



Patient  
Safety

# CASE STUDY

## Patient Safety

Clinical Audit Awareness Week 2025 (#CAAW25)  
featuring the Clinical Audit Heroes Awards  
2-6 June 2025

[www.hqip.org.uk/clinical-audit-awareness-week](http://www.hqip.org.uk/clinical-audit-awareness-week)



## Project: Sepsis Audit 2023–2024 – Haywood Community Hospital

### The Why

*Sepsis is a common and potentially life-threatening condition early identification and treatment of sepsis can improve survival and reduce long term disability for patients.*

### Who Was Involved

- **Lead:** Lyn Charlton, Modern Matron, Haywood Hospital – Midlands Partnership University NHS Foundation Trust (MPFT).
- **Participants:** Medical and nursing staff involved in the recognition, escalation, and treatment of sepsis at Haywood Hospital.
- **Primary Audience:** Patients at risk of sepsis within Haywood Hospital.
- **Secondary Audience:** Clinical teams responsible for the timely recognition and management of sepsis.
- **Wider Impact:** Trust-wide learning across MPFT and the dissemination of best practice to improve sepsis outcomes.

### Timings

- **Audit Period:** November 2023 – March 2024
- **Reporting Date:** April 2024
- **Audit Cycle:** Quarterly data collection; annual reporting as part of MPFT's ongoing clinical audit programme.

### Project Aims

- To assess compliance with MPFT's Sepsis Screening and Management Policy.
- To ensure timely identification and management of sepsis in alignment with national guidance.
- To evaluate the documentation of sepsis screening, escalation, and treatment.
- To improve patient safety, early recognition, and clinical outcomes.

### What Happened – How We Did It

The audit was conducted across all wards at Haywood Hospital and evaluated six key clinical indicators, including:

- Use of sepsis screening tools
- Completion of the Sepsis Six bundle
- Documentation of escalation and senior clinical review
- Timely administration of antibiotics

Any patient diagnosed with sepsis or who triggered a sepsis alert via the National Early Warning Score 2 (NEWS2) tool during the audit period was included.

An audit tool, adapted from the previous year's audit, was used to ensure continuity and consistency in data collection. Data was gathered by ward staff monthly between April 2023 and March 2024.







An action plan was developed by the project lead and informed by audit findings, identifying areas requiring improvement and reinforcing best practices. Data validation was completed by a Quality Nurse Practitioner.

## Changes Involved

- Reinforcement of:
  - NEWS2 early warning score implementation
  - Prompt use of the sepsis screening tool
  - Standardised documentation and escalation processes
- Findings informed local education sessions and ward-based improvement plans.

## Successes

- Improvement was noted compared to the 2022–2023 audit cycle.
- 100% of audited patients had a completed sepsis screening tool.
- In confirmed sepsis cases, treatment was timely and in line with national guidance.
- Strong adherence to sepsis management protocols was observed.
- Gaps in escalation documentation were identified, leading to focused improvement actions.
- The audit action plan was developed and shared with clinical and governance teams.

	All patients who trigger Sepsis should have had a NEWS2 form completed.	<b>Overall</b> <b>100%</b> (37/37)
	All patients who trigger Sepsis should have had a Sepsis screening tool completed.	<b>100%</b> (36/36)*
	All elements of the sepsis pathway should be completed.	<b>77%</b> (23/30)*
	Outcome of the review: was antibiotics (abx) indicated?	<b>92%</b> (24/26)*
	If yes, have iv antibiotics (abx) commenced within the hr?	<b>90%</b> (18/20)*
	An incident form should be completed for patients with red flag for Sepsis.	<b>88%</b> (21/24)*



*"This work strengthens our ability to deliver safer care and identifies where we can continue to grow."*

*– Debbie Denning Clinical Audit Co-ordinator.*

## Insights and Learning Points

- Timely escalation and comprehensive documentation continue to be areas for improvement.
- Reinforced the importance of consistent use of screening tools like NEWS2 and Sepsis Six.
- Ongoing staff education and regular monitoring are essential for sustained improvement.
- Early identification saves lives – staff awareness is critical to success.

## Outcomes

- Full audit report with findings and recommendations (available internally via the Trust's systems).
- Local action plan addressing areas of non-compliance.
- Staff education sessions implemented post-audit to reinforce learning and improve practice.
- Continued monitoring and auditing.



## Further Information

- Access to the full report is available internally via MPFT's Clinical Audit Platform.
- No public-facing link is currently available for this project.

*"Sepsis is everybody's business to reduce harm mortality and improve outcomes Know your symptoms this is our message to all"*

*- Lyn Charlton Modern Matron*

## The Facts - Global Sepsis Statistics (2025)

- **Incidence:** Approximately 48.9 million cases of sepsis occur globally each year.
- **Mortality:** Around 11 million deaths annually are attributed to sepsis, accounting for 20% of all global deaths
- **Severity:** Mortality rates vary widely depending on the severity and speed of treatment, ranging from 15% to 50%
- **Key Trends in Sepsis for 2025 | AseBio:** [www.asebio.com/en/news-events/news/key-trends-sepsis-2025](http://www.asebio.com/en/news-events/news/key-trends-sepsis-2025)

## Further reading

NHS England » Sepsis: [www.england.nhs.uk/ourwork/clinical-policy/sepsis/](http://www.england.nhs.uk/ourwork/clinical-policy/sepsis/)