

## Sepsis Recognition Policy

Reference No:	P_CS_49
Version:	2
Ratified by:	LCHS NHS Trust Board
Date ratified:	14 April 2020
Name of originator / author:	Deteriorating Patient & Resuscitation Training Officer
Name of responsible committee / individual:	Effective Practice Assurance Group
Date Approved by committee:	9 March 2020
Date issued:	April 2020
Review date:	April 2022
Target audience:	All Staff
Distributed via:	Website

**Lincolnshire Community Health Services NHS Trust**

**Version Control Sheet**

**Sepsis Recognition Policy**

<b>Versi</b>	<b>Section/Para /Appendix</b>	<b>Version/Description of Amendments</b>	<b>Date</b>	<b>Author/Amended by</b>
1		New Guideline G_CS_54		Tim Balderstone
	Footer	Updated to current post holders	12.02.06	Tim Balderstone
	7.3.3	Requirement to submit audit data added	12.02.16	Tim Balderstone
	11	Audit process added	12.02.16	Tim Balderstone
		Conversion to policy to incorporate NG51 compliance	7.02.18	Tim Balderstone
2		Title amended from Sepsis Screening to Sepsis Recognition and reference to 'screening' changed to 'recognition' throughout.	10/2/2020	Tim Balderstone
	Throughout	NEWS amended to NEWS2, references to PEWS removed.	10/2/2020	Tim Balderstone
	'Soft Signs'	Insertion of 'soft signs' indicators	4/02/2020	Tim Balderstone
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## Lincolnshire Community Health Services

### Policy Statement

#### Sepsis Recognition Policy

#### Background

Sepsis is a medical emergency with potentially devastating consequences and a high mortality rate. It is often under-recognised and frequently under-treated in both hospital and pre-hospital environments. This guideline aims to give clinicians outside of the acute environment an awareness to enable early recognition and treatment and improve outcomes

#### Statement

This guideline outlines how LCHS following NPSA Patient Safety Alert NHS/PSA/R/2015/015 and NICE NG51 & QS161 2017 will meet the requirement for a documented process for managing the risks associated with the deteriorating patient due to sepsis.

The guideline incorporates guidance and includes Clinical Toolkits from the UK Sepsis Trust.

#### Responsibilities

Compliance with the guideline will be the responsibility of all Lincolnshire Community Health Services NHS Trust staff.

#### Training

Sepsis Awareness Workshops, Sepsis E-Learning.

#### Dissemination

Website/intranet

**Abbreviations / Definitions**

Acronym	Term / Definition
NEWS2	National Early Warning Score
POPS	Paediatric Observation Priority Score
NICE	National Institute for Clinical Excellence
SIRS	Systemic Inflammatory Response Syndrome
LCHS	Lincolnshire Community Health Services
WBC	White Blood Count
NICE	National Institute for Health & Care Excellence
NPSA	National Patient Safety Agency
RCP	Royal College of Physicians
SP0 <sup>2</sup>	Oxygen Saturation

**Lincolnshire Community Health Service NHS Trust**  
**Sepsis Recognition Policy**

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## Introduction and Summary

Sepsis is a time-critical medical emergency, that can occur as the body responds 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<sup>1,2</sup>.

The successful management of sepsis requires a very high index of suspicion and early recognition<sup>3</sup>.

Patients cared for in the home, ambulatory care settings, and Urgent Treatment Centres must be identified and transfer organised to ensure treatment can be initiated quickly, this places additional emphasis on recognition skills without the use of higher level diagnostics available in the acute hospital setting.

Equally clinicians suspecting sepsis in a community hospital will not have the same diagnostics available as in an acute hospital and will have to act quickly to reduce the risk to patients in locations where treatment options are limited.

It is therefore essential clinicians have access to both awareness training and clinical toolkits to support their clinical findings and clinical intuition when suspecting patients at risk of sepsis<sup>3</sup>.

## Aims and Objectives

The purpose of this policy is to ensure a standardised Trust wide approach to the processes for recognition for sepsis and the actions which should be triggered in the case of abnormality or suspicion.

- To articulate the standards expected of those working as clinical staff within the Trust.
- Improve the quality of sepsis recognition and immediate treatment
- The process of referral when a patient is found to be deteriorating

## Scope

All clinical staff should be aware of potential patients 'at risk' of sepsis.

