Acacium Group

Sepsis Policy

Policy Reference | CLIN 50

Version | V3.1

Policy Name	Sepsis Policy
Purpose of Document	This policy aims to improve outcomes for patients / clients / service users presenting with sepsis or developing sepsis by providing evidence-based recommendations for practice
Target Audience	All Acacium Group staff
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Associated Strategies and SOPs	CLIN 01 Clinical Risk Management Policy CLIN 06 Consent Policy CLIN 08 Safeguarding and Protecting Children Policy CLIN 09 Safeguarding Vulnerable Adults Policy CLIN 14 Health Records Management Policy CLIN 40 Do Not Attempt Resuscitation Policy CLIN 51 NEWS2 Policy CLIN 53 PEWS Policy GEN 23 Vital Signs and Observations
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
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V3.1	June 2024	Review and Update	Clinical Advisory Group

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1. Introduction

1.1 The NICE definition is as follows Sepsis is a syndrome defined as life-threatening organ dysfunction due to a dysregulated host response to infection. Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities that are associated with a greater risk of mortality than sepsis alone. It is thought to be a multifactorial response to an infecting pathogen that may be amplified by host factors (such as genetics, age, and co-morbidities), the pathogen (type, virulence, and burden), and the environment. The most common sites of infection leading to sepsis are the respiratory, gastrointestinal, renal, and genitourinary tracts (NICE 2024).

1.2 The successful management of sepsis requires a very high index of suspicion, early recognition, and timely intervention.

1.3 Patients cared for in the home, 'walk in' centres and minor injury & illness units must be immediately identified, and transfer organised to ensure treatment can be initiated quickly as a 999 response, this places additional emphasis on recognition skills without the use of higher-level diagnostics which are available in the acute hospital setting. Over 70% of cases arise in the community (NCEPOD, 2015).

1.4 Equally clinicians suspecting sepsis in a community hospital or minor injuries unit will not have the same diagnostics available as in an acute hospital.

1.5 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.

1.6 This policy has been developed in line with the Care Quality Commission (CQC) Key Line of Enquiry that helps to ensure that the care provided to the client is safe, effective, responsive and well-led.

2. Purpose and Policy Statement

2.1 The purpose of this policy is to ensure a standardised business wide approach to the screening 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 Acacium Group
- Improve the quality of sepsis screening and immediate treatment
- The process of referral when a patient/client/service user is found to be deteriorating

3. Scope of Policy

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

3.2 Those staff engaging in patient/client/service user observations in the acute setting using the National Early Warning Score 2 (NEWS2) or Paediatric Early Warning Score (PEWS) systems together with clinical judgement to determine if sepsis may be present or suspected and those in the community setting using the patients care plan and clinical assessment documentation.

4. Definitions

4.1 The definition 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'. It is almost certain that the definitions of sepsis and septic shock will continue to develop as an iterative process over time. It is important to note that the term "Severe Sepsis" is no longer a classified definition due to the interchangeability between defining sepsis and severe sepsis.

Topic	Explanation
Sepsis	Sepsis is characterised 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 Urgent Care situations significant hypotension in the presence of presumed infection is an appropriate surrogate to describe presumed septic shock.

5. Roles & Responsibilities

5.1 The overall organisational roles and responsibilities are set out in the policy document: Policy for drafting, approval and review of policies and SOPs.

Job Title	Responsibilities
Chief Executive Office	• To ensure that Acacium Group adheres to relevant national guidance and standards for Sepsis • To ensure and promote appropriate, safe, multiagency/interagency partnership working practices and information sharing practices operate within the organisations.
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Board Members	• Understand the statutory role of the Board including partnership arrangements, policies, risks and performance indicators, staff roles and responsibilities in sepsis • The Board will be held accountable for ensuring that children and adults receive high quality, evidence-based care and are seen in appropriate environments with the right staff.
Individual Acacium Group workers	• Be familiar with Acacium Group policies procedures and guidance for sepsis • Ensure that they report any concerns immediately to their Line Manager/appropriate other • Document reasons for their concerns and actions taken • Take part in voluntary training, including attending updates, so that they maintain their skills and are familiar with procedures associated with the identification of sepsis • Access regular supervision and support in line with local procedures

