

Clinical and scientific letters

Responding to NICE – developing a regional sepsis pathway

A complex landscape

Sepsis is a major cause of avoidable death. Early recognition and treatment of sepsis might save up to 10,000 lives in the UK each year, but survival falls by up to 7–8% for every hour delay in treatment.¹ Differing international and UK (National Institute of Health and Care Excellence [NICE]) guidelines were published in 2016,^{1–3} resulting in confusion among clinicians

about the most appropriate strategy for sepsis identification and management.

A recent national survey demonstrated substantial variation in local guidelines and practice.⁴ For example, only one-quarter of acute trusts planned to implement the NICE guidelines as published. Most planned to adapt the guidelines for local implementation. Many respondents felt that the NICE guidance required simplification to ensure better adherence. Proposed modifications included using aggregate rather than single ‘red flag’ National Early Warning Scores for high-risk

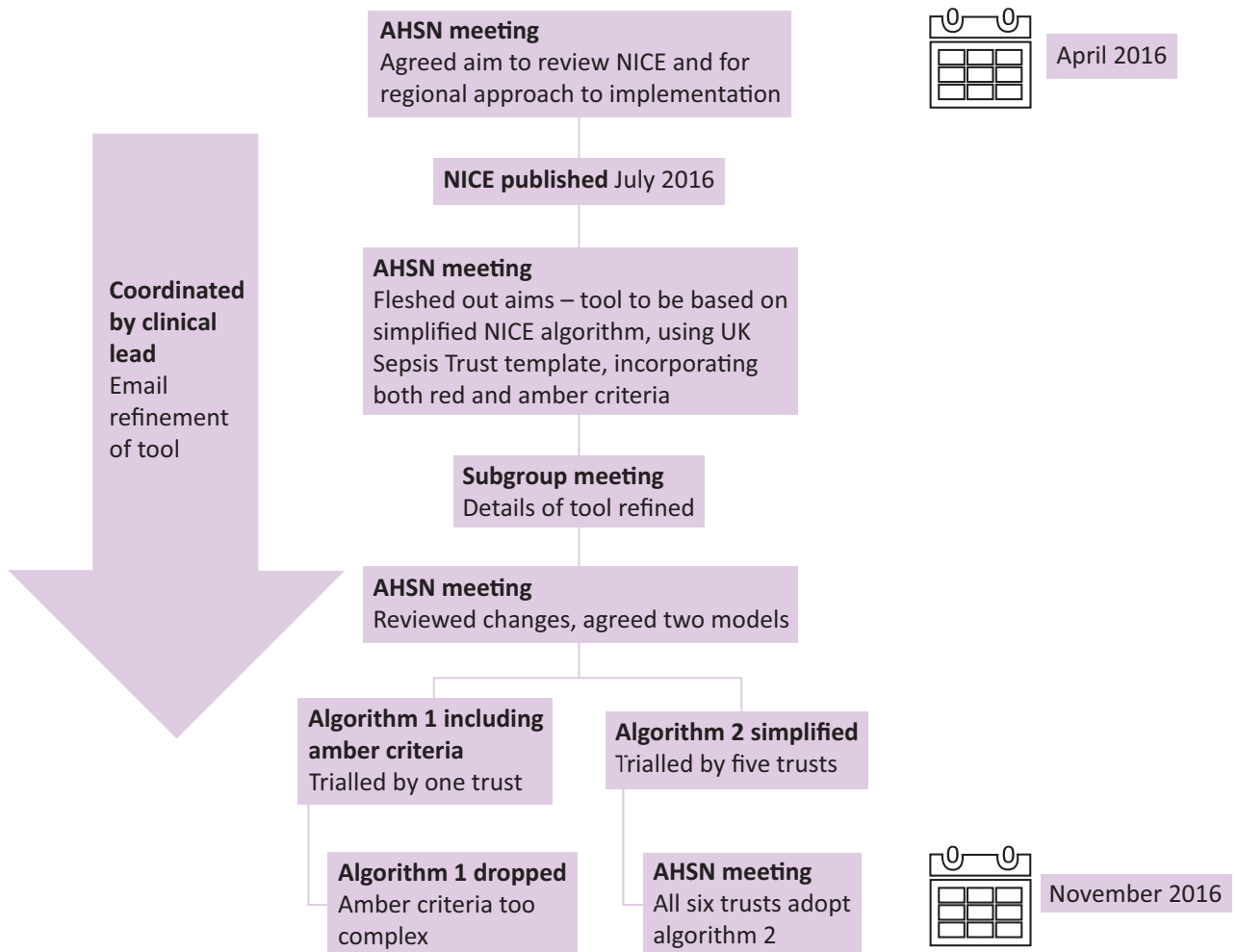


Fig 1. Process for developing a regional sepsis pathway.

criteria; removing moderate risk criteria; amalgamating moderate and high-risk criteria; including lactate earlier in the pathway; and including neutropaenic sepsis in the high-risk pathway.

The complexity of the sepsis landscape has therefore resulted in the emergence of substantial variation in practice.

A standardised approach to sepsis

We established a regional sepsis stakeholder group through the Oxford Academic Health Science Network (AHSN) Patient Safety Collaborative in February 2016. The group comprises clinicians with responsibility for sepsis care in 25 partner organisations and other colleagues with an interest in improving sepsis care.

To improve the consistency of care for adult patients at risk of sepsis we aimed to agree a standardised approach to sepsis management across the acute hospital trusts within the Oxford Academic Health Science Network (AHSN) region.

Developing a standardised pathway

There was a consensus that the complexity of the NICE management algorithm for adults in hospital presents a challenge to real world implementation, without good evidence to support that complexity. Through a series of stakeholder meetings (Fig 1) we simplified the algorithm using the UK Sepsis Trust template. Key principles included:

- > simplicity to ensure reliable implementation
- > incorporation of successful existing tools (early warning scores [EWS], 'red flag' sepsis criteria and the sepsis six care bundle)
- > ensuring a generic pathway applicable to trusts with varying resources.

The final pathway greatly simplified the NICE algorithm by removing amber criteria (see link below). This was justified on the basis that any patient meeting the EWS criteria for pathway entry merits an assessment including blood tests.

Implications and impact

The simplified regional pathway was implemented by all six participating acute hospital trusts in 2017. We believe a benefit of this regional approach is more consistent, safer care for sepsis patients, particularly by rotating medical staff. Collaborative working provides peer support, reduces variance throughout trusts, reduces workload locally, supports shared learning, and facilitates collection of consistent regional data. ■

Acknowledgements

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www.patientsafetyoxford.org/clinical-safety-programmes/sepsis/sepsis-resources/sepsis-resources-pathways/

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Are we doing enough to detect paroxysmal atrial fibrillation after an acute ischaemic stroke? Survey of cardiac monitoring methods among stroke physicians

Detecting paroxysmal atrial fibrillation (PAF) is challenging given the intermittent and often asymptomatic nature of the condition. Stroke secondary prevention guidelines acknowledge that longer duration of monitoring (>24 hours) after an ischaemic stroke is likely to yield a higher frequency of PAF, but are unable to provide precise guidance on 'how long' to monitor after stroke.^{1,2} A recent systematic review suggested increased AF detection among unselected acute ischaemic stroke patients with prolonged methods of monitoring (>24 hours) but the precise method, duration and time to intervention following a stroke remains unknown.³

In the absence of robust evidence-based guidelines and the existence of advanced cardiac monitoring devices, the main objective of the survey was to explore cardiac monitoring strategies to detect PAF after an acute ischaemic stroke among stroke specialists. A questionnaire (nine questions) was created using SurveyMonkey and sent through a mailing list of the British Association of Stroke Physicians (BASP). The questionnaire