NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ADULT SEPSIS PATHWAY

Use for patients 16 years or older in any clinical setting to support recognition and management of sepsis

For pregnant women and up to six weeks post-pregnancy use the CEC Maternal Sepsis Pathway

Use local febrile neutropenia guideline where relevant

RECOGNISE

COULD IT BE SEPSIS?

Sepsis is **infection** with **organ dysfunction** and is a **medical emergency**

Does the patient have any signs or symptoms of INFECTION?

- ☐ Looks very unwell
- ☐ History of fever, rigors, hypothermia
- ☐ Tachypnoea, short of breath, cough, new O_2 requirement
- ☐ New confusion, change in behaviour or altered level of consciousness, delirium
- ☐ Unexplained pain
- ☐ Wound or line redness, pain, swelling, exudate
- ☐ Non-blanching rash
- ☐ Abdominal pain, distension, vomiting, diarrhoea
- ☐ Dysuria, oliguria, frequency, odour
- ☐ Raised lactate, WCC or CRP (if known)

AND/OR any of the following risk factors?

- ☐ Aged ≥ 65 years
- ☐ Frail, chronic condition or recent fall
- ☐ Aboriginal and Torres Strait Islander people
- ☐ Immunocompromised
- ☐ Indwelling medical device or line
- ☐ Patient, carer or family concern
- ☐ Recent trauma, surgery, procedure
- ☐ Known infection not responding to treatment
- ☐ Re-presentation, deterioration or no improvement with the same illness

Commence A-G systematic assessment and document a full set of vital sign observations

RESPOND & ESCALATE

Does the patient have signs of ORGAN DYSFUNCTION?

Early signs include hypotension, tachypnoea, altered mental state, raised lactate

☐ **ANY RED ZONE observation OR additional criteria** (including lactate ≥ 4 mmol/L)

→ Call a **RAPID RESPONSE** (as per local CERS) and refer to any Resuscitation Plan

→ This patient has **PROBABLE SEPSIS** with a high risk of deterioration and **SEPTIC SHOCK**

☐ **TWO or more YELLOW ZONE observations OR additional criteria** (including lactate ≥ 2 mmol/L)

→ Call for a **CLINICAL REVIEW** within 30 minutes (as per local CERS) **AND** consult with the **SENIOR CLINICIAN**

→ Does the senior clinician consider the patient has **POSSIBLE SEPSIS?**

NO → Consider other causes of deterioration

If infection treat with antibiotics

Increase frequency of vital sign observations as indicated by the patient's condition

Reconsider sepsis if the patient deteriorates

YES

Commence sepsis treatment (over page) AND inform the Attending Medical Officer

Discuss the management plan with the patient, carer or family including any Advance Care Plan

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ADULT SEPSIS PATHWAY

RESUSCITATE

Complete actions 1 to 5 within 60 minutes with ongoing A-G systematic assessment

1. Get help

2. Commence monitoring

- Escalate as per local CERS (if not already called)
- Give oxygen as required to maintain SpO_2 ≥ 95% (88 - 92% for COPD)

WITHIN 5 min

3. Obtain access and collect pathology

- ☐ Vascular access
- ☐ Lactate (unless collected)
- ☐ Pathology (FBC, EUC, LFTs, VBG + CRP if available)
- ☐ Blood cultures
- ☐ Other cultures / investigations
- ☐ Blood glucose level

- Call for expert assistance after 2 failed attempts at cannulation and prepare for intraosseous access
- Collect venous blood gas or point of care test if available
- Collect 2 sets of blood cultures from 2 separate sites; if difficult to obtain do not delay antibiotics
- If CVAD in situ, take 1 blood culture set from CVAD and 1 set peripherally

WITHIN 30 min

Do not wait for test results: commence fluids and antibiotics

4. Commence fluid resuscitation

- ☐ First fluid bolus given
- ☐ Second fluid bolus given
- ☐ IDC considered
- ☐ Vasopressors commenced

- **Give 500mL crystalloid bolus STAT**
  e.g. sodium chloride 0.9% / Hartmann's / Plasma-Lyte
- Assess response, aim for systolic blood pressure ≥ 100mmHg
- Monitor and document strict fluid input / output
- **Repeat 500mL bolus if ongoing hypotension**
- Closely monitor patients with cardiac or renal dysfunction, pulmonary oedema, elderly or frail when giving repeated fluid boluses

WITHIN 60 min

If ongoing hypotension, consider commencement of vasopressors and escalate to Intensive Care or retrieval service

5. Commence antibiotics

- ☐ First / new antibiotic commenced

- Document source of infection if known
- Use Therapeutic Guidelines: Antibiotic or local sepsis guideline
- Consult expert advice for complex patient or multiple sources

REASSESS & REFER

6. Reassess

- ☐ Repeat lactate taken

- Re-examine for other sources of infection
- Update nurse in charge and Attending Medical Officer - use ISBAR
- Discuss the management plan with the patient, carer, family
- Repeat lactate within 2 hours

7. Refer

- ☐ Intensive Care / retrieval service contacted

- Refer for surgical source control if required
- Escalate to Intensive Care or retrieval service if no improvement or further deterioration

Continue to monitor vital sign observations and fluid balance – **minimum** frequency every 30 minutes for 2 hours then hourly for 4 hours
Actively seek microbiology and other investigation results and review treatment plan
Escalate as per local CERS if any signs of deterioration

Print Name: _____ **Signature:** _____

Designation: _____ **Date:** _____/_____/_____

NO WRITING