Newark Beth Israel Medical Center

AIM Statement and Goals:

The Team Newark Beth Israel Medical Center is committed to accomplish a 20% reduction in the severe sepsis/septic shock mortality from 2014 to 2015 through a multifaceted approach.

The team is committed to provide consistent high quality care aimed at the reduction of mortality through the implementation of a system wide team approach; standardizing evidence based processes, implementation of 3 hour bundle protocols, education, early identification alert systems, and targeted performance measures to evaluate the reduction of mortality related to sepsis.

Our goals are :

- Reduce Severe Sepsis/Septic Shock by 20%
- Implement hospital wide evidenced based severe sepsis protocol
- Evaluate and implement St. John's Alert available in our CIS (automated early identification of severe sepsis/septic shock)
- Improve outcomes of care to 90% or better for the 3 hour bundle elements of care
- Improve time to Lactate by 50%

Team Members include:

Patient Safety Officer/ Physician Director of the ICU
Physician Director of the Emergency Department
Infection Prevention physician/ Director of Internal Medicine GME
Chief Nursing Officer/AVP of Patient Care Services
Director Quality, Director of Special Projects

Residents
Bedside Nurses
Pharmacists
Standards Department
Nursing Education

NBI changes tested

- We trialed the use of I-O needles for difficult IV sticks.
- Use of the RRT team to respond to the ED for sepsis patient
- Initiated CODE “SMART” ….rapid communication for sepsis alert and response
- Added Pharmacy as a first responder
- Hospitalist were required to respond to the inpatient CODEs.
- Improved lactate time by giving the lab supervisor a Code SMART beeper

NBI Changes regarding the AIM statement

- Use of St John's sepsis alert in Cerner
  - Automatic overhead page
  - Multidisciplinary response (RRT, Hospitalist, Pharmacy)
- Lab supervisor beeper alert for Lactate
- Root cause analysis of all outliers for 3 hour bundle.
- Debriefing each code sepsis to identify any opportunities for improvement

We were surprised to learn…..

- No “Vanco” routinely stocked in the ED Pyxis
- Unprepared for the level of resistance from some physicians to the rapid fluid administration
- Blood cultures were not always drawn before the antibiotic administration ☹

We were wondering what the next steps should be……

- Expansion to include the inpatient units not just a trial unit
- Drafting standing orders for the nurse to initiate the fluids based on the computer alerts from the St John's sepsis alert
- Initiating end of life conversations sooner ….getting patients to the appropriate care including palliative care.