SUBJECT: Sepsis Alert	Board Chair:
DEPARTMENT: Emergency Department, Nursing, Lab, Radiology	Chief of Staff:
Date Developed: 3/17/2021	Nurse Practitioner:
Date Reviewed:	CEO:
Date Revised:	DON:

KEEFE MEMORIAL HOSPITAL
POLICY AND PROCEDURE

Purpose: Guideline for appropriate and timely interventions for the care of patients with severe sepsis.

Guideline: Sepsis alert in the Emergency Department (ED) or Inpatient care settings will be referred to as Sepsis Alert.

PROCEDURE

Sepsis Alert

1. A Sepsis alert will be activated with;
   a. A patient presents to the ED with a known or suspected infection;

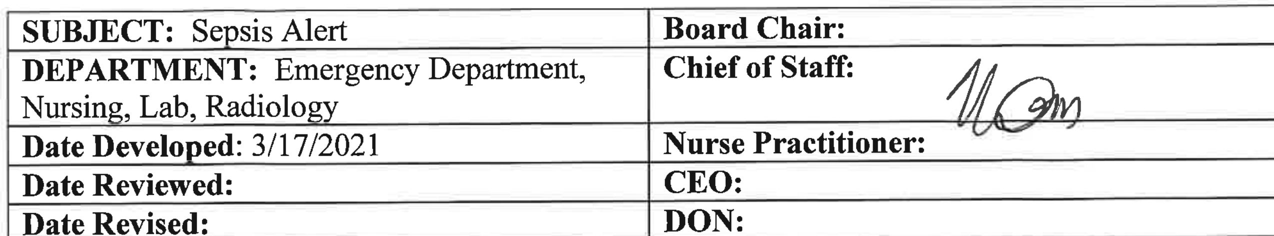
   PLUS

   b. 2 or more SIRS Criteria:
      i. Heart rate greater than 90 bpm
      ii. Respiratory rate greater than 20 breaths a minute
      iii. Temperature greater than 100.4˚ F (38˚ C)
      iv. WBC greater than 12,000 or less than 4,000

   PLUS

   c. 1 or more Acute Organ Dysfunction:
      i. Systolic blood pressure less than 90 mmHg or MAP less than 65 mmHG
      ii. Lactate greater than 2.0
      iii. Creatine greater than 2.0
      iv. Bilirubin greater than 2.0
      v. Platelets less than 100,000
      vi. GCS less than 13
      vii. Acute need of BiPAP or mechanical ventilation

2. Sepsis Alert activation will be initiated by notifying the ED Provider.
   a. A sepsis alert can be activated by an RN, Physician, Nurse Practitioner, or Physician Assistant.
   b. Sepsis Alert can be paged over the intercom using 5555.
      i. Patient location/room number



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        ii. The time (either now or with an ETA if coming by EMS)
    c. Sepsis Alert can also be completed by contacting the departments that are designated to respond.

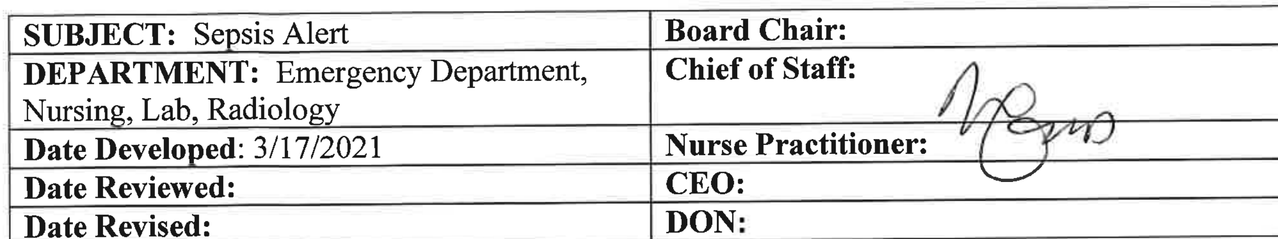
3. Sepsis Alert Responders:
    a. ED Physician or Nurse Practitioner
    b. RN
    c. Radiology
    d. Lab
    e. CNA (if available)
    f. Respiratory therapy (if found necessary to manage airway)

4. Evaluation of the Sepsis Alert Patient:
    a. Stabilize patient
    b. Identify suspected site of infection
    c. Continuous cardiac monitoring
    d. Maintain adequate O2 saturation
    e. ED Physician or Nurse Practitioner will decide on further course of action

5. Diagnostic testing:
    a. Stat laboratory tests:
        i. Lactate
        ii. CBC with diff
        iii. Comprehensive Metabolic Profile (CMP)
        iv. Blood cultures x2 ordered and drawn before antibiotic
        v. DO NOT DELAY antibiotic if unable to obtain blood cultures
    b. Stat Radiology tests:
        i. Chest x-ray per order
        ii. EKG
    c. Fluid resuscitation (crystalloid)
        i. IV bolus started
        ii. IVF 30 mL/kg crystalloid for hypotension or lactate greater than or equal to 4 mmol/L
        iii. Repeat STAT Lactate immediately post fluid bolus (or before transport when possible)
        iv. Vital signs to be completed at least every 15 minutes during ED stay

6. Transfer of patient
    a. ED Physician or Nurse Practitioner to determine appropriate transfer
    b. RN to ensure appropriate transport ambulance (i.e., helicopter or ground) contacted and notified of patient condition.

7. Roles and Responsibilities during a Sepsis Alert:



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a. ED Physician
    i. Evaluation and initial assessment of patient
    ii. Enter ED sepsis order set into EHR
    iii. Consultation to be completed
    iv. Communicates with patient/family regarding plan of care and treatment
    v. Determine need for transfer and facilitate any transfer to a higher level of care.

b. RN
    i. Coordinate the care for the patient's entire emergency department stay
    ii. Assess ABC's, vital signs and neuro status
    iii. 2 Large Bore IV sites or IO sites
    iv. Apply cardiac monitor and pulse oximetry
    v. Initiate fluid resuscitation as ordered by physician
    vi. Coordinate transfer per provider request
    vii. Administer antibiotics as ordered **(do not delay if unable to obtain second set of blood cultures)**
    viii. Complete CNA tasks or delegate as appropriate if CNA is not available

c. CNA
    i. Ensure that registration is completed
    ii. Assist with transport of patient
    iii. Ready stretcher for flight
    iv. Assist with patient care as delegated by RN

d. Lab
    i. Ensure labs and blood cultures are drawn and sent
    ii. Ensure RN and Physician are notified of all Lab results
    iii. Antibiotics will not be delayed for second set of blood cultures

References:

1. Sepsis Alert Emergency Department Policy and Procedure. Centura Health: Clinical Patient Care. 2/10/2020. p1-3.
2. Specifications Manual for National Hospital Inpatient Quality measures v5.6a (applicable 7/1/2019-12/31/2019). Joint Commission.org on November 11, 2019 (Level IV)
3. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016 Rhodes et al. Critical Care Medicine: March 2017 – Volume 45 – Issue 3 – p486-552. (Level IV)