Sepsis: A 2019 Update on Critical Issues

January 17, 2019
Webinar Month 122

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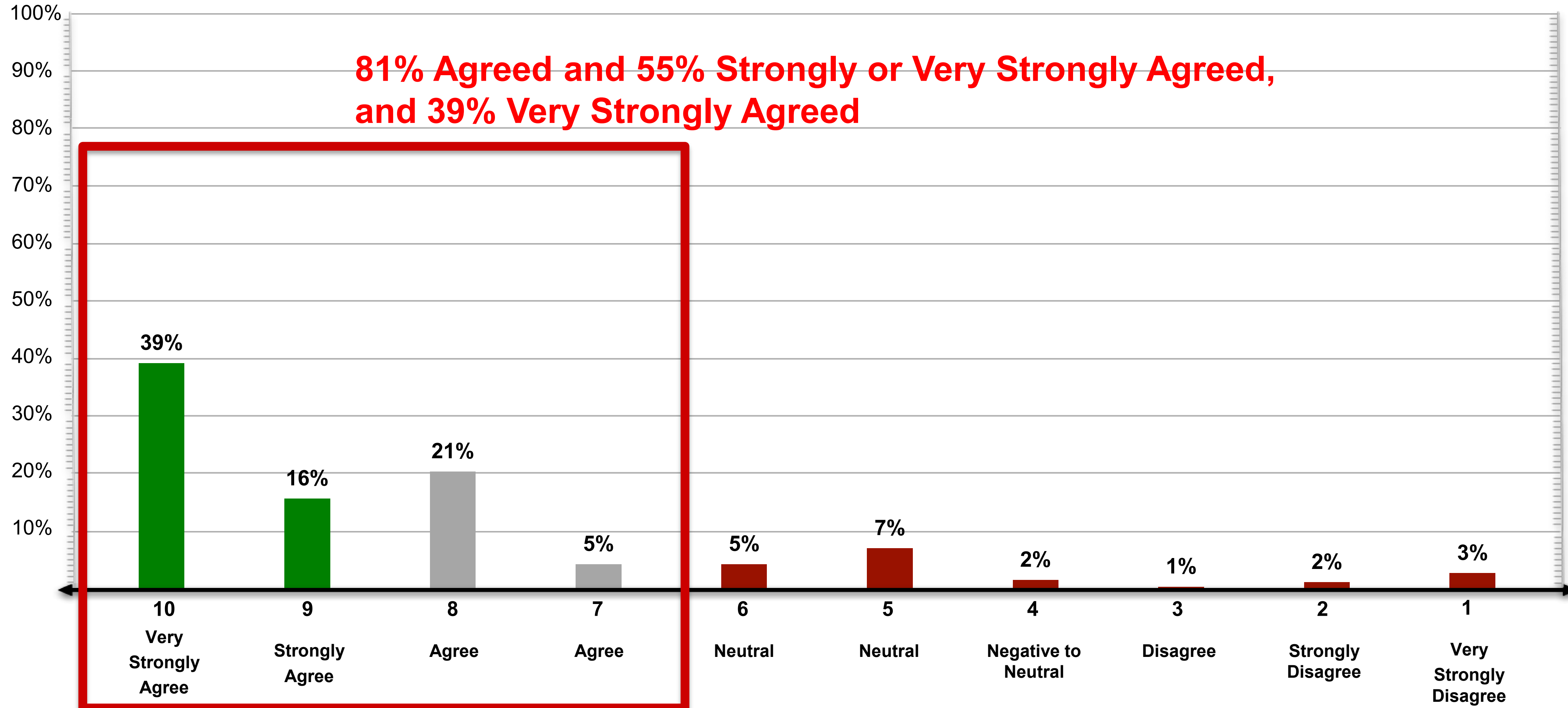
Anonymous Survey Questions

I am interested in ANOTHER WEBINAR on:

RESPONDING TO SERIOUS ADVERSE EVENTS



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Specific Issues Regarding the RESPONSE TO ADVERSE EVENTS
I would like covered include:

