Summer 2021

Early Detection of Sepsis in Direct Admit Hospitalized Patients: Implementing a New Sepsis Screening Checklist

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DNP Manuscript Defense Approval

First Name: * Connie Last Name: * Lasley Student ID: *

Date: * 06/29/2021

Choose your DNP program: *
- ○ Adult-Gerontology Acute Care Nurse Practitioner (Doctor of Nursing Practice)
- ◉ Family Nurse Practitioner (Doctor of Nursing Practice)
- ○ Post-Master's DNP (Doctor of Nursing Practice)

Manuscript Title: * Early Detection of Sepsis in

Date of Manuscript Approval: * 06/29/2021

Student Signature	Electronically signed by Connie Lasley on 06/29/2021 6:36:57 PM
Chair, DNP Manuscript Signature	Electronically signed by Dana Mikel on 06/29/2021 6:34:50 PM
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Early Detection of Sepsis in Direct Admit Hospitalized Patients:

Implementing a New Sepsis Screening Checklist

A DNP Project Submitted to the
Graduate Faculty
of Jacksonville State University
in Partial Fulfillment of the
Requirements for the Degree
of Doctor of Nursing Practice

By
CONNIE JEANINE LASLEY
Jacksonville, Alabama
June 28, 2021

Connie Jeanine Lasley June 28, 2021

ABSTRACT

Background: Early detection of sepsis in hospitalized patients in small rural hospitals can save lives. Subtle changes in patients can go undetected by nurses and doctors, leading to septic shock, increasing the length of stay in the hospital or death. In a small Alabama hospital, nurses were missing the early signs and symptoms of developing sepsis due to a lack of a monitoring system and proper education regarding sepsis.

Objective: The development of a sepsis screening checklist to place on each direct admitted patient's chart to collect vital signs every four-hours each 12-hour shift to alert nurses of early signs of sepsis.

Methods: The sepsis checklist was used in a six-week period and then compared to six-weeks without the checklist. The number of sepsis cases data was collected by measuring the quantity of patients with sepsis diagnosis and the reporting of cases to the Centers for Medicare and Medicaid.

Results: The first six-weeks resulted in four cases of sepsis out of 100 direct admit patients without the use of the sepsis checklist. The length of stay varied with each patient. The second six-weeks the sepsis checklist resulted no diagnosis of sepsis out of 80 direct admit patients.

Conclusion: It is unsure if the sepsis checklist prevented sepsis or would have decreased the length of stay in direct admit patients in the second six-week period. The sepsis checklist did provide a means to fill a gap in patient monitoring.

Keywords: **Sepsis, septic shock, septic bundling, septic guidelines, septic protocol**

ACKNOWLEDGEMENTS

I would like to thank Dr. Stacy Mikel, Dr. Jeffrey Voreis, the Administrator, and the staff, who were involved in making the project possible. I would also like to thank my family for always supporting me in all my education endeavors. Thank you to all my nursing instructors for guidance and support during all my education challenges to fulfill my dream of becoming a Doctorate Prepared Nurse.

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Early Detection of Sepsis in Direct Admit Hospitalized Patients: Implementing a New Sepsis Screening Checklist

Introduction

Prevention of adverse conditions by improving quality care should be the ultimate goal of a nurse. Subtle changes in a patient's condition from sepsis can slowly escape the nurse's attention and lead to devastation and irreversible effects on the hospitalized patient, increasing the risk for mortality, which signals a gap in quality care given to these patients. The nurse is in constant contact with the patient during the 12- hour shift and should be the first to recognize the decline in the patient (Kleinpell, 2017). Educating nurses on the early signs and symptoms of developing sepsis is top priority. Designing a new sepsis checklist can serve as a guide for nurses to assist them with recognizing developing sepsis. The Cleveland Journal of Medicine has evidence-based guidelines to quickly recognize developing sepsis using the Systemic Inflammatory Response Syndrome (SIRS) parameters, which were used in this project (Dugar, Choudhary, & Duggal, 2020). These guidelines were was used to develop a sepsis checklist, which gives guidance to nurses and doctors in recognizing signs and symptoms of sepsis, thus decreasing the length of stay in the hospital.

