

# CAMPAIN Update

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

March/April 2008



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](mailto:campaignupdate@survivingsepsis.org).



## The Surviving Sepsis Campaign Netherlands: Early promising results and a bright future for nation-wide implementation

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The Surviving Sepsis Campaign (SSC) was introduced in The Netherlands in December 2005 during a 2-day conference on sepsis and the international SSC initiative. In this meeting, national and international speakers including Professor M. Levy and Professor G. Ramsay presented sepsis-related topics. The second day a start-up meeting of the Dutch Network was chaired by Professor M. Levy. He explained the SSC goals and bundles and introduced the SSC database. Professor G. Ramsay showed examples of established networks.

Eleven hospitals joined the Dutch SSC and 10 more hospitals sent representatives. The hospitals agreed to start treating patients according to the international SSC guidelines and to collect patient data to improve the outcome of patients with severe sepsis.

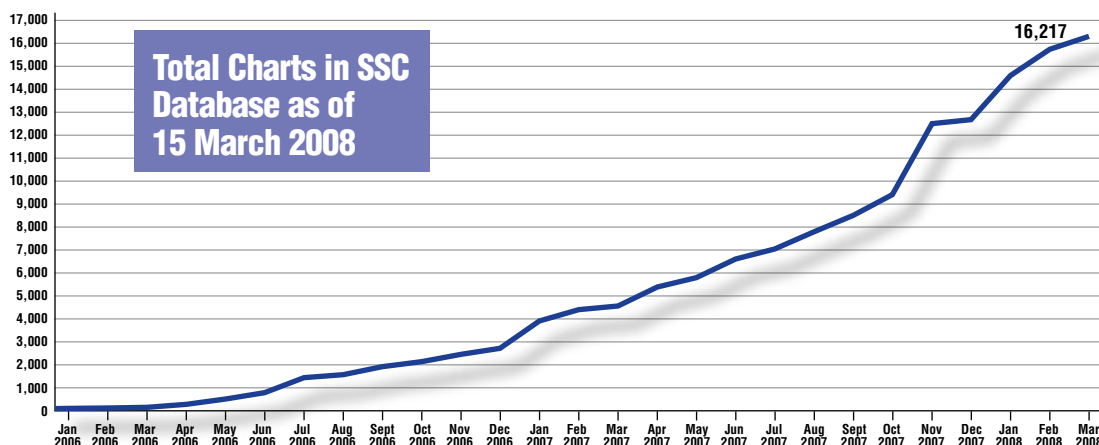
The Netherlands has a population of more than 16 million people. Of 109 hospitals in the country, 8 are university hospitals. Ninety-two hospitals have one or more Intensive Care Units (ICU). This meant that more than 10% of the general hospitals joined the SSC initiative from the start. Eleven intensivists of the participating hospitals formed a national steering group. Since then, more health care professionals have become involved in local SSC projects in many different hospitals,

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## R. Phillip Dellinger 2008 Guidelines: A significant achievement



When the revised Surviving Sepsis Campaign guidelines were published this past January, more than a few landmark events had occurred. First, “Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2008” represented a

consensus opinion of 18 organizations around the world and involved a writing group of more than 50 international experts. Secondly, the ability to review the literature, develop levels of evidence using a new evaluation system (see “Leader Perspective: Achieving the writing group’s consensus with GRADE” in the November/December issue of *Campaign Update*), and publish a document in a short timeframe was laudatory. The new grading system continues to categorize quality of evidence graded from A to D with A being the highest. More importantly, this system adds a numerical score where 1 means “recommend,” “strong recommendation,” or “do it” and 2 means “suggest,” “weak recommendation” or “probably do it.” And finally, the interval between publication of the original guidelines and the revision is quite compact compared to most guideline publications. I’d also like to point out that no industry funding was used for the guidelines revision meetings.