- 2nd victim
- Adverse events list and reporting
- An overview. I didn't attend the previous webinar
- Boarding patients in the ED
- Can telemedicine assist in preventing adverse events
- Capturing events
- Changes which have occurred
- Deterioration and failure to recognize, errors in resuscitation, difficult airway intubation outside the OR
- Disclosure of events to patients-who discloses the event?
- Discussing inpatient sepsis workflow to include use of rapid response teams and sepsis screening criteria
- Drug adverse events
- DVT 's not POA
- Electronic medical record documentation
- Emotional harm, second victim, interdisciplinary hand-off
- Environmental safety
- Examples of policies and practice related to adverse events, patient and family communication.
- Failure to rescue
- Failure to rescue/failure to determine early signs of deterioration
- Family disclosure; strong action plans to mitigate recurrence
- First response
- Fluid management and fluid overload
- Grading or prioritizing types of events
- High-risk medications
- How to address the issues without an undue burden of auditing etc as a result
- How to alleviate involved staff stress when being interviewed
- How to be nonpunitive but held accountable
- How to deal with septic joint replacements
- How to discuss with staff after the fact
- How to explain complications that don't have external cause
- How to prevent school shooting
- Hypoglycemia in diabetes patients, medical device related pressure injuries
- Hypoglycemia,
- I didn't attend this but intend to listen to the recording. First time attendee here.
- ICU availability - bringing the ICU to the patient when the ICU is full
- Identification
- Importance in documenting
- Including patient/family/caregiver input on root cause analysis
- Infectious disease
- Infiltrates, medication errors,
- Just culture
- Major medication errors, ID exposures
- Medication
- Medication errors
- Medication reconciliation
- More discussion of the specific sepsis research being done and the outcomes. Also interested in hypoglycemic event research and appropriate measures to prevent and treat
- More on sepsis
- Outcomes
- Patient response
- pediatric emergencies

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Specific Issues Regarding the RESPONSE TO ADVERSE EVENTS
I would like covered include:

- Physician and hospital staff response
- Pre-hospital identification and care of sepsis - with EMS, home care, prevention etc.
- Pt. Information
- RCA process
- Response from leadership and how results are disseminated throughout the organization to identify whether the adverse event can occur somewhere else within in the organization.
- Second victims of adverse events
- Sentinel events
- Sepsis
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- Sepsis
- Sepsis in infants and children
- Sepsis, suicide
- Sepsis; stroke
- Server sepsis
- Signs/symptoms/assessment
- SIRS alert and source of infection - start orderset for sepsis
- Specific requirements for staff
- Stroke and sepsis
- Systemic
- Top 3 adverse events
- Transparency internal & external such as AHRQ
- Unsure
- Using data to trend adverse events
- Violence/dealing with medical errors
- Who's in charge

