# SEPSIS SIDEBAR

**Does your patient meet 2 or more of the SIRS criteria?**

- RR >20
- HR >90
- Temp >100.9 or <96.8 (treat fever per orders if identified)
- WBC <4 or >12

**Does the patient have a confirmed OR suspected infection?**

- Possible infectious etiology (ex: wound, PNA, cellulitis, UTI)
- High risk populations:
  - Dialysis/ Existing invasive/ Indwelling tubes
  - Resident of nursing home/LTAC
  - Recent hospitalization/ surgery
  - Immune compromised/suppressed

1. Baseline assessment, Confirm patients HT/WT, check MEWS score
2. Notify the provider via Amion (if 2 SIRS criteria + possible infection is present) put the wording "possible sepsis" in notification.
3. If provider states this is a Code Sepsis or Sepsis order set is initiated:
   a. Automation of Carelink notifications/eLink monitoring
   b. If issues with Carelink call 336-271-4845
   c. Call Charge RN and Rapid Response RN (IP only) for assistance
   d. Lab notification (Collection of Lactic Acid, Blood cultures, PCT)
   e. Pharmacy to respond (Unit based vs Page Pharmacist)

**Code Sepsis Activation: Hours 0-1**

1. Establish 2 IVs (notify resources if needed)
2. If ordered by provider
   a. Collect urine for UA (I/O Cath only)
3. Notify MD for SBP <90, MAP <65, and/or Lactate ≥ 4 - Anticipate 30ml/kg of IV fluid
   a. IBW (Ideal Body Weight) can be used if BMI >/= 35
4. Start antibiotics AFTER blood cultures have been collected

If unable to infuse both antibiotics because of compatibility **hang broad spectrum first:**

**Common Broad Spectrum Abx: Cefepime, Rocephin, Zosyn,**

**REMINDER: VANCOMYCIN IS A NARROW SPECTRUM ABX**

| 1 Hour Reassessment<br>Possible Severe Sepsis/ Severe Sepsis with Organ Dysfunction<br>Does the patient have one of the following signs of organ dysfunction? | |
|---|---|
| • SBP < 90 despite fluid resuscitation<br>• MAP < 65 despite fluid resuscitation<br>• Worsening respiratory status | • Decreased LOC<br>• Lactate ≥ 2<br>• Creatinine / Total bilirubin > 2<br>• Platelets < 100,000 |
| **Note the above assessment is your 1-hour REASSESSMENT. Call Provider with findings.**<br>• **If above findings are positive, consider higher level of care**<br>• **If above findings are negative, consider cancelling code sepsis** | |

**Code Sepsis Activation: Hours 1-3**

1. Repeat Lactic Acid within a 3-hour window if initial was greater than 2
    a. Continue to draw If Lactic Acid is trending up
2. Ensure that Provider is aware of fluid bolus completion
3. Consider maintenance fluids following bolus
4. If SBP <90, MAP <65, OR lactate ≥ 4 after 30ml/kg bolus.
    a. Expect CCM consult
    b. Vital signs Q15 minutes x 8 (T, HR, R, B/P), q30 mins x 4, q2 hours x 2, Q4 hours x 6

**Code Sepsis Activation: Hours 3 and on**

1. Notify MD of significant changes:
    a. Monitor for persistent hypotension/ Anticipate administration of Vasopressors
    b. Change in respiratory effort/rate
    c. Fever
    d. Persistent/increasing lactic acid levels
    e. Decrease LOC
2. RN to remind provider to document Repeat Assessment