

CAMPAIN Update

A global effort to improve care for patients with severe sepsis and septic shock

March/April 2007



Campaign Update is the official newsletter of the Surviving Sepsis Campaign. The Surviving Sepsis Campaign is a partnership of the European Society of Intensive Care Medicine, the International Sepsis Forum and the Society of Critical Care Medicine. This bi-monthly communiqué focuses on topics related to local, regional and national SSC activities. Feedback and content suggestions may be sent to campaignupdate@survivingsepsis.org.



Virginia network experience: Launching SSC in an Integrated System

Sentara Healthcare has joined the Surviving Sepsis Campaign (SSC) as the largest, most integrated US system so far to take on the Campaign. The health system, located in Virginia, initiated its activities through a planning meeting that included SSC leaders in September 2006. The Campaign is included in Sentara's system-wide performance improvement goals for 2007 and 7 Sentara hospitals will be submitting patient data to the global database by the end of April. Data is reviewed in detail in monthly and quarterly system-wide quality meetings.

Under the leadership of William A. Brock, MD, FCCM, Medical Director for Critical Care Quality at Sentara Healthcare, representatives from 7 Sentara system hospitals, 2 Bon Secours system sites, and Chesapeake General Hospital participated in the day-long meeting. According to Dr. Brock, "the challenges to SSC implementation will vary among system hospitals.

Solutions will be specific to each site, based upon their individual needs and resources. But the important thing is *all* are committed to improving the care of patients presenting to their hospital with sepsis."

Extrapolating from 2005 patient data, Dr. Brock provided projections during the launch meeting indicating that potentially 200 lives will be saved per year within the system through implementation of the Campaign. Sentara's Chief Medical Officer and Senior Vice-President Dr. Gary Yates stated that the SSC is an imperative to the system, in that "it represents a powerful opportunity to improve the care of the patients we serve, and by doing so save lives."

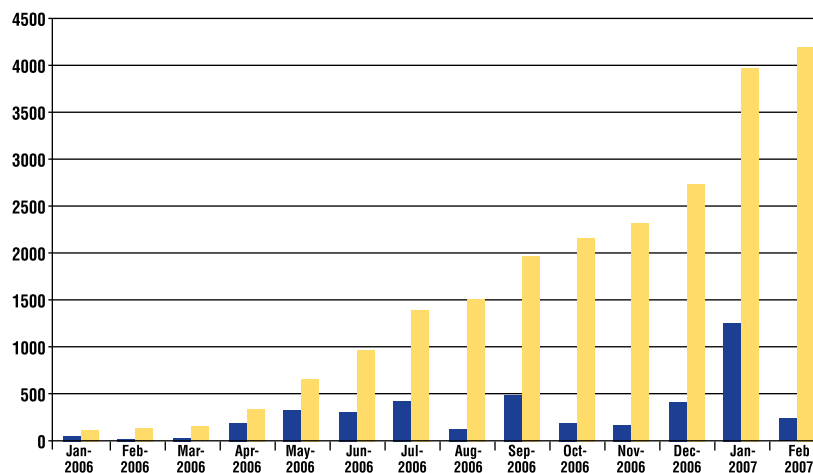
To ensure that all staff members involved in the Campaign have the tools they need to participate fully in all aspects of the Campaign's elements of patient care and data collection as a quality improvement effort, 15 various interdisciplinary in-service education and discussion sessions have been conducted for attending physicians, nurses, house staff, respiratory therapists, and administrators by Dr. Brock and Tina Liske, RN, MSN, CCRN, NP, clinical nurse educator at Sentara Norfolk Hospital. Order sets and other resources

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Total chart submission over time

- Monthly Charts
- Cumulative Charts



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Trust is a basic tenet of public service and professionalism, and underpins virtually every aspect of our daily lives. It is also a remarkably fragile construct: encase it with prohibitions and rules, hem it in with demands for proof, and it soon withers and fades; as Onora O’Neil argues, more controls may simply breed more suspicion.¹ How then do we achieve an effective balance between trust and regulation, between professional independence and public protection? The conventional answer is accountability – the requirement that we answer for our actions to those we serve and justify them against explicit performance standards. But this raises another question: where to place the balance between the two on a continuum from automaton to autocrat.

