## SEPSIS ASSESSMENT PROFORMA

### SEPSIS MANAGEMENT PROFORMA

### CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 INTRODUCTION</td>
<td>5</td>
</tr>
<tr>
<td>1.1 PURPOSE</td>
<td>6</td>
</tr>
<tr>
<td>1.2 SCOPE</td>
<td>6</td>
</tr>
<tr>
<td>1.3 PRINCIPLE LEGISLATION OR GUIDANCE REFERENCED</td>
<td>6</td>
</tr>
<tr>
<td>1.4 STANDARD SUPPORTED</td>
<td>7</td>
</tr>
<tr>
<td>1.5 READER PANEL</td>
<td>7</td>
</tr>
<tr>
<td>1.6 TRUST VALUES</td>
<td>8</td>
</tr>
<tr>
<td>1.7 GLOSSARY</td>
<td>8</td>
</tr>
<tr>
<td>1.8 DISTRIBUTION CONTROL</td>
<td>8</td>
</tr>
<tr>
<td>2.0 GUIDE FOR PRACTICE</td>
<td>9</td>
</tr>
<tr>
<td>2.1 TRAINING</td>
<td>9</td>
</tr>
<tr>
<td>2.2 GUIDELINE OBJECTIVES</td>
<td>9</td>
</tr>
<tr>
<td>2.3 GUIDELINES DEFINITION</td>
<td>9</td>
</tr>
<tr>
<td>2.4 SUPPORT FOR THIS GUIDELINE</td>
<td>9</td>
</tr>
<tr>
<td>2.5 AUDIT INDICATORS</td>
<td>9</td>
</tr>
<tr>
<td>2.6 CRITERIA FOR STAFF CARRYING OUT THE ACTION</td>
<td>10</td>
</tr>
<tr>
<td>3.0 GUIDANCE FOR PRACTICE</td>
<td>10</td>
</tr>
<tr>
<td>3.1 DIAGNOSIS OF INFECTION</td>
<td>10</td>
</tr>
<tr>
<td>3.2 DIAGNOSIS OF SEPSIS</td>
<td>10</td>
</tr>
<tr>
<td>3.3 MANAGEMENT OF SEPSIS</td>
<td>11</td>
</tr>
<tr>
<td>3.4 DIAGNOSIS OF SEVERE SEPSIS</td>
<td>11</td>
</tr>
<tr>
<td>3.5 MANAGEMENT OF SEVERE SEPSIS</td>
<td>12</td>
</tr>
<tr>
<td>3.6 DIAGNOSIS OF SEPTIC SHOCK</td>
<td>12</td>
</tr>
<tr>
<td>3.7 MANAGEMENT OF SEPTIC SHOCK</td>
<td>12</td>
</tr>
<tr>
<td>3.8 ANTIBIOTICS</td>
<td>12</td>
</tr>
<tr>
<td>3.9 BLOOD PRODUCTS</td>
<td>13</td>
</tr>
<tr>
<td>3.10 SOURCE CONTROL</td>
<td>13</td>
</tr>
<tr>
<td>4.0 MONITORING COMPLIANCE - CQUIN AUDIT FORM</td>
<td>14</td>
</tr>
</tbody>
</table>

Appendix 1 EQUALITY IMPACT ASSESSMENT | 16 |
Sepsis Assessment Proforma

Clinical suspicion of infection?

Yes

Systemic response?

Yes

Patient has sepsis

Ensure bloods taken. Send blood and other cultures as indicated. Give prompt antibiotics and hydration.

No

Organ dysfunction?

Yes

Patient has severe sepsis

- Commence sepsis management protocol (see overleaf)
- Contact ITU if organ support needed now, unless inappropriate (record overleaf)

No

Hypotension? Hypoperfusion?

Yes

- Hypotension despite fluid challenge
- Lactate >4

No

Call ITU NOW unless inappropriate (record overleaf)
- Ensure full sepsis management protocol underway (see overleaf)
- Continue fluid resuscitation

No

Any of the following, present and new:

- Hypotension systolic ≤100mmHg or ≤40mmHg of pts norm.
- Hypoxaemia (new O₂ requirement to maintain SpO₂ ≥94%)
- Creatinine >177 (or >44 increase)
- Urine output <0.5ml/kg/hr
- Bilirubin >34
- Platelets <100
- INR >1.5
- aPTT >60
- Lactate >2

2 or more of the following:

- Temp >38°C
- Temp <36°C
- Tachycardia >90/min
- Tachypnoea >20bpm
- White cell count >12 or <4x10⁹/L
- Acutely altered mental state
- Glucose >7.5 in absence of diabetes

Yes

ID: Patient Label

DoB:
# Sepsis Management Proforma

**Management of sepsis/severe sepsis and septic shock**

<table>
<thead>
<tr>
<th>Management</th>
<th>Time done</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Cultures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hourly Urine Output</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional management of septic shock**

<table>
<thead>
<tr>
<th>Management</th>
<th>Time done</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scope of treatment**

Please record the scope of treatment options appropriate for this patient, and any which are not. Consider resuscitation status, suitability for organ support, HDU/ITU and any palliative care measures. Give rationale if appropriate.

- **Name:**
- **Signature:**
- **Designation:**
1.0 INTRODUCTION

The terms used in this guideline have been taken from the Surviving Sepsis Guidelines (Dellinger et al., 2004). These have been agreed upon by international consensus meetings and are used throughout the guidance. For ease and consistency the same definitions are used here:

Sepsis can be defined as infection with systemic signs there of (Levy et al., 2003)
SIRS Systemic Inflammatory Response Syndrome is defined as a non clinical response including ≥2 of the following:
- Temperature >38c or <36c
- Heart rate >90
- Respiratory rate >20
- White blood cell count >12 < 4

Severe sepsis is sepsis and organ dysfunction or tissue hypo perfusion, induced by sepsis (Bone et al., 2003)
Septic shock is defined as sepsis-induced hypotension persisting despite adequate fluid resuscitation (Systolic blood pressure <90mmHg or mean arterial pressure <70mmHg or drop in systolic blood pressure >40mmHg or >2 standard deviations below normal for age)
Sepsis-induced hypo perfusion is defined as any of: septic shock, elevated lactate or oliguria

1.1 Background

There are 18 million cases of sepsis a year worldwide and an estimated 36,000 deaths per year in the UK - more than from breast and bowel cancer combined. The risk of death from sepsis is six times that from a myocardial infarction. The mortality from severe sepsis is 35% and from septic shock 50% (Dellinger et al, 2004).

In an international survey of senior physicians about 80% felt that sepsis was poorly identified and inconsistently managed (Townsend et al., 2005). The American Society of Critical Care Medicine, European Society of Intensive Care Medicine and the International Sepsis Forum subsequently developed a three-phase campaign, ‘Surviving Sepsis’, to provide a uniform, evidence-based approach to the management of patients with sepsis worldwide.

In 2001, Rivers et al. published a landmark study which analysed the use of a care bundle for patients with severe septic and septic shock, which he titled ‘Early goal directed therapy’ (EGDT) 8. Patients receiving EGDT had a 34% reduction in mortality, compared to patients receiving standard treatment. The ‘Surviving Sepsis’ campaign (www.survivingsepsis.org) was launched in 2002 to improve the management and outcome of patients with sepsis with consensus guidelines, which were first published in 2004 (Dellinger et al., 2004).

Early Goal Directed Therapy has been shown to reduce mortality from sepsis in UK hospitals (Reuben et al., 2006).

Further work has shown that initiation of the ‘Sepsis Six’ care bundle to patients with severe sepsis and septic shock within one hour of the recognition of sepsis halves mortality (Daniels et al, 2010).
1.2 Purpose

The purpose of this guideline is to assist clinicians in the identification, assessment and management of sepsis, severe sepsis and septic shock.

1.3 Scope

This guideline applies to all patients with a suspected diagnosis of infection, excluding:

Assessment and management of sepsis in children (under the age of 16 years)
Management of sepsis in High Dependency / Intensive Care
Management of sepsis in neutropenic Patients

Please refer to intranet policies for their management.

1.4 Principle Legislation or Guidance Referenced

This guideline is based on the guidelines from the International Sepsis Forum (Dellinger et al., 2004 – below) in conjunction with a panel of local experts, and the following papers:


GRADE working group: Grading quality of evidence and strength of recommendations; BMJ 2004; 328:1490–1498

Harrison DA, Welch CA, Eddleston JM; The epidemiology of severe sepsis in England, Wales and Northern Ireland, 1996 to 2004: secondary analysis of a high quality clinical database, the ICNARC Case Mix Programme Database; Critical Care 2006, 10:R42

International Surviving Sepsis Campaign guidelines


Further resources from the Surviving Sepsis Campaign can be found at: www.survivingsepsis.org

The following Trust guidelines provide important additional information:

Kader A; Antibiotic Guideline for the Empirical Treatment of sepsis in Adults

Elumogo, N; Quick Reference Guidelines for Collecting Blood Cultures; available on the Trust intranet

Cotter T & Babu P; Guidelines for the management of community acquired pneumonia in adults; available on the Trust intranet at: Community Acquired Pneumonia (87 KB)

Gomez, C et al.; Clinical guidelines for the prophylaxis and management of sepsis in neutropenic patients; available on the Trust intranet at: Prophylaxis & Management of Sepsis in Neutropenic Patients (85 KB)

Hawtin L & Hoadley M Clostridium Difficile Infection (CDI) Policy for the management of Clostridium Difficile Infection (Sporadic cases, Period of Incidence or Outbreak Situation) – available on Trust intranet

1.5 Standard Supported

Surviving Sepsis Campaign guidelines available at: www.survivingsepsis.org/Guidelines

College of Emergency Medicine Standards for severe sepsis and septic shock management in adults, available at: www.collemergymned.ac.uk/Shop-Floor/Clinical%20Audit/default.asp

1.6 Reader Panel

The following formed the Reader Panel that reviewed and endorsed this document:

- Miss S Downey Consultant General Surgeon Divisional Director
- Dr C. Gomez Consultant Haematologist
- Dr J. Preston Consultant Obstetrician & Gynaecologist, Divisional Director
- Dr M. Williams Consultant Gastroenterologist
- Dr M Wright Consultant Anaesthesics and ICU
- Dr D. Wade Accident & Emergency Consultant
- Dr M. Venu Consultant Physician, Acute Medicine
- Dr A. Blackburn Consultant Physician Acute Medicine
- J Copping Deputy Director of Nursing
- V. Foley Nurse Consultant Critical Care Outreach Team
- J. Grayston Head of Biochemistry
1.7 Trust Values

This Procedure conforms to the Trust’s values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly.

1.8 Glossary

The following terms and abbreviations have been used within this Guideline:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGDT</td>
<td>Early Goal Directed Therapy</td>
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</tbody>
</table>

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.
2.0 GUIDE FOR PRACTICE

This guideline will set the standard for:

- Diagnosis of sepsis
- Diagnosis of severe sepsis
- Diagnosis of septic shock
- Management of sepsis
- Management of severe sepsis
- Management of septic shock

2.1 Training

Training for Registered Nurses will consist of a 90 minute training session on the management of septic patients, to be facilitated by the Critical Care Outreach team.

Medical staff will receive sepsis management training as part of their Trust induction, facilitated by the Trust Sepsis Group. In addition all doctors working in the Emergency Department will receive regular updates as part of a the rolling rota of teaching sessions

2.2 Guideline Objectives

The objective of the Guideline is to ensure prompt recognition of sepsis, and appropriate early interventions to maximize patient survival rates.

2.3 Guideline Definition

Sepsis can be defined as infection with systemic signs thereof (Levy et al, 2003)

Severe sepsis is sepsis and organ dysfunction or tissue hypoperfusion, induced by sepsis (Bone et al, 2003).

Septic shock is defined as sepsis-induced hypotension persisting despite adequate fluid resuscitation (Systolic blood pressure <90mmHg or mean arterial pressure <70mmHg or drop in systolic blood pressure >40mmHg or >2 standard deviations below normal for age).

Sepsis-induced hypo perfusion is defined as any of: septic shock, elevated lactate or oliguria.

2.4 Support for this Guideline

Support and advice can be obtained form the Critical Care Outreach Team, The Sepsis Group and the Hospital at Night Team.

2.5 Audit Indicators

The Sepsis Six Care Bundle will be administered within 1 hour of identification of sepsis or clinical reason for omission recorded (e.g. if lactate measurement not felt to be clinically warranted)
(Appendix1 Sepsis CQUIN Audit Criteria)
Audit of compliance will be carried out monthly by the sepsis group as part of the 2012/13 Sepsis CQUIN. Following this, bi-annual audits will take place.

2.6 Criteria for staff carrying out the Action
All Trust nursing and medical staff is responsible for the early identification of sepsis, and alerting appropriate medical staff, or the Critical Care Outreach Team, to ensure administration of the sepsis six bundle within one hour of recognition of sepsis.

3.0 GUIDANCE FOR PRACTICE

The assessment and management of patients should occur in a stepwise fashion, from diagnosis of infection, to assessment of systemic illness (sepsis), to identification of severe sepsis, to identification of septic shock.