	• Maintain accurate comprehensive and legible records, with records being stored securely in line with Acacium Group policy. See the Record Management Policy
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

6. Competence for Practice

6.1 Awareness of sepsis can be increased by use of online training.

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

7. Identification of Sepsis

7.1 Signs of Sepsis in Children:

- Blue, pale or blotchy skin, lips or tongue
- A rash that does not fade when you roll a glass over it, the same as meningitis
- Difficulty breathing (you may notice grunting noises or their stomach sucking under their ribcage), breathlessness or breathing very fast
- A weak, high-pitched cry that's not like their normal cry
- Not responding like they normally do, or not interested in feeding or normal activities
- Being sleepier than normal or difficult to wake
- They may not have all these symptoms

7.2 Signs of Sepsis in Adults

- Slurred speech, acting confused, or not making sense
- Extreme shivering, muscle pain
- Passing no urine (in a day)
- Severe breathlessness, difficulty breathing or breathing very fast
- It feels like you're going to die
- Skin mottled or discoloured, a rash that does not fade when you roll a glass over it, the same as meningitis
- They may not have all these symptoms.

7.3 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. It is for this reason that the International Consensus Definitions for Sepsis Task Force have advised SIRS markers no longer be used as an identification of sepsis.

7.4 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.

7.5 The use of National Early Warning Scores 2 (NEWS2) and Paediatric Early Warning Scores (PEWS) are recommended in the identification of potential sepsis (see Appendix D and E).

7.6 The policy should be used in conjunction with the Acacium Group CLIN 51 NEWS 2 (National Early Warning Scores) Policy and Acacium Group CLIN 53 PEWS (Paediatric Early Warning Scores) Policy.

8. 'Higher Risk' Condition Factors

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

8.2 Those at extremes of age e.g. very young 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
- People with learning disabilities
- People with long term conditions
- Women who are pregnant, have given birth or had a termination or pregnancy or miscarriage in the past 6 weeks, with co-morbidities, impaired immune systems
- People with multiple conditions/co-morbidities

9. Children

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

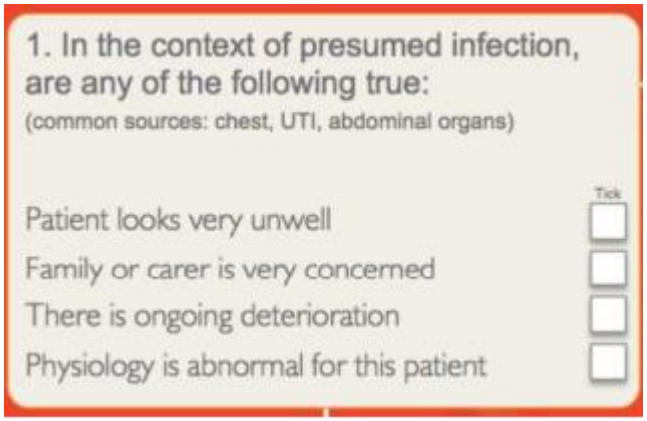
9.2 Young children and babies (<5yr) require an even greater understanding of developmental differences, behavioural changes can be subtle, physiological changes may appear late in the deterioration and parental anxiety can make history and information difficult to obtain.

9.3 The use of PEWS identifies the ranges for physiological observations within children and can assist in the identify of sepsis red flags.

10. Infection

10.1 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.

10.2 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.



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

11. Sepsis Risk Stratification

11.1 NICE (2017, NG51 updated March 2024) built upon the UK Sepsis Trust's **Red Flag Sepsis** approach, launched in 2015, for determining which patients should immediately be transferred for life saving therapy. The first step in NICE Sepsis: Risk Stratification toolkits should be to (see Appendix E):

1) THINK "Could this be Sepsis?"

2) If Sepsis is suspected, assess further using the appropriate person's age group and settings algorithm.

Available via:
For Adults: https://www.nice.org.uk/guidance/ng51/chapter/Could-this-be-sepsis
For Children: https://www.nice.org.uk/guidance/ng51/chapter/Under-16s-evaluating-risk-and-managing-suspected-sepsis

11.2 NICE (2017, NG51) recognises that different ages, clinical services and locations will have disparate abilities to consider and mange sepsis and provides relevant guidance in relation to this.