This issue of trust and professionalism has been raised in several ways recently. In the USA, Stern and Papadakis² have drawn our attention to the importance of teaching appropriate attitudes and behaviours to undergraduates in order to foster professional behaviour throughout medical

as Mitchell Levy described in the November issue of this newsletter. An important aspect which we have discussed is whether individuals who have received any form of support from industry – funding educational meetings, paid consultancies, unpaid consultation with reimbursement of expenses, a cup of coffee at a promotional stand, or using a ball-point pen with an industry logo – should be excluded from contributing to the guidelines review on the basis that such people are fatally contaminated. Should the difficult interpretations of scientific fact be made only by those so far from the field that they have no communication at all with that aspect of medicine under consideration? Should those of us who have had meetings (without personal financial benefit) with Eli Lilly to discuss and encourage their plans for further research into activated protein C be excluded from guidelines referencing this drug? Do the eight publications by Eichacker and his colleagues (see reference 6) equally disturb their capacity for equipoise?

Our preferred approach has been to combine transparency (required disclosure of all external relationships) with consensus techniques for guidelines development. During the past year we have been working with the originators of the GRADE system, and for this second phase of the guidelines review we have developed a template based on GRADE for closed voting by all participants on those elements of the guidelines for which complete unanimity could not be achieved. We call this template the GRADE Grid, and have found it very helpful in characterising the nature and extent of consensus and disagreement. Importantly, by combining public discussion with private voting it ensures that all voices in the guidelines process are heard equally.

We would like to see much greater investment by governmental and research agencies in supporting quality improvement initiatives, particularly those that transcend national borders. In this respect, we welcome the approach of the European Commission, which has included a call for proposals focussed on “optimising the delivery of health care to European citizens,” and translating clinical research outcomes into clinical practice in its strategic priorities for the FP7 programme for health.⁷ The Commission has also adopted a very positive approach to collaborative partnerships between academic and industrial organisations. This is good news, and we hope that other major agencies will follow this lead. In the end, one of the best answers to concerns about public trust in healthcare professionals is for all of us as front-line clinicians to demonstrate that initiatives like

“Our preferred approach has been to combine transparency with consensus techniques for guidelines development”

careers. In the UK, a new system of regulating doctors has recently been presented by the Chief Medical Officer³ following several high-profile failures of single individuals within a system of regulation which assumed too much trust and not enough control. And the link with the Surviving Sepsis Campaign? Our duty to put reliable care of our patients before personal reward has been examined in a commentary in the *New England Journal of Medicine* by Eichacker et al⁴, who have accused the Campaign of having been subverted by industry for marketing purposes, and have characterised the guidelines process as biased, and hence an abuse of public trust. Detailed and cogent responses to this article have appeared elsewhere.^{5,6} As the authors of the commentary do not declare their own biases and potential lack of equipoise in this matter, trust and transparency are clearly central issues for us all.

How should the Campaign respond to these criticisms? Given the current lack of funding for quality improvement collaboratives and quality improvement research, industry remains the main source of support for major projects of this sort. We take great care to distance the science and the guidelines process from potential industry influence

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In the Literature

Listed below are articles that may provide additional background to practitioners as they implement the SSC.

Durbin CG. **Is Industry Guiding the Sepsis Guidelines? A Perspective.** *Crit Care Med* 2007; 35:689-691.

Dr. Durbin's (SCCM president at the time the perspective was written) take-home message is that the SSC is a fundamentally sound and promising endeavor to improve patient care, and that our goals remain vital and important. The SCCM strongly supports our efforts and the need to continue to search for non-industry funding. See Julian Bion's Leadership Perspective in this issue of Campaign Update

Barie PS. **An Opinion Too Far: The Campaign against the Surviving Sepsis Campaign.** *Surg Infect* 2006; 7:485-488.

Dr. Barie (editor-in-chief of Surgical Infections and president-elect of the SCCM) assesses the SSC as a well-intentioned approach to transfer knowledge from bench to bedside and improve process of care. He considers it folly to consider to criticize broadly the evidence-based methodology in the guidelines and bundles with considerable harm to occur if improvement-minded institutions limit their current efforts in this regard. See Julian Bion's Leadership Perspective in this issue of Campaign Update.

Ranieri VM, Mareno RP, Rhodes A. **The European Society of Intensive Care Medicine (ESICM) and the Surviving Sepsis Campaign (SSC).** *Intensive Care Med* 2007; 33:423-425.

