Safer Care Victoria

Health service logo

Victorian Adult Sepsis Pathway

Family name | MRN

Given name | Gender at birth ◯ Male ◯ Female

D.O.B

Address

Location/Ward

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

1. Could it be Sepsis?

RECOGNISE

Does your patient have a known or suspected infection?

- ◯ History of fevers or rigors
- ◯ **Skin:** cellulitis, wound, petechial rash, cool peripheries
- ◯ **Respiratory:** cough, shortness of breath
- ◯ **Abdominal:** pain, peritonism, diarrhoea or vomiting
- ◯ **CNS:** decreased mental alertness, headache
- ◯ **Genitourinary:** dysuria, anuria, or frequency

AND/OR any of the following increased RISK Factors?

- ◯ Aged ≥65
- ◯ Frail, chronic condition or recent fall
- ◯ Aboriginal and Torres Strait Islander people
- ◯ On immunosuppressive treatment
- ◯ Patient, carer or family concern
- ◯ Re-presentation or deterioration
- ◯ Possible neutropenia
- ◯ Indwelling medical devices
- ◯ Recent surgery or invasive procedure

2. Does your patient have abnormal vital signs?

RESUSCITATE & REFER

≥ 2 of the following:

- ◯ SBP < 90 mmHg
- ◯ Altered mental status
- ◯ Lactate ≥2 mmol/L

OR

≥ 2 of the following:

- ◯ Temperature < 36°C **or** > 38°C
- ◯ Heart rate >90 bpm
- ◯ Respiratory rate > 20 per minute
- ◯ WCC < 4 **or** > 12 x 10^9/L

NO

Consider other causes:

- ◯ Myocardial infarct
- ◯ Haemorrhage
- ◯ Ischaemia
- ◯ Pulmonary embolism
- ◯ Transfusion or drug reaction
- ◯ Intoxication/ withdrawal
- ◯ Dehydration
- ◯ Endocrine/pancreatitis

YES

Initiate **EMERGENCY CALL** as per local guidelines

YES

Call for **senior clinical review** as per local guidelines

Treat as SEPSIS and /or SEPTIC SHOCK until proven otherwise

Does the patient have **POSSIBLE SEPSIS?**

NO

Patient requires:

- ◯ Clinical assessment
- ◯ Repeat observations within 30 minutes and manage according to Step 2 of this pathway

YES

COMMENCE SEPSIS TREATMENT IMMEDIATELY

- ◯ Review the patient's Goals of Care (GOC)/Advanced Care Plan (ACP)
- ◯ Consider if patient requires transfer to a higher acuity setting
- ◯ Discuss treatment plan with patient, carer, and/or family

3. Six key actions in 60 minutes

1. **Oxygen administration**
2. **Two sets of blood cultures**
3. **Venous blood lactate**
4. **Fluid resuscitation**
5. **Intravenous antibiotics***
6. **Monitoring observations and fluid balance**

*Antibiotics should be administered within 60 minutes. Cancer patients currently undergoing systemic chemotherapy and patients with suspected meningitis require first antibiotics within 30 minutes.

For further Sepsis information and resources for Consumers and Clinicians please see
Sepsis Clinical Care Standard | Australian Commission on Safety and Quality in Health Care
<https://www.safetyandquality.gov.au/standards/clinical-care-standards/sepsis-clinical-care-standard>

4. Document and monitor

Sepsis Pathway Commenced	Name/Designation:		
	Date/Time:		Initials:
	Triage Category:		Time:
Has the GOC/ACP/resuscitation options been completed?	◯ Yes	◯ No	Initials:
Has the diagnosis and treatment plan been discussed with the patient, carer, or family member?	◯ Yes	◯ No	Initials:

FIRST 30 MINUTES FROM PRESENTING SIGNS/SYMPTOMS

Key Actions

Senior Medical Review		Name/Designation:		
		Time:		Initials:
Oxygen Administration	◯ Aim SpO2 92–96% (or 88–92% for COPD and chronic type II respiratory failure)	Time:		Initials:
Ensure IV Access	Large bore peripheral cannula available for fluid bolus, **OR** access to a suitable central venous access device (CVAD)			
Blood Cultures	◯ **Two sets** of blood cultures (2 peripheral; both sets can be taken from same site/stab or 1 peripheral and 1 from CVAD lumen)	Time:		Initials:
Lactate	◯ **Venous blood lactate**	Time:	Level:	Initials:
Pathology	Collect FBC, UEC, CRP, LFTs, coags and blood glucose level Consider cross match if patient at risk of anaemia or known recent surgery			

DO NOT WAIT for test results. Commence fluid resuscitation and antibiotics ASAP

Fluid Resuscitate If hypotensive (SBP < 100mmHg) or lactate > 2mmol/L

Fluids must have medical officer authorisation and be prescribed on the IV Therapy Chart

Give RAPID fluid bolus STAT 500 mL. Hartmann's* or plasma-lyte, or 0.9% sodium chloride

◯ **First bolus required and given** Initials:

If hypotension persists after the initial fluid resuscitation, administer second fluid bolus

◯ **Second bolus required and given.** Caution if signs of pulmonary oedema, history of cardiac dysfunction or elderly patient Initials:

*Antibiotics **MUST NOT** be administered concurrently with Hartmann's. Flush with compatible fluid before and after.

If blood pressure does not improve after fluid boluses ESCALATE care and consider inotropes

FIRST 60 MINUTES FROM PRESENTING SIGNS/SYMPTOMS

Clinically examine the patient for a focus of infection, e.g. chest, urinary tract

Check the patient's **ALLERGY STATUS**	◯ No penicillin allergy ◯ Non-life threating penicillin allergy (e.g. rash) ◯ Life-threatening penicillin allergy (e.g. anaphylaxis)	**Record antibiotic allergy and reaction:**	Initials:

For SUSPECTED, KNOWN OR UNKNOWN infection refer to local antimicrobial policy

Antibiotics must be prescribed on a medication chart

Administer Antibiotics*	*Antibiotics should be administered within 60 minutes. Cancer patients currently undergoing systemic chemotherapy require first antibiotic within 30 minutes.	Time prescribed: Time given:	Initials:
Steroids	◯ **Consider hydrocortisone if patient taking corticosteroids or known/suspected steroid deficiency**	Time prescribed: Time given:	Initials:

FIRST 6 HOURS

Ongoing Care

Source control	**ALWAYS CONSIDER THE NEED FOR SOURCE CONTROL** Refer to infectious disease and/or surgical teams early		Initials:
Investigation Initiate investigations as directed by likely source	◯ Diagnostic Imaging ◯ Urine MSU (or CSU) for MCS ◯ Throat swap for respiratory multiplex PCR	◯ Sputum for MCS ◯ Wound swab for MCS ◯ Stool for *C. difficile* testing (if diarrhoea present)	Initials:
Monitoring Monitor vital signs and fluid balance every 30 minutes for 2 hours, then hourly for 4 hours or more frequently as needed	◯ Keep oxygen saturation >92% (88–92% if at risk of CO_2 retention)		

Assess for deterioration which may include one or more of the following:

◯ Increasing respiratory rate (in orange or purple zone on observation chart)	
◯ SBP < 100 mmHG	◯ Urine output < 0.5ml/kg/hour
◯ Decreased or no improvement in consciousness	◯ If lactate elevated, repeat in 2 hours

If pathway is no longer indicated, document in medical records Time: Initials: