Are you Sepsis Aware?

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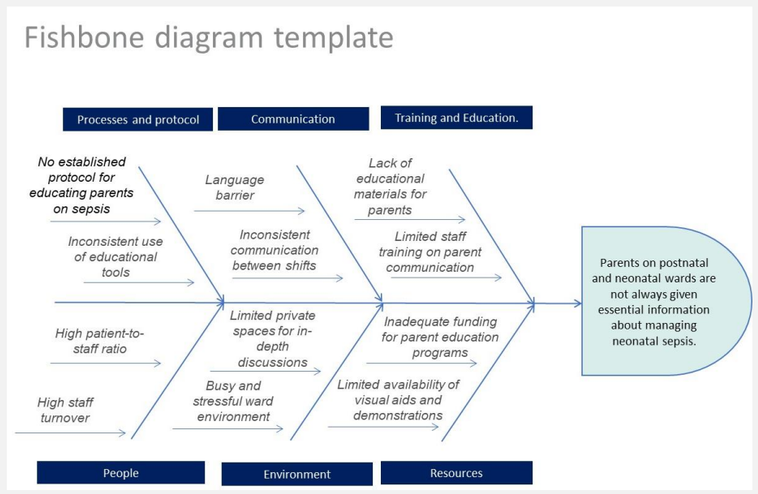
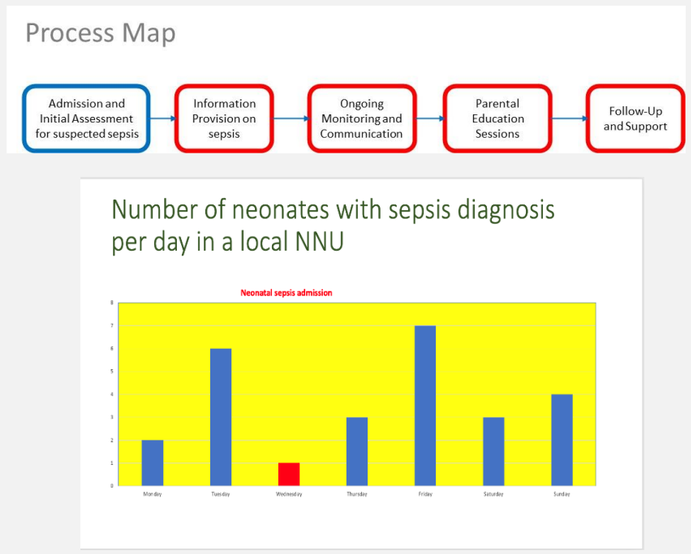
Many parents in postnatal and neonatal wards lack essential sepsis management information. This results in confusion and stress. 20% feel uninformed, affecting their child's care and their own emotional well-being.

BACKGROUND

Neonatal sepsis is a leading cause of morbidity and mortality in newborns, especially in preterm and low birth weight infants. Early recognition and prompt management are vital for improving outcomes, but many parents lack essential information, leading to confusion and delayed responses. This gap in knowledge affects both the child's care and parents' emotional well-being. Improving parental understanding of neonatal sepsis is crucial for reducing complications and enhancing outcomes.

DIAGNOSTICS





AIM & MEASUREMENT DEFINITION

By August 2024, I aim to ensure that 90% of parents in postnatal and neonatal wards have a good understanding of what has happened to their baby, improving their understanding through the implementation of staff training programs and distribution of educational materials.

Chosen measure:
The number of parents on neonatal and postnatal ward who have a good understanding of their child's sepsis diagnosis and future care.

