
HOSPITAL LITIGATION

Sepsis and the Clinical Meaning of Time

Recognition, Response, and Whether the Delay Mattered

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Sepsis cases are about time. When should the changing picture have prompted a different response? How long did it take to act? Did that gap change anything? Both sides have to answer those questions, and they're easy to answer badly. Highlight one hour in red on a chronology and it looks decisive. Whether it actually mattered depends on the clinical evidence on either side of it.

THE CLINICAL AND QUALITY FRAMEWORK

The CDC describes sepsis as a life-threatening emergency that happens when the body's response to infection damages its own tissues and organs, and it stresses that fast treatment is essential. The current consensus definition, Sepsis-3 (published in *JAMA* in 2016), defines sepsis as life-threatening organ dysfunction caused by a dysregulated response to infection, with organ dysfunction shown by a rise of two or more points in the SOFA score. Septic shock is the sicker subset: patients who need vasopressors to keep their mean arterial pressure at 65 or above and who have a lactate over 2 despite adequate fluids.

The treatment guidance most people cite is the Surviving Sepsis Campaign's 2021 adult guidelines. For possible septic shock or a high likelihood of sepsis, they recommend antibiotics immediately, ideally within one hour of recognition. For possible sepsis *without* shock, they recommend a rapid assessment of whether the cause is infectious and, if concern persists, antibiotics within three hours. They recommend measuring lactate and drawing blood cultures before antibiotics when that doesn't meaningfully delay them. For low blood pressure or poor perfusion from sepsis, they *suggest* at least 30 mL/kg of IV fluid in the first three hours. That's a weak recommendation that leaves room for judgment. And they recommend against using qSOFA alone as a screening tool, compared with SIRS, NEWS, or MEWS.

The one-hour versus three-hour distinction matters in litigation. Holding a patient whose picture was genuinely unclear to a one-hour antibiotic expectation can overstate the deviation.

Then there's the quality measure. CMS's SEP-1 measure requires, within three hours of "time zero," a lactate, blood cultures before antibiotics, broad-spectrum antibiotics, and 30 mL/kg of fluid for low blood pressure or a lactate of 4 or more. Within six hours it requires a repeat lactate if the first was high, vasopressors for persistent low pressure, and a documented reassessment of volume status and perfusion in septic shock. SEP-1 has long been reported through Medicare's inpatient quality reporting program, and CMS moved it into the Hospital Value-Based Purchasing Program starting with fiscal year 2026 payments, based on 2024 performance. Hospitals' scores are public on Care Compare.

At the organizational level, the CDC's 2023 *Hospital Sepsis Program Core Elements* describe how hospitals should run sepsis improvement: leadership commitment, accountability, multidisciplinary expertise, action, tracking, reporting, and education.

One caution matters more than any of the details above. A quality measure, a clinical guideline, a hospital policy, and the legal standard of care are four different things. SEP-1 has its own abstraction rules and still uses older SIRS-based "severe sepsis" criteria that predate Sepsis-3. A SEP-1 "fail" can be a charting or abstraction problem rather than a care problem, and a "pass" doesn't prove the care was right. How many of these bears on the standard of care is for qualified experts and counsel.

START BEFORE ANYONE SAYS "SEPSIS"

A fictional older woman comes to the ER weak and not eating or drinking much. Her daughter says she's been less alert since that morning. She has several chronic conditions. The first findings are worrying but don't explain everything. Over the next few hours, new information points toward infection and failing organs. A physician note that evening uses the word "sepsis."

Start your analysis at that note and you'll miss the decisions that mattered most. Work backward to the earlier observations, and resist hindsight, the pull to treat the final diagnosis as if it had been obvious all along.

The meaning is in the pattern and the trend. One high heart rate or temperature can have many explanations. A heart rate climbing, breathing speeding up, blood pressure drifting down, new confusion, and less urine, all together and all getting worse, can call for a response no single number would.

KNOW HER BASELINE

Someone with chronic memory problems can still have an acute change in alertness. Someone with chronic kidney disease can still develop acute kidney injury. To recognize those changes you need a reliable picture of her usual self, from prior records, from the family, and from

whoever sent her.

Suppose her daughter clearly described a sudden change, but the triage note called the confusion chronic. That's worth a close look. What exactly did the daughter say? What did earlier records show? Did later assessments fix the mistake or build on it? An acute change mistaken for baseline is one of the most common routes to a late sepsis diagnosis, which is why Baseline Profiling is its own pillar in the Lexcura Clinical Intelligence Model.

A TIMELINE THAT SHOWS WHEN PEOPLE COULD ACT

The most useful sepsis timeline separates when something *happened* from when someone *could act on it*. For labs, that means collection time, result time, and when a clinician was told or looked at it. For orders, it means when they were written, when pharmacy verified them, and when the treatment actually started. For vital signs, when they were taken versus when they were charted, since flowsheets sometimes get filled in in batches. For communications, when the nurse became concerned, when the provider was contacted, and when the provider answered or came to the bedside.

