SEPSIS/DETERIORATING PATIENT PATHWAY

NHS | HEART of ENGLAND NHS Foundation Trust

PID: DOB: / /

PATIENT NAME:
(affix label)

NURSE / DOCTOR NAME:

TITLE / GRADE:

Screen if MEWS ≥4? Fever or other symptoms of infection? Unexplained deterioration?

Are any 2 of the following present? (TICK ALL THAT APPLY)

- ☐ Temperature <36°C or >38.3°C
- ☐ Respiratory rate >20/minute
- ☐ Heart rate >90/minute
- ☐ New onset confusion (delirium) or altered conscious level
- ☐ Glucose >7.7mmol/L (unless DM)
- ☐ White Cell Count (WCC) <4 or >12 (if available)

NO →

CONSIDER ESCALATION TO APPROPRIATE CLINICIAN +/- CRITICAL CARE OUTREACH TEAM (CCOT) AND REPEAT OBSERVATIONS

(according to MEWS protocol)

CONSIDER OTHER CAUSES OF ACUTE DETERIORATION e.g.

- Hypovolaemia, PE, ACS/LVF Neuro Event, Addisonian Crisis, Anaphylaxis

RESUSCITATE PATIENT

(using an ABCDE approach)

INITIATE APPROPRIATE INVESTIGATIONS & TREATMENT

CONSIDER TREATMENT & CPR STATUS

YES ↓

Does your patient have symptoms or signs suggestive of a *new* infection?

If Yes please state source/ symptoms.

E.g. UTI ; abdo pain, SOB, sputum, ?appendicitis, cellulitis etc.

NO → (see box above)

YES: PATIENT HAS SEPSIS ↓

Are there any immediate RED FLAGS? (TICK ALL THAT APPLY)

- ☐ Heart rate >130/min
- ☐ Systolic BP <90mmHg or MAP <65mmHg
- ☐ Respiratory rate > 25/min
- ☐ SpO_2 <90% or (SpO2 only 90% with oxygen)
- ☐ Responds only to Voice / Pain or Unresponsive

NO →

Contact appropriate clinician to review within 30 minutes and state 'uncomplicated sepsis'

Remember to use SBAR

Further Assessment ↓

Are there any other red flag markers of severe sepsis?

(TICK ALL THAT APPLY)

- ☐ Lactate >2.0mmol/L
- ☐ Urine output <0.5mL/kg for 2h or creatinine >177µmol/L
- ☐ Bilirubin >34µmol/L
- ☐ Platelets <100 x 10^9/L
- ☐ INR >1.5 or aPTT >60s

YES ← (to Severe Sepsis)

NO ↓

TREAT FOR UNCOMPLICATED SEPSIS

YES ↓ (Red Flags)

Contact appropriate clinician +/- CCOT to review immediately and state 'SEVERE (Red Flag) SEPSIS'

Remember to use SBAR

ACT NOW ↓

TREAT FOR SEVERE (Red Flag) SEPSIS:

COMPLETE SEPSIS 6 BUNDLE WITHIN 1 HOUR OF RECOGNITION (TIME ZERO)

<u>THIS IS A MEDICAL EMERGENCY</u>

DO NOT DELAY MANAGEMENT FOR INVESTIGATIONS OR RESULTS

SEPSIS TREATMENT PATHWAYS—TURN OVER THE PAGE

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MAKE A TREATMENT ESCALATION PLAN AND DECIDE ON CPR STATUS

Type of Sepsis	Date	Time Zero	Actions
☐ Uncomplicated Sepsis	/ /	:	Antibiotics for suspected focus as per Trust guidelines, other elements of 'Sepsis 6' as appropriate
☐ Severe (Red Flag) Sepsis	/ /	:	GRAB THE SEPSIS 6 TROLLEY/EQUIPMENT AND COMPLETE THE 'SEPSIS 6 BUNDLE' WITHIN 1 HOUR

	Sepsis Six® 60 MINUTES	Time done	Initials	Reason NOT done or Result
1.	**Oxygen** titrate to achieve target SpO_2 94-98% (88-92% if at risk of CO_2 retention e.g. COPD)	:		
2.	**Take Blood Cultures** at least one set peripherally (and separately from any indwelling long lines/central venous catheters)	:		Attach yellow sticker from blood culture pack here
3.	**IV Antibiotics** according to trust guidelines	:		
4.	**IV Fluid Resuscitation** 30mL/kg bolus of 0.9% Saline/Hartmann's STAT if sBP <90mmHg (500mL STAT if NOT hypotensive)	:		
5.	**Check Lactate and Hb** VBG/ABG plus blood for FBC, U&E, LFT, CRP, clotting	:		Lactate = mmol/L
6.	**Commence Fluid Balance Monitoring** consider urinary catheter	:		

REASSESS: repeat lactate, review observations (including hourly urine output), check blood results
REPEAT RISK STRATIFICATION: are there any red flags or markers of organ dysfunction? (see over)

Diagnosis:	Uncomplicated Sepsis (lactate <2)	Severe (Red Flag) Sepsis (lactate >2) (where critical care input is not *immediately* required)	Septic Shock (lactate >4mmol/L Or systolic BP <90mmhg)
Senior (ST3+) Review:	Discuss as condition dictates or as per MEWS protocol	*Review* within 60 minutes of recognition	IMMEDIATELY
Consultant Review:	Discuss as condition dictates or as per MEWS protocol	SPR/Consultant review within 1 hour as per high MEWS escalation policy	IMMEDIATE telephone call to Consultant (if not present)
Repeat Observations:	Every 30 minutes until MEWS <4	Every 30 minutes until MEWS <4	IMMEDIATE referral to Critical Care Outreach Team (CCOT) and/ or ITU Registrar If there is any delay in medical review, nurses should contact CCOT or Consultant directly ***Or a fall of >40 mmHg from patient's usual systolic blood pressure which persists AFTER delivery of ≥30 mL/kg body weight of IV fluids**
Repeat Bloods:	Lactate within 4 hours if clinically indicated E.g. fails to improve	Repeat lactate within 2 hours; other blood tests within 14 hours unless required sooner	
Reassess:	Escalate IMMEDIATELY if markers of severe sepsis or septic shock develop (including patients with 'cryptic shock' i.e. normal blood pressure but elevated lactate)	Escalate IMMEDIATELY if septic shock (including cryptic shock) or organ dysfunction requiring critical care (e.g. AKI, refractory hypoxaemia) develops	

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