nurses
• Creation of a mandatory sepsis checklist in the ED
• Creation of a Critical Care Acute Care Nurse Practitioner driven sepsis team
• Provider bundle fallout feedback to ED Medical Director
• ED nurse bundle fallout feedback to individual ED nurses via QI sheets
• Development of ED nursing sepsis standardized procedure
• Monthly interdisciplinary sepsis committee

Results
• Sepsis screening tool used on all patients during triage in ED
• Sepsis screening tool used on all patients on arrival to inpatient unit
• Sepsis alerts sent to Sepsis ACNP
• Sepsis order sets created by Regional Sepsis Collaborative = consistent patient management
• Sepsis flag added to ED tracker board to increase recognition of positive sepsis screens