Say an antibiotic is ordered at 10:00 and the MAR shows it hung at 12:15. That gap is something to investigate, not a conclusion. Pharmacy verification, a hard IV start, the drug not being on hand, a changed order, or late charting could each explain it. Find the real explanation if the records allow, and don't fill the gap with guesses.

Escalation works the same way. A nursing note showing concern before any provider note doesn't prove when the provider found out. Paging logs, secure messages, rapid response records, and order activity may clear it up. If they don't, say the timing is uncertain. This is what the Timeline Reconstruction pillar is built for.

RECOGNITION HAPPENS OVER TIME

It's tempting to hunt for the single moment when sepsis "should have been diagnosed." Some charts have one, like a lactate of 5 or a blood pressure of 72/40. Many show concern building gradually, with several reasonable points where someone could have reassessed.

In that second situation, explain the progression. What was the first working diagnosis? What new information made it stop fitting? Did the team respond? Picking a "time zero" just because it makes the delay look longest is advocacy, not analysis, and the other side's expert will take it apart.

Keep recognition and labeling separate, too. A team can draw cultures and start antibiotics and fluids before anyone writes "sepsis." And the word can appear in a note without the needed care happening on time. The label points you in a direction; the care itself is what you have to examine.

TREATMENT IN CONTEXT

Reviews tend to shrink down to a few bundle items. Those matter, but the record also has to show how the team judged her response to treatment and dealt with the source of infection, what the guidelines call source control.

Be skeptical of any review that treats every patient as needing the identical response. Heart failure, advanced kidney disease, and competing diagnoses can legitimately shape fluid and treatment decisions. Those risks don't settle whether the care was right; they tell you what the clinical explanation has to address. Look for documented reasoning and reassessment instead of inferring negligence, or justification, from the problem list.

Imaging often matters, such as a CT showing an abscess that needed drainage. Imaging Analysis, the third Lexcura pillar, asks what the study showed, when the result was available, and how it changed the next decision. If what the images actually show is disputed, you may need a radiologist.

Follow the transfer and escalation decisions. Was ICU or a higher level of care considered? How was she doing while she waited, and what monitoring and treatment did she get in the meantime? The transfer request is one event; the care until it happened is another.

PROCESS PROBLEMS AREN'T THE SAME AS CAUSATION

Sepsis can get worse even with excellent care, so a bad outcome doesn't prove an earlier decision caused it. The severity of the illness also doesn't make every delay irrelevant. A fair analysis keeps both of those in view.

Observational studies have linked later antibiotics to higher death rates, especially in septic shock, but the size of that effect varies a lot across studies and populations, and a population-level association doesn't prove causation for one patient. The questions are specific to her. If there was a delay, how long was it, and what would reasonably have been done sooner? What was her body doing during that window, and was she already far along? Did she get relevant treatment some other way? Did later findings reveal a different source, a resistant organism, or a complication that drove the outcome on its own? And how does the evidence support a possible, or probable, different result under the legal standard that applies?

Ask your reviewer to show the reasoning step by step: the supported concern, the alternative action, and how that action connects to what was happening to her. If the evidence can't pin down what a particular gap did, the report should say so.

WHAT AN EARLY REVIEW SHOULD GIVE YOU

A useful early sepsis review gives you a clear account of her baseline health; the first supported signs of infection and organ dysfunction, with sources; the sequence of recognition, escalation, and treatment, with firm timestamps separated from shaky ones; a clear line between a missing

record and a missing intervention; any specific questions that need an intensivist, infectious disease physician, or emergency physician; and the evidence that supports the care provided, examined as carefully as the evidence against it.

RECORDS WORTH REQUESTING

- The complete ER record, including triage and nursing flowsheets
- Labs with collection, receipt, and result times
- Order audit history and pharmacy verification logs
- MAR with administration times, and IV access documentation
- Rapid response and code records, paging and secure messaging logs
- Sepsis screening tool output and any EHR sepsis alerts, with acknowledgment data
- The hospital's sepsis policies and order sets in effect at the time
- Where appropriate and discoverable, the hospital's internal SEP-1 abstraction for the admission

SOURCES

- CDC, *About Sepsis*, and *Hospital Sepsis Program Core Elements* (2023)
- Singer M, et al., *The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)*, JAMA 2016;315(8):801–810
- Evans L, et al., *Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021*, Crit Care Med 2021;49(11):e1063–e1143
- CMS, SEP-1 measure specifications; Hospital Value-Based Purchasing Program, FY 2026 measures

This newsletter is for education only and isn't medical or legal advice or a treatment protocol. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a sepsis case and want a timeline that separates when information existed from when someone could act on it, and a causation analysis tested against the whole record, we'd welcome the conversation.

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