**Professional Roles NU350**

**STEP (RNtoBSN) Program**

**PEEP Assignment**

**Learning Objectives**

Review the Learning Objectives you developed for your PEEP Project specific to quality and safety initiatives in healthcare.

**State the problem:** Identification, care and management of sepsis in patients of the Emergency Department (ED).

Recipient of direct care/Patient Population \_\_\_\_Sepsis victims in the emergency department\_\_\_\_

**Be sure to list the 3 LOs and Objectives below (you may copy and paste from your approved objectives document) and then provided a detailed response to each question.**

**For each entry, answer the following questions: (A)** Was this Learning Objective met and discuss the experience you feel allowed you to meet this objective. **(B)** Do you feel this objective was pertinent to the quality/safety project/stated problem and the Patient Population? Tell why or why not. **(C)** Did the stated project’s/problem’s outcomes improve? If yes, how? If no, why? **(D)** Were practices or policies utilized/implemented/created/revised related to the stated problem/quality/safety review or your findings? Please list. **(E)** Would you have handled this experience differently? If so, what would you have done differently?

Include at least a two-three paragraph response for each objective.

1. **Critical Thinking - Interpret the symptoms and complex criteria of severe sepsis and shock and analyze the common reasons that those are missed in patients being treated in the ED.**

The learning objective to interpret the symptoms of sepsis or shock and reasons why they are missed was met. A form of sepsis signs and symptoms was printed and sent facility-wide to the units to be displayed for the nurses and physicians. I was shown a patient chart who had expired from sepsis during mortality prevention checks that had documentation of the presenting signs that had been misdiagnosed. In addition, I was able to go in and assess a patient who had septic shock developing in the emergency room. I believe the objective was met because I learned the more minor details behind sepsis presentation from the charts and form, such as low urine production, slight dizziness, and muscle weakness. The reason these had been missed were because, in their notes, providers had been considering these symptoms to be consistent with simple dehydration.

This objective was pertinent to the quality problem stated and patient population because my facility had been highest in the number of deaths from sepsis or septic shock, most cases being in the emergency room, before the development of quality improvement measures related specifically to sepsis. After displaying the raw statistics of sepsis mortality during a safety huddle, the nurses and physicians acknowledged the need for change. Being a severe problem in the emergency department, the CEO of the facility mandated an educational course on sepsis to be required for all emergency room nurses. It was also decided that a sepsis/septic shock would be added to the skills fair agenda. After implementing laminated forms on the units with signs and symptoms of sepsis and a required sepsis documentation tool for every patient on every shift, sepsis numbers shifted for the better.

The quality improvement officer went through the most recent clinical scorecard that displayed how much improvement in the sepsis response percentage our facility had increased since the last quarter. The outcome of sepsis mortality has improved immensely because of implementation of education on the signs and symptoms via emails to directors and printed information on units, required sepsis tool documentation for nurses per shift with manager auditing, and emergency-room specific mandated education on sepsis. Policies on documentation were revised. Previously, nurses only had to document on sepsis protocol with a confirmed, diagnosed infection, however, now the sepsis tool must be documented on every shift for every patient. If two or more signs were present in documentation of this tool, it is now required that fluids be started within an hour after assessment along with IV antibiotics. These are great policies to revise to begin erasing death from sepsis or septic shock, so I would not have done much differently.

If I were to do anything differently to handle sepsis for emergency department patients in my facility, it would be to require physicians to assess the patient within one hour if the nurse questions possible sepsis or septic shock. As far as changing anything with my experience with the quality improvement officer, I would have asked his opinion on sepsis protocol at my facility, but I learned so much during my experience, I could not have asked for much more. He dove into detail about sepsis and why it is so prevalent in the emergency room, things we are doing to decrease mortality from sepsis, and allowed me to see examples of misdiagnosed patients.

