Australasian College
for Emergency Medicine

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Submission to the Sepsis Clinical Care Standard Consultation – September 2021

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide this submission to the Australian Commission on Safety and Quality in Health Care on their draft Sepsis Clinical Care Standard.

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring that the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

Sepsis is often under-recognised or diagnosed too late, especially in the elderly or very young where signs and symptoms are not so obvious. We believe sepsis is an extremely important health issue that needs more equitable and rational resource allocation, as with many other health issues. We believe sepsis to be as important as acute coronary syndromes, stroke and trauma, all of which at times could be described to receive inequitably greater resources applied to them when compared to sepsis.

The College commends the work of the Commission in developing the draft Standard and is generally supportive of standards and indicators presented here. ED physicians and other staff strive to offer the best possible care, however systemic issues are increasingly impacting on their ability to fully implement important standards such as these.

The unprecedented pressures on EDs across Australia can present a barrier to the timely identification of sepsis in some circumstances. This is primarily due to the increasing occurrence of access block. Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours because of a lack of inpatient bed capacity. Access block is the single most serious issue facing emergency departments in Australia and New Zealand as it negatively affects the provision of safe, timely, and quality medical care to patients.

Access block not only results in delays for patients to be seen and sepsis identified, it also results in patients waiting unreasonably long periods in ED for admission. This can sometimes include waiting in ED corridors, with nurse-to-patient ratios completely disregarded, resulting in inadequate care for patients subject to these waits of 8 to sometimes over 24 hours. Whilst ED staff do their utmost to care for patients access blocked in ED, our speciality is not the ongoing care for admitted patients while we are still endeavouring to assess and manage all the newly arriving patients. Moves to address access block in EDs involve whole-of-hospital system improvement in resources and infrastructure.

The College has set out its feedback relating to each of the quality statements below:

1. Could this be sepsis?

A diagnosis of sepsis is considered in any patient with an acute illness or clinical deterioration that may be due to infection. The use of a clinical support tool that includes assessment of vital signs and lactate is essential.

A core role for physicians in the ED is the rapid assessment of patients to assist in their stabilisation and referral. Comprehensive assessment tools are already in use and ACEM supports education and processes to ensure that sepsis is considered in patients with an infection.

2. Escalation of Care

If sepsis is suspected, the patient is promptly reviewed by a clinician experienced in recognising and managing sepsis. The patient is escalated to a higher level of care when required.

As noted in the Standard, Fellows of ACEM are experienced clinicians who can recognise and manage sepsis. EDs operate 24 hours a day, 365 days of the year, while other parts of the hospital do not, so there can be delays in patients being admitted to an appropriate inpatient unit. Escalation to other specialists may depend on the time of the day and this, coupled with access block, means that some patients with sepsis may need to be managed for inappropriately long periods in the ED.

3. Time Critical Treatment

Suspected sepsis is a time-critical medical emergency. Urgent treatment is commenced according to a locally approved sepsis pathway, and the response to treatment is monitored and reviewed.

ACEM supports standards that promote improved access to urgent treatment along locally approved sepsis pathways. Local policies and pathways require whole of hospital systems and communication for them to be effective. Clear joint decision making and escalation protocols support improved collaboration between specialities and higher quality care for patients (also see response to Q7 below).

4. Management of antimicrobial therapy

A patient with suspected or proven sepsis has blood cultures taken immediately where this does not delay the administration of appropriate antimicrobial therapy. First antimicrobials are started within 60 minutes from triage or recognition of deterioration. Antimicrobial therapy is managed in accordance with the Antimicrobial Stewardship Clinical Care Standard.

ACEM supports rapid initiation of antimicrobial therapy and immediate blood cultures for patients with suspected or proven sepsis. While the blood culture process may be started rapidly, the results cannot be guaranteed to be returned in a timely manner due to system issues, particularly in regional and rural healthcare settings.

In addition, identification and sampling of the suspected source of infection (for example urinary tract or a joint) is encouraged but antibiotic administration is not unreasonably delayed if this source sample cannot be rapidly collected (urine sample or joint aspirate). Some outdated practice still recommends withholding antibiotics until source identification (for example bone and joint infections) and ACEM strongly discourages any unreasonable delays in antibiotic administration in these circumstances.

5. Patient and carer education and information

A patient and their carer receive information about sepsis from the time it is suspected, in a way they can understand and in both verbal and written formats. Information includes the expected treatment, potential health effects of sepsis, as well as the signs and symptoms of sepsis recurrence.

ACEM supports this standard and its associated indicator. The timing of this information will reflect the capacity of the ED and the need for clinicians to be managing multiple complex presentations. For instance, information about the signs and symptoms of sepsis recurrence may not be appropriate early in the treatment cycle but needs to be given prior to discharge from the health service. This connects to Quality Statement 6 and the need for high quality communication between all involved in the patient's care.

6. Transitions of care and clinical communication

A patient with suspected or proven sepsis has a documented handover at transitions of care. Clinical communication and documentation include the suspected or proven sepsis diagnosis and the appropriate management plan, which contains underlying diagnoses, medicines and the care plan. This information is also provided to the patient and carer.

Effective transitions and handover of care are a fundamental aspect of the work of EDs and understood to be inherently risky. ACEM supports standards that improve the quality of these processes.

7. Multidisciplinary coordination of care

Sepsis is a complex, multisystem disease requiring a multidisciplinary approach to treatment. Treatment is coordinated by a senior clinician with expertise in managing patients with sepsis.

A senior ED clinician may initially be the coordinating clinician on the patient's initial presentation to the department, however, when the patient is transferred to another department for further care, the role of coordinating clinician will also need to be transferred. ACEM is aware of certain cases of sepsis where the admitting speciality can be disputed, such as sepsis resulting from cellulitis, which can result in delays in definitive care and admission. We are aware of healthcare systems where the admitting team is dependant of the body region involved with the cellulitis and this can be up to a dozen different specialities, that can result in disputed disposition of the patient. Clear delineation of speciality involvement may vary between hospitals and jurisdictions and must be clearly documented and planned with guidelines in advance.

8. Post-acute care and survivorship

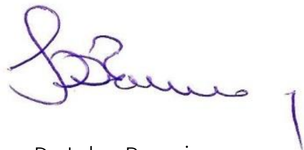
A patient who has survived sepsis receives individualised follow-up care to optimise functional outcomes, avoid unnecessary rehospitalisation and manage the ongoing health impacts of sepsis. This requires structured, holistic and coordinated post-discharge care that involves the patient's family and carer. Support and information should be offered to the family or carer of a patient who has died from sepsis.

ACEM supports this standard and the associated indicator on readmittance rates.

9. Any other matters

Thank you again for the opportunity to provide feedback to this consultation. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement jesse.dean@acem.org.au; +61 423 251 383).

Yours sincerely,



Dr John Bonning
ACEM President