Those staff engaging in patient observations should use the National Early Warning Score (NEWS2) and Paediatric Observation Priority Score (POPS) systems together with clinical judgement to trigger use of the Sepsis Recognition Tools (**See Appendices**).

This policy applies to all patients all patient settings across Lincolnshire Community Health Services NHS Trust (LCHS).

To discuss all possible clinical circumstances of patients within the care of LCHS is beyond the scope of this policy. The reader is therefore referred to local process and protocol documents, which may describe protocols specific to individual patients and conditions as by specialists.

The policy is produced in the context of prevention of patient deterioration and should be read in conjunction with the Physiological Observations Policy (P\_CS\_16) and Resuscitation Policy (P\_CS\_08).

## **Review**

This guideline will be reviewed tri-annually by the group acting as Resuscitation Committee.

## **Evidence Base**

See References

## **Duties within the organisation**

### **The Chief Executive:**

has overall responsibility for the strategic and operational management of Lincolnshire Community Health Services NHS Trust, including ensuring that the organisation's policies and guidelines comply with all legal, statutory and good practice requirements.

### **General Managers and Heads of Clinical Service:**

Responsible for identifying and implementing policies and guidelines relevant to their area of responsibility. They are also responsible for ensuring that all staff have access to and are made aware of policies that apply to them.

### **All staff**

Responsible for the implementation of LCHS policies and guidelines as part of their core duties:

### **Practitioners measuring and recording the observations for sepsis recognition**

It is the responsibility of these individuals to ensure that they are competent to undertake, record and report abnormalities in physiological observations in accordance with the recognition tools within this policy.

### **Practitioners interpreting observations for sepsis recognition**

It is the responsibility of these individuals to ensure that they are competent to interpret observations and make judgements about them taking into account normal parameters, baseline parameters for the individual patient and acceptable or target parameters according to the plan of care. Interpretation should lead to appropriate action where there is abnormality (NEWS2/POPS) and the use of the appropriate sepsis recognition tool. If there is any doubt about abnormal observations and the potential for sepsis these should always be reported to a more senior and experienced professional (Senior Nurse, Advanced Nurse Practitioner, Emergency Care Practitioner, Doctor).

### **Practitioners responding to abnormal observations and a sepsis suspicion**

It is the responsibility of the practitioner responding to abnormal observations and undertaking the recognition process to ensure that they are competent to intervene should treatment be indicated, recognise the limits of their competence and initiate patient transfer as required to ensure timely completion of the regimen.



## **All clinical professionals**

Who are involved in monitoring, recording, interpreting and acting to treat changes in physiological observations in a suspicion, or diagnosis of sepsis should be aware of this policy and its principles. Documentation and communication are pivotal to minimising risks for patients and all actions should be documented contemporaneously or as soon as possible after the event.

Senior help and advice should be sought by all professionals who are concerned about patients regardless of their observations. All should be aware of the NEWS2/POPS processes and what actions are necessitated by the range of scores generated in the presence or suspicion of infection. This includes Registered (e.g. Nurses, Paramedics, Physiotherapists, Doctors) and non-registered (e.g. Healthcare Assistants/Support Workers) staff.

Failures to comply with this policy and adverse clinical incidents occurring in relation to sepsis recognition processes should be reported in accordance with Trust policy.

## **The senior clinician in charge of the clinical area**

It is the responsibility of the senior clinician working in conjunction with Clinical Practice Educators to ensure that all staff are competent to undertake their role in relation to physiological observations that facilitate correct use of the sepsis recognition tool.

The senior clinician should identify any additional training that may be required for appropriate staff to facilitate the treatment actions of the sepsis toolkits (**See Appendices**)

The senior nurse, in collaboration with the matron and other relevant professionals, should investigate all adverse clinical incidents in relation to sepsis recognition processes and develop action plans to prevent their future occurrence.

## **Monitoring Compliance**

The senior clinician in overall charge of each clinical area is responsible for ensuring that the standard of sepsis recognition in their clinical area is audited for compliance with this document at least annually.

## **Competence for Practice**

Awareness of sepsis can be raised by use of e-learning packages or attendance at Sepsis Awareness Workshops.

It is the responsibility of the individual undertaking the sepsis recognition to ensure they have the knowledge and understanding that is required around the parameters being considered within the sepsis toolkit. Any intervention actions must form part of an assessed process for extended role skills practice if not normally appropriate for role.