The leaders of the European Society of Intensive Care Medicine express their opinion that they have never doubted the principles of the SSC and its leadership. They reinforce the independence and reproducibility of data and conclusions produced. See Julian Bion's Leadership Perspective in this issue of Campaign Update.

Barletta JF, Thomas WL, Slot MC, et al. **Compliance with Guidelines for Treating Sepsis.** *Am J Health-Syst Pharm* 2007; 64:133-134.

Spectrum Health Hospitals through their participation in the Surviving Sepsis Campaign have done a specific analysis on those bundle elements related to antibiotic administration and additional data collected around the SSC. They show 80% of patients are now receiving antibiotics within one hour of sepsis recognition, and 67% have antibiotics subsequently narrowed while 56% get appropriate cultures.

Nguyen HG, Corbett SW, Stelle R, et al. **Implementation of a Bundle of Quality Indicators for the Early Management of Severe Sepsis and Septic Shock is Associated with Decreased Mortality.** *Crit Care Med* 2007; 35 [Epub ahead of print Feb. 19, 2007].

Nguyen and coauthors use a variation of the Surviving Sepsis Campaign bundles, which are demonstrated to modify physician behavior and to be associated with decreased in-hospital mortality.

Education

Pan-European Networks Meeting March 26

A meeting of SSC European network participants will be held on March 26 during the ISICEM meeting in Brussels. The meeting will begin at 13:00 with a global overview of the Campaign including an update on the guidelines revision process and discussion of the proposed changes via the GRADE system. Surviving Sepsis Campaign Executive Committee members will facilitate the afternoon's activities.

Representatives from the UK and Italian networks will present their experiences in implementing change through education in a session chaired by Graham Ramsay. Examples of changing process and overcoming barriers will be given by Campaign participants from the UK, the Netherlands, and Italy and moderated by Mitchell Levy. Outcome measurement and compliance will be chaired by R. Phillip Dellinger and will include the experiences of network participants from North America, Spain, Germany, Poland and Portugal. Sean Townsend will lead the final session of the afternoon on next steps of the Campaign related to process change and outcome measures.

The afternoon's schedule will provide opportunity for sharing experiences and gaining insight from other Campaign participants to ensure success for all networks. For more information about the meeting, contact Elaine Rinicker at erinicke@tampabay.rr.com

CALENDAR

2007

March 26

2nd Pan European
User Group Meeting
1:00 - 6:00 pm
Royal Windsor Hotel
Brussels, Belgium

April 25

Arizona Regional Training
Program
10:00 am - 3:00 pm
location tbd
Phoenix, AZ

October 7-10

ESICM 20th Annual
Congress
SSC Educational Session
Wednesday, October 10, 2007
11:10 am - noon
Berlin, Germany

2008

February 2-6, 2008

SCCM 37th Annual
Congress
SSC Educational Session
TBD
Honolulu, Hawaii

Send us your SSC meeting information and we will include it in future issues of *Campaign Update*. Send submissions to campaignupdate@survivingsepsis.org.



CAMPAIGN at-a-Glance

Asia

China

Europe

Denmark—*Lone Poulsen*

England—*Jane Eddleston*

Germany—*Konrad Reinhart*

Ireland—*Jeanne Moriarty,*

Brian McCloskey

Italy—*Massimo Antonelli,*

Roberto Fumigalli

Netherlands—*Arthur Van Zanten,*

Dave Tjan

Poland—*Andrzej Kubler*

Portugal—*Antonio Cameiro*

Scotland—*Simon Mackenzie,*

Louie Plenderleith

Spain—*Antonio Artigas*

Sweden—*Hans Hjelmqvist*

Wales—*Mark Smithies*

Latin America

Brazil—*Eliezer Silva*

Chile

North America

Alabama—*Moustaffa Hassan*

California (Southern)—

Herbert Rogove

California (Sutter)—*John Mesic*

Colorado—*Ron Rains*

Connecticut—*Dawn Martin*

Florida—*Edgar Jimenez*

Georgia—*Kenneth Kalassian*

Illinois—*Nathan Lidsky, John Butler,*

Michael Ries, Jay Cowen

Iowa—*James Boddicker, Jill Morgan*

Kansas—*Steve Simpson*

Maryland/Washington, DC—

Gabriel Hauser

Michigan—*Joseph Bander*

Minnesota—*Henry Mann*

New Jersey—*R. Phillip Dellinger*

New York (NYHHC)—

Karen Scott Collins

North Carolina—*C. Diane Byrum*

Puerto Rico—*Gloria Rodriguez*

Texas (Memorial-Hermann)—

James Heisler

Virginia—*William Brock*

Virginia network experience

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were developed to facilitate consistent implementation of the Campaign. Watch for these and other tools to be available to all Campaign participants on the Surviving Sepsis Campaign website at www.survivingsepsis.org soon. In addition, sepsis screening has been integrated into nurse shift-change reports.

Issues related to compatibility with the SSC global database arose during planning stages, which have been resolved through working with the SSC database manager (see "Version 3.0 is Worth the Update").

The Campaign leadership thanks Dr. Brock and the entire Sentara system for their participation and willingness to share their experiences and resources with other hospitals as part of the global effort to achieve Campaign goals.

Achieving Balance

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the Surviving Sepsis Campaign create better outcomes for our patients through improving the reliability of delivery of best practice care.

Julian F. Bion, MD

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Queen Elizabeth Hospital

Birmingham, West Midlands, UK

1. O'Neill, O: *Autonomy and Trust in Bioethics*, Cambridge, Cambridge University Press, 2002 http://www.open2.net/trust/oneill_on_trust/oneill_on_trust1.htm

2. Stern DT, Papadakis M. The developing physician: Becoming a professional. *N Engl J Med* 2006; 355: 1794-9

3. Good doctors, safer patients. Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. A report by the Chief Medical Officer. Department of Health, London, 2007

4. Eichacker PQ, Natanson C, Danner RL: Surviving sepsis: Practice guidelines, marketing campaigns, and Eli Lilly. *N Engl J Med* 2006; 355:1640ñ1642

5. Durbin CG: Is industry guiding the sepsis guidelines? A perspective. *Crit Care Med* 2007; 35: 689-691

6. Barie PS. An opinion too far: The campaign against the Surviving Sepsis Campaign. *Surgical Infections* 2006; 7 (6): 485-8

7. http://cordis.europa.eu/fp7/dc/index.cfm?fuseaction=UserSite.CooperationDetailsCallPag&call_id=10

Version 3 is worth the update

Hospitals that are exporting anonymous chart extracts to SSC know they are contributing to an historic project creating changes in how severely septic patients are treated resulting in decreased mortality worldwide. Just as you are using the sepsis database to track and improve processes in your hospitals' ICUs and emergency departments, the Campaign will use the consolidated sepsis database to track and improve the sepsis bundles by documenting the progress globally.

If you are using Version 2.0 of the sepsis database, upgrading to Version 3.0 will be a benefit to you and the Campaign as a whole. If you are located in a non-English speaking country, this is particularly important as you should be using the international version of the database, Version 3.0. Version 2 allows tracking of only a portion of the data in the consolidated database, where Version 3.0 allows analysis of all data points.

Another reason to upgrade to Version 3.0 is that the ftp transmission is more reliable. Some instances have occurred where hospitals have transmitted export data by ftp that unfortunately never reached SSC. Only through discussions with Campaign staff and the hospital was it determined that the data was not transmitted accurately. If you have transmitted data by ftp, please send an email to data manager Neal Sosnowski at nsosnowski@sccm.org to ensure that your data is included in the consolidated database. If you have sent export data by email attachment, you should have received an automatic reply acknowledging receipt.

Many hospitals have installed the database and have never sent a data export. In these cases, you may be making major improvements in your facility, but your contribution to the global campaign is not being counted or credited. Please, contact the data manager if this is the case. The Campaign cannot estimate the total impact of the Campaign without knowing how many hospitals are actually using the database to track completion of the quality indicators and bundles.

If you need installation or operating help or just have questions about the database itself, feel free to contact Neal Sosnowski, SSC data manager, at 1-847-493-6418 or nsosnowski@sccm.org for any assistance.

Campaign Update is a bi-monthly publication of the Surviving Sepsis Campaign. Comments or suggestions should be sent to campaignupdate@survivingsepsis.org.

SSC Industry Support Policy: The SSC leadership adopted the policy document titled *Surviving Sepsis Campaign Implementation and the Appropriate Role of Industry* in February 2006. This policy is intended to clarify and delineate official SSC implementation activities from those initiated by third parties, including, but not limited to, the pharmaceutical and medical device industries. A copy of the policy is available at www.survivingsepsis.org.