Deterioration

Oxford
Patient Safety Collaborative

Nationally, the PSCs aim to reduce avoidable harm and enhance outcomes and experiences of deteriorating patients across England by improving the reliability of recognition, response and communication, including supporting the use of NEWS2 (an early warning system for identifying acutely unwell patients).

Our ambition, as part of this work, is for people to use clear and common language when patients are deteriorating. This includes when healthcare staff are communicating with each other, across different parts of the healthcare system and when clinicians communicating with patients and their carers.

This work is part of our ongoing Sepsis Programme. Sepsis is the number one cause of hospital mortality. It is:

- Under-recognised
- Under-estimated
- Under-treated
- The most expensive admission diagnosis

Our programme focuses on standardising sepsis management across the whole care pathway. Achievements so far include:

- Collaborating on a regional sepsis pathway
- Publication of Suspicion of Sepsis Methodology (defining and measuring through routine data analysis) in the BMJ Open and a supporting “how to guide”
- A QI project with GPs gathered baseline data and learning to inform future projects
- Contribution to NHS Digital consultation on coding definitions

Version 2 22/03/2018

“Working together regionally for a common goal has resulted in a pathway we are happy to use to save lives from sepsis.”

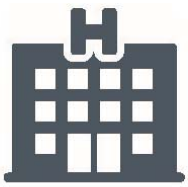
Amanda Pegden

Acute Medical Consultant & Sepsis Clinical Lead

Great Western Hospital NHS Foundation Trust

6 Regional Hospital Trusts using 1 Standardised Pathway

Measurement methodology used on National Dashboard by Patient Safety Measurement Unit

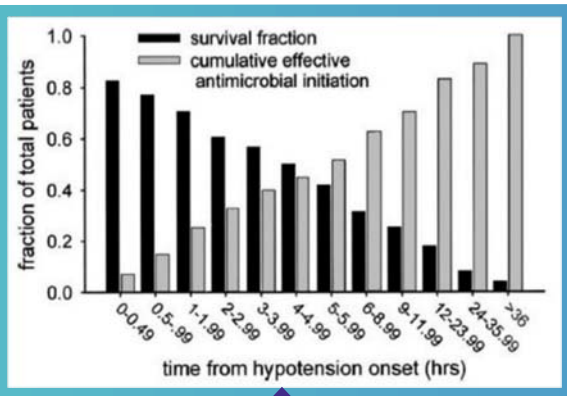


Regional pathway linked to decreased length of stay

The AHSN Network

NHS Improvement

Leadership
Culture
Capability
Learning
Measurement
Process
Innovation



Kumar A, *et al,* (2006):

Each hour of delayed IV antibiotic administration reduces survival rates by 7 – 8%

"We believe a benefit of this regional approach is more consistent, safe care for sepsis patients, particularly by rotating medical staff."

Dr. Andrew Brent
Sepsis Clinical Lead
Regional Stakeholders Group

Geoff's Encounter with Sepsis …

In January 2014, Geoff had a splinter in his hand that was not healing. The GP prescribed antibiotics but weeks later Geoff experienced flu-like symptoms and woke up with chest pain which moved down his arm. An ambulance took him to hospital for a suspected heart attack but was discharged. Sometime later he became violently ill with a temperature, continued pain, red rash and vomiting. He was also extremely sleepy. His wife rushed him to A&E.

Upon admission, the clinicians realised he was in septic shock with all his organs in failure or in the process of failing. They were unable to stabilise his vitals and at one point felt he only had an hour to live. His family were advised that they should say their goodbyes.

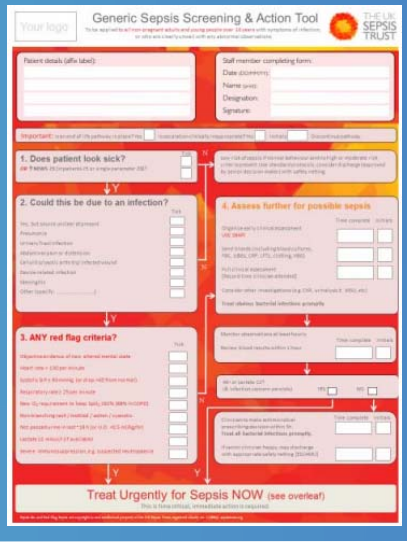
The clinicians admitted him to intensive care and gave him IV antibiotics swiftly. Slowly he started to recover and by the end of the month he was home.

This is a powerful reminder of how delayed diagnosis may have life-threatening consequences. You can view Geoff's story online. Search: *Treating Sepsis: Geoff's Story*.

In response to differing international and UK (NICE) guidance and definitions for sepsis, a standardised approach was agreed.

The regional sepsis pathway simplified the algorithm using the UK Sepsis Trust template to ensure reliable implementation, incorporation of successful existing tools (e.g. early warning scores, "red flag" sepsis criteria and Sepsis Six Care Bundle) and ensure a generic pathway applicable to Trusts with varying resources.

All six acute hospital trusts in the region have now implemented the simplified pathway.



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