Queensland Government

Adult Sepsis Pathway

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Clinical pathways never replace clinical judgement.
Care outlined in this pathway **must** be altered if it is not clinically appropriate for the individual patient.
For use in maternity patients of any gestation up to six weeks postpartum.

Sepsis is a MEDICAL EMERGENCY. If you suspect post-operative bleeding, pulmonary embolism (PE), acute myocardial infarction (AMI), stroke, or peri-partum bleeding or amniotic fluid embolus for maternity patients, immediately escalate to senior medical staff.

Screen ALL adult patients who meet ANY of the following criteria *(tick all that apply)*

- ☐ Looks sick
- ☐ You suspect they may have sepsis
- ☐ Has a suspected infection
- ☐ Patient / family / carers concerned about patient condition
- ☐ Current or recent fever with or without chills or rigors
- ☐ Hypothermia <35.5°C
- ☐ Signs of clinical deterioration (e.g. change in behaviour or new onset confusion or total *Q*-ADDS / *Q*-MEWT score of ≥4)

If you suspect **neutropenic sepsis**, refer to local guidelines if available, otherwise continue screening on this pathway

SCREEN and RECOGNISE

Screening initiated: DD / MM / YY HH : MM (24hr)

Are ANY of the following risk factors present? *(tick all that apply)*
Absence of risk factors does not exclude sepsis as a cause of deterioration

- ☐ Re-presentation within 48 hours or requiring repeated reviews
- ☐ Malnourished or frail
- ☐ Impaired immunity (e.g. diabetes, steroids, chemotherapy, neutropenia, asplenia)
- ☐ Indwelling medical device (e.g. PIVC, catheter, drain)
- ☐ Alcohol or drug use disorder
- ☐ Recent trauma / surgery / invasive procedure
- ☐ Postpartum / miscarriage
- ☐ Aboriginal and / or Torres Strait Islander

AND / OR

Is there ANY potential source of infection? *(tick all possible sources that apply)*

- ☐ Genital tract / reproductive system
- ☐ Respiratory tract
- ☐ Urinary tract
- ☐ Abdomen / GIT
- ☐ Breach of skin integrity / soft tissue / joint
- ☐ Implantable device / prosthesis
- ☐ CNS / meningitis
- ☐ Surgical site / wound
- ☐ Source is unclear
- ☐ Other *(specify)*: .....

YES / **NO**

Does the patient have ANY high risk criteria? *(tick all that apply)*

- ☐ **Systolic BP <90mmHg (or drop >40 from normal)**
- ☐ **Lactate ≥2mmol/L**
- ☐ **Non-blanching rash / Mottled / Ashen / Cyanotic**
- ☐ Respiratory rate ≥25 breaths per min
- ☐ New oxygen requirement to keep oxygen saturation ≥92%
- ☐ Heart rate ≥130 beats per min
- ☐ Has not passed urine in past 18 hours *OR* urinary output (UO) <0.5mL/kg/hr (if known)
- ☐ Evidence of new or altered mental state
- ☐ Recent chemotherapy

NO

Does the patient have ANY moderate risk criteria? *(tick all that apply)*

- ☐ **Systolic BP 90–99mmHg**
- ☐ Respiratory rate 21–24 breaths per min
- ☐ Heart rate 90–129 beats per min *OR* new arrythmia
- ☐ Has not passed urine in past 12–18 hours
- ☐ Temperature <35.5°C or ≥38.5°C (≥38.0°C for maternity patients)
- ☐ Family members / carers concerned about mental state
- ☐ Acute deterioration in functional ability

YES / **NO**

ESCALATE or DE-ESCALATE

Patient has SEPSIS or SEPTIC SHOCK until proven otherwise

- Obtain immediate senior medical review
- Commence resuscitation *AND* consider calling Retrieval Services Queensland (RSQ) 1300 799 127 if rural or remote
- Increase observation frequency
- Ensure lactate taken

Patient may have SEPSIS

- Obtain immediate senior medical review and/or consider calling RSQ if rural or remote
- Ensure lactate taken

Low risk for SEPSIS

- Look for other common causes of deterioration
- Consider hypovolaemia, AMI, stroke and PE
- In the event of deterioration reassess sepsis risk using a new copy of this form
- If to be discharged home, give patient sepsis discharge instructions

Senior medical review attended: DD / MM / YY HH : MM (24hr)

PRINT name of senior medical reviewer: PRINT NAME

Does the senior medical reviewer think sepsis or septic shock is likely?

