DOES YOUR PATIENT HAVE A KNOWN OR SUSPECTED INFECTION?

Does your patient have any of the following sepsis risk factors, signs or symptoms present?

- History of fevers or rigors
- Cough/sputum/breathlessness
- Abdominal pain/distension
- Line associated infection/redness/swelling/pain
- Dysuria/frequency/odour
- New onset of confusion or altered LOC
- Recent surgery/ cellulitis/wound infection
- Immunocompromised/chronic illness

Have a higher level of suspicion of sepsis for patients age > 65 years

Does your patient have any RED ZONE observations or additional criteria?

NB: LACTATE > 4mmol/L = Rapid Response

Does your patient have TWO or more YELLOW ZONE observations or additional criteria?

Patient may have SEPSIS

- Obtain senior clinician review
- Call for a Clinical Review (as per local CERS) unless already made
- Look for other causes of deterioration
- Commence treatment as per sepsis resuscitation guideline
- Inform the Attending Medical Officer that your patient has sepsis

Look for other common causes of deterioration

- New arrhythmia
- Hypovolaemia/haemorrhage
- Pulmonary embolus/DVT
- Atelectasis
- AMI
- Stroke
- Overdose/over sedation
- Initiate appropriate clinical care
- Repeat observations within 30 minutes AND increase the frequency of observations as indicated by the patient’s condition
- Re-evaluate for sepsis if observations remain abnormal or deteriorate

Patient has SEVERE SEPSIS or SEPTIC SHOCK until proven otherwise

- Sepsis is a medical emergency
- Call for a Rapid Response (as per local CERS) unless already made
- Commence treatment as per sepsis resuscitation guideline
- Inform the Attending Medical Officer that your patient has sepsis

Discuss management plan with patient and family
### SEPSIS PATHWAY – ADULT – INPATIENT
### SEPSIS RESUSCITATION GUIDELINE

<table>
<thead>
<tr>
<th>A</th>
<th>Maintain patent airway</th>
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</table>
| B | Give oxygen  
Aim SpO₂ ≥ 95% (or 88-92% for COPD & chronic type II respiratory failure) |
| C | Large bore intravenous access, collect and check results:  
- Lactate  
- Blood gas  
- Blood cultures x 2  
- Coags  
- FBC  
- EUC  
- CRP  
- LFTs  
- Glucose  
*Call for expert assistance after two failed IVC attempts*  
IV Fluid Resuscitation  
Give initial 250-500mL 0.9% sodium chloride bolus STAT: aim for SBP > 100mmHg  
If no response, repeat 250-500mL 0.9% sodium chloride boluses STAT until SBP > 100mmHg unless there are signs of pulmonary oedema  
Escalate to Rapid Response if no response in SBP after 1000mL of fluid |
| D | Assess level of consciousness (LOC) using Alert, Verbal, Pain, Unresponsive (AVPU)  
If V or less conduct a GCS  
If P or U reassess Airway, Breathing and Circulation |
| E | Examine patient for source of sepsis  
Collect appropriate swabs, cultures, chest X-ray, ECG if indicated |
| F | Fluid balance  
Monitor and document fluid input & output - consider IDC  
Maintain urine output ≥ 0.5 mL/kg/hour |
| G | Check Blood Glucose Level: if > 12mmol/L consider glycaemic control |

**MONITOR & REASSESS**

Continue monitoring and assess for signs of deterioration:
- Respiratory rate in the Red or Yellow Zone
- SBP < 100mmHg
- Decreased or no improvement in level of consciousness
- Urine output < 0.5mL/kg/hour
- Increasing or no improvement in serum lactate

**THIS PATIENT HAS SEVERE SEPSIS OR SEPTIC SHOCK ESCALATION IN LEVEL OF CARE IS REQUIRED**

This patient may need transfer to an Intensive Care Unit:
- Discuss the patient’s condition with the Attending Medical Officer
- Consider a higher level of care as per local CERS
- Discuss management plan with patient and their family/carers

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