## **Definitions**

Scientific understanding of sepsis continues to evolve, and in February 2016 the International Consensus Definitions for Sepsis Task Force published recommendations for

a revised set of definitions termed 'Sepsis-3'<sup>5</sup>. It is almost certain that the definitions of sepsis and septic shock will continue to develop as an iterative process over time. International guidelines recommend the application of standards of care including first-hour antibiotics to patients with sepsis and septic shock.

### ***Sepsis.***

Sepsis is characterized by a dysregulated reaction to infection mediated by the immune system and resulting in organ dysfunction, potentially multi-organ failure, shock and death.

### ***Septic shock***

Septic shock is defined as a subset of sepsis where particularly profound circulatory, cellular and metabolic abnormalities substantially increase mortality.

The international definitions require that hypotension requiring the use of vasoactive infusions and a high arterial lactate content be used to describe septic shock. In General Practice and non-acute location urgent care situations significant hypotension in the presence of presumed infection is an appropriate surrogate to describe presumed septic shock.

### ***Uncomplicated sepsis***

This is caused by viral and bacterial infections and can often be treated in the community but where there is evidence of organ dysfunction or tissue hypo-perfusion that accompanies severe sepsis or septic shock, transfer to the acute sector is vital to reduce the mortality associated with the advanced stage of the illness.

## **Identification of sepsis**

Previous systems designed to aid recognition of sepsis concentrated on systemic inflammatory response (SIRS) markers, however not all patients with sepsis showed SIRS markers and some patients show some SIRS criteria without infection being present!

The change of philosophy suggested by NICE in Guideline 51<sup>2</sup> is to appreciate sepsis will always have an infective cause.

Patients presenting with a known or suspected infection and physiology that suggests something is going wrong should therefore be assessed with the aim of excluding the presence of sepsis, much as patients presenting with chest pain are examined with the aim of excluding acute coronary syndromes.

### **'Higher Risk' condition factors**

It is important to recognise and identify the type of patients who may inherently be at higher risk of sepsis:

- Those at extremes of age e.g. very young (<12m), elderly (>75) or very frail
- people who have impaired immune systems because of illness or drugs, including:
  - people being treated for cancer with chemotherapy
  - people who have impaired immune function (for example, people with diabetes,
  - people who have had a splenectomy, or people with sickle cell disease)
  - people taking long-term steroids

- people taking immunosuppressant drugs to treat non-malignant disorders such as rheumatoid arthritis
- people who have had surgery, or other invasive procedures, in the past 6 weeks
- people with any breach of skin integrity (for example, cuts, burns, blisters or skin infections)
- people who misuse drugs intravenously
- people with indwelling lines or catheters.

## Children

REMEMBER children (<12yr) are not just small adults when considering sepsis, behaviour changes may be more significant than physiological observations due to their enhanced compensatory systems.

Young children and babies (<5yr) require an even greater understanding of developmental differences, behavioural changes can be subtle, physiological changes may appear late in the deterioration and parental anxiety can make history and information difficult to obtain.

The Clinical toolkits provide reference ranges for physiological observations as well as the criterion used to identify Red and Amber sepsis flags, reference to those is vital.

## NEWS2/POPS/PEWS

It is unlikely sepsis will present without physiological changes identifiable with NEWS2/POPS, however evidence suggests we listen to the patient and their relatives, phrases such as 'I've never seen him this ill' or 'I feel like I'm going to die' should never be ignored.

## 'Soft Signs' recognition

It is now increasingly understood the 'soft signs' of deterioration may be more helpful in recognition of sepsis than previously acknowledged.

Of particular note in current literature is the interest being paid to signs such as:-

- Changes in mood or outlook
- Changes in behaviour
- Altered sleeping patterns
- Appetite changes
- Sudden decline or apparent increase in medication effectiveness

More research is ongoing but staff should be aware these may indicate early signs of a patient's condition changing and should be considered an element of assessment worthy of recording and inclusion in consideration processes.

## Infection?

Clinical curiosity to investigate history is important, the broad question "Is the history suggestive of infection?" will guide examination and investigations.

It is not always possible to define a source of infection in a patient presumed to have sepsis, particularly at initial assessment.