11.3 NEWS2 is used as the screening tool for Sepsis for aged 16 and above.

11.4 NICE Sepsis: Risk Stratification toolkit stratify risk of severe illness and death from sepsis (**low, moderate to high or high**) using the tool appropriate to age and clinical setting and recommend appropriate actions. Below is an example of "Out of Hospital Sepsis risk stratification tool for:

- Children aged under 5 years
- Children aged 5 – 11 years
- Children aged 12 – 15 years
- People aged 16 years and over out of hospital.

Risk stratification for adults, children, and young people with suspected sepsis can be found via NICE: guidelines **https://cks.nice.org.uk/topics/sepsis/diagnosis/risk-stratification/** (NICE 2024)

11.5 If a patient meets at least one of the **high-risk criteria**, this is time critical and immediate action is required. The patient must be urgently sent for emergency treatment.

11.6 All patients, who do not meet the **high-risk criteria** should immediately be screened for moderate to **high-risk criteria.**

11.7 **Moderate to high risk Sepsis**

11.7.1 The sepsis risk will normally be determined by the ability to fully understand the patient's condition and provide ongoing care. Patients with **moderate to high risk** sepsis can deteriorate rapidly.

11.7.2 If a patient, with presumed new infection, has neither **high risk criteria or moderate to high risk,** they should be assumed to be at **low risk**. Decisions to refer for acute hospital assessment can therefore be 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.

11.7.3 For those at **low risk** 'Safety netting', the process of providing written and verbal advice needs to be 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.

11.7.4 Patients who present with infections but without meeting **high risk** or **moderate to high risk** criteria require appropriate safety netting advice and signposting to GP/111/999 route if deterioration occurs.

12. Situation, Background, Assessment & Recommendation (SBAR) Referral

12.1 **S**ituation, **B**ackground, **A**ssessment & **R**ecommendation (SBAR) is an easy to remember mechanism that can be used to frame referral communications. It is structured in a way that communicating information requires a response from the receiver.

12.2 SBAR can be used effectively to escalate a clinical concern that requires immediate attention.

12.3 SBAR stands for:

- **S** – Situation: What is happening at the present time?
- **B** – Background: What are the circumstances leading up to this situation?
- **A** – Assessment: What do I think the problem is?
- **R** – Recommendation: What should we do to correct the problem?

13. Management of Sepsis

13.1 **Sepsis Six**

13.1.1 The key immediate interventions that increase survival from sepsis are described in a bundle termed the Sepsis Six. The Sepsis Six bundle should be implemented within the first one hour of suspected sepsis, as this has been shown to be associated with significant mortality reductions.

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

In the community setting, upon identification of sepsis the inability to FULLY COMPLETE the Sepsis Six regimen within the 60-minute timescale should prompt the requirement for IMMEDIATE acute hospital transfer.

13.2 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.

13.3 A patient who looks unwell with presumed infection who displays at least **ONE high risk criteria** should be transferred to an acute hospital environment immediately and **The Sepsis Six** regimen commenced.

13.4 Transfer should be by 'blue light' ambulance, with a Paramedic crew if immediately available. The call should include direct reference to the acuity of the condition, using the term 'High risk Sepsis'. Where possible, a telephone referral to the receiving Emergency Department should be made, using the term '**High risk Sepsis'**.

13.5 Elements of treatment within **The Sepsis Six** may usefully be undertaken whilst transfer is awaited. There is strong evidence that expedient delivery of 'basic' aspects of care limits the maximum acuity of intervention required. Early intervention can prevent the requirement for invasive monitoring and vasoactive support later in hospital.

14. Oxygen

14.1 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. Hypoxia (lack of oxygen in the blood) will kill before hypercapnia (elevated carbon dioxide levels in the blood).

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

14.3 Patients with COPD and other risk factors for hypercapnia who are at risk of critical illness should have the same initial target saturations as other critically ill patients, pending blood gas measurements. After this time, they may need controlled oxygen therapy.

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

15. Blood Cultures

15.1 Cultures should be taken before antibiotics are started, unless this would significantly delay the first dose of antibiotics. They should be taken percutaneously, and from any intravenous access device that has been in place for more than 24 hours. 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.

16. Antimicrobials

16.1 The administration of Antimicrobials is paramount in the management of sepsis and a 1-hour door to needle approach is essential.

