STAG Audit: Sepsis Phase 2 GP

Family name: ______________________________ First name: ________________________________

Case note number: CHI number: Audit no.

STAG Audit: SEPSIS Phase 2 GP

Hospital code: Audit no:

Postcode: Sex: 1 = Male 2 = Female Age: yrs

Pre-hospital Care (Note: not yet discussed with SAS)

Mode of Arrival: Not known = 0 Self = 1 Ambulance = 2 Air = 3

SAS Incident Number:

Enter Hospital

Date: . . Time: : Arrived Intubated: not known = 0 Yes = 1 No = 2

Information On Admission

Initial Area: ED Resus = 1 Other ED = 2 Admissions Unit = 3

Referred by GP to: Medical = 1 Surgical = 2 Orthopaedic = 3 Other = 4 Specify: ______________________________

Time of admission values: : Source of Admission Values : ED = 1 SAS = 2 Unit = 3

	Values		Source
Temperature:	. °C		
Heart rate:	beats/min		
Respiratory Rate:	breaths/min		
Systolic BP:	mm.Hg	Diastolic BP: mm.Hg	
O_2 Saturation:	% on: Litres O_2	and/or %age: %	
Eye Opening:	Motor Response:	Verbal Response: Total GCS	
AVPU Score (if available):	Alert = 0 Verbal =1 Pain = 2 Unresponsive = 3		
BM:	. mmol/l	(HI/high > 30 LO/low < 4)	

Total SEWS Score on chart: Type of chart: SEWS = 1 MEWS = 2 Modified Mews = 3 not applicable = 4

Lactate level recorded: Yes = 1 No = 2 1st Lactate level: . mmol/l Time Lactate was taken: :

Admission Diagnoses/Presenting Complaints by Group

Yes = 1 No = 2

Trauma (1):	Neurological (2):	Cardiac (3):	Respiratory (4):
Toxicology (5):	GI (6):	Vascular (7):	Sepsis (8):
Metabolic/Endocrine (9):	Cardiac Arrest (10):	Environmental(11):	Other/Unknown(12):
None Documented (13):	Specify:		

Were IV antibiotics given in first 8 hours? not known = 0 Yes = 1 No = 2

If yes, time given: :

Any Area

	Dr GradeEM	Dr Grade2	Specialty2
Most senior doctor present:			other specify:..............................

Doctor: Consultant = 1, ST/FTSA = 2, Foundation Doctor = 3, Other Career Grade = 4, No otherdoctor/ specialty = 0
Specialty: EM = 1, Ortho = 2, Anaesthesia = 3, ICM = 4, General Surgery = 5, General Medicine = 6, Specialty = 7, Radiology = 8, Other = 9, not applicable = 0

Other Values during ED Stay/First 6hours

Urine Output: Catheterised? ☐ Yes=1 No=2 If yes, hourly measurements? ☐ Yes=1 No=2 and volume: ☐☐☐ ml

If no, output documented? ☐ Yes = 1 No = 2 If documented, volume: ☐☐☐☐ mls

Bloods: WBC count: ☐☐☐.☐☐ cells/litre ABGs done: ☐ Yes=1 No=2 If yes, Time taken ☐☐:☐☐

Poorest Values during ED Stay/First 6hours

Highest Temp: ☐☐.☐ °C **Lowest** Temp: ☐☐.☐ °C

Highest HR: ☐☐☐ beats/min **Lowest** HR: ☐☐☐ beats/min

Highest RR: ☐☐☐ breaths/min **Lowest** RR: ☐☐☐ breaths/min

Highest Sys BP: ☐☐☐ mm.Hg **Paired** diastolic: ☐☐☐ mm.Hg

Lowest Sys BP: ☐☐☐ mm.Hg **Paired** diastolic: ☐☐☐ mm.Hg

Lowest O_2 Saturation: ☐☐☐ % on: ☐☐ Litres O_2 and/or %age: ☐☐☐ %

O_2 Saturation: ☐☐☐ % on **highest**: ☐☐ Litres O_2 and/or %age: ☐☐☐ %

Lowest Glasgow Coma Scale: E: ☐ M: ☐ V: ☐ Total GCS: ☐☐ **Highest** AVPU score: ☐ (if available)

Highest Lactate: ☐☐.☐ mmol/l

Highest Total SEWS Score on chart: ☐ Type of chart: ☐ SEWS = 1 MEWS = 2 Modified Mews = 3 n/a = 4

Intubated in initial area: ☐ not known = 0 Yes = 1 No = 2 If yes, time intubated: ☐☐:☐☐

Extubated before departure from initial area: ☐ not known = 0 Yes = 1 No = 2

Patient Disposal From Initial Area

Date left : ☐☐.☐☐.☐☐ Time left : ☐☐:☐☐

Primary Diagnosis in First 6 hrs: ☐☐ Use numerical value Patient's Weight: ☐☐☐.☐☐

Destination: ☐☐ Ward = 1 Radiology/PCI = 2 HDU = 3 ICU = 4 Theatre = 5 Mortuary = 6 Other Hospital = 7
Neuro = 8 SIU = 9 CCU = 10 SSW = 11 Home = 12 Irregular discharge = 13 did not wait = 14

If discharged to Other Hospital, was it to ICU? ☐ Not known = 0 Yes = 1 No = 2 If yes, complete discharge information

Ultimate Destination for patients whose initial destination was radiology or theatre: ☐☐

Patient Discharge From Hospital

Highest level of care: ☐ not applicable = 0 Ward = 1 HDU = 2 ICU = 3

Outcome: ☐ Dead = 0 Alive = 1 Discharge Date: ☐☐.☐☐.☐☐ Total in-patient days: ☐☐

Ward diagnosis: ☐☐ Use numerical value Patient still inpatient at 28 days? ☐ Yes = 1 No = 2

Patient for Audit? ☐ ☐ No = 0 Initial Area = 1 Post Initial Area = 2 Transfer = 3 Other = 4

Reason for Audit: ....

Comments