Background

With research and evidence-based practice, a gap in assessment by healthcare providers can be investigated. New data can be collected on where the system fails and then new interventions can be implemented to manage sepsis in clinical settings. Investigating and finding the gaps in healthcare prevents sepsis, patients' mortality, and morbidity by providing guidelines, which have been tried and proven to advocate for patients with the early recognition and treatment for sepsis (Rudd, et al., 2018).

Sepsis can occur from germs entering the body through the skin, lungs, urinary tract, or gastrointestinal tract. These germs can begin multiplying within the human body, which can cause an infection. In extreme cases of infection, the body responds through an adverse inflammatory response, and sepsis can quickly occur. The risk factors for developing sepsis are patients over 65, immunocompromised patients, younger children, and those with chronic conditions, such as diabetes, cancer, kidney disease, or lung disease. The Centers for Disease Control and Prevention (CDC) reports at least one out of three hospitalized patients will develop sepsis during the hospital stay (2018). The CDC (2018) also reports at least 1.7 million people develop sepsis yearly, and 270,000 of the patients have died from the disease.

Problem Statement

This project will examine the following question: in direct admitted hospitalized patients how does the early recognition of sepsis symptoms detected by nurses using a

sepsis checklist, compared with no sepsis checklist, affect the length of stay in hospitalized patients within a six-week time frame?

Sepsis develops from a gap in patient care and can be prevented by recognizing early signs and symptoms of sepsis. Sepsis occurs and increases the length of stay for patients admitted in a small private owned community hospital in southern Alabama. The developing sepsis is occurring after the patient is directly admitted to the medical-surgical floor. Patients who are admitted to the facility are experiencing symptoms of developing sepsis and these symptoms are undetected by the nurses. The facility does not utilize a sepsis checklist during the hospital stay.

Organizational Description of Project Site

The project site is a small community hospital located in southern Alabama. The hospital was first opened in the 1950s. The private owned hospital has a 36-bed medical-surgical floor. The hospital has a steady influx of patients daily. Patients are admitted to the hospital medical-surgical floor from the emergency room and private physician's offices. Patients admitted from the emergency room are currently screened for sepsis through the T-charting system upon admission. All direct admit patients are initially screened for sepsis, but not during their stay in the hospital.

The Review of Literature

Literature for review came from the CDC, PubMed, National Institute for Health, Cochrane, Cleveland Clinic Journal of Medicine, Sepsis Alliance, World Health Organization, and Mayo Clinic. The keywords used were sepsis, septic shock, septic

bundling, and septic protocols. The literature was reviewed, and current data was used within the last five years. The information came from articles within the United States. Articles titles and abstracts were reviewed to determine the relevance of the individual studies to the purpose of this review. Full text articles were obtained and assessed for inclusion. Studies were excluded if the authors described the topic in a different aspect as the review required.

Pub Med articles published in *Critical Care Journal* were viewed, which stressed the importance of nurses assessing patients for sepsis due to constant interaction with patients (Kleinpell, 2017). The article demonstrated a study, which reported a decrease in sepsis from assessing the patients twice within a shift (Kleinpell, 2017). Another *Critical Care* article was reviewed regarding the global burden of the cost of treating septic shock and the increased risk of death from shock (Rudd, 2018).

An article obtained from the World Health Organization (WHO) (2020), discusses how sepsis affects people of all ages all over the world. Based on findings from 2017, the author notes that 48.9 million people affected by sepsis with 20% of people dying that year. The infections associated with the cause of sepsis are becoming resistant to treatment with antibiotics leading to the deterioration of patients. This article explains the people at higher risk for sepsis, signs and symptoms of sepsis, common causes, diagnosis, clinical management, substantial development, goals, and sepsis response (WHO, 2020).

Sepsis Alliance (2020), has an article describing sepsis and using the acronym TIME. T is for measuring temperature, I is for signs of infection, M is for mental decline and E is for extreme pain or the patient feels like dying. Sepsis alliance also gives vital signs and laboratory parameters to use as a guide for caring for people at high risk for sepsis (2020).

All of the articles used in this project were based on evidence-based practices and statistics, which focused on the signs and symptoms of sepsis, the statistics of sepsis around the world and in the United States. The articles listed vital signs and laboratory parameters to measure and give the nurse an idea of what is considered normal and abnormal to use as a guide to monitor patients throughout the hospital stay.

Evidence-Based Practice: Verification of Chosen Option

Information on sepsis was reviewed from the CDC, which focused on the signs and symptoms of sepsis, treatment process, the risk for death, and how important it is to quickly recognize sepsis symptoms (2018). The *Cleveland Journal of Medicine* published an article by Dugar, Choudhary, and Duggal (2020), which emphasized the use of several screening devices for sepsis such as; Sequential Organ Failure Assessment (SOFA), Quick Sequential Organ Failure Assessment (qSOFA), or Systemic Inflammatory Response Syndrome (SIRS}. According to this article, the United States Center of Medicare and Medicaid Services (CMS) recommended the SIRS criteria for the early detection of sepsis. CMS recommends qSOFA to be used only as a triaging tool and not a monitoring tool (Dugar et al., 2020).

Theoretical Framework/Evidence-based Practice Model

Ernest Codman, both a surgeon and doctor, focused on the work done in the hospital setting, and on quality patient outcomes. Dr. Codman began his work by tracking surgery patients and their outcomes after surgery. Dr. Codman was concerned with finding the root cause of adverse outcomes in surgery patients and sought to correct the cause (Butts & Rich, 2018). Dr. Codman's theory has been used in this project as (1) a guide to track sepsis patients and their outcomes (2) to find the variable causing the problem and intervene (3) measure the standard of care through the use of quality indicators, and (4) to form a committee to monitor and establish high quality standard care of patients who are at a greater risk for sepsis (Butts & Rich, 2018).

Evidence-based practice guidelines derived from the *Cleveland Clinic Journal of Medicine* have been utilized at a small hospital in southern Alabama to design a sepsis checklist for healthcare personnel to follow (Dugar et al., 2020). The sepsis checklist will help detect the subtle changes in patient vital signs of developing sepsis in hospitalized patients. The outcome of using the sepsis protocol is to prevent septic shock, decrease the length of stay in the hospital, decrease the cost of care, and improve the quality of care for patients. Dr. Codman was concerned with a higher standard of care given to patients and improvement of care measures. Dr. Codman's theory can be continued from the past and used in the present time to address quality improvement of patient care (Butts & Rich, 2018). Finding the root cause of a problem in a patient care setting should always be addressed and corrected by healthcare providers to improve the standard and quality of

care given to patients. Addressing quality indicators, which are used to measure the outcomes of interventions has allowed for change and improvement in the outcome for the patient.

Goals, Objectives, and Expected Outcomes

The goal of this project was to design a sepsis checklist utilized by nurses on each 12-hour shift. This checklist will help detect changes in a patient's vital signs that can result in the patient developing sepsis; this detection should result in a decreased length of stay in the hospital. The checklist was designed on a sheet of paper with places to document vital signs every four hours with date and time. The checklist had vital sign SIRS parameters to follow and instructed what to do if two or more of the vital signs were abnormal. If sepsis was caught early, the sepsis checklist provided by the hospital has protected the patient from septic shock or death. The sepsis checklist utilized by nurses within a six-week time frame has been tallied for a decrease in length of stay in admitted hospital patients.

Patients who are hospitalized may develop sepsis symptoms and these symptoms may be missed by the nurse or doctor caring for the patient. Steps have been taken by using evidence-based guidelines derived from the Cleveland Clinic Journal of Medicine utilized by a committee of highly educated nurses and doctors to (1) decrease the length of stay in direct admit hospitalized patients by 50%, (2) formalizing a process to monitor patients during the admission stay, (3) implementing an effective monitoring system

through the use of the sepsis checklist to accomplish continuous monitoring with documentation based on the changes in a patient's vital signs, (4) educate nursing staff on the use of the checklist, and (6) measure the results within six-weeks.

The expected outcome of the objectives was to decrease the length of stay with a diagnosis of sepsis in the hospital by 50%. The suspected outcome goal has been met by utilizing a sepsis checklist form on every shift by the nurse caring for the patient. The sepsis checklist provided a means to closely monitor patients for developing sepsis. The checklist monitored vital signs and provided parameters to alert the nurses of the early development of sepsis. The expected outcome was to detect sepsis early, treat quickly, decrease the length of stay in hospital and provide a quality improvement in the care of patients.

