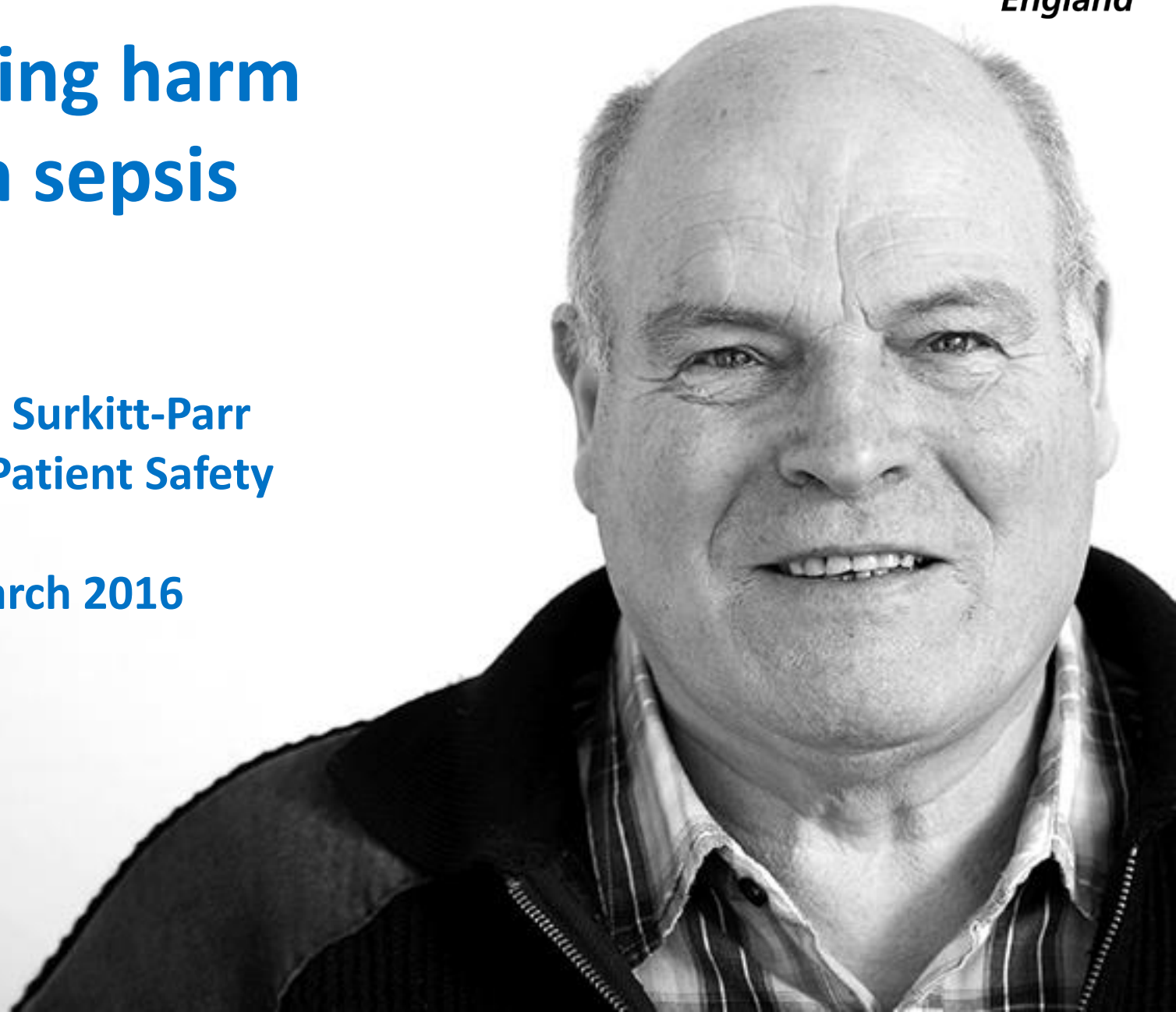
Reducing harm from sepsis

Michael Surkitt-Parr
Head of Patient Safety

8 March 2016



What do we know?

- Sepsis is now widely recognised as a time-critical medical emergency, which can occur as part of the body's response to infection and a cause of avoidable death and lasting ill health.
- Sepsis at its inception is difficult to recognise but easier to treat; left unattended it becomes easy to recognise but difficult to treat
- There were 123,000 cases of sepsis in 2013/14 and it is estimated that there are 36,800 associated deaths as a result
- Around 10,000 of these deaths are thought to be preventable.

How do we know?

- Parliamentary and Health Service Ombudsman (PHSO)'s report *Time to Act* highlighting the shortcomings in care that can lead to unavoidable deaths from sepsis.
- *An Avoidable Death of a Three Year Old* published by the PHSO found failings to care for a child who died of sepsis.
- NCEPOD published their report *Just Say Sepsis!* in November 2015 highlighting that only half of patients with sepsis received good quality care.

Cross System Programme Board on sepsis

- Group set up January 2015
- Co-chaired by two NHS England Directors
- Wide membership
  - Royal Colleges
  - UK Sepsis Trust
  - National organisations
  - Clinicians

Improving outcomes for patients with sepsis

Remit

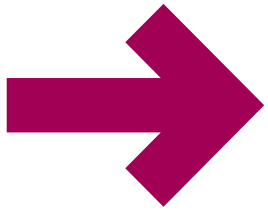
"..our critical task now is focussing on *how* to make changes happen, rather than considering *what* needs to be done"

Bruce Keogh

- Inpatient settings
- Out of hospital settings
- Clinical coding
- Education and training
- CQUIN and financial incentives
- Identifying opportunities and barriers

Areas of focus

1. Prevent avoidable cases of sepsis
2. Increase awareness of sepsis amongst professional and the public
3. Improve the identification and treatment of sepsis across the whole patient pathway
4. Improve consistency of standards and reporting
5. Underpin all actions with the principles of appropriate antibiotic use and antimicrobial stewardship



Increasing awareness

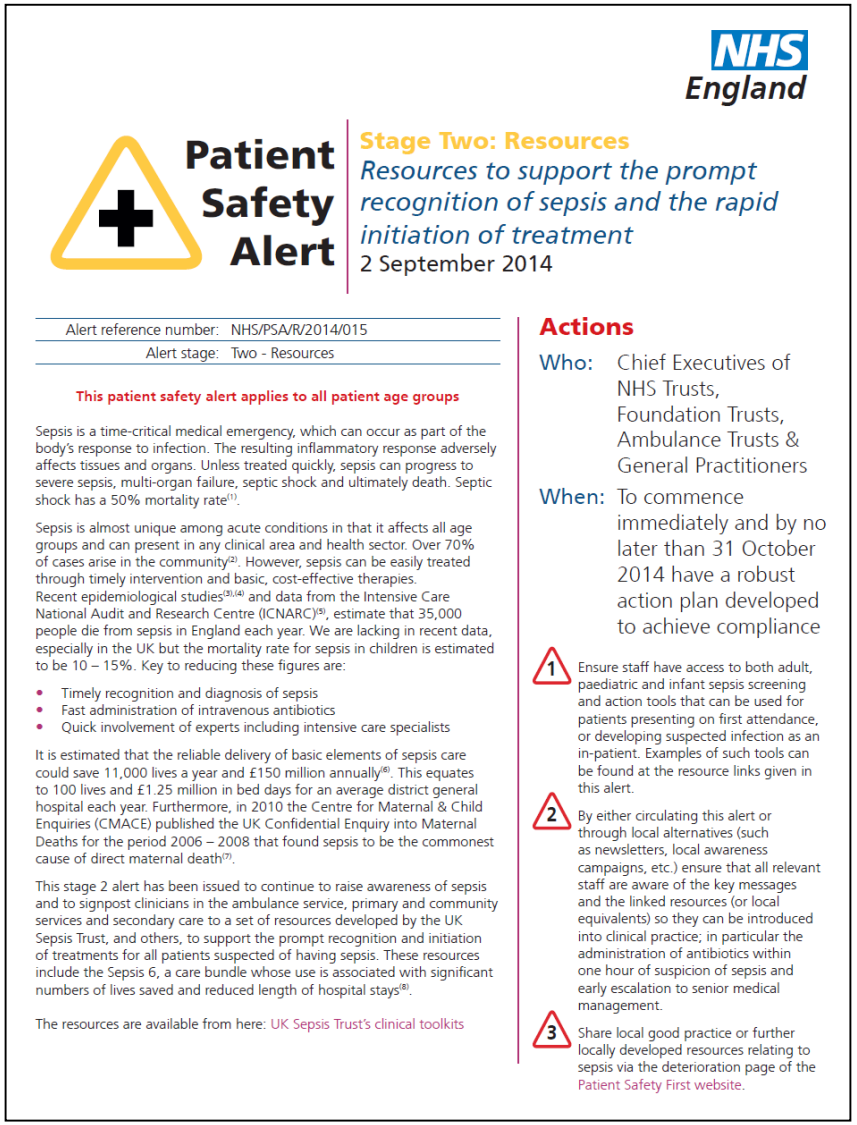
- Amongst the public and professionals
- 70% of cases of sepsis arise in the community
- 42% public in UK had not heard of the term sepsis and 32% of respondents did not know if it was a medical emergency or not

UK Sepsis Trust and YouGov

  - Informing public of signs and symptoms and when to seek help – particularly in high risk groups
  - Balance public awareness message with creating excessive anxiety
  - Align message with AMR agenda

Patient Safety Alert – issued 2 September 2014

Patient Safety Alert (stage two: resources) issued to support the successful implementation of the current resources and guidance on sepsis



NHS England

Patient Safety Alert

Stage Two: Resources

Resources to support the prompt recognition of sepsis and the rapid initiation of treatment

2 September 2014

Alert reference number: NHS/PSA/R/2014/015

Alert stage: Two - Resources

This patient safety alert applies to all patient age groups

Sepsis is a time-critical medical emergency, which can occur as part of the body's response to infection. The resulting inflammatory response adversely affects tissues and organs. Unless treated quickly, sepsis can progress to severe sepsis, multi-organ failure, septic shock and ultimately death. Septic shock has a 50% mortality rate[1].

Sepsis is almost unique among acute conditions in that it affects all age groups and can present in any clinical area and health sector. Over 70% of cases arise in the community[2]. However, sepsis can be easily treated through timely intervention and basic, cost-effective therapies. Recent epidemiological studies[3],[4] and data from the Intensive Care National Audit and Research Centre (ICNARC)[5], estimate that 35,000 people die from sepsis in England each year. We are lacking in recent data, especially in the UK but the mortality rate for sepsis in children is estimated to be 10 – 15%. Key to reducing these figures are:

- Timely recognition and diagnosis of sepsis
- Fast administration of intravenous antibiotics
- Quick involvement of experts including intensive care specialists

It is estimated that the reliable delivery of basic elements of sepsis care could save 11,000 lives a year and £150 million annually[6]. This equates to 100 lives and £1.25 million in bed days for an average district general hospital each year. Furthermore, in 2010 the Centre for Maternal & Child Enquiries (CMACE) published the UK Confidential Enquiry into Maternal Deaths for the period 2006 – 2008 that found sepsis to be the commonest cause of direct maternal death[7].

This stage 2 alert has been issued to continue to raise awareness of sepsis and to signpost clinicians in the ambulance service, primary and community services and secondary care to a set of resources developed by the UK Sepsis Trust, and others, to support the prompt recognition and initiation of treatments for all patients suspected of having sepsis. These resources include the Sepsis 6, a care bundle whose use is associated with significant numbers of lives saved and reduced length of hospital stays[8].

The resources are available from here: UK Sepsis Trust's clinical toolkits

Actions

Who: Chief Executives of NHS Trusts, Foundation Trusts, Ambulance Trusts & General Practitioners

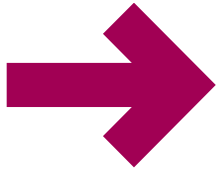
When: To commence immediately and by no later than 31 October 2014 have a robust action plan developed to achieve compliance

1. Ensure staff have access to both adult, paediatric and infant sepsis screening and action tools that can be used for patients presenting on first attendance, or developing suspected infection as an in-patient. Examples of such tools can be found at the resource links given in this alert.
2. By either circulating this alert or through local alternatives (such as newsletters, local awareness campaigns, etc.) ensure that all relevant staff are aware of the key messages and the linked resources (or local equivalents) so they can be introduced into clinical practice; in particular the administration of antibiotics within one hour of suspicion of sepsis and early escalation to senior medical management.
3. Share local good practice or further locally developed resources relating to sepsis via the deterioration page of the Patient Safety First website.

Education and training

- Series of workshops and master classes
- Creation and maintenance of a virtual community of interest – initially via the deterioration platform of the Patient Safety First website.
  - sharing and learning opportunities such as regular webinars, surveys and links with other websites and resources
  - a method of showcasing exemplar organisations and improvements, including opportunity for others to learn from them and connect with them
- The co-production (with the UK Sepsis Trust) of a 'serious game' on sepsis.

Make it personal !!



Make it local!!

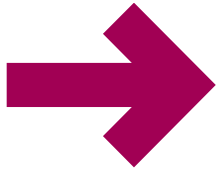
Failure to undertake observations	33%	7%	<1%
Failure to escalate triggering EWS	31%	5%	<1%
Failure to instigate appropriate treatments **	9%	2%	<1%

****** **It should be noted that a number of these incidents would be themed as treatment error or delay**

Deteriorating patients – an aggregate review of RCA investigations

	Problem identified	Staff group implicated		
		Medical	Registered nurse	Unregistered nurse
Failure to escalate triggering EWS	65%	6%	82%	12%
Failure to undertake observations	48%		83%	17%
Failure to instigate appropriate treatments	45%	62%	38%	
Professional communication failures	39%	60%	40%	
Failure to accurately record observations	23%			
Failure to accurately calculate observations	32%		73%	27%

Know your processes!!



UKSNF

NHS England

@UKsepsisnurses

UK SEPSIS Nurse Forum

To join –
Sally.Wood@nuh.nhs.uk

Thank you

Michael.surkitt-parr@nhs.net