Complete this form and apply if a patient presents to the Emergency Department with symptoms and/or signs of infection.

Section 1  Sepsis screen for Nursing Staff

Suspicion of infection

AND

Patient presentation

Date:                                      Triage Time:                                      Triage Category:...
Sepsis Form - ED Adult

Treatment, Risk Stratification and Escalation

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Section 6

**SEPSIS 6 - aim to complete within 1 hour**

- **BLOOD CULTURES**: Take blood cultures prior to giving antimicrobials unless this leads to delay > 45 minutes. Other cultures as indicated by history and examination.
- **BLOOD TESTS**: Point of care lactate (venous or arterial). FBC, U&Es, LFTs +/- Coag. Other tests and investigations as indicated.
- **URINE OUTPUT**: Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis or septic shock start hourly urinary output measurement.
- **OXYGEN**: %, Range 21% (R/A) to 100%. Titrate to saturations of 94-98%, 88-92% in chronic lung disease.
- **FLUIDS**: Volume in 1st hour mls. Patients who present with hypotension should receive 30 mls/kg of a balanced salt solution within 1 hour of presentation. Start pressors in patients who are fluid unresponsive. Patients with hypoperfusion should receive fluid to restore perfusion using a bolus and review technique. 500ml boluses are recommended but may be amended based on clinical context. See fluid resuscitation algorithm.
- **ANTIMICROBIALS**: Give antimicrobials as per local antimicrobial guideline based on the site of infection, community or healthcare acquired and the patient’s allergy status. Assess requirement for source control.

**Section 7**

**Look for signs of new organ dysfunction after the Sepsis 6 bundle has been given or from blood test results – any one is sufficient:**

- Lactate ≥ 4 after 30 mls/kg Intravenous therapy
- Cardiovascular - Systolic BP < 90 or Mean Arterial Pressure (MAP) < 65 or Systolic BP more than 40 below patient’s normal
- Respiratory - New need for oxygen to achieve saturation > 90% (note: this is a definition not the target)
- Renal - Creatinine > 170 micromol/L or Urine output < 500 mls/24 hrs – despite adequate fluid resuscitation
- Liver - Bilirubin > 32 micromol/L
- Haematological - Platelets < 100 x 10⁹/L
- Central Nervous System - Acutely altered mental status

**One or more new organ dysfunction due to infection:**

- **This is SEPSIS**: Seek senior input as per local guideline.

**No new organ dysfunction due to infection:**

- **This is NOT SEPSIS**: If infection is diagnosed proceed with usual treatment pathway for that infection.

**Section 8**

**Look for signs of septic shock**

(following adequate initial fluid resuscitation, typically 2 litres in the first hour unless fluid intolerant)

- Requiring inotropes/pressors to maintain MAP ≥ 65

- This is SEPTIC SHOCK

- Inform Consultant
- Contact CRITICAL CARE

**Practical Guidance**

Re-assess the patient’s clinical response frequently. Re-assess and repeat lactate, if the first is abnormal, by 3hrs. Achieve source control as soon as practicable.

If the patient is deteriorating, despite appropriate treatment, seek senior assistance, re-assess antimicrobial therapy and the need for source control.

**Pathway Modification**

All Pathway modifications need to be agreed by the Hospital’s Sepsis Committee and be in line with the National Clinical Guideline.

**Section 9**

**Clinical Handover. Use ISBAR, Communication Tool**

This section only applies when handover occurs before the form is completed and the form is then signed off by the receiving doctor.

*Doctor’s Name (PRINT):* 
*Doctor’s Signature:* 
*Doctor’s Initials:* 
*MCRN:* 

*Patient care handed over to:* 
*Time:* 
*Sections completed:* 

*Form completed by* 

*Doctor’s Name:* 
*Doctor’s Signature:* 
*MCRN:* 
*Date:* 
*Time:* 

File this document in the patient notes – other aspects of patient management should be documented on the continuation sheets.