**Mather Hospital Sepsis Team**

**Improving Sepsis Handoff Communication:**
**Emergency Department to Critical Care**

**Background**
- Create a paper tool for the ER and ICU staff to use to increase communication and bundle adherence regarding patients with Severe Sepsis and or Septic Shock

**Project**
- Develop a standardized tool to enhance information exchange during transitions of care for the sepsis patient. Trial in ED as a paper tool
- Develop Code Sepsis House Wide Education
- Build the Code Sepsis Structured Note In Allscripts

**Challenges**
- ED Triage staff becoming complacent to calling Code Sepsis.
- Encouraging ED physicians to use the ED Sepsis Order set so that the targeted volume of fluids is being ordered for those patients with a BMI > 30
- ED Staff not documenting reassessment of fluid resuscitation.
- Administration of Antibiotics without an order for Blood Cultures or prior to the Blood Culture being drawn.

**Lessons Learned**
- Enhanced communication regarding Code Sepsis. Daily Brief is 3 times a day to include all shifts.
- 2019 Q3 89.5% compliance rate with Timely Blood Cultures prior to Antibiotics. This is down from 2019 Q2 94.3%. The lab, physician and nurse involved in these cases are receiving Sepsis Grams.
- We learned that the lab was only using the Purple Dot on Blood culture draws on Code Sepsis Patients. Re-educated the Lab techs to place Purple Sticker on ALL patients in ED with Blood Cultures.
- IBW used to determine target ordered volume based on patients with BMI>30 was added to the IV Bolus orders on the ED Sepsis OS.

**Next Steps**
- IT building mandatory field in the Fluid Bolus order that RN’s will need to document VS in order to complete the task.
- Meeting scheduled with IT, Nursing Education, and CMIO to build a structured Code Sepsis Note in Allscripts
- Code Sepsis to go live “Housewide”

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**CODE SEPSIS - HANDOFF TOOL**

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<th></th>
<th>Info</th>
<th>ED/Location</th>
<th>Time</th>
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<tr>
<td>P</td>
<td>Patient</td>
<td>Face patient risk for S.</td>
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<tr>
<td>A</td>
<td>Assessment</td>
<td>Complete set of s/s documented</td>
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<tr>
<td>S</td>
<td>SIRS</td>
<td>Additional SIRS signs</td>
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<td>T</td>
<td>Time</td>
<td>Respiratory: G: Skin:</td>
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<td>Note</td>
<td>Complete set of s/s documented</td>
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Not Part of Permanent Record – Return to ER

**Code Sepsis Tool**