1. **Effective Communication - Identify the key communication strategies which have proven most effective in educating ED nurses and providers on how to identify septic shock and related symptoms and treat sepsis while patients are still in the ED.**

The learning objective to identify the key communication strategies which have proven most effective in educating ED nurses and providers on how to identify septic shock and related symptoms and treat sepsis while patients are still in the ED was met. I was informed that emergency room nurses and physicians were required to take a course on sepsis and was able to personally speak with an ED nurse who had taken it. I asked what she learned and how she implemented this education in her practice. The nurse went into great detail about how she would treat sepsis differently and would spread the word and her ideas to other ED nurses to enhance patient care. This kind of effective communication can improve outcomes and enhance understanding of sepsis in the acute setting.

I believe this objective was pertinent to the quality problem stated because effective communication with emergency room nurses and doctors on sepsis symptoms and treatment is crucial to prompt, safe care. It was brought forth that the most effective strategy proved to be in-person educational courses because of low attention-span. Before the course on sepsis and septic shock, an ED physician explained how he would not have known the preceding signs that one of his patients came in with. Due to the physician’s recognition after the new course education, the patient received fast and appropriate care that ultimately saved their life. This displays how effective communication can affect sepsis outcomes.

Outcomes did improve with this project because ED nurses and physicians testified to their newfound understanding of sepsis and septic shock along with giving examples of outstanding patient stories. The communication with the ED nurses and doctors spread to other units throughout the facility, so brief, in-person meetings were done with each floor regarding signs of sepsis and septic shock. The policy changes included required monthly in-person huddles on unit sepsis numbers by directors with unit nurses and required quarterly scorecards on sepsis and septic shock mortality and time of treatment. If I were to have done anything differently in this experience, it would have been to speak with the ED director on possible communication strategies specifically for physicians because they can be resistant to change.

1. **Professional Behavior - Understand and explain the evidence-based sepsis guidelines to ED nurses and providers and explain the dangers of septic shock to patients and family members.**

The learning objective to understand and explain the evidence-based sepsis guidelines to ED nurses and provider and explain the danger of septic shock to patients and family members was met because I was able to assess and talk with a patient and his family about septic shock after the patient had his infected gallbladder removed. The patient presented with nausea, confusion, and diarrhea, so this was misdiagnosed as diverticulitis, but the patient ended up staying 27 hours in the ED having a blood pressure that dipped to 50/30 and being given massive amounts of fluids and vasopressors before transport to the intensive care unit. He nearly died before a provider realized that this was a ruptured gallbladder. I educated them on why the minor signs of sepsis are pertinent and spoke with the nurse and provider in the ED over his care about the new evidenced-based guidelines to starting IV antibiotics within an hour of presentation. I told the family what signs to watch for and the dangers that could occur if care is delayed.

This objective was pertinent to the quality problem stated and patient population because understanding the evidence behind the sepsis guideline and the dangers of septic shock are crucial to decreasing sepsis mortality. Since the emergency room has the majority of sepsis patients, it makes sense that the ED nurses and providers need to understand the evidence-based sepsis guidelines for treatment. The problem’s outcome improved because the patient that I spoke to, along with his family, was able teach-back the dangers of sepsis and septic shock to me after the education. Two ED nurses that I spoke with explained how much improvement they saw in their sepsis patient with the new evidence-based guidelines of antibiotics within an hour and the required sepsis protocol checklist to identify sepsis before it progresses to shock. An ED physician spread word to other physicians across the facility about the new evidence-based guidelines, helping the sepsis mortality numbers decrease. Practices that were changed include education by ED nurses to patients and families on dangers of sepsis and more advanced physician assessment of patients with criteria for sepsis present. I believe this experience to explain new evidence-based guidelines and education of patients on sepsis dangers went well, so not much needed to be changed.

If I were to change anything about this experience, it would be help implement required documentation of a sepsis danger education by ED nurses to patients and families if shock did occur during the stay or was present on admission.

Grading Rubric:

A. Discussion regarding met or unmet objective was thorough, addressing the specific experience and how you met or did not meet this objective. (20 points)

B. Discussion is adequate regarding the application of the quality/safety problem to the selected patient population. (20 points)

C. Discussion included regarding the quality/safety problem’s outcome during the student’s experience. (10 points)

Discussion includes how the outcome improved or did not improve. (10 points).

D. Listing of policies or practices used in the PEEP project. (20 points)

E. Discussion adequate regarding change. Example: Discussion of the students’ perspective if things could have been changed and how. (20 points)