ABSTRACT REQUEST CHECK - SHEET

Please identify the following:

Track (Select one)

- DNP in Practice / Clinical
- DNP in Nursing Education

DNP in Practice / Clinical (Select at least one)

- Cost effective measures and/or techniques
- Improving access
- Improving quality

DNP in Nursing Education (Select at least one)

- Curriculum changes as a result of the inclusion of DNPs on faculty
- Change in trends of nursing education with the inclusion of DNPs on faculty
- Addition or augmentation of formal evidence-based practice courses

Setting (Select all environments that reflects your professional work setting)

- Academia
- Independent practice
- Clinical collaborative practice
- Aggregate care environment

Systems Leadership

- Local
- Regional
- National
- International
Objective: Demonstrate the application of the Iowa Model of EBP in the improvement of ED sepsis care including:

1. Identification of sepsis as an institutional priority based on problem and knowledge triggers
2. Synthesis of literature to plan, implement and evaluate strategies to support change in practice
3. Discuss the role of intradisciplinary practice in the success of any EBP project.

Severe sepsis mortality (60%) now exceeds AMI and stroke (AHA, 2006). It is more common that AIDS, colon and lung cancer combined (Angus, et.al, 2001). With 750,000 cases a year, severe sepsis diagnosis and treatment is now at the forefront of clinical transformation. It is a time sensitive ischemic event that leads to organ failure thus deserving equal attention afforded to AMI, stroke or trauma patients. The vehicle of change is to bring evidence to the bedside utilizing systems and quality outcomes approach and current evidence. According to Dellinger (2008), Early Goal Directed Therapy (EGDT) bundles have shown decrease sepsis mortality. In a national study, Wang et al (2007) states that more than 69% of Emergency Department (ED) patients present with signs/symptoms that meet sepsis criteria. Regardless of data, most sepsis initiatives are focused in intensive care. Thus problems with timely/accurate identification of sepsis still exist in both the ED and ICU (Nguyen, 2006).

Purpose: This project aim to promote an evidence based approach in the diagnosis and treatment of sepsis patient.

Framework: The Iowa model directed the following: the identification of sepsis care as a quality improvement priority based on current mortality and cost, synthesis of evidence, (use of technology for hospital wide education, marketing) and process/outcomes tracking and measurement.

Implementation: Strategies included a sepsis workshop for ED staff. Focus was given on rapid identification/triaging of patients who fit the criteria including: possible source of infection, 2 or more of the Systemic Inflammatory Response Criteria and timely implementation of the resuscitation and management bundles. A nurse driven electronic screening tool was created to accurately triage ED patients and track compliance to process standards of time to antibiotics, labs, central line placement, SCVO2 reading and time to ED bed. A sepsis order set and pathway were also created. All adult ED patients were screened. Those who fit criteria had labs drawn to determine infection indicators. Patients diagnosed with severe sepsis/septic shock were given priority for an ICU hospital bed. Outcomes include mortality, length of hospital stay and cost of hospitalization. Preliminary Results/Conclusion: Sepsis mortality decreased from 60% (50 patients baseline) to 15% within a year. Screening compliance (80%) and pathway use is (99.9%). Compliance to standards: time to antibiotics is 98% and central line placement is 100%. Data abstraction and process evaluation is ongoing. The initiative shows that mortality markedly improved with evidence based therapies. Sepsis stay, patient cost/reimbursement, proper coding/diagnosis, and risk management are major contributors to a hospital’s economic well-being, patient satisfaction and staff empowerment.