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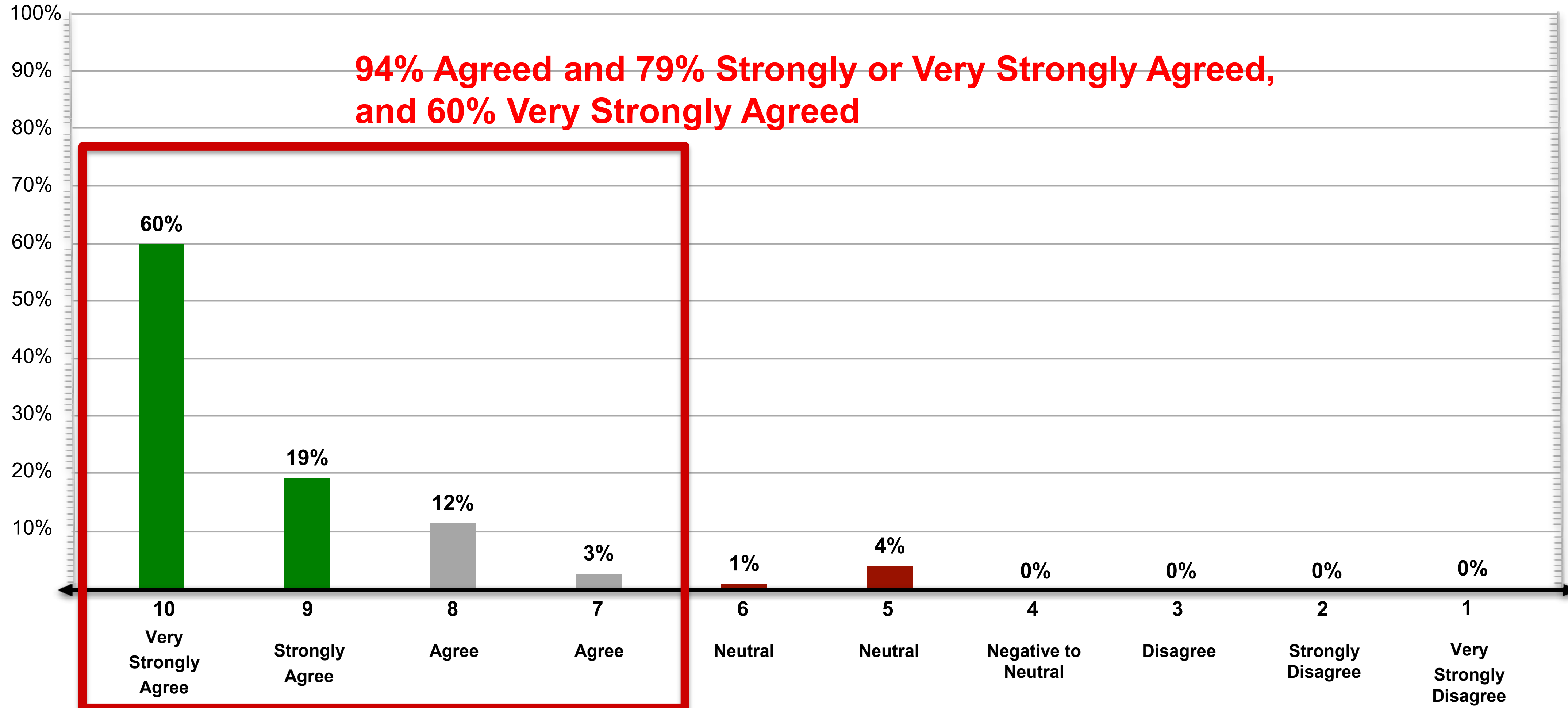
I am interested in another webinar on CRITICAL ISSUES IN SEPSIS:



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Specific additional CRITICAL SEPSIS ISSUES I would like covered include:

- 2019 treatment protocols in a world that only looks at metrics that may not be relevant.
- 30 ml/kg crystalloid fluid bolus recommendation and other methods of improving patient outcomes and mortality.
- Abstraction info
- Addressing earlier sepsis recognition in snfs and early intervention by EMS
- All issues
- Alternative treatments for sepsis
- Antibiotics being given prior to arrival by EMS
- Antibiotics, procalcitonin
- Any information
- Any topic
- Applicability of procalcitonin as screening tool
- Assessment steps
- Best practice implementation models or process
- Best practices on sepsis 3 implementation
- Building a strong sepsis program in a community hospital. (Do not have residents)
- CMS requirements
- CMS response
- CMS SEP-1, antibiotic stewardship
- Community public district hospitals metrics in managing sepsis, best practices in these environments.
- Data of harm caused by one hour bundle and what portion of that bundle in one hour caused most harm
- Decrease mortality
- Documentation requirements, how to acknowledge best clinical practice vs meeting SEP-1/ govt funding
- Early identification/ recognition- what is working for other hospitals?
- Early recognition (before sepsis shock) and treatment
- Early recognition of sepsis in community, by EMS, by public
- Elimination of sepsis; very broad; varied treatment options - deal only with septic shock
- Factors shown to improve mortality
- Fluid
- Fluid bundle
- Fluid load
- Fluid requirement for septic shock versus other underlying diseases such as CHF
- Fluid resuscitation
- Fluid resuscitation
- Fluid resuscitation recommendations
- Fluid resuscitation, efforts toward reducing overkill for labs/etc.
- How did you role out education and obtain by-in from staff and physicians
- How do you obtain antibiotics in timely manner
- How practices changes can influence how the organization implements safe practices and evidence-based outcomes; not data entry activities for checking the box. An ah-ha moment during this webinar for me was recognizing shock which would in effect drive interventions or care.
- How to convince your board that a metric is flawed and we need to rely on outcomes
- How to engage physicians to identify early recognition of infection
- How to get doctors to use correct antibiotic.. We even have a protocol
- How to get physicians and facilities on board with recognizing, treating and documenting clinical indicators and treatment for patients.
- How to get physicians on board to meet the CMS sep-1 core measures
- How to keep up to date on best practice
- How to meet the measures
- How to move the measures
- How to reduce over-reaction to sepsis CMS scores.