**It is important to reinforce that patients with signs and symptoms of infection together with physiological deterioration in the absence of a clear source should continue to be presumed to have sepsis.**

In the community or, non-acute urgent care environment, broad questioning can be used to guide and confirm that sepsis risks are present and that Sepsis Risk Stratification is required.

02

YES  
COULD THIS BE  
DUE TO AN INFECTION?

**LIKELY SOURCE:**

<input type="checkbox"/> Respiratory	<input type="checkbox"/> Urine	<input type="checkbox"/> Skin / joint / wound	<input type="checkbox"/> Indwelling device
<input type="checkbox"/> Brain	<input type="checkbox"/> Surgical	<input type="checkbox"/> Other	

For an acute setting the ready availability of a fuller patient history and capability of diagnostic tests and examination may allow greater

identification of an infective source.

### Red Flag Sepsis

NICE NG51 built upon the UK Sepsis Trust's **Red Flag Sepsis** approach<sup>4</sup>, launched in 2015, for determining which patients should immediately be transferred for life saving therapy. The first step in Sepsis Risk Stratification should be to confirm or exclude the presence of any ONE high risk, **Red Flag Sepsis** criterion.

The UK Sepsis Trust NG51 compliant Clinical Toolkits recognise that different clinical services and locations will have disparate abilities to consider sepsis so different wording and depth of investigation of the criteria can be applied to the same end – are signs of serious organ dysfunction present?

The difference can be seen in the examples, firstly for an acute in-patient area and second an Out of Hours Telephone Triage service

#### In-patient RED FLAG criteria

- Responds only to voice or pain/ unresponsive
- Systolic B.P ≤ 90 mmHg (or drop >40 from normal)
- Heart rate > 130 per minute
- Respiratory rate ≥ 25 per minute
- Needs oxygen to keep SpO2 ≥92%
- Non-blanching rash, mottled/ ashen/ cyanotic
- Not passed urine in last 18 hours
- Urine output less than 0.5 ml/kg/hr
- Lactate ≥2 mmol/l
- Recent chemotherapy

#### Telephone Triage RED FLAG Criteria

- Objective change in behaviour or mental state
- Unable to stand/ collapsed
- Unable to catch breath, barely able to speak
- Very fast breathing
- Skin that's very pale, mottled, ashen or blue
- Rash that doesn't fade when pressed firmly
- Not passed urine in last 18 h
- Recent chemotherapy

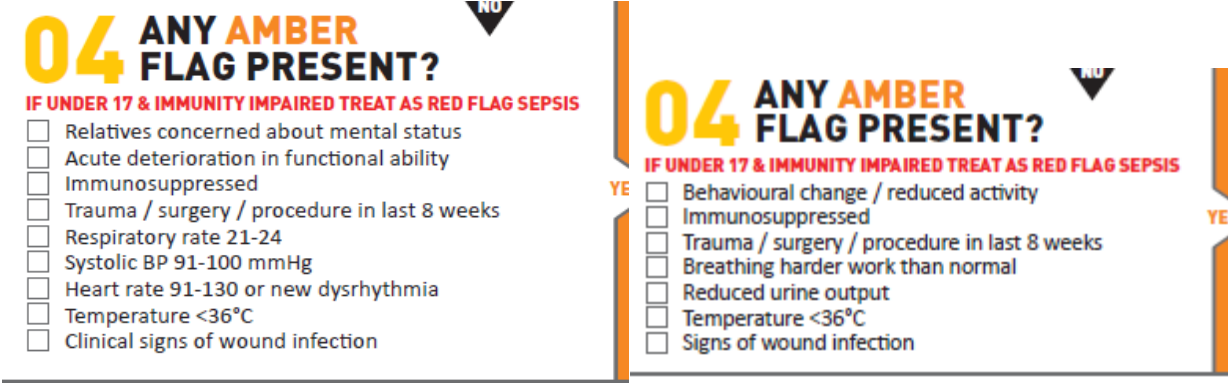
Any patient with presumed sepsis who has one or more **Red Flag Sepsis** criteria should be assumed to have sepsis or septic shock, and immediately transferred to an acute hospital if appropriate. (see Management of Sepsis)

Patients who have no **Red Flag Sepsis** Criteria should immediately be reviewed for **Amber Flags**.