Assessment and treatment should be undertaken as described below in the context of the individual patient – not all elements will be appropriate for all patients. Where such omissions are made the reasons for doing so should be clearly documented in the medical notes and on the Sepsis Proforma (Appendix 2)

3.1 Diagnosis of infection

The diagnosis of an infection should be made primarily on clinical grounds, by taking a thorough history and performing an appropriate examination. Simple bedside tests and observations may support the diagnosis, but further investigations should be taken in the context of this initial clinical assessment.

3.1.1 All patients, with an infection should have basic observations recorded at regular intervals, in accordance with the Early Warning Scoring System, Sepsis Proforma and/or management plan including pulse rate, respiratory rate, blood pressure and temperature. Blood glucose should be recorded. Having triggered the EWSS and/or Sepsis proforma patients should be assessed by a doctor for evidence of sepsis.

3.2 Diagnosis of sepsis

3.2.1 Sepsis is diagnosed when there is a clinical diagnosis of infection with systemic signs, including 2 or more of the SIRS criteria listed below:

Hyper or hypothermia (>38°C, <36°C)
Tachycardia (>90)
Tachypnoea ( RR >20)
WCC <4 OR >12
Acutely altered mental status
Hyperglycaemia (>7.5 mmol/L) in the absence of

3.2.2 Patients identified as having sepsis (infection with systemic evidence or dysfunction) should undergo the following investigations:

Urea & electrolytes
Liver function tests
Coagulation
Lactate
Arterial or venous blood gases
Chest x-ray where clinically indicated
Urinalysis +/- mid-stream urine
Wound swabs / culture from central lines or any other potential sources of infection.

3.2.3 Urine output should be monitored and recorded. Consider bladder scanning and catheterisation for accurate fluid balance, weighed against the risk of causing bacteraemia in urinary tract infections

3.3 Management of patients with sepsis

3.3.1 Observation and monitoring should be instigated if not already started. This should include recording of pulse rate, blood pressure, respiratory rate, temperature and urine output. These should be recorded at least every 1 hour and more frequently where clinically necessary

3.3.2 Early Warning Scores should be calculated and recorded each time observations are recorded, and whenever there is a change in the patient’s clinical condition

3.3.3 Antibiotics appropriate to presumed source of infection should be given. If source of infection is unclear, Tazocin 4.5g and Gentamicin 5mg/kg should be given unless penicillin allergy is present – see section 3.7, below

3.3.4 Neutropenic sepsis and immunosuppressed patients should be managed according to the Trust guideline ‘Clinical guidelines for the prophylaxis and management of sepsis in neutropenic patients’

3.3.5 All patients should be reviewed by a consultant within 24 hours of admission and ideally within 12 hours. Review by a Registrar or above should be undertaken within 1 hour of the commencement of the Sepsis Six Care Bundle. Hourly monitoring of vital signs should continue until Senior Medical review (Registrar or above) has taken place.

3.3.6 Consider the use of antipyretics for patient comfort

3.4 Diagnosis of severe sepsis (defined as organ dysfunction as a consequence of sepsis) is made when any of the following are present as new findings in a patient diagnosed with sepsis:

- Hypotension (defined as a systolic blood pressure <100 mmHg or mean arterial pressure <70mmHg)
- Creatinine >177 μmol/L or >44 increase from baseline
- Bilirubin >34 μmol/L
- Platelets <100 x10⁹/L
- Arterial hypoxaemia pO₂/FiO₂ ratio >40, or SaO₂ < 95%.
- Coagulopathy (INR >1.5)
- Lactate >2 mmol/L

3.5 Management of severe sepsis

3.5.1 All patients diagnosed as having severe sepsis should have the ‘Sepsis Six’ care bundle within 1 hour of first set of abnormal observations:
1) High flow oxygen (15litres via a non-rebreathe mask, unless patient has COPD or other contraindications. These patients should be given 28% oxygen if tolerated, with monitoring of ABG’s after 1 hour).

2) Blood cultures - these should ideally be taken prior to administration of antibiotics, from at least 2 sites (see hospital guideline), but this should not delay antibiotic administration.

3) Lactate measurement via a venous or arterial blood gas sample

4) Bloods taken and sent for investigations as above, to include a FBC

5) Intravenous fluid bolus, recommended 20mls/kg, with care and frequent reassessment in patients with impaired cardiac function.

6) Antibiotics administered as above

The patients should be reassessed by the medical team caring for the patient within 1 hour of commencement of the sepsis six bundle. In addition senior medical staff should be informed and asked to review the patient.

3.5.2 Scope of treatment

A clear management plan should be documented by a Consultant or other senior doctor (Registrar or above) regarding the appropriate ceiling of treatment, and resuscitation status.

3.6 Diagnosis of septic shock

3.6.1 Septic shock is said to be present when a patient with a diagnosis of severe sepsis remains hypotensive (blood pressure <90mmHg systolic), remains oliguric (urine output <0.5ml/kg/hour), or lactate remains >4 after fluid resuscitation with a minimum of 20ml/kg fluid bolus.

3.7 Management of septic shock

3.7.1 Patients with septic shock should be treated as detailed in the management of severe sepsis. In addition all patients with a diagnosis of septic shock should be discussed with intensive care for consideration of inotropes, unless ICU management is deemed clinically inappropriate by the Parent Consultant and the Critical Care Consultant.

3.8 Antibiotics

3.8.1 Antibiotics should be administered within 1 hour of identifying severe sepsis. Mortality increases by 8% for each hour this is delayed.

3.8.2 Antibiotics should be selected according to severity and source of infection, in consultation with the hospital’s antibiotic prescribing guidelines, or a consultant microbiologist where appropriate.
3.8.3 Antibiotics should be reviewed daily and in the context of clinical and microbiological data, considering the necessity, route and spectrum of action.

3.9 Blood products

3.9.1 Septic patients should be transfused with red cells if the Hb is <7 to increase the oxygen carrying capacity of the blood. The decision to transfuse at higher Hb levels will be made on clinical grounds.

3.10 Source control

3.10.1 Early evaluation of the patient should seek to identify any focus of infection amenable to control measures. Examples include surgical debridement of abscess, repair of GI perforation, removal of infected device etc.

3.10.2 Control measures should be initiated as soon as possible after adequate resuscitation of the patient has occurred.
## 4.0 Monitoring Compliance

### Sepsis CQUIN Audit - Criteria

The notes of 10 patients with a diagnosis of sepsis will be audited each month for the duration of the CQUIN. These will include 3 x ICU patients (or less if less than 3 patients admitted to ICU in that month), 3 patients who have died as a result of sepsis, with the remaining 6 patients (or more if less than 10 in total due to low numbers of ICU patients) to be taken from other patients with a diagnosis of sepsis. Where more than 10 patients fit the criteria, data from the first 10 patient patients admitted in that month will be taken. The notes of these patients will be audited according to the following criteria:

<table>
<thead>
<tr>
<th>Study Number</th>
<th>Was Sepsis Management Proforma used?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**PLEASE TICK RELEVANT CLINICAL PROMPT TO INITIATE SEPSIS SIX**

- Abnormal observations and/or blood results indicating SIR's plus organ dysfunction:
  - Date
  - Time

- Blood results indicating SIR's plus organ dysfunction:
  - Date
  - Time

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1a</td>
<td>Was patient given high flow oxygen?</td>
<td>Yes</td>
</tr>
<tr>
<td>1b</td>
<td>Was oxygen administered at 15L / min via a non-rebreath mask?</td>
<td>Yes</td>
</tr>
<tr>
<td>1c</td>
<td>Was oxygen administered within 1 hour of abnormal observations and/or blood results indicating SIR's plus organ dysfunction?</td>
<td>Yes</td>
</tr>
<tr>
<td>2a</td>
<td>Was IV fluid resuscitation started?</td>
<td>Yes</td>
</tr>
<tr>
<td>2b</td>
<td>Did patient have minimum 250mls crystalloid over 30 mins?</td>
<td>Yes</td>
</tr>
<tr>
<td>2c</td>
<td>Was IV fluid started within 1 hour of abnormal observations?</td>
<td>Yes</td>
</tr>
<tr>
<td>3a</td>
<td>Were patient's blood cultures taken?</td>
<td>Yes</td>
</tr>
<tr>
<td>3b</td>
<td>Were blood cultures taken within 1 hour of abnormal observations?</td>
<td>Yes</td>
</tr>
<tr>
<td>4a</td>
<td>Were IV antibiotics prescribed?</td>
<td>Yes</td>
</tr>
<tr>
<td>4b</td>
<td>Were IV antibiotics administered within 1 hour of abnormal observations?</td>
<td>Yes</td>
</tr>
<tr>
<td>5a</td>
<td>Did patient have full blood count checked?</td>
<td>Yes</td>
</tr>
<tr>
<td>5b</td>
<td>Was FBC checked within 1 hour of abnormal observations?</td>
<td>Yes</td>
</tr>
<tr>
<td>5c</td>
<td>Did patient have lactate checked?</td>
<td>Yes</td>
</tr>
<tr>
<td>5d</td>
<td>Was lactate checked within 1 hour of abnormal observations?</td>
<td>Yes</td>
</tr>
<tr>
<td>6a</td>
<td>Was the patient’s hourly urine output monitored?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
6b Did monitoring commence within 1 hour of abnormal observations?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
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<tbody>
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<td></td>
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</tbody>
</table>