Source: TMIT High Performer Webinar Series; Sepsis: A 2019 Update on Critical Issues – January 17, 2019

Specific additional CRITICAL SEPSIS ISSUES I would like covered include:

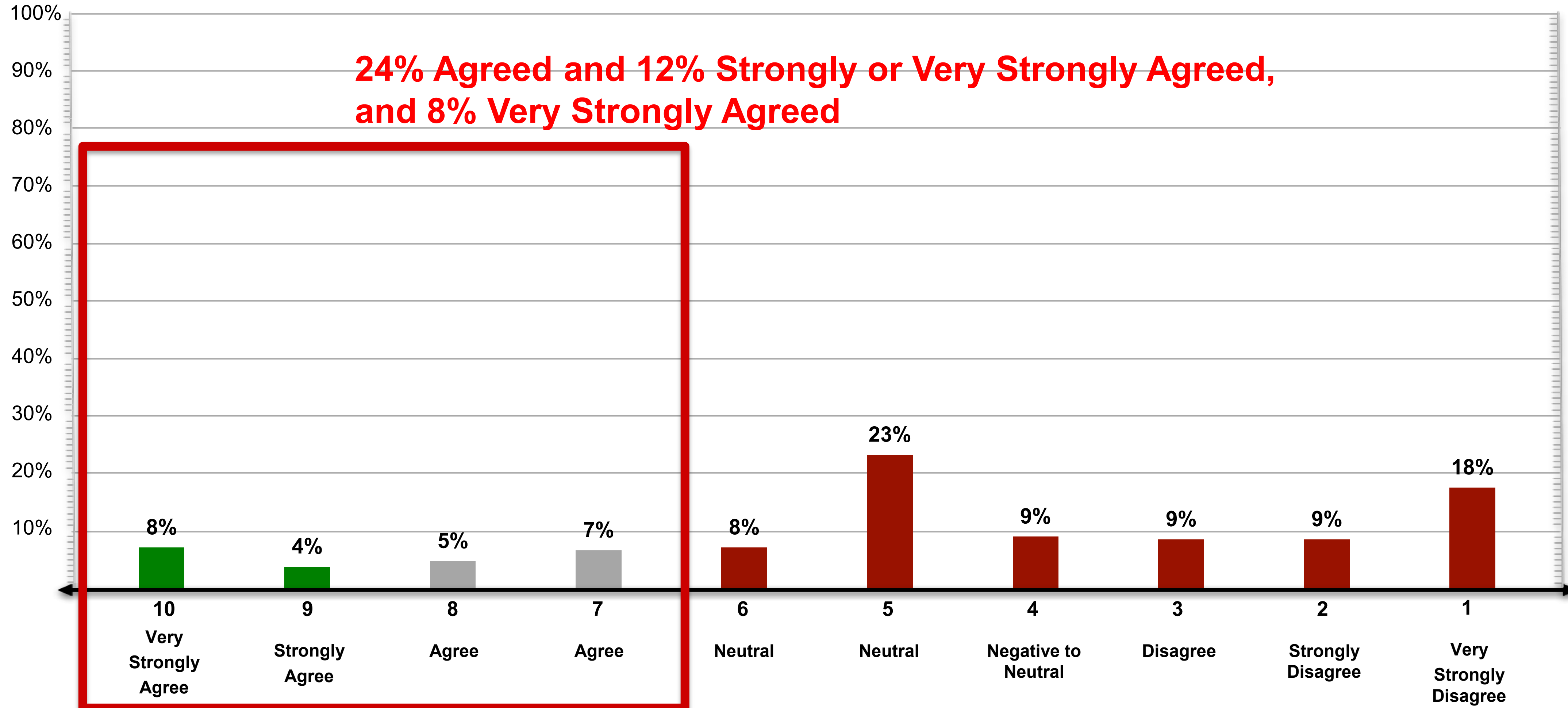
- I appreciate the annual updates
- I would like information on pediatric sepsis
- Lactate evaluation in oncology patients
- Length of stay
- Life after sepsis and education for caregivers
- Maternal sepsis
- Meeting CMS guidelines
- More information about mortality and effects of bundles on mortality
- More like this one
- More of pro CMS issue
- More of the same as today
- More research based information on what works and why, what doesn't work and why (outside of the mayo research)
- New sepsis testing
- Ongoing changes
- Pediatric clarification
- Pediatrics <17 years of age
- Physician education
- Pi
- Post sepsis syndrome
- Post sepsis syndrome; community level resources for septic patients
- Practical screening in the ED
- Preventing readmissions
- Procalcitonin's role in sepsis
- Relapse of septic shock after initially resolved.
- Related to the rural and frontier hospitals and volunteer ems providers
- See above
- Sepsis alert programs
- Sepsis alerts, do they work?
- Sepsis bundle compliance aliened with most current research
- Sepsis coordinator role in coordinating abstraction and best patient outcomes.
- Sepsis in the pediatric patient
- Sepsis in the postpartum patient
- Soft tissue infections all ages and co morbities
- Start of the clock presentation time and focusing on compliance around the reassessment/re-eval documentation within the time frame
- Streamlined ER sepsis standing orders
- Team communication b/w ED and ICU
- Treatment modalities
- Understanding the SEP 1 algorithm; maybe a review of the steps
- Update in a few months of mayo clinics sepsis management and best practices - evidence based. Also same items as presented today.
- Updates re: cms requirements. If and when outcomes become the metric for evaluating SEPSIS bundles, will there be a scoring system for expected outcomes (similar to what we have in trauma) that is epected mortality and survived.
- Use of bpas or other nursing driven initiatives
- Use of vitamins in sepsis treatment
- Vitamin C vs antibiotics in treating sepsis
- Ways to identify sepsis for ED and inpatients
- Ways to meet measures.
- What is having with community facilities that don't have intensivists
- When not to give the fluid bolus