**Amber Flag Sepsis**

In the absence of Red Flag (high risk) criterion but assumed infection and physiological abnormality a further determination needs to be made to consider the moderate to high risks of sepsis as this will guide treatment options.

Again the patient and location differences in ability to undertake investigations can be accounted for in criteria wording.



For patients 18 years old and over, NICE recommend that the presence of any ONE **Amber Flag** criterion prompt a binary clinical decision. Clinical judgment should be used to determine whether the patient can be managed in the current setting or requires acute hospital assessment.

Within LCHS this will normally be determined by the ability to fully understand the patients condition and provide ongoing care. Patients with as yet 'minor' sepsis can deteriorate rapidly. Patients with Amber Flags who have one or more 'higher risk' condition risk factors should receive particularly careful consideration as to whether hospital assessment is required, as should patients who live alone with poor access to communication and transport.

If a patient with presumed new infection has neither Red Flag nor Amber Flag criteria (or for whom there is little clinical concern following assessment), they should be assumed to be at low risk. Decisions to refer for acute hospital assessment can therefore made according to routine protocols based around capacity to provide further treatments, supported by clinical judgment- most patients in this group will appropriately receive ongoing care in the community even if initial presentation is to an urgent care setting.



‘Safety netting’, the process of providing written and verbal advice needs to fully utilised together with an invitation for open self-referral should the patient deteriorate or they or their relatives be concerned for any patients deemed able for management within community settings.

A safety-netting tool is produced by The UK Sepsis Trust, “Symptom Checker Cards”, this should be given to all patients with infections.

## Management of Sepsis

### The Sepsis Six

The key immediate interventions that increase survival from sepsis are described in a bundle termed the **Sepsis Six**. This bundle has been shown to be associated with significant mortality reductions when applied within the first hour<sup>7</sup>.

- The Sepsis Six**
1. Administer oxygen to maintain saturations >94%
  2. Take blood cultures and consider infective source
  3. Administer intravenous antibiotics
  4. Consider intravenous fluid resuscitation
  5. Check serial lactates
  6. Commence hourly urine output measurement

**It must be appreciated within LCHS that upon identification of sepsis the inability to FULLY COMPLETE the Sepsis Six regimen within the 60 minute timescale should prompt the requirement for acute hospital transfer.**

In addition to completion of the regimen expert attention needs to be directed toward identification and control of the infective source, this may require additional diagnostic processes and potentially surgical interventions. It is unlikely that LCHS can provide the breadth of services to complete this process in the timescales required.

A patient who looks unwell with presumed infection who displays at least ONE Red Flag Sepsis criterion has **Red Flag Sepsis** and transfer to an acute hospital should immediately be arranged and **The Sepsis Six** regimen commenced

The 999 call should include direct reference to the acuity of the condition using the term ‘**Red Flag Sepsis**’, the caller needs to be prepared to offer the clinical information on the signs identified.

Where possible, a telephone “pre-alert” referral to the receiving Emergency Department should be made, using the term ‘**Red Flag Sepsis**’.

Elements of treatment within The Sepsis Six may usefully be undertaken whilst transfer is awaited in a number of LCHS locations.

There is strong evidence that expedient delivery of ‘basic’ aspects of care limits the maximum acuity of intervention required - early resuscitation can prevent the requirement for invasive monitoring and vasoactive support later in hospital.

Within LCHS the range of treatments possible may be severely restricted by the scope of practice within differing services.

### **Oxygen**

Patients with sepsis are exempt from British Thoracic Society guidelines for the administration of oxygen to acutely ill adults, the pathophysiology of sepsis is such that organs become critically hypoxic<sup>4</sup>. Hypoxia will kill before hypercapnia.

Oxygen should be given to maintain target saturations of 94% or higher.

Where patients are known to have moderate to severe diagnosed pulmonary disease the recommend that oxygen be administered remains, but to maintain a lower target oxygen saturations, above 88%. Oxygen will not cause sudden apnoea in such patients.

**It must be remembered that to titrate oxygen delivery to maintain a specified saturation is provision of oxygen therapy, that requires a prescription. High flow continuous oxygen delivery via non-rebreathing mask for the express purpose of life saving does not require prescription.**

### **Antimicrobials**

If transfer times to hospital are routinely in excess of one hour consideration of whether it is appropriate and feasible to administer intravenous (or intramuscular) antimicrobials needs to take place.