16.2 Treating sepsis with the right antibiotics is crucial, however test results might not always be readily available to identify the responsible microbe and local Trust guidelines should be followed on the appropriate Antimicrobials to prescribe/administer.

16.3 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 if possible, by paramedics or GP's.

16.4 If the cause of the illness is infection, antibiotics must be given promptly. Once test results are available, the antibiotics must be changed or stopped accordingly.

16.5 **A delay of one hour in administering antimicrobials in septic shock is associated with an increase in mortality rates of 8%** (Improving time to antibiotics and implementing the "Sepsis 6", McGregor. 2014).

17. Intravenous Fluids

17.1 The bolus administration of IV fluids is a cornerstone item within The Sepsis Six to counter hypotension.

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

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

18. Clinical Toolkits

18.1 A range of toolkits developed by NICE and The UK Sepsis Trust is available to assist staff in the process of sepsis recognition and awareness of treatment pathways; The Sepsis Manual, 5th Edition, 2019.

19. Consent

19.1 For some patients, severe co-morbidity and 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 and documented as appropriate. Mental capacity should always be considered.

19.2 Reference to the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 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.

19.3 All healthcare professionals, , 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.

19.4 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 the office notified to consider whether specialist safeguarding advice is required.

20. Training

20.1 Acacium Group will enable staff to participate in any required additional training in sepsis management and, where appropriate, this will be included in any client specific training in the home. Any training provided, whether that be attended voluntarily or not, will be proportionate and relevant to the roles and responsibilities of each staff member.

20.2 Staff must evidence their level of competency or voluntarily attend an Acacium Group Core Skills workshop to ensure that they are competent and have reached an agreed standard of proficiency. The Clinical Governance Committee will be responsible for ratifying the policy, standard operating procedures (SOP) and levels for competency.

20.3 Any additional delivery of training is the responsibility of the operational teams.

20.4 It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

20.5 Any training provided will be mapped to the requirements of individual care packages, the appraisal process, and noted in the personal development plan.

21. Associated Policies / SOPs

Policies
CLIN 01 Clinical Risk Management Policy
CLIN 06 Consent Policy
CLIN 08 Safeguarding and Protecting Children Policy
CLIN 09 Safeguarding Vulnerable Adults Policy
CLIN 14 Health Records Management Policy
CLIN 40 Do Not Attempt Resuscitation Policy
CLIN 51 NEWS2 Policy
CLIN 53 PEWS Policy
GEN 23 Vital Signs and Observations

22. References

- NHS England Patient Safety Alert “Resources to support the prompt recognition of sepsis and the rapid initiation of treatment” – 2 September 2014 NHS/PSA/R/2014/015
- NICE NG51 Sepsis: recognition, diagnosis and early management. July 2016. https://www.nice.org.uk/guidance/ng51
- National Confidential Enquiry into Patient Outcome and Death, 2015, London. Just Say Sepsis! Available online at https://www.ncepod.org.uk/2015report2/downloads/JustSaySepsis_FullReport.pdf

- UK Sepsis Trust, 2016. Derived from data provided by the Health and Social Care Information Centre (HSCIC). Available at http://sepsistrust.org/our-statistics-and-why-itmatters-march-2016/ Last accessed September 2019 https://sepsistrust.org/
- 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
- 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
- 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): 459-46
- Care Quality Commission Key Lines of Enquiry
- https://www.nice.org.uk/guidance/ng51/resources/algorithms-and-risk-stratification-tables-compiled-version-2551488301
- The Sepsis Manual 5th Edition 2019 the UK Sepsis Trust.
- The Statement on the initial antimicrobial treatment of sepsis.
- Professor Dame Helen Stokes-Lampard (Academy of Medical Royal Colleges, May 2022).
- https://cks.nice.org.uk/topics/sepsis/

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla Part of Acacium Group	Ellea Nursing Part of Acacium Group	CHS Healthcare Part of Acacium Group
DUNN REGULATORY ASSOCIATES Part of Acacium Group		

