Sepsis Identification - November 2021

Category:	Treatment, Procedure: Connected with the management of operations / treatment
Speciality:	Emergency Medicine
When:	11/11/2021
Reference:	186964 / 2021 26134
Keywords	Sepsis, Urgent Care pathway

Incident Summary

This investigation involves an 80-year-old who received care for sepsis within an urgent and emergency care pathway. An ambulance was called by the Next of kin who found the patient to be very short of breath on the 11 November 2021 at 8.23am. On arrival, the crew identified sepsis and took the patient to hospital where further care was provided by the hospital and ambulance teams. Due to a lack of space in the Emergency Department, the patient received care within the ambulance until he was transferred into the resuscitation area of the Emergency Department. During a clinical examination by the Emergency Department Doctor, the patient went into cardiac arrest. The team worked to resuscitate the patient who sadly passed away in the Emergency Department on 11 November 2021.

Summary of findings, safety actions and recommendations

- Sepsis was identified by all clinicians who assessed the patient with appropriate screening tools being used.

- The systems pressures within the emergency and urgent care pathway meant the patient was not conveyed to an Emergency Department within the expected timeframe. The recommendation is for system partners to work together to improve the availability of ambulances.

- Safety net calls, made by the ambulance service for patients experiencing waits for ambulances were new at the time of the incident and in this case the call was not made. It is therefore recommended that a review of the safety calls service is shared with the Cornwall Urgent Care Board to provide an updated position.

- The patient experienced delays in bloods being taken to confirm sepsis and further treatment. There is a recommendation for blood to be taken on arrival to the Emergency Department and to scope the potential for ambulance crews in administer antibiotics as part of sepsis treatment. The feasibility of this recommendation will need to be explored further with the relevant system partners.

- The patient could not be transferred immediately into the resuscitation area of the Emergency Department as there was no bed available. Entry to the resuscitation area would have meant an earlier medical review. There is a recommendation that when a patient cannot enter the resuscitation space, they are moved to the rapid assessment area and seen by a doctor.

- Following this incident, the triage pathway in the Emergency Department has changed, the patient is now seen by the team in the Emergency Department rather than an information transfer. A review of the triage pathway changes is recommended to consider efficiencies and efficacy.

- Although sepsis was identified, access to antibiotics was not prompt. The investigation identified that not all nurses were able to work within the Patient Group Direction, a framework which allows the administration

of medicine without prescription. The investigation recommends that all nurses undertaking triage can operate under the relevant patient group directions.

- There is no single clinical patient record in the Emergency Department due to the multiple systems and organisations involved. A review of the systems in place is recommended to consider a single patient record.

- The patient was not periodically re-assessed by the Emergency Department or hospital ambulance link officer, the ambulance crew did monitor the patient and escalated concerns as required. It is recommended a safety netting system is out in place between the Emergency Department and ambulance service for those awaiting entry into the Emergency Department.

Urgent Emergency and Eldercare Medicine Learning Summary completed September 2022

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