ADULT SEPSIS PATHWAY

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**
- ❑ **$Sp0_2$ < 95%**
- ❑ **Systolic blood pressure ≤ 100 mmHg**
- ❑ **Pulse ≤ 50 OR ≥ 120 per minute**
- ❑ **Altered LOC or change in cognitive status**
- ❑ **Temp ≤ 35.5 or ≥ 38.5^{O}C**

NO → Treat and re-assess simultaneously: **Sepsis may still be a concern** → **Re-assess**

YES → **Perform venous blood gas if available**

Does your patient have any red criteria?

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

NO

Respond and Escalate

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

YES

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

ADULT SEPSIS PATHWAY: Resuscitation Guideline

RESUSCITATE

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

- **Patient assessment and treatment proceeds simultaneously**
- **Maintain** $SpO_2 \geq 95\%$
- **Monitor** respiratory rate, SpO_2, 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	• Continue monitoring vital signs closely • Strict monitoring of fluid balance • Investigate and treat the source of infection
Urine Output > 0.5mL/kg/hr	
$SpO_2 \geq$ 95%	
Decreasing serum lactate level	
Improving LOC	

REFER

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

SEPSIS KILLS
RECOGNISE · RESUSCITATE · REFER