

RECOGNISE



Does your patient have risk factors, signs or symptoms of infection?

- | | |
|-----------------------------------|---|
| Immunocompromised | Skin: cellulitis, wound |
| Indwelling medical device | Urine: dysuria, frequency, odour |
| Recent surgery/invasive procedure | Abdomen: pain, peritonism |
| History of fever or rigors | Chest: cough, shortness of breath |
| Red Flags in ambulance handover | Neuro: decreased mental alertness, neck stiffness, headache |

AND

Does your patient have 2 or more yellow criteria?

- Respirations ≤ 10 or ≥ 25 per minute
- $SpO_2 < 95\%$
- Systolic blood pressure ≤ 100 mmHg
- Pulse ≤ 50 OR ≥ 120 per minute
- Altered LOC or change in cognitive status
- Temp ≤ 35.5 or $\geq 38.5^\circ C$

NO

Re-assess

Treat and re-assess simultaneously:
Sepsis may still be a concern

YES

Perform venous blood gas if available

Does your patient have any red criteria?

- SBP ≤ 90 mmHg
- Lactate ≥ 4 mmol/L
- Base Excess $< - 5.0$
- Age > 65 years
- Immunocompromised

NO

YES

This patient may have SEPSIS:

- Inform the doctor-in-charge
- Monitor vital signs & fluid balance
- Obtain blood cultures x 2 sets
- Investigate source of infection: e.g. urinalysis, urine M/C/S, chest x-ray
- Obtain IV access and start IV fluids
- Administer empiric antibiotics within one hour unless another diagnosis is more likely Refer to *Therapeutic Guidelines: Antibiotic*, version 14 <http://proxy9.use.hcn.com.au/>
- Refer / communicate with admitting team

This patient has SEVERE SEPSIS or SEPTIC SHOCK until proven otherwise:

- Inform the doctor-in-charge
- Expedite transfer to a resuscitation area or equivalent
- Turn over page for Resuscitation Guideline

CONSIDER ELIGIBILITY for ARISE

Respond and Escalate

SEPSIS PATHWAY: Resuscitation Guideline

RESUSCITATE

Does the patient have an **Advance Care Directive**? Are there **treatment limitations**?

- **Patient assessment and treatment proceeds simultaneously**
- **Maintain** SpO₂ ≥ 95%
- **Monitor** respiratory rate, SpO₂, heart rate and rhythm, blood pressure, temp, fluid balance
- **Obtain intravenous access**
Take two sets of blood cultures, FBC including lactate OR venous blood gas for lactate, EUC, LFT, coagulation & glucose (glucometer or formal)
- **Fluid resuscitate**
 - i. Give 20mL/kg of 0.9% sodium chloride STAT fluid challenge
 - ii. If no response, repeat 20mL/kg once (unless there are signs of pulmonary oedema)
 - iii. If no response, insert IDC and commence vasopressors (as per local protocol) to achieve a MAP of ≥ 65mmHg in consultation with Doctor-in-Charge

Start IV antibiotics within 60 minutes

**** Do not wait for results of investigations ****

- **Investigate source of infection** e.g. urine M/C/S, chest x-ray, sputum, wound
- **Refer /communicate** with admitting team and ICU

RE-ASSESS

IS YOUR PATIENT RESPONDING TO RESUSCITATION?

Signs of improvement	If improving take the following action:
MAP ≥ 65mmHg	<ul style="list-style-type: none">• Continue monitoring vital signs closely• Strict monitoring of fluid balance• Investigate and treat the source of infection
Urine Output > 0.5mL/kg/hr	
SpO ₂ ≥ 95%	
Decreasing serum lactate level	
Improving LOC	



IF NO IMPROVEMENT INTENSIVE CARE MANAGEMENT IS REQUIRED

1. Reassess suitability to continue resuscitation
2. Request review by ICU doctor to occur within 30 minutes
3. If you do not have an ICU at your facility, seek advice immediately from the

**ADULT MEDICAL RETRIEVAL SERVICE 1800 650 004 or
the local Critical Care Advisory Service**

Minimum requirements for patient monitoring:

- Continuous blood pressure, continuous urine output via IDC
- Repeat serum lactate every 4 hours

REFER