Please state reason for any exceptions (N/A):

Successful completion of the sepsis six will only be considered to have occurred if the answer to all of these questions is yes. Results of the audit will be fed back monthly to the PCT as part of the CQUIN, and also to the sepsis group to action as appropriate.
Appendix 3 - Equality Impact Assessment

Policy or function being assessed: Assessment and Management of Sepsis Guidelines  
Department/Service: James Paget University Hospital NHS Trust  
Assessment completed by: Bridget Inyang  
Date of assessment: 05/08/2012

1. Describe the aim, objective and purpose of this policy or function.

   The purpose of this guideline is to assist Clinicians and Nursing Staff in the identification, assessment and management of sepsis, severe sepsis and septic shock. It aims to ensure consistent, through and prompt interventions to maximize the chances of patients’ survival from sepsis.

2i. Who is intended to benefit from the policy or function?

<table>
<thead>
<tr>
<th>Staff</th>
<th>Patients</th>
<th>Public</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□ X</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2ii. How are they likely to benefit?

   Delivery of Sepsis Six Care Bundle within 1 hour halves the mortality in patients with severe sepsis and septic shock.

2iii. What outcomes are wanted from this policy or function?

   Improved identification, assessment and management of sepsis, severe sepsis and septic shock

For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>3.</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their <strong>race/ethnicity</strong>?</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>4.</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their <strong>gender</strong>?</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>5.</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their <strong>disability</strong>?</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>6.</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their <strong>sexual orientation</strong>?</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Question</td>
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<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their pregnancy or maternity?</td>
</tr>
<tr>
<td>8</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their religion/belief?</td>
</tr>
<tr>
<td>9</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their transgender?</td>
</tr>
<tr>
<td>10</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their age?</td>
</tr>
<tr>
<td>11</td>
<td>Are there concerns that the policy/function does or could have a detrimental impact on people due to their marriage or civil partnership?</td>
</tr>
<tr>
<td>12</td>
<td>Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?</td>
</tr>
<tr>
<td>13</td>
<td>Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.</td>
</tr>
</tbody>
</table>

14. **Specific Issues Identified**

Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment Page/paragraph/section of policy/function that the issue relates to

1. None

15. **Proposals**

How could the identified detrimental impact be minimised or eradicated? 

N/A
If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?  

| 16. Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted? | N/A | N |

17. **Policy/Function Implementation**

Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust.

Please print:

? Val is head of service for this. I'm not entirely sure who is – possibly D.Wade as CQUIN lead.

**Name of Director/Head of Service:** Valerie Foley  **Title:** Nurse Consultant Critical Care  
**Date:** August 2012

**Name of Policy/function Author:** Bridget Inyang  **Title:** Clinical Nurse Specialist Critical Care  
**Date:** August 2012

(A paper copy of the EIA which has been signed is available on request).

18. **Proposed Date for Policy/Function Review**

August 2015

Please detail the date for policy/function review (3 yearly): August 2015

19. **Explain how you plan to publish the result of the assessment?** *(Completed E.I.A’s must be published on the Equality pages of the Trust’s website).*

Standard Trust process

20. **The Trust Values**
In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures.

They are that all staff intend to do their best by:

Putting patients first, and they will:
- Provide the best possible care in a safe clean and friendly environment,
- Treat everybody with courtesy and respect,
- Act appropriately with everyone.

Aiming to get it right, and they will:
- Commit to their own personal development,
- Understand theirs and others roles and responsibilities,
- Contribute to the development of services

Recognising that everyone counts, and they will:
- Value the contribution and skills of others,
- Treat everyone fairly,
- Support the development of colleagues.

Doing everything openly and honestly, and they will:
- Be clear about what they are trying to achieve,
- Share information appropriately and effectively,
- Admit to and learn from mistakes.

I confirm that this policy/function does not conflict with these values. ☑