



SPSP Acute Adult Programme Sepsis Change Package 2023

Sepsis Driver Diagram 2023

What are we trying to achieve...

Improve outcomes for people with sepsis by reducing infection-related mortality by 10%

We need to ensure...

Early recognition of sepsis

Timely structured response to sepsis

Safe communication*

Leadership to support a culture of high quality care and patient safety

Which requires...

Recognition of suspected infection and new organ dysfunction
Regular reassessment for worsening physiology or clinical concern
Recognition and escalation of patient, family and carer concern
Escalation of clinical concern

A structured response to deterioration
Sepsis Six and source control informed by illness severity and likelihood of infection
Effective antimicrobial stewardship
Senior clinical decision maker review

Person and family centred care planning*
Effective multidisciplinary and multiagency team working
Psychological safety to support escalation of concerns

Visible leadership at all levels
Safe staffing* and resources to enable delivery of safe care
System for learning* to support continuous improvement
Staff wellbeing*

*Essentials of Safe Care

Primary Driver

Early recognition of sepsis



Healthcare
Improvement
Scotland



Secondary drivers

Change ideas

Recognition of infection and new organ dysfunction

Use of NEWS2 to identify deterioration and organ dysfunction

Process to determine likelihood of infection, e.g. AoMRC decision making framework

Use of electronic observations to support clinical decision making

Process to identify variation in presentation, e.g. considerations of ethnicity in pulse oximetry, deterioration in optimal posture

Regular reassessment for worsening physiology or clinical concern

NEWS2 charting allows documentation of clinical judgement that may alter frequency of observations

Patients, families, and carers are given advice to support identification of further deterioration

Local process to proactively identify and reassess people at higher risk of deterioration, e.g. neutropenia

Patient, family and carer view of illness and concerns consistently sought e.g. asking 'how well are you feeling compared to the last time we asked you?'

Recognition and escalation of patient, family and carer concern

Provision of accessible information to patients, families, and carers to support early recognition and access to treatment in sepsis

Process for patients, families, and carers to raise concerns about acute deterioration

Locally agreed process for staff to document and escalate concerns raised by patients, families and carers

Process to reliably provide feedback to the person who raised concern

Escalation of clinical concern

Locally agreed escalation framework that incorporates clinical concern

Reliable notification of deterioration to consultant in charge of patient's care

Reliable timely triage of people with sepsis including in transition from NHS24, primary care, and SAS

Consider system-wide escalation mechanisms e.g. outreach team, electronic NEWS2 and decision support

Primary Driver

Timely structured response to sepsis



Healthcare
Improvement
Scotland



Secondary drivers

Change ideas

A structured response to deterioration

Locally agreed standardised approach to structured response to deterioration

Shared decision making supported by access to any existing future care plan

Locally agreed criteria for completion of person centred TEP

Reassessment criteria documented as part of management plan e.g., worsening NEWS2 despite treatment

Sepsis Six and source control informed by illness severity and likelihood of infection

Use of AoMRC decision making framework to support timely delivery of Sepsis Six

Process to ensure assessment for source control and implementing any source control interventions in a timely manner

Collection of appropriate samples for infection investigations, including blood cultures, prior to first antimicrobial

Clinical assessment considers non-bacterial causes (e.g. viral infection) and associated de-escalation

Effective Antimicrobial stewardship

Process to establish true allergy status to maximise opportunity for first line antimicrobials

Antimicrobial plan documented in clinical notes, HEPMA and handover

Daily antimicrobial review informed by clinical assessment and microbiology results

Antimicrobials prescribed in line with local guidance, severity, and relevant past medical history

Daily antimicrobial review considers IV-Oral Switch Therapy (IVOST) in line with local guidance

Senior clinical decision maker review

Local escalation processes enable early involvement of a senior clinical decision maker

Locally agreed process for critical care review

Consultant review at least daily and within 14hrs of hospital admission

Local escalation processes set out who to contact and when

Primary Driver

Safe communication*



Healthcare
Improvement
Scotland



Secondary drivers

Change ideas

Person and family
centred care
planning

Existing complex care plans, e.g. patient passports, used to inform acute care planning

Locally agreed process to understand pre-hospital baseline

Use of 'what matters to you' approach to plan and deliver care

Use of the word 'sepsis' in person centred conversations at point of deterioration

Documented person centred discussion with patient and family about recovery trajectory and rehabilitation planning

Effective
multidisciplinary and
multiagency team
working

Patients of concern identified during board rounds, unit safety briefs and hospital huddles

Structured handovers within and between teams e.g. use of SBAR

Process for engaging all specialist and community teams involved in the person's care, e.g. social work, home care

Clarity of team roles and responsibilities in the care of a deteriorating patient

Psychological safety
to support escalation
of concerns

Processes to support a culture which supports staff and students to raise concerns

Process for managers at all levels to effectively recognise and respond to patient safety concerns

Promotion of Speak Up advocates and ambassadors to encourage staff to raise concerns

Process to reliably provide feedback to the person who reported concern

Primary Driver

Leadership to support a culture of safety



Secondary drivers

Change ideas

Visible leadership at all levels

Conduct and share learning from leadership walkrounds

Opportunity for senior leaders to review sepsis related data and trends

Access to clinical and improvement leadership time to support sepsis improvement work

Sepsis improvement work aligns with organisational priorities

Safe staffing and resources to enable delivery of safe care

Identify and mitigate staffing needs using real time staffing tools, including acuity assessment

Process to escalate staffing shortfalls

Education and induction includes local processes for early recognition and response for sepsis

Identify and mitigate time periods where escalation response is less reliable

System for learning to support continuous improvement

Collect, share, and act on data and learning between teams, hospitals, and boards

Identify and share learning through existing processes e.g. MDT morbidity and mortality meetings

Structured process for multidisciplinary hot and cold debriefs

Forums for staff, patients and families, to identify areas for improvement

Staff wellbeing

Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing

Prioritise civility through communication and teamwork, e.g. use of TeamSTEPPS

Support job satisfaction through evidence based interventions, e.g. Professional Identity Development Programme

Access to senior support and discussion for all staff, e.g. through clinical supervision