A delay of one hour in administering antimicrobials in septic shock is associated with an increase in mortality rates of 8%<sup>6</sup>.

Urgent Care facilities may have available the local formulary recommended antimicrobial agents for community-acquired pneumonia, urinary tract infection, skin and soft tissue infection and intra-abdominal infection which together account for 90% of cases of sepsis<sup>4</sup>.

### **Blood Cultures**

If clinicians elect to administer antimicrobials, the feasibility of sampling blood for culture should be evaluated. While modern blood culture media are able to bind antimicrobials and thus increase the capture rate of organisms after antibiotic administration, this is not fully effective and capture rates remain higher if cultures are sampled first.

Should blood for cultures be drawn after antibiotic administration it is VITAL that the antibiotic treatment be disclosed on the sample order sent to the laboratory.

### ***Intravenous Fluids***

The bolus administration of IV Sodium Chloride is a cornerstone item within The Sepsis Six to counter hypotension<sup>6</sup>.

It does however require suitable venous access and it is recognised this in itself may be difficult to achieve in patients with hypotension.

**Delays in the other treatment elements or transfer must not happen through repeated attempts to secure venous access.**

### **Amber Flag Sepsis**

The presence of **Amber Flag Sepsis** criterion in the absence of Red Flags indicate the patient has sepsis, this may not have yet progressed to cause serious organ dysfunction but careful consideration of the potential need for acute hospital assessment is needed.

Treatment is still indicated for the sepsis, clinicians need to consider the appropriateness of the patient location together with the range of treatment options and skillsets of the staff available. Patients with as yet 'minor' sepsis can deteriorate rapidly.

Uncomplicated sepsis, where the patient does not have the suspected organ dysfunction or tissue hypo-perfusion that accompanies severe sepsis or septic shock may be safely managed without acute hospital admission.

However it is often difficult to determine patients that can be safely treated in the community and in circumstances where there is doubt transfer to an acute hospital is recommended. Additional 'higher risk' condition factors, patients who live alone with poor access to communication and transport difficulties all need to be taken into account.

**Where clinical assessment is unable to identify a suspected source of infection, acute hospital assessment must also be very carefully considered and the rationale for decision making explained within the patient record.**

For those in whom community-based care is deemed safe and appropriate, consideration should be given to providing a scheduled review appointment/visit, clear records should be made of the decision, rationale and the safety netting provided.

If transfer to acute hospital is considered necessary the call to the Ambulance Service should include direct reference to the acuity of the condition, using the terms '**Amber Flag Sepsis**'. A brief, clear handover should accompany the patient to include observations, any relevant medical history and antibiotic history including allergies.

Where possible, a telephone referral to the receiving Emergency Department should be made, using the terms '**Amber Flag Sepsis**' or 'sepsis'. The presence of any risk factors and the rationale for the clinical decision to refer for hospital assessment should be discussed.



## **'Low risk' patients**

Patients who present with infections but without Red or Amber flags require appropriate safety netting advice and signposting to GP/111/999 route if deterioration occurs.

Patients records must reflect what information was given to the patient as it is this information that will be used to determine how appropriate the treatment given by LCHS was in the event of future clinical incident or deterioration.

## **Clinical Toolkits**

A range of toolkits developed by The UK Sepsis Trust is available to assist staff in the process of sepsis recognition and awareness of treatment pathways.

These are listed in the Appendices and are available to download from the Trust intranet site;- <https://staff.lincolnshirecommunityhealthservices.nhs.uk/index.php?clD=1731>

## **Consent to treatment or transfer**

For some patients, severe co-morbidity and/or pre-existing limitations to functional status may make referral to hospital inappropriate, even though basic interventions may remain appropriate and require admission - such cases should be considered carefully and discussed with the patient, family and colleagues as appropriate. Mental capacity should always be considered.

Reference to the ReSPECT policy should be made if escalation is deemed inappropriate.

Should a patient have a relevant advance directive precluding active intervention, or a competent and informed patient refuse transfer or treatment, clearly those actions would be inappropriate.

Clinical staff, both nursing and medical, should constantly review the risk and implications of transfer and/or treatment refusal and should consider whether the patient has the mental capacity to understand and or consent.

