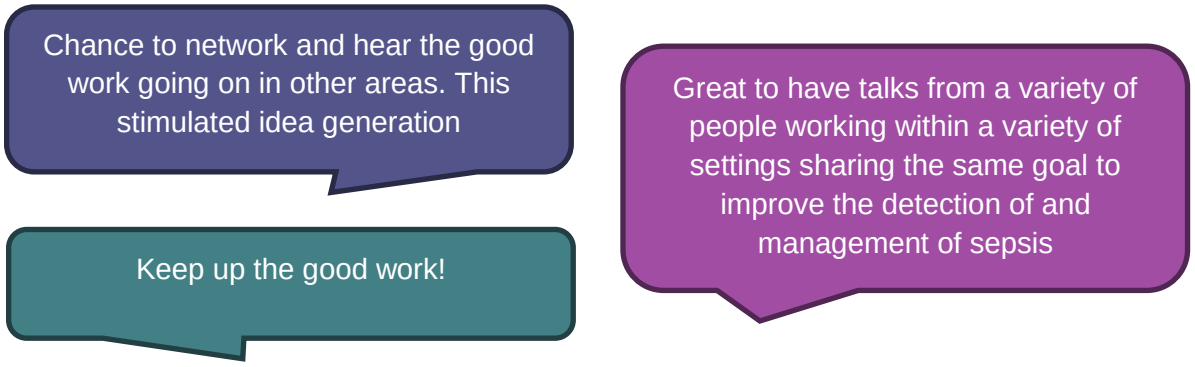
Evaluation report – Summary

Sepsis Masterclass 2, 10 June 2015

Following the first regional Quality Improvement Masterclass on Sepsis Management in Swindon on 25th February 2015, the South and West Regional Sepsis working group in association with the West of England Academic Health Science Network held a second Masterclass on Wednesday 10 June at Tracy Park in Bath.

48 people attended the event. 83 people from 25 organisations are now signed up to the sepsis mailing list for future events. 94% of attendees gave the event an overall rating of Good or Excellent.



Comments from attendees

***@MarkCJuniper** – great day @weahsn meeting. Some stimulating discussion about being #sepsissavvy*
***@MoxhamE** – @WEAHSN @SironaCIC @nhsbanesccg #sepsissavvy collaborative working. A good group of CCGs, ED staff, community staff, GPs. Fantastic*
***@lythell_nic** – Lots of ideas for new projects already @GWH_NHS #sepsissavvy*
***@TriciaQIF** – @sepsissavvy @WEAHSN hearing repeatedly how listening to patients would have made the difference to speed of recognition & treatment*
***@MarkCJuniper** – Patient stories so powerful..... Great introduction to the day Let's learn how to do things better! #sepsissavvy*
***@TriciaQIF** – @weahsn SEPSIS workshop 2. Sharing resources & solutions across the system. Great learning already*
***@paramedicjoanna** Looking toward to today's Sepsis Masterclass with @WEAHSN. A great program develop further collaborative working to improve patient care.*

Attendees fed back that they liked the chance to network, group discussions, and hearing from the speakers. Attendees liked that the delegates came from a range of specialities and professions. CCG representatives and input from specialists in paediatrics and maternity would be welcome at the next event.

Attendees suggested the following topics for future sessions:

- Sepsis in paediatrics, maternity care and elderly care settings;
- Connecting for Care – communication between primary and secondary care, including IT linkages, and discharge summaries.
- Post-sepsis care and support.

Photos from the event: presentations, group work and resource table

Common themes for feedback to colleagues, and suggested actions for improvement are as follows:

- **Awareness** of sepsis – importance of early awareness in the community. Ideas included promoting public awareness through websites and team awareness through education and training – including podcasts and e-teaching packages.
- **Blood** testing including point-of-care lactates, and the need for the right equipment.
- **Common language** for coding (write “Sepsis secondary to…” rather than “? Sepsis”) and communication, including sepsis in team meetings and within surgical ambulatory clinics.
- **Data collection** including audit and standardised measurements, using standard documentation throughout the region, and sharing data between hospitals and community (e.g. out-of-hours) to understand the impact of changes to improve care.
- **Early warning scores** and appropriate **escalation** of concerns, with the need for baseline observations in primary care so can assess change when patients are seen in hospitals. A suggestion was that “new onset confusion/ behaviour change” and “oliguria” could be added to NEWS tool for sepsis screening.
- **Feedback** both ways between GPs and hospitals, e.g. pre-alerts from GPs and including sepsis on the discharge summaries from hospitals

Word cloud from delegate comments

Plans are being made for the third Masterclass in the series in November 2015. Keep an eye on http://www.weahsn.net/events/ for more information or contact Nathalie Delaney nathalie.delaney@weahsn.net