I have enumerated some of the key recommendations that relate to the sepsis bundles:

- Obtain blood cultures and lactate level as soon as possible after diagnosis of sepsis (Grade 1C)
- Antibiotic therapy: Begin intravenous antibiotics within the first hour of recognition of severe sepsis (Grade 1B)
- Fluid therapy: Fluid-resuscitate using crystalloids or colloids (Grade 1B)
- For sepsis induced tissue hypoperfusion, target (a) CVP of 8-12 mm Hg (higher in select patients with altered ventricular compliance or being mechanically ventilated) and (b) ScvO<sub>2</sub> saturation of 70% (Grade 1C)
- Vasopressors: Norepinephrine or dopamine administered through a central catheter are the initial vasopressors of choice (Grade 1C). Epinephrine is now the next agent of choice if blood pressure cannot be adequately maintained with norepinephrine and/or dopamine (Grade 2C)
- Steroids: Intravenous hydrocortisone only for adult septic shock when hypotension responds poorly to adequate fluid resuscitation and vasopressors (Grade 2C)
- Recombinant human activated protein C (rhAPC): rhAPC in adult patients with sepsis-induced organ dysfunction with clinical assessment of high risk of death if there are no contraindications (Grade 2B; 2C for postoperative patients)
- Glucose control: Use intravenous insulin to control hyperglycemia in patients with severe sepsis following stabilization in the ICU (Grade 1B). Aim to keep blood glucose < 150 mg/dL (8.3 mmol/L) using a validated protocol for insulin dose adjustments (Grade 2C).
- In patients with sepsis induced acute lung injury maintain

inspiratory plateau pressure of 30 cm H<sub>2</sub>O or less and tidal volume of 6 ml/kg/predicted body weight (lower to 4 ml/kg/PBW if necessary to achieve plateau pressure target) (Grade 1B )

I’d also like to bring to your attention that, unfortunately, the original publication in the January 2008 issues of *Critical Care Medicine* and *Intensive Care Medicine* contained a few errors. Two tables were left out of the introductory portion of the publication. Those 2 tables, now referred to as “schemes,” explained the definition of sepsis and referred to the original guidelines. They, along with corrections of other errors, are published as errata in the April 2008 issues of *Critical Care Medicine* and *Intensive Care Medicine*. Online readers will be directed to the errata, but it is important to refer to both publications to ensure that you obtain the complete and correct information. When citing the guidelines, use Dellinger RP, Levy MM, Carlet JM et al: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008 [published errata appear in *Crit Care Med* 2008; 36:1394-1396]. *Crit Care Med* 2008; 36:296-327 or Dellinger RP, Levy MM, Carlet JM et al: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008 [published errata appear in *Intensive Care Medicine* 2008; 34: 783-785]. *Intensive Care Medicine* 2008; 34: 17-60.

I will close by addressing a frequently asked question: how do the new guidelines affect the sepsis bundle indicators? The short answer is that they do not. All of the indicators are still recommended, although 3 of the 4 management indicators are now grade 2 recommendations. This is in line with the current emphasis by the SSC on the first 6 hours, yet the management bundle remains important for many patients. The grade 2 status of the recommendations for steroids for septic shock and use of rhAPC for severe sepsis might influence a hospital’s policy on use of these agents; however, because the management indicators only require that you document consideration in accordance with a hospital policy—whatever that may be—the indicators are still valid.

On behalf of the entire group of clinicians involved in the development of this edition of the sepsis guidelines, I wish to invite your comments and suggestions as you implement these new recommendations. It is our sincere belief that doing so will reduce mortality and improve healthcare around the world.

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 Robert Wood Johnson Medical School  
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 Camden, New Jersey, U.S.

Member, SSC Executive Committee

The following were presented at the Society of Critical Care Medicine's 37th Critical Care Congress February 2-6, 2008. They may provide additional insight as you implement the Surviving Sepsis Campaign.

Djurkovic S, et al. **Implementation of sepsis guidelines in the United States: A comparison between critical care and emergency department physicians.** *Crit Care Med.* 2007; 35(12 Suppl.): A274

*Significant differences in the management of severe sepsis patients by critical care and emergency department physicians were observed. Intensivists were more likely to obtain lactate levels ( $p=0.002$ ), measure central venous pressure ( $p<0.001$ ) and ScvO<sub>2</sub> ( $p=0.001$ ), administer steroids and drotrecogin alfa (DA), and maintain normoglycemia and inspiratory plateau pressures of less than 30 cm H<sub>2</sub>O (all  $p<0.001$ ). Note that the SSC does not score glucose compliance during the first 6 hours of management. Decisions on DA have traditionally been delegated to the intensivist.*

Masud FN, et al. **Implementation of sepsis bundles for severe sepsis/septic shock patients in surgical ICUs can improve outcomes.** *Crit Care Med.* 2007; 35(12 Suppl.): A274

*Data were compared between the first 6 months following initiation of the SSC performance improvement program and the following 6 months in surgical ICUs (70 beds). By increasing awareness with education and a multidisciplinary team approach, intensivist-led team implementation of sepsis protocol/bundles (based on IHI/ SSC) reduce mortality, length of stay (LOS), and costs (approximately \$ 690,000).*

Ruckshanda M, et al. **Investigating the effect of introducing a sepsis nurse on improving inpatient outcomes.** *Crit Care Med.* 2007; 35(12 Suppl.): A275

*After adding a sepsis nurse who was trained to identify and follow high risk inpatients (central lines, diabetes, liver or kidney disease, leukocytosis,*

*neutropenia, or an obvious source of infection), the number of calls made to the rapid response team increased and the number of codes decreased. Bringing high risk patients to the attention of intensivists earlier is suggested to have positive clinical impact.*

Babak S, et al. **Interdisciplinary rapid response systems decrease the time to stat antibiotic administration.** *Crit Care Med.* 2007; 35(12 Suppl.): A276

*By embedding a pharmacist within a rapid response system (RRS), the time to antibiotic administration was reduced to less than one hour in hospitalized patients with suspected sepsis. An RRS can serve as a vehicle to deliver timely, evidence-based sepsis care.*

Hayatdavoudi S, et al. **Effect of the implementation of a protocol utilizing the 6hr and 24hr bundles on the survival of the sepsis sub group as defined by APACHE II scoring.** *Crit Care Med.* 2007; 35(12 Suppl.): A275

*Implementation of the SSC guidelines was facilitated by using pre-printed order sets with shared patient management including critical care physicians when patients were grouped into two categories using APACHE II scores  $< 25$  and  $\geq 25$  (at time of diagnosis). APACHE II  $< 25$  appeared to have the greater benefit from this protocol.*

Badawi O, et al. **Severe sepsis (SS) is underreported in the ICU.** *Crit Care Med.* 2007; 35(12 Suppl.): A256

*The authors have demonstrated that nearly half of ICU patients who met criteria for severe sepsis did not have the diagnosis documented in the chart. The authors concluded that clinicians are likely underreporting severe sepsis in charting while*

*directing charting to cardiovascular organ dysfunction.*

Rincon T, et al. **Screening for severe sepsis: An incidence analysis.** *Crit Care Med.* 2007; 35(12 Suppl.): A257

*The incidence of severe sepsis was assessed using an electronic screening tool (161 ICU beds at 10 hospitals). The incidence of severe sepsis by this diagnostic method was higher than previously reported. This method of identifying to facilitate timely intervention might have a significant impact on outcome of at-risk patients.*

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## CALENDAR

### 2008

**April 29**

SSC North American Summit, Session II  
West Coast Collaborative  
8am-5pm  
The Brown Palace  
Denver, Colorado, USA

**June 28-July 2**

6th Congress of the International Federation of Shock Societies  
31st Annual Conference of the US Shock Society  
7th International Conference on Complexity in Acute Illness  
Cologne, Germany

**September 21-24**

ESICM Annual Meeting  
Lisbon, Portugal

**November 19-21**

International Sepsis Forum:  
Sepsis 2008  
Granada, Spain

### 2009

**January 31-February 4**

SCCM 38th Critical Care Congress  
Nashville, Tennessee, USA

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

## The Surviving Sepsis Campaign Netherlands

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which has increased SSC awareness considerably. The SSC guidelines were translated into the Dutch language and some hospitals started to collect data in the SSC database. Many more collected patient data for local hospital use only.

### Sepsis incidence and mortality in The Netherlands

The Dutch Medical Registry (LMR) reports a sepsis incidence of 55 per 100,000, which is less than the reported incidence in the United States. This means that more than 13,000 patients are treated annually for severe sepsis in The Netherlands. Hospital mortality rates are comparable with those in North America, and, depending on numbers of failing organs, mortality ranges between 20 and 40%.

Incidence rises with age and doubles after the age of 75 years. Mortality from severe sepsis also increases in the elderly. This makes severe sepsis the leading cause of death on the Dutch ICUs.

