ACUTE HOSPITALS ONLY
(NON MATERNITY) ≥16 YRS

Addressograph

SEPSIS SCREENING TOOL FOR ADULTS

THIS FORM DOES NOT REPLACE CLINICAL JUDGEMENT

Any Healthcare Professional (HCP) should start this tool if CONFIRMED or SUSPECTED INFECTION present PLUS presence of ≥1 of the triggers listed below

- ☐ Patient looks sick
- ☐ Emergency Dept. Manchester Triage Category 2
- ☐ Elevated EMEWS or INEWS (INEWS ≥ 4 or ≥5 if on O_2)
- ☐ Patient/Family/Carer/Clinician Concern
- ☐ GP/ Ambulance personnel queries sepsis

Score: ☐☐

YES *Time Zero: ☐☐:☐☐

*When the patient 1st triggers for sepsis screen

Name _____ Grade_____

NMBI/MCRN_____ DATE: ___/___/____

REQUEST MEDICAL REVIEW AS PER ESCALATION AND RESPONSE PROTOCOLS TO RISK ASSESS PATIENT USING ISBAR

Is any ONE RED FLAG present?

Signs of Shock

- ☐ Systolic Blood Pressure < 90mmHg (or drop of > 40mmHg below normal +/- Point of care lactate > 2mmols/L)

OR

Risk of Neutropenia

- ☐ Recent chemotherapy/radiotherapy

OR

Evidence of New Organ Dysfunction
(any one of the following)

- ☐ New Acutely altered Mental Status
- ☐ Respiratory Rate > 30 bpm
- ☐ Heart rate > 130 bpm
- ☐ Not passed urine in 12 hours or urine output < 0.5mls/kg/hr
- ☐ Non blanching rash
- ☐ New or increased need for O_2 to achieve SpO_2 >90%
- ☐ Pallor/mottling with central CRT > 3 seconds
- ☐ Other organ dysfunction

YES

NO

NO RED FLAGS - CHECK FOR AMBER FLAGS

≥ 2 Systemic Inflammatory Responses (SIRS) that are sustained PLUS ≥ 1 Comorbidity.

SIRS (check for 2 or more listed below)

- ☐ Respiratory rate ≥ 20 bpm
- ☐ Heart rate 91- 130 bpm
- ☐ Temperature < 36 or > 38.3 °C
- ☐ Blood glucose level > 7.7 mmol/l (in absence of diabetes mellitus)
- ☐ WCC < 4 or > 12 x 10^9 /L

AND

≥ 1 Comorbidity (listed below)

- ☐ Aged ≥ 75 years
- ☐ Frailty
- ☐ Diabetes Mellitus
- ☐ COPD
- ☐ Cancer
- ☐ Chronic Renal Disease
- ☐ Chronic Liver Disease
- ☐ Recent Surgery /Trauma (past 6 weeks)
- ☐ Immunosuppression (due to medication or disease)

YES NO

YES

PROBABLE SEPSIS
IMMEDIATE ACTION IS REQUIRED

YES

POSSIBLE SEPSIS

NO

YES

NEGATIVE SCREEN SEPSIS UNLIKELY AT THIS TIME ☐

EXIT PATHWAY

Sign_____

MCRN / NMBI (ANP)

_____

Treat as per diagnosis and continue to monitor. Rescreen if deteriorates

SITE OF INFECTION (IF KNOWN) _____

START SEPSIS 6 NOW

INFORM SENIOR DECISION MAKER

See overleaf

Is there an End-of-Life Pathway in place? Yes ☐ No ☐ Is escalation clinically appropriate? Yes ☐ No ☐

If Sepsis 6 is not clinically appropriate, exit the sepsis pathway.

Doctor Signature_____ MCRN_____

SEPSIS TREATMENT PROTOCOL FOR ADULTS (NON MATERNITY) ≥16 YRS

SEPSIS 6 BUNDLE

- COMPLETE WITHIN 1 HOUR

Addressograph

TAKE 3

1 TAKE BLOOD CULTURES

2 sets of peripheral blood cultures (aseptic technique) prior to giving antimicrobials unless this leads to a delay >45mins. If patient has CVAD, take line cultures at the same time. Other cultures as indicated by history and examination.

Time Taken: ☐☐:☐☐

2 TAKE BLOOD TESTS

FBC, Renal and Liver profile, point of care **lactate**, CRP +/- coagulation screen.

If initial lactate elevated > 2mmols/L, repeat lactate after sepsis 6 bundle to assess response.

Time Taken: ☐☐:☐☐

3 URINARY OUTPUT ASSESSMENT

Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis/septic shock start fluid balance charts. Catheterisation and hourly measurements may be required.

Time: ☐☐:☐☐

Fluid balance chart commenced ☐

GIVE 3

4 IV ANTIMICROBIALS (if appropriate), THINK SOURCE CONTROL. Consider Microbiology review

Red Flags (PROBABLE SEPSIS) 	Amber Flags (POSSIBLE SEPSIS) 
IV Antimicrobials within **1 HOUR**	Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within **3 HOURS**. **Note:** If infection with new onset organ dysfunction present (e.g. AKI, thrombocytopenia or hyperlactatemia etc.) administer antimicrobials immediately.
TIME GIVEN ☐☐:☐☐	TIME GIVEN ☐☐:☐☐

☐ Patient already on appropriate antimicrobials

☐ This patient does not require antimicrobials at this time

5 GIVE IV FLUID BOLUS IF REQUIRED

For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/ vasopressors, Reassess response to fluid resuscitation frequently.
Refer to fluid resuscitation algorithm.

Time Given: ☐☐:☐☐ or N/A ☐

6 GIVE OXYGEN IF REQUIRED

Titrate supplementary oxygen to maintain oxygen saturations 94-96% (88-92% for patients with chronic lung disease).

Time Given: ☐☐:☐☐ or N/A ☐

Reassess vital signs at least every 30 minutes.
IF CONDITION WORSENING / NOT IMPROVING, ESCALATE TO CONSULTANT.
Consider SEPTIC SHOCK if MAP less than 65mmHg DESPITE FLUID RESUSCITATION and escalate to critical care.

☐ **Sepsis UNLIKELY at this time, treat as per working diagnosis, continue to monitor. Rescreen if deteriorates**

☐ **This is likely to be SEPSIS at this time**

☐ **Senior Clinician informed**

Signature _____ **MCRN / NMBI (ANP)** _____

Print _____ **Date:** ___/___/____ **Time** ☐☐:☐☐

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