


<p>THE TWEED/BYRON HEALTH SERVICE GROUP</p>	<p>EMERGENCY MEDICINE DEPARTMENT ADULT PROTOCOLS & GUIDELINES</p> <p>Date Issued: November 2013 Last Review Date: Next Review: 28/11/2015</p> <p>Authority: Dr Robert Davies, Network Director Emergency Medicine</p>	<p>Policy Number: NC-TWB-CLP-1748-</p> <p>Authority Initial: </p>
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ADULT SEPSIS PATHWAY v2

Use local febrile neutropenia guideline if patient has haematology/oncology diagnosis

RECOGNISE

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

- | | |
|--|---|
| <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Abdomen: pain, peritonism |
| <input type="checkbox"/> Indwelling medical device | <input type="checkbox"/> Lung: cough, shortness of breath |
| <input type="checkbox"/> Recent surgery/invasive procedure | <input type="checkbox"/> Neuro: altered LOC, new onset of confusion, neck stiffness, headache |
| <input type="checkbox"/> History of fever or rigors | <input type="checkbox"/> Skin: wound, cellulitis |
| <input type="checkbox"/> Re-presentation within 48 hours | <input type="checkbox"/> Urine: dysuria, frequency, odour |
| <input type="checkbox"/> Fall not related to mechanism of injury | |

AND

Does your patient have 2 or more yellow criteria?

- | | |
|---|--|
| <input type="checkbox"/> Respirations ≤ 10 or ≥ 25 per minute | <input type="checkbox"/> Heart rate ≤ 50 OR ≥ 120 per minute |
| <input type="checkbox"/> SpO ₂ $< 95\%$ | <input type="checkbox"/> Altered LOC or new onset of confusion |
| <input type="checkbox"/> Systolic blood pressure ≤ 100 mmHg | <input type="checkbox"/> Temp < 35.5 or $> 38.5^{\circ}\text{C}$ |

YES
Perform venous
blood gas if
available

Does your patient have any red criteria?

- | | |
|--|--|
| <input type="checkbox"/> SBP < 90 mmHg | <input type="checkbox"/> Age > 65 years |
| <input type="checkbox"/> Lactate ≥ 4 mmol/L | <input type="checkbox"/> Immunocompromised |
| <input type="checkbox"/> Base excess < -5.0 | |

NO

NO

YES

RESPOND & ESCALATE

Sepsis may still be a concern

- Monitor vital signs and fluid balance
- Treat and re-assess
- Consider septic screen


Patient may have SEPSIS

- Obtain senior clinician review within 30 minutes
- Look for other causes of deterioration
- Treat as per Sepsis Six if no other diagnosis is more likely

Patient has SEVERE SEPSIS

until proven otherwise

- Obtain IMMEDIATE senior/FACEM clinical review
- Expedite transfer to resuscitation area or equivalent
- Commence resuscitation as per Sepsis Six

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RESUSCITATE

Does the patient have an Advance Care Directive; are there any treatment limitations?	
Sepsis Six <i>Acknowledgement: The Sepsis Six in this document is an adaption of the Sepsis Six by Ron Daniels, UK Sepsis Trust.</i>	
1. OXYGEN	Administer oxygen to maintain SpO ₂ > 95%
2. BLOOD CULTURES	Take blood cultures (2 aerobic, 2 anaerobic), FBC, EUC, LFTs, coags, glucose, +/- wound, urine, sputum or other cultures
3. LACTATE	Take blood for formal lactate or VBG
4. IV FLUIDS	Give 20mL/kg 0.9% sodium chloride fluid challenge STAT Aim to achieve MAP of > 65mmHg or SBP > 100mmHg If no response, repeat 20mL/kg 0.9% sodium chloride <i>unless there are signs of pulmonary oedema</i> If no response commence inotropes as per local protocol and in consultation with senior doctor
5. IV ANTIBIOTICS	Prescribe and commence within 60 MINUTES from triage/time of diagnosis <i>or within 30 MINUTES if haematology/oncology patient</i> (refer to local guidelines and seek specialist advice) Do not wait for results of investigations
6. MONITORING	Monitor respiratory rate, SpO ₂ , blood pressure, heart rate, temperature, LOC, fluid balance, urinary output Review antibiotics when blood/specimen results available

RE-ASSESS

SIGNS OF IMPROVEMENT	
<input type="checkbox"/> SpO ₂ > 95%	<input type="checkbox"/> MAP > 65mmHg or SBP > 100mmHg
<input type="checkbox"/> Decreasing tachycardia	<input type="checkbox"/> Decreasing serum lactate level
<input type="checkbox"/> Improving LOC	<input type="checkbox"/> Urine output > 0.5mL/kg/hr
IF IMPROVING TAKE THE FOLLOWING ACTION	
<ul style="list-style-type: none"> Refer to admitting team/ICU Continue monitoring vital signs and fluid balance closely Investigate and treat the source of infection 	

REFER

IF NO IMPROVEMENT THIS PATIENT NEEDS INTENSIVE CARE MANAGEMENT
<ul style="list-style-type: none"> Reassess suitability to continue resuscitation Request review by ICU doctor to occur within 30 minutes If no ICU at your facility, seek advice immediately from the ADULT MEDICAL RETRIEVAL SERVICE 1800 650 004 or local Critical Care Advisory Service <p>Minimum patient monitoring requirements:</p> <ul style="list-style-type: none"> Respiratory rate, SpO₂, blood pressure, heart rate, temperature, LOC Repeat serum lactate every 4 hours Fluid balance, consider measuring urine output via IDC