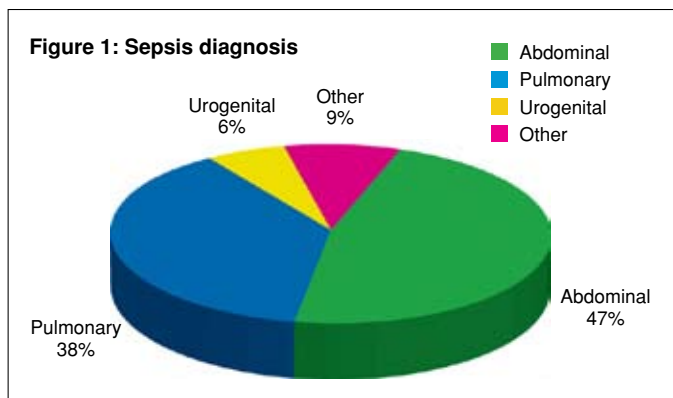
ICU care in The Netherlands is being provided by intensivists, often in a closed-format organization. The majority of intensivists are internists or anaesthesiologists and less often are surgeons or pulmonologists. ICUs are being qualified by the Dutch Health Care Authority in three levels (I, II, and III). Level II and III ICUs provide the highest ICU care with 24/7 intensivist care for their patients and exclusive ICU nurses. More than 80% of ICU patients in The Netherlands are treated in a level II or III ICU.

### Surviving Sepsis Campaign in Ede

The ICU in Ede has 12 beds and is the coordinating center for SSC Netherlands. Medical care is provided in a closed-format intensivist system. More than 600 patients are treated annually with more than 3,000 mechanical ventilation days.

Twenty-five percent of these patients are admitted with the diagnosis of sepsis. Around 150 patients develop severe sepsis or septic shock. In 47%, the sepsis origin is abdominal; in 38% pulmonary; and 6% urogenital. The remaining small group consists of line sepsis, mediastinitis, fasciitis, endocarditis, and meningitis (Figure 1).

When we started the Campaign in our hospital in January 2006, sepsis mortality was around 40%. Our ICU performed well in the resuscitation bundle with lactate measurements, volume resuscitation, and inotropes. However, timing of microbiological cultures and antibiotic use improved during the 2 years that the SSC was implemented in our ICU. SvO<sub>2</sub> was



not routinely measured before the SSC introduction. In the management bundle, compliance with steroids, strict glucose regulation, and pressure-regulated mechanical ventilation have always been part of our protocol. rhAPC is not prescribed in our ICU.

Many patients with severe sepsis admitted to the ICU developed the first clinical signs on the general hospital wards many hours before SSC therapy guidelines were initiated. We realized that the detection and treatment of severe sepsis in these patients had to be improved to achieve a 25% reduction in mortality. Doctors and nurses needed to be aware of the standard definitions of sepsis and the recommendations for its initial management. The results of an audit that was carried out on the

hospital wards to assess knowledge of sepsis showed that medical doctors and ward nurses appeared to have a poor knowledge of the signs and symptoms of sepsis, severe sepsis, septic shock, and many aspects of its initial management. Following the results of the audit, various educational initiatives were introduced to raise awareness of the standard definitions and the surviving sepsis management guidelines.

### Education and evaluation

An educational program was started by a special SSC team (2 ICU nurses and 1 intensivist). All ICU nurses and ICU doctors received the SSC guidelines and were educated in a special training program.

To focus on the importance of achieving the SSC goals in the prescribed time, we introduced a special SSC sticker that is placed on the medical order sheet for every patient that is admitted with the diagnosis of severe sepsis on the ICU. On this sticker T=0 (SSC inclusion time) is noted and the ICU nurse has to reach the SSC goals in the set time window

and document this on the sticker. The introduction of the sticker has increased time awareness, reduced time delay significantly, and improved compliance with SSC management guidelines. Every 3 months, the results of our SSC database are presented to the ICU team to reinforce adherence to the protocols and stimulate SSC interest.

To evaluate the impact of introducing the SSC treatment guidelines for severe sepsis on ICU care, understanding the underlying epidemiology and outcome is required. The SSC sepsis database was an important tool to analyze our results. Since we started, 302 total patients were identified as having severe sepsis in the first 24 hours following admission, which is 27% of