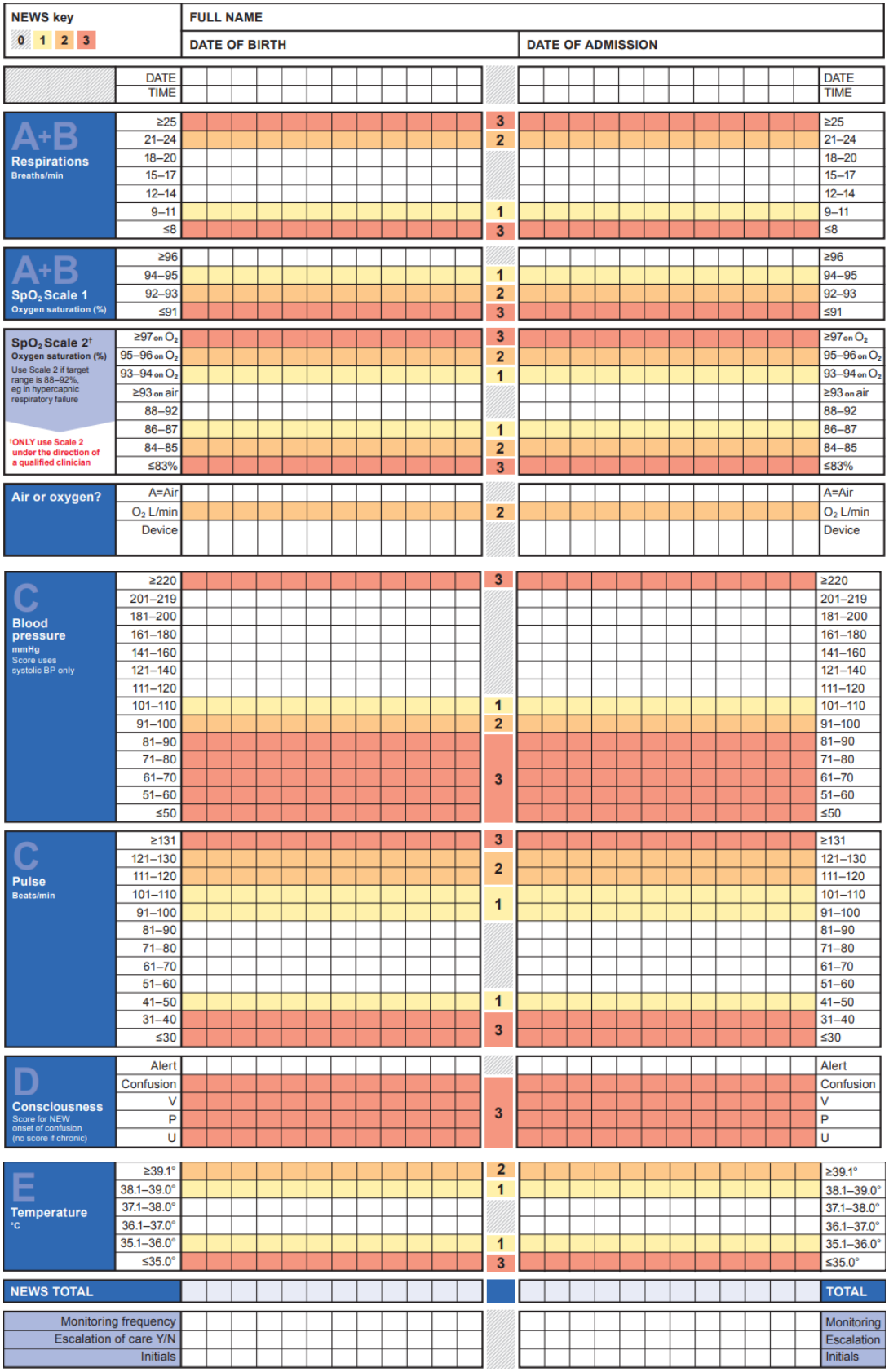
Appendix B: Legislation

NHS England Patient Safety Alert	Resources to support the prompt recognition of sepsis and the rapid initiation of treatment
NICE (2017) NG51 Sepsis	This guidance identifies the key issues for recognition, diagnosis and early management of Sepsis
UK Sepsis Trust, 2016. Derived from data provided by the Health and Social Care Information Centre (HSCIC); Updated 2019	The UK Sepsis Trust exists to fight this life-threatening condition, stop preventable deaths and support those affected by Sepsis.
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to.

Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: NEWS2 Observation Chart



Appendix D: PEWS Observation Chart