The Royal College of Emergency Medicine

Clinical Audits

EXCELLENCE IN EMERGENCY MEDICINE

Severe sepsis and septic shock (2016/17)
Audit proforma

Data should be submitted at https://rcem.l2s2.com between 1 Aug 2016 – 31 Jan 2017

Organisational audit			
Only one response per ED is required for questions Q1a-f			
Q1a	Has your department started to use the new definitions of sepsis (Sepsis-3)?	Yes No	
Q1b	Does your Trust/ organisation have a sepsis lead?	Yes No	
Q1c	Does your department have a formal protocol for the early identification and immediate management of patients with sepsis?	Yes In development No	
Q1d	If yes, does the protocol include guidance on: (tick all that apply)	Which antibiotics to use	
		Investigation and control of the source	
		Antibiotic stewardship	
Q1e	Does your department/ Trust/ organisation provide sepsis education for all ED staff?	Yes No	
Q1f	Does your department provide patient information for patients and/or relatives admitted with sepsis?	Yes No	

Patient audit

Q2	Patient reference	
Q3	Date of arrival *(dd/mm/yyyy)*	dd/mm/yyyy
Q4	Time of arrival *(Use 24 hour clock e.g. 11.23pm = 23:23)*	HH:MM

Q5	Were the following vital signs recorded on arrival: Respiratory Rate, Oxygen Saturations (SaO_2), Supplemental Oxygen Requirement, Temperature, Blood Pressure, Heart Rate, Level of Consciousness (AVPU or GCS) and Capillary Blood Glucose	Yes, all	
		Partially (tick all that apply):	
		- *Respiratory Rate*	
		- *Oxygen Saturations (SaO_2)*	
		- *Supplemental Oxygen Requirement*	
		- *Temperature*	
		- *Blood Pressure*	
		- *Heart Rate*	
		- *Level of Consciousness (AVPU or GCS)*	
		- *Capillary Blood Glucose*	
		Not recorded	

Q6a	Was the patient reviewed by a senior (ST4+ or equivalent) ED medic before leaving the ED?	Yes	
		No – reasons recorded	
		Not recorded	
		Time seen	HH:MM
Q6b	Was the Critical Care medic (including the outreach team or equivalent) involved in the patient's care before leaving the ED?	Yes	
		No – reasons recorded	
		Not recorded	
		Time seen	HH:MM

		Yes	*Time (leave blank if unknown)*	*Date (for use if different to date of admission)*	*No – reasons recorded (e.g. done pre-hospital)*	*No / not recorded*
Q7	Was oxygen initiated to maintain SaO_2>94%		HH:MM	dd/mm/yyyy		
Q8	Was serum lactate measurement obtained prior to leaving the ED?		HH:MM	dd/mm/yyyy		
Q9	Were blood cultures obtained prior to leaving the ED?		HH:MM	dd/mm/yyyy		
Q10	Was the first intravenous crystalloid fluid bolus (up to 30ml/kg) given in the ED?		HH:MM	dd/mm/yyyy		
Q11	Were antibiotics administered in the ED?		HH:MM	dd/mm/yyyy		
Q12	Was urine output measurement/ Fluid Balance Chart instituted prior to leaving the ED?		HH:MM	dd/mm/yyyy		

Notes

Question and answer definitions

Term	Definition
Q1c. Formal protocol for the early identification and immediate management of patients with sepsis	This may include a screening tool
Q7. Was oxygen initiated to maintain SaO_2>94%	If the patient's normal SaO_2 are less <94% (e.g. COPD), was oxygen initiated to maintain their target range?
Q10. Was the first intravenous crystalloid fluid bolus (up to 30ml/kg) given in the ED?	If the first bolus was given pre-hospital, please tick 'no – reason recorded'
Q11. Were antibiotics administered in the ED?	If antibiotics were administered pre-hospital, please tick 'no – reason recorded'
Q12. Was urine output measurement/ Fluid Balance Chart instituted prior to leaving the ED?	Please enter the time urine output was measuered