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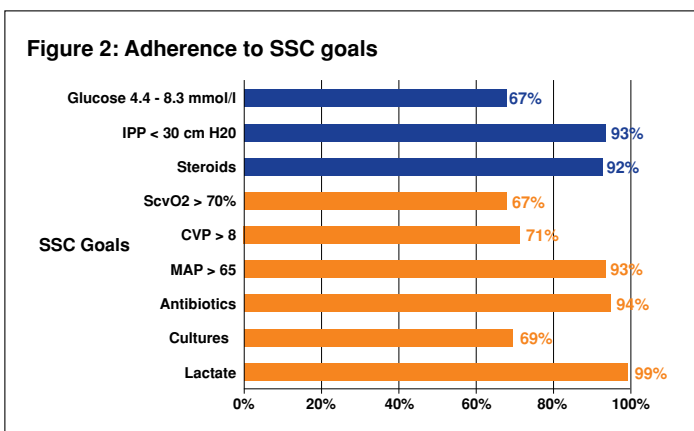
## The Surviving Sepsis Campaign Netherlands

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the total of admitted ICU patients.

The number of patients admitted with severe sepsis on the ICU increased to 35% in 2007 from 2006. The increase is due to more patients' being admitted to our hospital and to a better detection of severe sepsis on the general wards. ICU mortality for admissions with severe sepsis decreased from 37% in 2006 to 31% in 2007.

Significantly better outcome has been achieved with strict adherence to SSC goals, as shown in Figure 2. When fewer than 7 SSC goals were achieved, the ICU mortality was 42%. With 8 or more goals achieved, the ICU mortality was reduced to 27%. Analysis of the influence of the resuscitation and management goals showed that achieving early resuscitation had the greatest impact on reducing the mortality, which is in concordance with other studies.



### The future

The introduction of the SSC has improved care of the patient with severe sepsis in our hospital. We are confident that this trend will be visible in other Dutch ICUs and more data will follow.

The Dutch health care authorities have started a nationwide patient safety campaign focusing on the reduction of avoidable adverse events in hospitals with a reduction of at least 50% in 5 years. The national medical specialist board has selected deterioration of vital signs (early recognition) and sepsis as 2 of 10 quality fields for good healthcare practice in hospitals.

The SSC Netherlands international liaison officer is chairing the Sepsis Expert Task Force. Therefore, it may be expected that in the near future all ICUs have to collect patient data of sepsis patients and the bundles. This expectation is underscored by the fact that the Inspectorate of the Ministry of Health will check the implementation of this safety program. In addition to the SSC bundles, a prevention program for nosocomial sepsis will commence. SSC Netherlands will continue the efforts to promote the SSC and hopes to achieve a major reduction in the mortality of severe sepsis in all hospitals in our country.

Please send correspondence to Tjand@zg.vnl

Laine G, et al. **Clinical and financial outcomes associated with a sepsis initiative.** *Crit Care Med.* 2007; 35(12 Suppl.): A258

*A multifaceted sepsis initiative that included a sepsis protocol, and focused education on early screening and the sepsis treatment bundle, improved clinical outcomes and substantially reduced cost of care (up to \$6.9 million for the 15-month post-implementation period) in a tertiary care hospital with 157 ICU beds.*

Mooney R, and Henry Ford Hospital Sepsis Collaborative Group. **An institutional sepsis collaborative: The impact of a continuous quality improvement process.** *Crit Care Med.* 2007; 35(12 Suppl.): A259

*652 patients with severe sepsis and septic shock were evaluated. Significant correlation between compliance to resuscitation bundle elements and mortality was found. The authors concluded that in spite of promising developments in therapy, compliance with bundle elements is likely the final path to improving outcome.*

Kinsella M, et al. **Implementation of the Surviving Sepsis Campaign Guidelines in a community teaching hospital did not result in a significant increase in cost.** *Crit Care Med.* 2007; 35(12 Suppl.): A260

*Effect on cost of implementation of SSC guidelines was assessed. Severe sepsis ICD-9 codes were used to compare costs before and after implementation of the SSC performance improvement program. There was an increase in the number of patients during the SSC performance improvement period without an increase in cost. The data also demonstrated that despite the increases in use of drotrecogin alfa (DA), total costs were still reduced, which may be due in part to the observed decrease in hospital length of stay.*

Simpson S, et al. **Outcomes in septic patients excluded from the Surviving Sepsis database.** *Crit Care Med.* 2007; 35(12 Suppl.): A156

*Because the SSC screening tool excludes some septic patients from database entry, patients in the SSC database were compared with those patients coded for severe sepsis in the hospital discharge database over the same period. Overall mortality was 28.5% in SSC, 30.7% in total, and 33.1% in non-SSC ( $p=0.331$  for SSC vs. non-SSC). The authors recommended that to obtain accurate and complete data on all severe sepsis patients, and to optimally affect mortality, the SSC database must allow data entry even for patients who are currently excluded.*



