THE UK SEPSIS TRUST

The Pennine Acute Hospitals NHS Trust

Adult Sepsis Inpatient Screening & Action Tool

Patient Name:	**Hospital No.:**	**DOB:**
Clinician Name (print):	**Date:**	**Time:**
Clinician Designation:		**Ward:**
Clinician Signature:	**Consultant:**	

1. Is EWS> 3 OR NEWS> 5 OR cause for concern?

OR does the patient look sick?

OR could this patient be neutropenic?

Contact FY1 doctor/Critical Care Outreach to review

N → Low risk of Sepsis
Use standard protocols, review if deteriorates

Y

2. Could this be an infection?

- Yes, but source unclear at present
- Pneumonia
- Urinary Tract Infection
- Abdominal Pain or Distension
- Cellulitis/septic arthritis /infected wound
- Device related infection
- Meningitis
- Gastrointestinal e.g Diarrhoea
- HCAI (e.g. MRSA, CDT, VRE, CPE)
- Suspected neutropenia and/or recent Chemo
- Other, specify ……

N

Any moderate risk criteria?

- Relatives concerned about altered mental state
- Acute deterioration in functional ability
- Rigors
- Immunosuppressed
- Trauma, surgery or procedure in last 6 weeks
- Clinical signs of wound, device or skin infection
- Respiratory rate 21-24 OR breathing hard
- Heart rate 91-130 OR new arrhythmia
- Systolic B.P 91-100 mmHg
- Not passed urine in last 12-18 hours
- Temperature <36˚C

N

Y

Y

3. **Is any ONE red flag present?**

- **Systolic B.P ≤ 90mmHg (or drop >40 from normal**
- **Lactate ≥2 mmol/l**
- **Heart rate ≥130 per minute**
- **Respiratory rate ≥25 per minute**
- **Needs oxygen to keep SpO_2 ≥92% (88% in COPD)**
- **Responds only to voice or pain/unresponsive**
- **Non-blanching rash, mottled/ashen/cyanotic**
- **Not passed urine in 18 hours**
- **Urine output less than 0.5ml/kg/hr**
- **Known neutropenia or at risk for neutropenia (E.g. recent chemo)?**

	Time Complete	Initials
Send Bloods To include FBC, U&Es, CRP, LFTs, Glucose, clotting		
Contact FY2 doctor or above to review		
Use SBAR! Must review results within an hour Has clinician attended?		

Y

Is AKI present? (tick one) YES NO
(Refer to AKI Protocol)

Y

- Document suspected source <2 hours of presentation
- Oxygen as per BTS Guidelines
- Give appropriate focused antibiotics as per Trust policy<3 hours of presentation
- IV fluid as per clinical volume status (if needing admission, start 2nd litre of crystalloid <4 hours of presentation unless contraindicated
- Continue to monitor urine output

Y

Y

Red Flag Sepsis - Start Sepsis 6 NOW - this is time critical

Sepsis 6 must be completed in the first hour of recognition

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Patient Name: **Hospital No.:** **DOB:**

Sepsis Six

To be applied to all adult patients with suspected or confirmed Red Flag Sepsis **in the first hour of recognition**

	Time	SPR/Cons informed?	Initials
Make a treatment escalation plan and decide on CPR status Inform senior clinician – SPR/Consultant (use SBAR) patient has Red Flag Sepsis			

Actions - complete ALL within 1 hour of arrival or recognition	Time Complete	Initials	Reason not done/variance
1. Prescribe & Administer Oxygen Aim to keep saturations >94% (88-92% if at risk of CO_2 retention e.g. COPD)			
2. Take Blood Cultures At least a peripheral set. Consider e.g. CSF, urine, sputum. **Think source control!** CXR/ Abdo Surgery/ Urinalysis. If needed call surgeon/radiologist.			
3. Give IV Antibiotics According to Trust guidelines Consider allergies prior to administration. If uncertain (e.g. multiple allergies) discuss with Microbiologist on call.			
4. Give IV Fluids If hypotensive/lactate >2mmol/l, up to 30ml/kg Give 500ml stat crystalloid (Hartmann's) if not hypotensive. Continuation of on-going fluid therapy dependant on blood results. **Caution in heart failure.**			
5. Check Serial Lactates Continue IV fluids. **If lactate >4mmol/l, recheck lactate after each fluid challenge (250-500ml) and call Critical Care Outreach**			
6. Measure Urine Output May require urinary catheter Ensure fluid balance chart commenced and completed hourly, Dip urine			

Escalation policy

1. Reassess observations and EWS (15 mins).
2. With every fluid bolus and intervention please repeat observations and lactate to assess response to intervention.
3. Escalation Decision:
   Is there a DNAR order in place? YES/NO (please circle)
4. Escalation Level:
   Ward Based Care ☐ Critical Care ☐
5. Is the patient improving? **YES** – continue steps above.
   NO – implement 6 hour resuscitation bundle checklist (at 30-60 mins)