

Facility:

D.O.B. ____/____/____

M.O.

ADDRESS

ADULT SEPSIS PATHWAY

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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?

- | | |
|---|--|
| <input type="checkbox"/> Looks very unwell | <input type="checkbox"/> Unexplained pain |
| <input type="checkbox"/> History of fever, rigors, hypothermia | <input type="checkbox"/> Wound or line redness, pain, swelling, exudate |
| <input type="checkbox"/> Tachypnoea, short of breath, cough, new O ₂ requirement | <input type="checkbox"/> Non-blanching rash |
| <input type="checkbox"/> New confusion, change in behaviour or altered level of consciousness, delirium | <input type="checkbox"/> Abdominal pain, distension, vomiting, diarrhoea |
| | <input type="checkbox"/> Dysuria, oliguria, frequency, odour |
| | <input type="checkbox"/> Raised lactate, WCC or CRP (if known) |

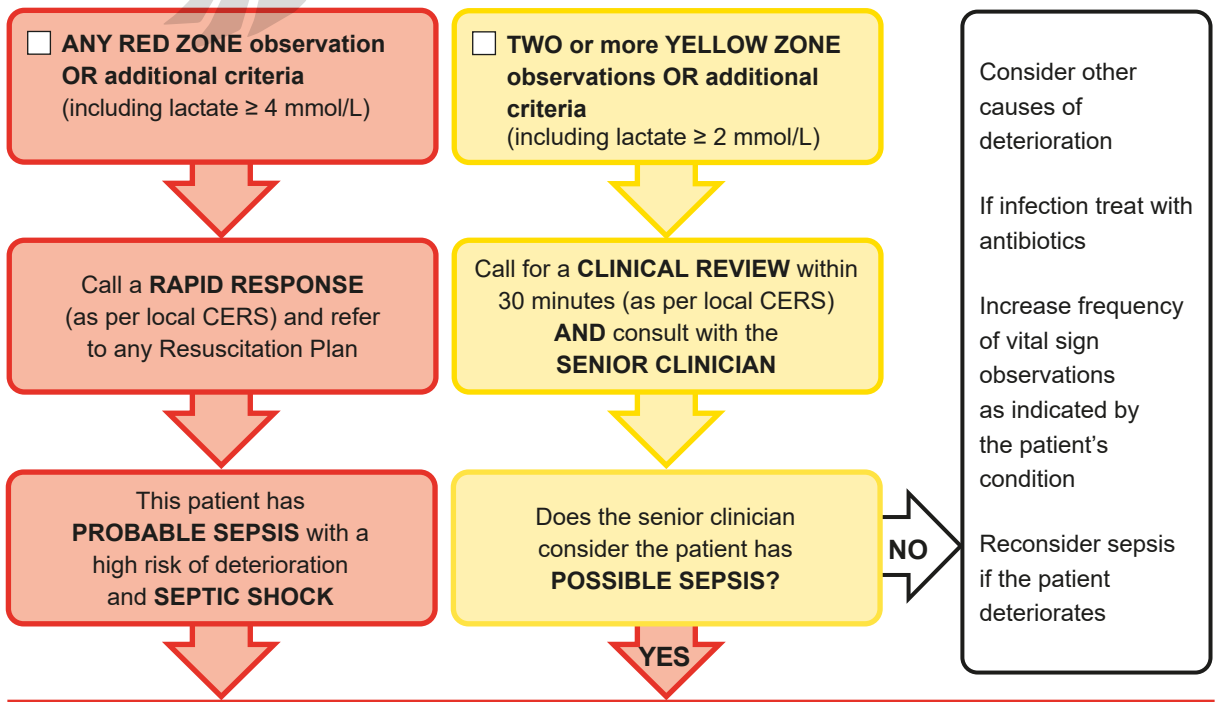
AND/OR any of the following risk factors?

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

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

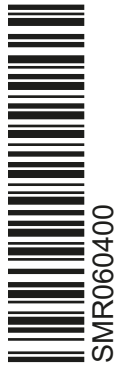
Does the patient have signs of ORGAN DYSFUNCTION?

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



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

RESPOND & ESCALATE



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 BINDING MARGIN - NO WRITING

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

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

1. Get help

- Escalate as per local CERS (if not already called)

2. Commence monitoring

- Give oxygen as required to maintain SpO₂ ≥ 95% (88 - 92% for COPD)

WITHIN



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



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



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

RESUSCITATE

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: ____ / ____ / ____

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