Source: TMIT High Performer Webinar Series; Sepsis: A 2019 Update on Critical Issues of Hospitalization, January 17, 2019

Anonymous Survey Questions

I am interested in A WEBINAR on:

STARTING A BYSTANDER CARE MED TAC PROGRAM



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Specific BYSTANDER CARE TRAINING Issues
I would like covered include:

- Are they covered under the good Smartian act?
- Basics and how to get started
- Curriculum, program length, cost, metrics on effectiveness.
- Early identification of sepsis
- General information
- Handouts and laminated card of steps and actions
- Hands only CPR
- I am a first time attendee and have no foundation
- Implementation process
- Legality
- Our organization already offers stop the bleed training
- Post acute care both home and snf
- Prioritizing life saving care
- Sepsis recognition
- Stop the bleed
- Stop the bleed
- Stop the bleed
- Wound care

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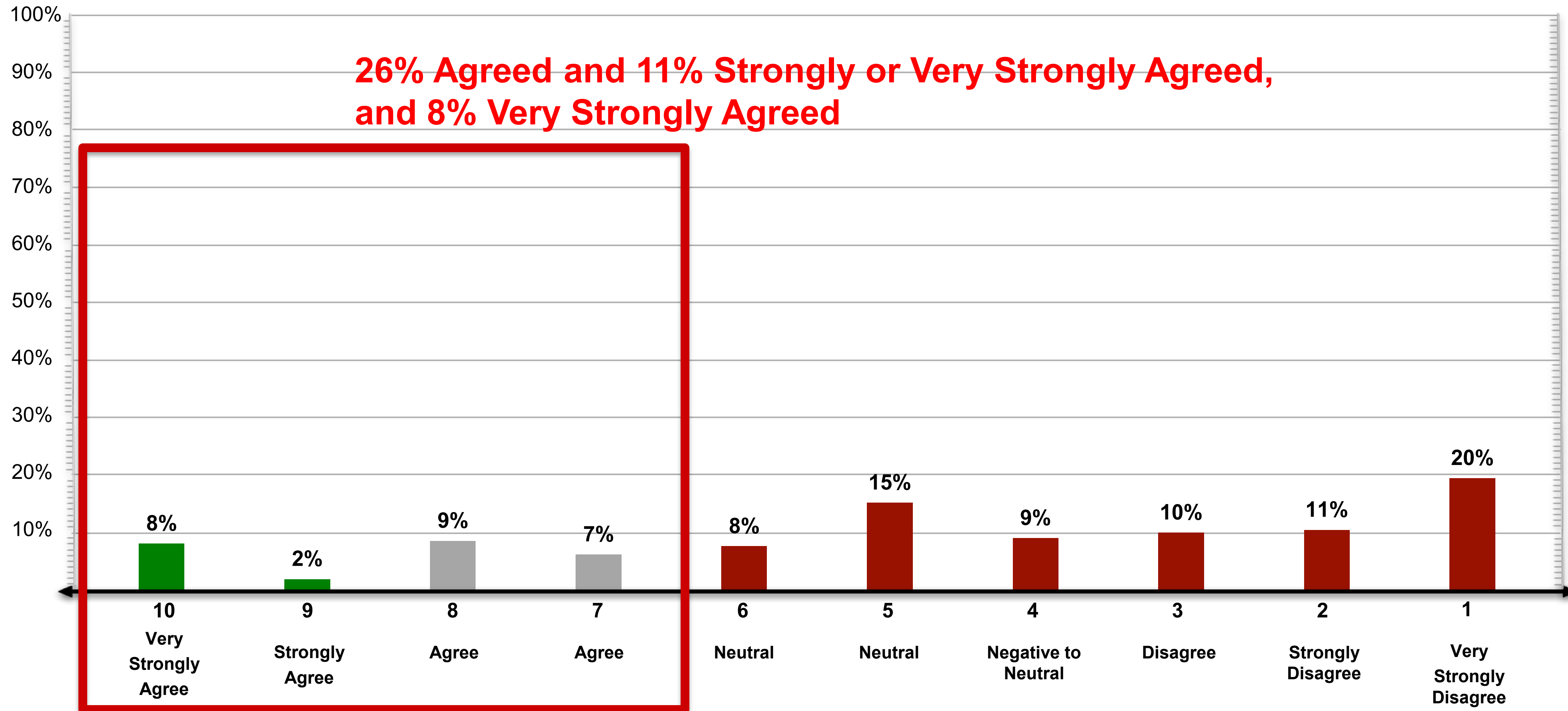
I am interested in a webinar on In CONFLICT OF INTERESTS & ACADEMIC FRAUD:



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Specific CONFLICT OF INTERESTS & ACADEMIC FRAUD I would like covered include:

- Accountability within profession
- Actual guidelines
- Any information would be appreciated
- Any, first time attendee
- Anything as this is a new topic for me
- Cms regulations
- Does quality improvement projects fit into this
- Don't know at this time
- For providers
- General information
- How to identify flawed studies & challenges of overcoming social media spread of flawed information.
- How to screen for academic fraud
- Ideas for how to read articles/research and recognize issues
- Informational
- Interpreting the research if fraud is suspected
- Medical fraud
- Physician transparency with relationships with pharmacy and device companies and impact on care.
- Plagiarizing
- Practical ways to avoid conflict of interests
- Reestablishing trust what questions to ask and data re-establish trust and to assess data presentation
- Relationship with pharmaceutical co. Specifically at levels of dinners, speakers bureaus
- Reliability of information, peer review process
- Review/discuss how this topic interfaces with research fraud, unethical publication practices, etc.
- What are the repercussions for conflicts of interest and academic fraud, if any?

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