

LET'S TALK SEPSIS WITH PATIENTS AND THEIR FAMILIES

**Improving
engagement &
communication
in line with the
values of
*Martha's Rule***

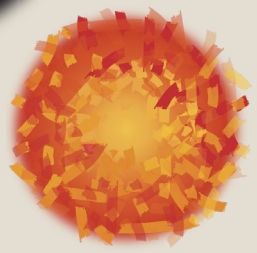
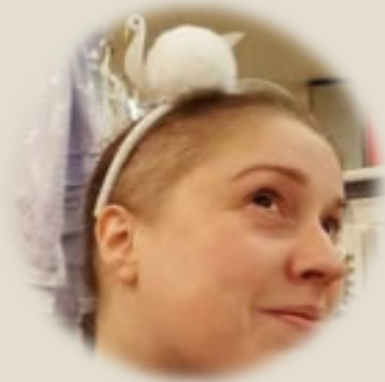
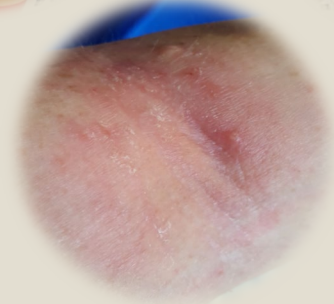
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Expert by Experience for Patient Experience and Safety



Who am I and why am I here?



My Sepsis Story



THE UK
SEPSIS
TRUST

SEPSIS CHANGES YOU, YOUR LOVED ONES, AND YOUR FUTURE



LISTEN

...To Your Training ...To Your Patients and Their Loved Ones ...To Your Instincts



Background
In 2017, I had a life changing experience with Sepsis. The sepsis was entirely preventable. It should NEVER have happened. Over the years, I have explored the reasons why this was allowed to happen. Over the grief and anger calmed, I began to imagine myself on the other side as the doctor, and human began large fighting themselves as possible options to the event. More awareness, was the positive force the simple act of listening may have had and so, the idea of using my experience to influence positive change was born, and this very QJ Project.

The NICE guideline Sepsis: recognition, diagnosis, and early management, includes some suggestions for further research. Many of the focuses coincided with the research I did in my own care. They state:

"Delay in detecting and treating sepsis increases mortality. Early detection and appropriate management will reduce mortality and mortality and will reduce NICE cases by reducing cross-site admissions, inappropriate antimicrobial use and length of hospital stay."

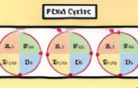
Sepsis management remains poor across the board. Factors such as having the right grade of clinician to grade the severity of the sepsis, continuing care across wards, sharing, preparing the patient and family, sharing knowledge, and improved training, are key. Without exploring these, we will continue taking a massive NICE guideline road runner, and there is no point in the patient's needs.

Project Aim:
To raise awareness of the importance of LISTENING in sepsis care and the past we lived a cat in the present, and the future.

Method
To make sense of the tasks in hand, and to learn about the elements involved with creating the site, I completed a driver diagram (see left). This had some serious adjusting as it turned out the project was much bigger than envisaged, and there did need to focus on one particular area. As much as I found it a challenge to complete initially it had such an impact on my ability to focus on what could be addressed in this period, it would be:

Using patient stories in training to aid retention of learning around patient safety and human factors

Now I had my focus, it was time to tell my patient story. By doing this, I was able to make over 1000 using the feedback, to create what I shared in the training was appropriate for the call once and had the impact desired. I did this by approaching a range of individuals, to gain a recorded view, using the POSA scale exercises of them.



Making Adjustments:
POSA Cycles and Tribo Correlations:
I get a POSA record of credible data from these two methods. They were found to be beneficial in creating the right story to tell, for the right people.

These are a few of the responses I received:
"Incredibly powerful and moving" "Words I can't find to describe the impact of your story" "Definitely an excellent project" "I gave professional advice on my own into the company of experts they may not have considered" "We need to make sure this isn't a one-off" "I hope you can make a huge difference, and prevent a lifetime of heart and pain" "Listen to the patient" "Hence any success of experience on my case loss of the trust experience" "Invaluable" "I just had to share!"