## CAMPAIGN at-a-Glance

### Asia

China

### Europe

Denmark—*Lone Poulsen*

England—*Ron Daniels*

Germany—*Konrad Reinhart*

Ireland—*Jeanne Moriarty,*

*Brian McCloskey*

Italy—*Roberto Furnagalli*

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

Venezuela—

*Pablo A. Pérez d'Empaire*

### North America

Alabama—*Moustaffa Hassan*

Arizona—*Donald Maxwell*

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)

North Carolina—*C. Diane Byrum*

Puerto Rico—*Gloria Rodriguez*

Texas (Memorial-Hermann)—

*James Heisler*

Virginia—*William Brock*

## IRB issue leads to meeting with HHS

When the issue of Institutional Review Board (IRB) approval for quality improvement research was raised by the US Office for Human Research Protection of the Department of Health and Human Services (HHS), the SSC advised participants that the Phase 3 data collection initiative had obtained IRB approval via Cooper University Hospital. It recommended that hospitals have IRB approval or confirm that it has been waived. In light of recent conversations with HHS, it is clear that SSC has followed the correct path.

As a result of the concerns about informed consent related to quality improvement activities, the Society of Critical Care Medicine (one of the 3 collaborating societies of SSC) joined 3 other US-based societies in meeting with senior HHS staff to discuss the vital

role that such activities play in advancing patient care. Mitchell Levy, SSC executive committee member and head of SSC Phase 3, represented SCCM. The group agreed that more precise and clear definitions of the terms *research*, *quality improvement*, and *quality improvement research* are required. In addition, it was clear from the meeting that further education and clarification about the existing regulations are needed from HHS to institutional review boards. Levy observed that “the alliance of professional organizations will help providers ensure that advances in healthcare developed from reliability and quality improvement research are not derived from compromised patient protection. The Surviving Sepsis Campaign plays a prominent part in improving patient care globally. You may be assured we will be diligent in tracking this issue.”

## Data entry survey needs your response

As analysis of the patient charts entered into the global Surviving Sepsis Campaign database commences, the importance of the survey regarding local methodology for determination of time zero for the 6-hour bundle increases. The survey, described in the January/February issue of *Campaign Update*, and sent to the major networks and contributors to the database, is still open for response. We are pleased that to date a majority of surveys has been returned, but every response is extremely valuable and needed by mid-April.

The Campaign held a drawing for free registration to the ESICM 2008 meeting and SCCM 2009 meeting among responses received by February 15, 2008. Winners are Enrique Piacentini from Terrassa, Spain, and Jose Mario M Tellaes from H.Portuguos, Brazil. The Campaign looks forward to greeting the winners at the respective meetings.

If you haven't responded yet, please access the brief questionnaire at [https://www.surveymonkey.com/s.aspx?sm=oyrkMsZOYD\\_2fQnk9Nwj2KQg\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=oyrkMsZOYD_2fQnk9Nwj2KQg_3d_3d)

Address any questions to [elaine@sepsisforum.org](mailto:elaine@sepsisforum.org)

## Reminder about data submission

Aggregate data from the global database will soon be analyzed with the intent of sharing results of the Campaign's improvement in individual bundle elements and overall. Please ensure your data submissions are up to date and that they are submitted via e-mail. As you were advised in January, the ftp site is no longer available and it is essential that you have upgraded your database to version 4. If you need assistance, go to [http://ssc.sccm.org/implement/resources/manual\\_database](http://ssc.sccm.org/implement/resources/manual_database)

## Resources expanded on [www.survivingsepsis.org](http://www.survivingsepsis.org)

To access resources for your in-hospital programs about the Surviving Sepsis Campaign, go to [www.survivingsepsis.org](http://www.survivingsepsis.org). Recent additions to the Web site include the revised guidelines, “Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008.” Additionally, abridged versions of the guidelines can be downloaded for use in poster format or pocket guides. They can be found on the Web site under the guidelines tab on the top navigation bar.

*Campaign Update* is a publication of the Surviving Sepsis Campaign. Comments or suggestions should be sent to [campaignupdate@survivingsepsis.org](mailto: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](http://www.survivingsepsis.org).