☐ Sepsis / septic shock likely ☐ Sepsis / septic shock unlikely → **NO**

YES

⚠ **Commence resuscitation and treatment for sepsis NOW** *(see page 2)*
Consider calling RSQ (1300 799 127) or RFDS (if normal pathway)

Signature Log

Every person documenting in this clinical pathway must supply a sample of their initials and signature below

Initials	Signature	Print name	Role	Initials	Signature	Print name	Role

DO NOT WRITE IN THIS BINDING MARGIN

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ADULT SEPSIS PATHWAY

Queensland Government

Adult Sepsis Pathway

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Notify nursing team leader ☐ and senior medical staff ☐ the patient has potential sepsis or septic shock *(tick when notified).* Confirm treatment aligns with **Acute Resuscitation Plan (ARP)** if relevant.

RESUSCITATE

Commence Actions 1–4 within:

30 minutes	From recognition of neutropenic or meningococcal sepsis
1 hour	From recognition of septic shock
1 hour	From triage or recognition of sepsis where there is high likelihood that organ dysfunction is due to infection
3 hours	From triage or recognition of organ disfunction where there is less certainty this is due to infection, but concern for infection persists after rapid clinical assessment

*Document variance in **medical record** if key tasks not commenced within these time frames.*

1. Measure (or remeasure) lactate
(Arterial / Venous / Point of care)

☐ **Lactate collected**

Date: DD/MM/YY | Time: HH:MM | Initials:

2. Take 2 sets of blood cultures
- Collect prior to antibiotics unless this would delay treatment for >1 hour
- If patient has a central line collect an additional (third) set of blood cultures via the line
- Collect FBC, UEC and glucose (or Chem8 iStat), LFT and lipase
- For septic shock add coagulation studies
- Collect urine, sputum and other relevant cultures but do not delay antibiotics

☐ **2 sets blood cultures collected**

Date: DD/MM/YY | Time: HH:MM | Initials:

3. Commence or review antibiotics
- Identify likely source of infection (including relevant imaging findings)
- Prescribe antibiotics according to guidelines. Modify for allergies or prior microbiological sensitivities
- Notify nursing staff of urgent need to administer antibiotics and ensure completed
- Consider referral to consulting microbiologist or infectious diseases physician (particularly if: septic shock, recent overseas travel, risk factors for multi-resistant organisms, IV drug use, morbid obesity or dialysis patient)

☐ **Antibiotics commenced**

Date: DD/MM/YY | Time: HH:MM | Initials:

4. Commence IV fluids if clinically indicated
- Consider volume of fluid based on patient's weight, cardiac function, comorbidities, current volume status and haemodynamics
- If bolus indicated, rapidly infuse 250–500mL IV or intraosseous Hartmann's or sodium chloride 0.9%
- Consider albumin 5% solution for patients with septic shock
- Assess response to fluid and consider repeating bolus if clinically indicated – do NOT exceed 30mL/kg without senior medical input
- If IV access not possible, consider intraosseous route

☐ **IV fluids commenced**
☐ **Not indicated**

Date: DD/MM/YY | Time: HH:MM | Initials:

5. Consider vasopressors / inotropes for hypotension during or after fluid resuscitation (e.g. Noradrenaline: usual commencing dose 5mcg/min) or consider referral to ICU or higher level of care

☐ **Vasopressors / inotropes considered**
☐ **Not indicated**

6. Facilitate source control
ATTENTION: Source control is URGENT – Ongoing sepsis treatment is unlikely to be effective without timely and comprehensive source control
- If source control requires operative intervention, immediately notify appropriate surgical or interventional team
- Consider removing or changing **existing** indwelling medical devices (e.g. IV lines or urinary catheters)

☐ **Source control facilitated**
☐ **Not indicated**

REVIEW

7. Reassess and monitor response to resuscitation – aim for:
- Oxygen saturation ≥92% and titrate to range of 92–96% (88–92% if COPD)
- Systolic BP >100mmHg
- Urine output >0.5 to 1.0mL/kg/hr – consider IDC with hourly monitoring

If haemodynamic status is not improving seek urgent (further) senior medical advice and escalate to higher level of care

8. Document and communicate ongoing management:
- Document appropriate criteria to ensure escalation if signs of deterioration
- Notify treating team of change in clinical condition
- Document clear management plan
- Review antibiotics as soon as possible
- Refer to infectious diseases, microbiologist or AMS team for review, particularly for septic shock

Facilitate transfer and provide clinical handover if patient requires admission to higher level of care

☐ **Referral completed and documented**

Communicate the patient's risk of deterioration during handover to accepting clinician
An emergency call can be initiated at any time if clinically concerned

Date and time completed: DD / MM / YY | HH : MM (24hr) | INITIALS

Transferring staff name:

Accepting staff name:

DO NOT WRITE IN THIS BINDING MARGIN