Inclusions
Neonates on postnatal and neonatal unit with sepsis diagnosis

Exclusions
Neonates with Complex cardiac conditions
Neonates of Non-consenting parents
Neonates not managed for sepsis

Sampling method and frequency: *10 Daily interview of parents and colleagues*

CHANGE IDEAS

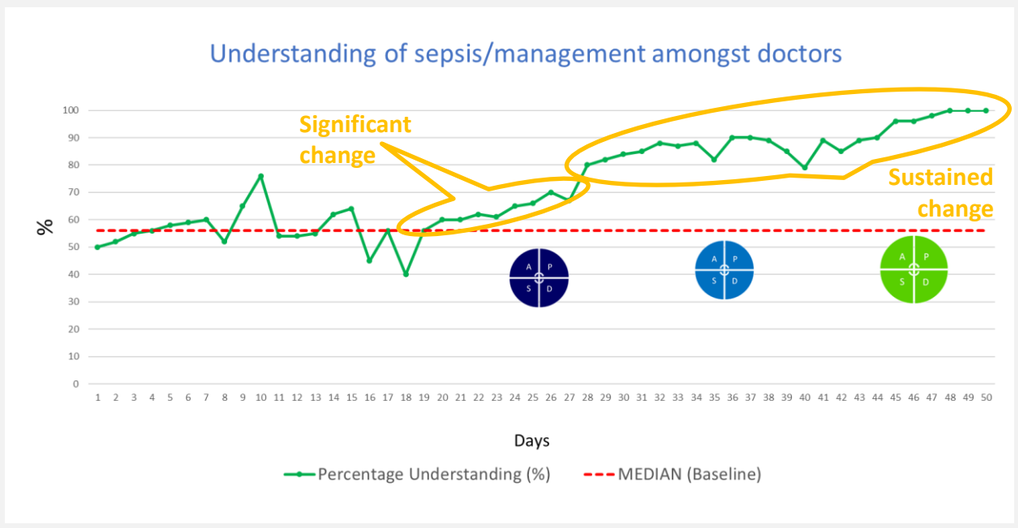
List all the ideas you could test…

1] Promote a healthy work-life balance and recognize staff efforts regularly through greatix.
2] Improve working conditions and provide career development opportunities to retain staff on communication.
3] Create private consultation rooms within the ward.
4] Use volunteer programs to provide additional support to staff and parents.
5] Regularly review and update educational tools to ensure they are effective and up-to-date.
6] Make parent education a mandatory part of the discharge planning process.
7] Implement follow-up calls or visits to check on parents' understanding and provide additional support.
8] Develop a standardized protocol for sepsis education, including checklists and step-by-step guides.
9] Create video tutorials and interactive online resources to supplement in-person education.
10] Partner with translation service providers to ensure timely and accurate translations.

PDSA cycles

Again - Repeat the test in another cycle to observe if engagement increases, and if parents reports increased understanding/received leaflets	Adopt reminders Greatix to outstanding colleagues	**Adopt** the practice of promoting parents update regarding sepsis/ leaflets as a key step in the handover/workflow.
I will send daily WhatsApp reminders to Doctors about following the sepsis proforma/checklist, and giving out information leaflet then, I will Collect data on views, replies, and interactions.	I will send daily WhatsApp reminders to Doctors about following sepsis proforma/ checklist, and giving out information leaflet then, I will Collect data on views, replies, and interactions.	Provide an orientation session for new doctors at the induction meeting, encouraging the need for parents updating regarding sepsis and management through providing information leaflets.
Few parents received information about sepsis management. Few responses from colleagues on Whatsapp.	Increased response rate. More information leaflet handed over to parents. Parents reported more satisfaction	Impressive response by colleagues noted.
1/8-10/8 I engaged parents on neonatal unit to find out if they had understanding and information regarding sepsis management	11-20/9/24 -sent daily WhatsApp reminders to Doctors about following the sepsis proforma/ checklist, interviewed parents to assess information received	Verbally engaged with colleagues to find out progress. Engaged with parents to assess understanding

RUN CHART



CONCLUSION & LEARNING

Aim Met: Understanding of sepsis improved from 56% to 100%, showing sustained progress.
What worked: Targeted interventions led to consistent improvement.
What didn't work: Initial variability required continuous monitoring and refinement.
In summary, Effective educational strategies like use of checklist, daily reminders, and sepsis information leaflets resulted in significant and lasting improvement in sepsis management understanding.

REFLECTIONS

The Model for Improvement enabled systematic and effective changes in sepsis management understanding. Rapid PDSA cycles and team involvement were crucial. However, sustaining progress beyond individual leadership is challenging. Embedding changes into routine practice, fostering a culture of continuous improvement, and establishing robust systems are essential for lasting impact.

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