Outgoing Plans:
This QJ project doesn't stop here! Where is my data? What are the results? These are parts of the journey that are still in progress. The data is there, thanks to the training, but more time is required. There are my own ongoing. I will get qualitative data by making use of short video prior to, and following the Patient Safety training sessions, and qualitative data in the form of open-ended questions in evaluations. I also intend to do an creative learning experience and I plan to offer the opportunity for reflection. To truly assess the success of the project, I will need to gather agreed maturity on reports of data. The quantitative data will be evaluated using diagnostic tools, such as Pareto charts, and the qualitative data will be reviewed using thematic data analysis. The hope using my patient story will help highlight the importance of listening to our patients, and their voices.

Reflecting on the QJ Journey (so far):
I've always thought: "If there's a problem, how could I make an impression?" I'd even plan ICM I would do it. This journey has taught me about exploring ideas, confronting all my (some changed) SO many friends, knowing the impact of the change, and not to be afraid of asking for it. It's more having the desired impact. For future QJ Silver projects, if you're anything like me, there may be times that you might not see your eyes at some of the theory and methodology. All I can say is: LISTEN TO THE PROCESS - IT WORKS! Thanks to our QJ journey: **lets go and change the world - One focused aim at a time!**

With Special Thanks to:
Marc Barry, Derm Road, Sarah Noble, Axa Whitefield, Helen Drumhead, Peleic Kala, Kate Coleman, Marc Hoad, Helen Chandler, Paul Parsons, Cathy Hunt, Katrina Kennedy, Jane Gorton, my long and loving family, our QJ training team, and all the others for the support throughout the course.

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What Happened Next?

- Learned how to live with who I had become
- Realised I wasn't as 'healed' as I thought
- Developed a real anger about what happened
- Sent complaint on advice of colleague
- Received my FIRST 'sorry' – 5 years after the event
- Worked with a brilliant CEO to make positive changes in the Trust
- Decided to use the experience to prevent future patients experiencing the same heartache
- Signposted to the Patient Experience team
- **Patient Experience and Involvement became my real therapy; my healer.**



WHY MARTHA'S RULE MATTERS



WHEN MARTHA'S RULE MEETS PATIENT INVOLVEMENT

MEET BEX, EXPERT BY EXPERIENCE

“ I became a part of the Involvement Network as an Expert by Experience, when I was signposted to them with ideas I had for improving patients' care. I had the chance to be part of changes to ensure the care offered to future patients is the best it can be. What's not to like about that? By being part of discussions and ideas, I get to use all my experiences, good and not so good, for positive change. It's actually quite exciting to hear all about and partake in the journey to optimising patient and carer encounters with the Trust.

My patient voice often returns to a simple act: listening. It's such a basic skill, but often is the first to be forgotten. Sometimes patient and carer voices aren't heard in the hustle and bustle of a busy department, and they could be the difference between giving the right care, at the right time, in the right place. ”





WHY IS PATIENT INVOLVEMENT IMPORTANT TO ME?

'The opportunity to influence patient care from a perspective based upon **experience**, rather than **an assumed understanding**.'

'The experience-sharing is not only an effective tool to **improve future patient care**, it also facilitates a level of **healing** in me.'

'The **power** of a **combined patient voice** - WE get to help **shape the services** to meet differing needs, because WE all have diverse experiences of care.'

How we can

SAVE LIVES

With Patient Engagement and Involvement

Rebecca Moss-Coleman, 2026

S – Share

Share learning, stories, and insight to strengthen understanding.

A – Actively Listen

Listen to patients, families, and colleagues with intention and respect.

V – Value Involvement

Involve people meaningfully in decisions that affect their care.

E – Engage & Co-produce

Engage openly and co-produce solutions with those who use services.

L – Lead with Inclusion

Ensure every voice is welcomed, represented, and heard.

I – Improve Together

Use feedback, reflection, and partnership to drive continuous improvement.

V – Voice Humanity

Humanise care by recognising the person behind the patient.

E – Empower Communication

Communicate clearly, compassionately, and consistently.

S – Strengthen Safety

By doing all of the above, we strengthen safety — and ultimately, **save lives**.



"THIS MAY NOT BE WHERE
I PLANNED TO BE, BUT IT'S
WHERE I'M MEANT TO BE"

Rebecca Moss-Coleman, 2026



Thank you for taking the time to listen to my sepsis story.

I hope it has helped underline just how crucial meaningful engagement and clear communication with patients and their families is to delivering safe, effective care — especially when it comes to the timely recognition and treatment of sepsis, and for shaping services tailored to their needs.

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