Introduction:
The Surviving Sepsis Campaign advocates the use of care bundles to guide the management of sepsis and septic shock [1]. Our study aim was to assess compliance with a locally introduced sepsis pathway and to review intensive care unit admission outcomes.

Methods:
We carried out a prospective audit of patients admitted to the ICU at Royal Surrey County Hospital with a diagnosis of sepsis between 19/3/19 and 19/11/19, assessing compliance with local sepsis bundle delivery, outcome of ICU admission and degree of associated organ dysfunction.

Results:
119 patients were identified, 71 male (59.7%), with a mean age of 65.7 (18-96). Mean 1st 24 hour SOFA score on ICU was 6.65 (2-15). 81% of patients required vasopressors, with 67% requiring noradrenaline >0.1mcg/kg/min, and 19% requiring an additional vasopressor/inotrope. 36% required NIV, 32% invasive ventilation and 15% RRT. ICU mortality was 15%, in-hospital mortality 24%, mean ICU stay 8 days (1-49), and mean length of hospital stay 28 days (1-163). In the presence of septic shock mortality was 47% with post-resuscitation lactate >4, versus 21% in patients with no vasopressor requirement or lactate <2 (p<0.05).

The sepsis bundle was delivered in one hour to 61 patients (51%). Where the bundle wasn’t completed, antibiotics were delayed in 26% of cases and blood cultures weren’t taken in 66%. Where the bundle was fully delivered, unit mortality was 12% vs. 21% where it was not (p<0.05), but there was no significant difference in hospital mortality (26% vs. 30%, p>0.5) or rates of vasopressor requirement, NIV, IPPV or RRT.

Conclusion:
There is room for improvement in timely delivery of the sepsis bundle in our hospital and various measures are being instituted. Though there was no significant difference in hospital mortality, ICU mortality was significantly lower in patients when the bundle was fully delivered.

References: