Queensland Government

Emergency Department Non-pregnant Adult Sepsis Pathway

For tertiary and secondary facilities

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.

Septic Shock = shock + infection (mortality 20–23%) **Sepsis = organ dysfunction + infection (mortality 10–12%)**

Screen ALL non-pregnant adult emergency department patients who meet ANY of the following criteria *(tick all that apply)*

- ☐ Looks sick
- ☐ You suspect they may have sepsis
- ☐ Has a suspected infection
- ☐ Fever symptoms (or recent fever symptoms)
- ☐ Hypothermia <35.5°C
- ☐ Signs of clinical deterioration (e.g. altered level of consciousness or total Q-ADDS score of ≥4)
- ☐ If you suspect **neutropaenic sepsis**, refer to local guidelines if available, otherwise continue screening on this pathway

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
- ☐ Malnourished or frail
- ☐ Immunocompromised / Asplenia / Neutropaenia
- ☐ Indwelling medical device
- ☐ Recent trauma or surgery / Invasive procedure
- ☐ Postpartum / Miscarriage
- ☐ IV drug use or alcoholism
- ☐ Aboriginal and / or Torres Strait Islander

AND / OR

Is there ANY reason to suspect an infection? *(tick all possible sources that apply)*

- ☐ Yes, but source is unclear at present
- ☐ Respiratory tract
- ☐ Urinary tract
- ☐ Abdomen / GIT
- ☐ Skin / Joint / Prosthesis / Device
- ☐ CNS / Meningitis
- ☐ New onset confusion
- ☐ Family members / carers are concerned there is an infection
- ☐ Other (specify): .....

YES / NO

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

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

NO →

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

- ☐ Respiratory rate 21–24 breaths/min
- ☐ Heart rate 90–129 beats/min *OR* new dysrhythmia
- ☐ Systolic BP 90–99mmHg
- ☐ Not passed urine in last 12–18 hours
- ☐ Temperature <35.5°C or ≥38.5°C
- ☐ Family members / carers concerned about mental state
- ☐ Acute deterioration in functional ability

ESCALATE / DE-ESCALATE

YES ↓

Patient has SEPSIS or SEPTIC SHOCK until proven otherwise
- Obtain immediate senior medical review
- Consider transfer to resuscitation area
- Commence resuscitation

YES ↓

Patient may have SEPSIS
- Ensure lactate taken
- Obtain senior medical review

NO →

Low risk for SEPSIS
- Look for other common causes of deterioration
- 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)

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)*

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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ED NON-PREGNANT ADULT SEPSIS PATHWAY TERTIARY AND SECONDARY

Queensland Government

Emergency Department Non-pregnant Adult Sepsis Pathway

For tertiary and secondary facilities

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Notify nursing team leader ☐ and SMO ☐ the patient has potential sepsis or septic shock *(tick when notified)*

ACTIONS 1–4 to be commenced for:

- Neutropaenic or meningococcal sepsis within 30 minutes of recognition
- Septic Shock within 1 hour of recognition of shock (mortality 20–23%)
- Sepsis within 3 hours of triage (mortality 10–12%)

(Document variance in comments section if key tasks not commenced)

RESUSCITATE

1. Measure (or remeasure) lactate	☐ **Lactate collected**
2. Take blood cultures x 2 sets • 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, BGL, LFT, lipase and VBG • For septic shock add coagulation studies • Collect other relevant cultures but do not delay antibiotics	☐ **2 sets blood cultures collected**
3. Commence appropriate IV 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 • Recommend 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**
4. Commence IV or intraosseous 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 250mL–500mL IV or intraosseous 0.9% NaCl or Hartmann's over 5 minutes • Assess response to fluid and consider repeating bolus if clinically indicated - do NOT exceed 30mL/kg without SMO input	☐ **IV fluids commenced** (or not indicated)
5. Consider vasopressors/inotropes for hypotension during or after fluid resuscitation (e.g. Noradrenaline: usual commencing dose 5mcg/min)	☐ **Vasopressors/ inotropes considered** (or not indicated)
6. Facilitate rapid source control - if this requires operative intervention ensure early notification of appropriate surgical or interventional team	☐ **Source control facilitated** (or not required)

REVIEW

7. Reassess and monitor response to resuscitation - aim for:

- Oxygen saturation >94% (88–92% if COPD)
- Systolic BP >100mm Hg
- Urine output >0.5 to 1.0mL/kg/hr – consider IDC with hourly monitoring
- Lactate <2mmol/L

If haemodynamic status not improving or if vasopressors/inotropes commenced refer to ICU

8. Early referral to relevant inpatient team with clinical hand-over, and document: • Appropriate criteria to ensure escalation of signs of deterioration • Requirement to review antibiotics as soon as possible • Need for infectious diseases, microbiologist or AMS team review, particularly in septic shock	☐ **Referral completed and documented**

Handover risk of deterioration to receiving nurse when patient transferred out of ED

An emergency call can be initiated at any time if you are clinically concerned.

Date and time complete: DD / MM | HH : MM (24hr) | initials

ED staff name: Ward staff name:

Comments / Variance from Actions

DO NOT WRITE IN THIS BINDING MARGIN