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Next Review:	*2 years after approval*
Responsible Party:	*Laura Fuller: Clinical Nurse Specialist*
Policy Area:	*Patient Care Services #3*
References:	
Applicability:	*Franciscan St. Anthony Health, MC*

Sepsis Identification and Treatment

POLICY

Sepsis, severe sepsis, and septic shock are life-threatening illnesses that rely on early recognition and treatment to improve patient outcomes.

PURPOSE/EXPLANATION

A. To implement evidence-based practice guidelines for early sepsis recognition in the Emergency Department (ED).

B. To delineate a standardized process for:

   a. Early identification of sepsis patients,

   b. Notification of ED practitioners of potential sepsis patients, and

   c. Initiation of Evidence Based Order Set (EBOS)/Sepsis Resuscitation Bundle within one hour of patient arrival at triage.

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EQUIPMENT/FORMS

N/A

PROCEDURE

A. Triage nurse will complete the ED Sepsis Alert tool located under “Screening” in the comprehensive-triage flowsheet on all patients >18 years of age.

B. ED Sepsis Alert screen includes:

   a. Suspected infection

   b. Altered mental status

   c. Temp > 100.4 F (38 C)

   d. Temp < 96 F (36 C)

   e. Respiratory Rate > 20

   f. SpO2 < 90

   g. Heart Rate > 90

h. Systolic Blood Pressure < 90

C. Three positive values on ED Sepsis Alert Screen confirm a POSITIVE screen which indicates the patient may be septic.

D. For POSITIVE screen the ED triage nurse must:

1. Obtain an i-STAT lactate level STAT
2. Notify ED practitioner of the patient with potential sepsis

E. If the Lactate is > 2.2 mmol/L the triage nurse will initiate a CODE SEPSIS.

F. Code Sepsis roles and responsibilities

i. Triage Nurse

a. Immediately move patient from triage to ED room (if available)

i. If not available beds, initiate protocol in triage or hallway gurney

ii. Charge RN to work on making ED room available

ii. Notify the Charge RN, HUC, and ED Practitioner of Code Sepsis initiation

G. Charge Nurse/Rapid Response Nurse

1. Assist with phone calls to coordinate care or be a contact person for resources outside of ED
2. Help bedside nurse initiate GEN ED Sepsis Adult Initial Resuscitation EBOS/Protocol

a. Two sets of blood cultures to be obtained prior to initiation of antibiotics.

i. Unless time to blood culture draw >45 minutes

b. Obtain IV access with 2 large bore peripheral IV's

c. Administer broad spectrum antibiotics within one hour of patient triage arrival.

d. Administer IV fluid (crystalloid) 30 ml/kg for hypotension (MAP < 65 mmHg) or lactate > 4 mmol/L.

e. Anticipate need for equipment depending on patient's clinical status

i. Bipap, Ventilator, Bedside Ultrasound, EKG, EZ I/O Drill, Central Venous Catheter, Advanced Airway Equipment

H. ED Practitioner

1. Initiate GEN ED Sepsis Adult Initial Resuscitation EBOS/Protocol
2. Initiate fluid resuscitation bolus (30ml/kg crystalloid) unless contraindicated and antibiotics within 1 hour of patient arrival in triage.

I. Lab Technician

1. Present to ED to draw and run labs STAT
2. Notify staff of critical values

J. HUC

1. Sends out e-notification of CODE SEPSIS
2. Check with Bed Board/House Supervisor on status of 2 East and ICU beds, inform of potential admission and need for inpatient bed.

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ATTACHMENT

N/A

REFERENCES

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Attachments:

No Attachments

Committee	Approver	Date
	Laura Fuller: Clinical Nurse Specialist	3/9/2016
	Robert Sego: Manager Nursing	3/9/2016
	Travis Thatcher-Curtis: Director Emergency Services	pending