Project Design

The project design is a sepsis checklist, which has vital signs with parameters located on the front of each direct admit hospital patient's chart admitted to the medical surgical hall. The project is based on quality of care given to patients. The project started with an intervention to be utilized by nurses and patient care technicians to monitor for sepsis through the use of a vital sign sheet. The sepsis checklist provides a means of providing safety to all direct admitted patients. The data is collected through a quantitative method of sepsis diagnosis codes and length of stay.

Project Site and Population

The project took place in a small rural 36-bed hospital in southern Alabama.

Suburban Stats (2020) reports the small community has a population of over 3900 people; who are either African Americans or Caucasians. The community has eight providers, who are medical doctors or nurse practitioners. Specialty providers provide services at least one to two days a week. The staffing at the hospital is based on a grid according to how many patients are admitted per nursing staff. The staff is a mixture of one registered nurse house supervisor to licensed practical nurses caring for patients. Implementing the project began with educating the staff on several different occasions on sepsis and the sepsis checklist. The staff and administrative personnel were willing to help with the project. The coding manager was willing to help gather data by finding the sepsis diagnosis and recording how long the patients stayed in the hospital. (see Appendix A).

Setting Facilitators and Barriers

Facilitators for the project are the quality management team. The team is looking for ways to improve care and change protocols and policies in providing patient care. Barriers could include patient vital signs, which are missed and not documented. Nurses may not want to help with the project and refuse to monitor changes. If a roadblock occurs, the data will be calculated and utilized in the best fashion it can be used. If sepsis was detected early in one patient during the six-week period of using the sepsis checklist, the goal will be met in this author's opinion.

Implementation Plan/Procedures

The project was selected due to a problem of patients developing sepsis after they were directly admitted to the hospital. Patients were not monitored closely for the subtle signs of developing sepsis. The facility administrator, director of nursing, and case management personnel were approached with the idea of implementing a sepsis checklist; it would be placed on the front of the direct admit patient's chart with a vital sign sheet with affiliated parameters to follow. The sepsis checklist sheet includes instructions on what to do if two or more changes in vital signs occurred in a four hour period. The sepsis checklist was based off recommendations of the Cleveland Journal of Medicine sepsis guidelines (Dugar et al., 2020). Implementing the project began with educating the staff on several different occasions on sepsis and the sepsis checklist. The staff and administrative personnel were willing to help with the project. The coding manager was willing to help gather data by finding the sepsis diagnosis and how long the patients stayed in the hospital. Data was collected through the diagnosis of sepsis codes and length of stay from the coding manager at the facility. The total number of patients diagnosed with sepsis is reported to CMS on a quarterly basis per the facility. (see Appendix A, B, and D).

Measurement Instruments

To measure this DNP Project's outcomes, the following instruments were used: data collected over a six-week period with the use of the sepsis protocol was analyzed and compared with a six-week period without the checklist. This data was determined by

the use of diagnosis-related codes and how long the patient stayed in the hospital. The data came from a computer-based data collection tool based on diagnosis-related codes of 'A 41.9' and patient admit numbers for direct admit patients from the coding manager at the facility and case management reporting of sepsis diagnosis to CMS.

Data Collection Procedures

Pre-intervention: Assess the problem, design a sepsis checklist using evidence-based practice guidelines.

Intervention: Place the sepsis checklist on each direct admit patient's chart and have nursing staff document and monitor vital signs every four hours.

Post-intervention: Assess for early detection of developing sepsis for a decrease in length of stay of patients in the hospital.

Data Analysis

Data collected from the project was quantitative. The amount of direct admitted patients was counted with the sepsis checklist and the diagnosis-related codes attached to the patient number attached to them as a direct admit. The diagnosis code 'A 41.9' was searched and there were four direct admits out of 100, who developed sepsis during the first six-week period analyzed without using the sepsis checklist. The sepsis checklist was implemented the second six-weeks and there were 80 direct admit patients without the diagnosis of sepsis. The data was inconclusive due to no sepsis cases in the second six -weeks with the use of the sepsis checklist. (see Appendix D).

Cost-Benefit Analysis/Budget

The cost affiliated with this project include copy paper and ink required to make copies of the sepsis checklist. The cost of the project also includes the amount of time needed to educate, train, and have personnel put the sepsis sheet on each direct admit chart and the nurse; time to document. The benefit of the project to the facility is the early diagnosis of sepsis with decreased length of stay in the facility, which saves the facility money and less risk of re-admission or death of the patient.

