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Improving ED Sepsis Bundle Compliance

Jen Selby

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Providence St. Joseph Health

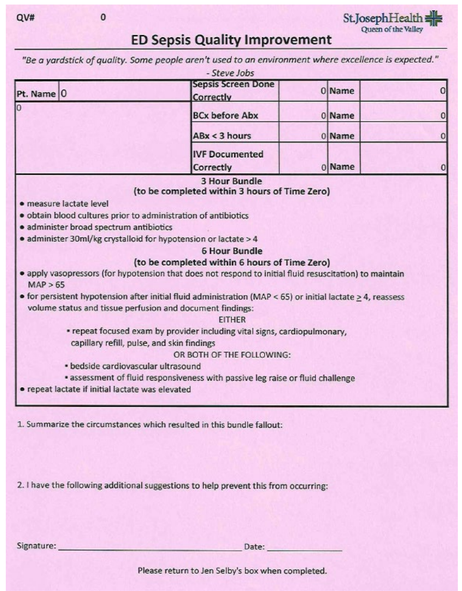
St. Joseph Health Queen of the Valley

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

QI sheets to individual ED RNs re: bundle fallouts w/loop closure



QV# 0

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ED Sepsis Quality Improvement

"Be a yardstick of quality. Some people aren't used to an environment where excellence is expected."
- Steve Jobs

Pt. Name	0	Sepsis Screen Done Correctly	0	Name	0
0		BCx before Abx	0	Name	0
		ABx < 3 hours	0	Name	0
		IVF Documented Correctly	0	Name	0

3 Hour Bundle
(to be completed within 3 hours of Time Zero)

- measure lactate level
- obtain blood cultures prior to administration of antibiotics
- administer broad spectrum antibiotics
- administer 30ml/kg crystalloid for hypotension or lactate > 4

6 Hour Bundle
(to be completed within 6 hours of Time Zero)

- apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain MAP > 65
- for persistent hypotension after initial fluid administration (MAP < 65) or initial lactate ≥ 4, reassess volume status and tissue perfusion and document findings:

EITHER

- repeat focused exam by provider including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings

OR BOTH OF THE FOLLOWING:

- bedside cardiovascular ultrasound
- assessment of fluid responsiveness with passive leg raise or fluid challenge

- repeat lactate if initial lactate was elevated

1. Summarize the circumstances which resulted in this bundle fallout:

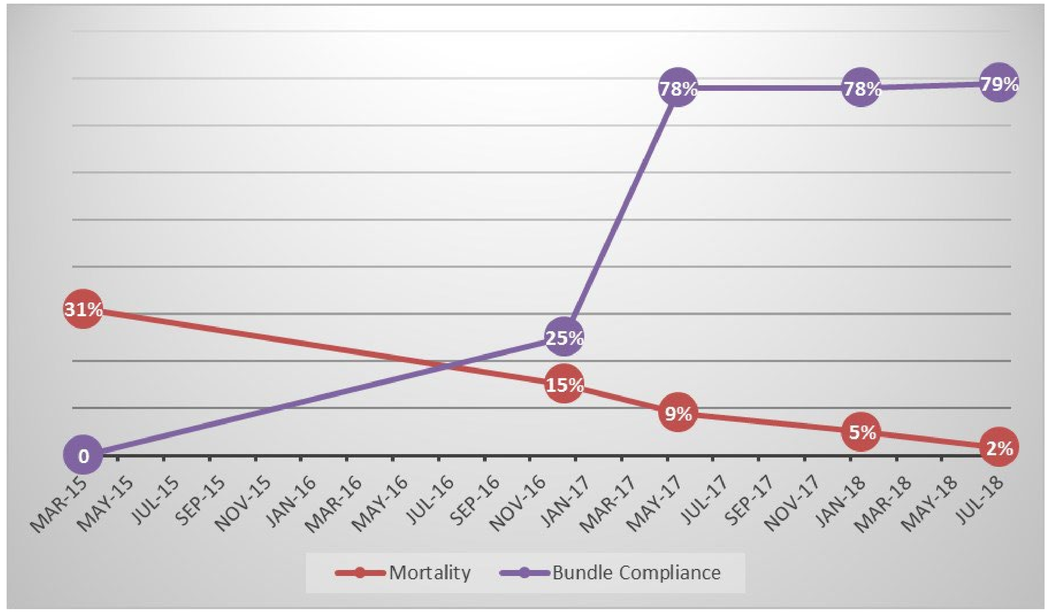
2. I have the following additional suggestions to help prevent this from occurring:

Signature: _____ Date: _____

Please return to Jen Selby's box when completed.

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