

## Abstract

**Background:** Delayed recognition and treatment of sepsis is associated with early and preventable death, therefore early detection is crucial to improving patient outcomes. Healthcare miscommunications during transfers-of-care lead to delays and misses, and pertinent sepsis-related information is no exception to this. Collaborative partnerships with patient-transport teams have the potential to improve sepsis recognition during this vulnerable transition-of-care. The purpose of this project was to communicate sepsis measures in the adult medical population being transferred between medical facilities through facilitating a standardized “Sepsis Sign-out”.

**Methods:** This quality improvement project took place in the medical transportation department within an academic teaching hospital in a metropolitan area of the Mid-Atlantic U.S. A preintervention-postintervention design was utilized in adapting, implementing, and evaluating a standardized hand-off tool to communicate sepsis measures in the adult medical population being transferred between facilities. Nurses were surveyed for satisfaction as well as tool utility and feasibility.

**Results:** The hand-off tool yielded low rates of compliance, capturing only 15.63% (n = 5) of the qualifying transfers over the 16-week study period. A total of 11 surveyed nurses met inclusion criteria for changes in median satisfaction scores with no statistically significant difference between pre- and post-intervention. Utility and feasibility of the tool was evaluated by a total of 29 nurses, yielding inconclusive findings.

**Conclusion:** Despite statistically insignificant results of this project, there is an identified need for further QI efforts in patient hand-off during transfers-of-care, specifically the hand-off of timely sepsis information. The unique role transport teams can play in timely sepsis detection and treatment remains a gap in the literature and warrants further investigation.