Timeline

The project was approved by the Institutional Review Board in the Fall of 2020. The new sepsis checklist was designed and education was provided to nurses the first week of March 2021. The sepsis checklist was placed on the front of all direct admit patient charts beginning on March 8th through April 23rd. The sepsis checklist was collected on April 23rd. Meetings with the code manager were scheduled during the first week of June 2021 to collect the diagnosis-related codes and the cases reported to CMS. Data was collected, tallied, and reported in the Doctorate Nurse Prepared poster, PowerPoint, and Manuscript. (see Appendix A, B, C, and D).

Ethical Considerations Protection of Human Subjects

The Jacksonville State University Institutional Review Board (IRB) approval was granted before initiating the DNP Project. Each patient and their identifiers were protected in this DNP project by the Health Insurance Portability and Accountability Act

of 1996 (HIPAA). The patient data, which was used in this project was confined to the office of the coding manager at the facility under lock and key. Patient data is protected within the computer system at the facility and can only be accessed by the code manager and administration. (see Appendix E).

Conclusion

The ultimate goal of a provider is to provide quality patient care. Prevention of disease is the top priority. Nurses have an obligation to advocate for the patient because they spend the most time with the patient. The shortage of nursing staff compared to assigned number of patients to care for, the Coronavirus epidemic, and the overall stress of being responsible for the care of patients, could cause the nurse to miss subtle changes in patients' status due to a busy schedule. A monitoring tool such as the sepsis checklist can prove to provide a form to document all the vital signs on a patient in an area in the patients' chart to alert the nurse to differences in the vital signs.

Even though the sepsis checklist was inconclusive in proving it prevented sepsis, or decreased the length of stay, it served as a documentation device to be utilized by nurses to closely monitor the direct admit patient. Problems encountered during the six-week period with the use of the checklist were nurses missed documenting vital signs every four hours on some of the patient's chart during the hospital stay. It will never be known if the sepsis checklist prevented sepsis from occurring during the second six-week period or if it would have decreased the patient's length of stay in the hospital. One success of the sepsis checklist is it proved a point by filling a gap in nursing by providing

a continuous monitoring tool for sepsis for direct admitted hospitalized patients. The facility was interested in utilizing this sepsis checklist in the care of hospitalized patients through an electronic form. This electronic form would be used with every admitted patient's admission process and continuation of care given throughout the hospital stay. This would add an excellent source of improving and giving quality care to patients by protecting them from septic shock or death. The use of a sepsis checklist would not be hard to implement into an electronic form by the Director of Nursing at this facility to carry on a quality monitoring tool to save lives, decrease the cost of treatment for sepsis, and length of stay in the hospital.

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APPENDIX A

Education PowerPoint

Slide one Title Page: Early Detection of Sepsis in Direct Admitted Hospitalized Patients: Implementing a New Sepsis Checklist by Connie J. Lasley, MSN, DNP Project for Jacksonville State University

Slide 2: Objectives of; Introduction, What is Sepsis?, Septic Shock, Early detection of sepsis, Checklist Implementation

Slide 3: Introduction, In the United States over 210,000 people die annually from sepsis and the sepsis cost of care expense exceeds $20.3 billion (Dugar, et al., 2020).

Slide 4: What is Sepsis? Sepsis the body's response to an infection. The infection triggers a chain reaction of events, which occurs within the body. Germs enter the body through some type of breach in the integumentary system or through an orifice in the body (World Health Organization, 2020).

Slide 5: Septic shock occurs when the body becomes dysregulated due to a response to an infection, which causes multiple organ failure. Sepsis causes abnormal blood clotting inside organs, which damages the organs leading to failure or even death (CDC, 2021).

Slide 6: Signs and Symptoms of Sepsis, Temperature over 100.4 degrees or below 98.6 degrees F, respiratory rate over 20-22 a minute, white blood count over 12,000 or under

4,000, mental confusion, lethargy, very sleepy, and difficult to arouse, and systolic blood pressure below 100mmHg (Mayo Clinic, 2021).

Slide 7: Early Detection of Sepsis, Early recognition of the subtle changes of developing sepsis with aggressive fast treatment increases the likelihood of survival (Dugar, et al., 2020).

Slide 8: Sepsis Diagnosis using TIME, T=temperature, I=infection, bacterial or viral, increased or decreased White blood count, M=Mental decline, and E=extreme pain or feels like dying (Sepsis Alliance, 2020).

Slide 9: Systemic Inflammatory Response System (SIRS). Assess vital signs every four hours, pulse over 90 a minute temperature over 100.4 or below 98.6 degrees F, skin cool, very warm or clammy to touch, respiratory rate over 20-22 per minute (Dugar, et al., 2020).

Slide 10: Sepsis checklist example

Date Shift Time

Temperature_____ Pulse_____

Respirations_____

Initial_____(Dugar, et al., 2020).

Slide 11: Conclusion, if a patient has at least two abnormal findings notify the house supervisor or the doctor and implement the sepsis protocol plan at the hospital. Early recognition and treatment will save lives or decrease the chance of disabilities in patients.

Any Questions?

APPENDIX B

SEPTIC CHECKLIST FOR DNP PROJECT BY CONNIE LASLEY, MSN, CRNP-C

Date _____ Shift_____ Time_____

Temperature_____ Pulse_____

Respirations_____ Initials_____

Date _____ Shift_____ Time_____

Temperature_____ Pulse_____

Respirations_____ Initials_____

Date _____ Shift_____ Time_____

Temperature_____ Pulse_____

Respirations_____ Initials_____

Look for Temp over 100.4 or below 98.6 degrees Fahrenheit

Pulse rate over 90 per minute Respirations over 20-22 per minute

Look for 2 or more of these changes and notify house supervisor or medical doctor (Dugar, et al., 2020).

APPENDIX C

Time Table

First DNP Semester	First semester Continued Summer 2020	2nd DNP Semester Fall 2020	3rd DNP Semester Spring 2021	4th DNP Semester Summer 2021
Choose problem TOPIC	Review literature using EBP	Got IRB approval in November 2020	Continue working with preceptor	Meetings with code manger and case management
Use EBP guidelines on topic	Put EBP together	Start on Manuscript after IRB Approval	Develop a sepsis checklist Educated Staff first week of March 2021	Present Poster of DNP project Powerpoint presentation Portfolio
Develop PICOT question	Seek out site to utilize DNP project	Work with preceptor and chair- person	Project started on 3/08/21 thru 4/23/21	DNP Manuscript Final
Seek IRB Approval and do IRB class	Seek approval of site, chair preceptor	Chair gives guidance on manuscript	Results of DNP project collected	

APPENDIX D

DATA COLLECTION

NEEDS ASSESSMENT FOR PROJECT JUNE-DEC 2020►	14 DIRECT ADMIT HOSPITALIZED PATIENTS DEVELOPED SEPSIS DURING HOSPITAL STAY
FIRST SIX-WEEKS NO SEPSIS CHECKLIST JAN13TH-FEB 26TH 2021►	FOUR DIRECT ADMITS OUT OF 100 PATIENTS DEVELOPED SEPSIS DURING THE HOSPITAL STAY
SECOND SIX-WEEKS SEPIS CHECKLIST IMPLEMENTED MARCH 8TH THROUGH APRIL 23RD►	OUT OF 80 DIRECT ADMITS NO ONE DEVELOPED SEPSIS DURING THE HOSPITAL STAY

APPENDIX E

November 30, 2020

Dear Connie Lasley:

Your proposal submitted for review by the Human Participants Review Protocol for the project titled: "Early Detection of Sepsis in Direct Admitted Hospitalized Patients: Implementing a New Sepsis Screening Checklist" has been approved as exempt. If the project is still in process one year from now, you are asked to provide the IRB with a renewal application and a report on the progress of the research project.

Sincerely,

Joe Walsh
Executive Secretary, IRB

JW/dh

APPENDIX

November 20, 2020

Dear Mrs. Lasley,

We are excited to provide any support that you may need in your DNP program project: Early Detection of Sepsis in Direct Admit Hospitalized Patients, Implemening a New Sepsis Checklist. We are excited and we look forward to utilizing your project infromation to improve the sepsis care that our patients receive.

Respectfully Your,

Melissa Dunn RN, BSN
Chief Operations Officer
Evergreen Medical Center
101 Crestview Avenue
Evergreen, Al. 36401