Mental Capacity must be formally assessed in circumstances where there is any doubt, although it is understood the clinician may need to make a 'best interest' decision based purely on the patients condition and available information.

Should any staff member have concerns regarding the refusal to consent for transfer or treatment and potential safeguarding implications the line manager should be involved and consider whether specialist safeguarding advice is required.

## **Audit and Reporting Standards**

Any outcomes from clinical audit examining the quality of record keeping or sepsis recognition process actions will be reported to the relevant Quality Assurance Groups, Safeguarding & Patient Safety Group and Learning From Deaths Panel as appropriate.

**Patient records should reflect the outcome of any recognition process, E.g low risk, amber flag, red flag etc and detail the actions taken whether 'safety netting' advice, referral, ambulance etc.**

# Monitoring Template

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Number of online sepsis questionnaires completed	SystemOne report	Safeguarding & Patient Safety	Quarterly	Safeguarding & Patient Safety	Safeguarding & Patient Safety	Safeguarding & Patient Safety

## References

1. NHS England Patient Safety Alert “Resources to support the prompt recognition of sepsis and the rapid initiation of treatment” – 2 September 2014 HS/PSA/R/2014/015
2. NICE NG51 Sepsis: recognition, diagnosis and early management.  
<https://www.nice.org.uk/guidance/ng51> Last accessed 4th February 2020
3. National Confidential Enquiry into Patient Outcome and Death, 2015, London. Just Say Sepsis! Available online at <http://www.ncepod.org.uk/2015sepsis.html> Last accessed 4<sup>th</sup> February 2020
4. UK Sepsis Trust, 2016. Derived from data provided by the Health and Social Care Information Centre (HSCIC). Available at <https://sepsistrust.org/about/about-sepsis/references-and-sources/> Last accessed 4<sup>th</sup> February 2020
5. Singer M, Deutschmann CS, Seymour CW, et al for the Sepsis Definitions Task Force. The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA 2016; 23;315(8):801-10
6. Kumar A, Roberts D, Wood KE et al. Duration of hypotension prior to initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Critical Care Medicine 2006; 34: 1589–96
7. Daniels R, Nutbeam I, McNamara G et al. The sepsis six and the severe sepsis resuscitation bundle: a prospective observational cohort study. Emergency Medicine Journal 2011; 28(6): 459-460

# Equality Analysis

<p><b>Name of Policy/Procedure/Function*</b></p> <p>Sepsis Recognition Policy</p> <p><b>Equality Analysis Carried out by:</b> Tim Balderstone</p> <p><b>Date:</b> 4th February 2020</p> <p><b>Equality &amp; Human rights Lead:</b> Rachel Higgins</p> <p><b>Director\General Manager:</b> Susan Ombler</p>
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**\*In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

**Section 1 – to be completed for all policies**

	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	To ensure that patients presenting to LCHS services are assessed in a uniform and structured manner to inform trigger actions which should be undertaken in the case of abnormality.		
	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? <b>Please give details</b>	Impacts on patients and staff		
	Is there is any evidence that the policy\service relates to an area with known inequalities? <b>Please give details</b>	No		
	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?			
		Yes	No	
	Disability		x	
	Sexual Orientation		x	
	Sex		x	
	Gender Reassignment		x	
	Race		x	
	Marriage/Civil Partnership		x	
	Maternity/Pregnancy		x	
	Age		x	
	Religion or Belief		x	
	Carers		x	
	<b>If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2</b>			
The above named policy has been considered and does not require a full equality analysis				
<b>Equality Analysis Carried out by:</b>		Tim Balderstone		
<b>Date:</b>		4 <sup>th</sup> February 2020		

## Appendices

### Recognition Tools

1. LCHS Community Hospital Recognition Tool
2. Community Nursing/Therapy Tools
3. Community Carers Tool
4. Urgent Care Adult Tool
5. Urgent Care u5 Tool
6. Urgent Care 5-12 Tool
7. Urgent Care Maternity Tool
8. OOH Adult Tool
9. OOH u5 Tool
10. OOH 5-12 Tool
11. OOH Maternity Tool
12. CAS Adult Tool
13. CAS u5 Tool
14. CAS 5-12 Tool
15. CAS Maternity Tool

These are all available to download from the Trust Intranet

<https://staff.lincolnshirecommunityhealthservices.nhs.uk/index.php?CID=1731>