

### Suspect Sepsis A&E

Does your patient have an EWS  $\geq 3$  and or do they appear sick?

Could this be caused by infection?



**Sepsis 6 Recognition**

Does your patient have a suspected or proven infection with an EWS  $\geq 3$  and/or do they appear sick? **If YES:**

**Do they meet  $\geq 1$  sepsis red flag criteria: TICK**

- New altered mental state
- Respiratory rate:  $\geq 25$
- Needs Oxygen to keep  $SpO_2 \geq 92\%$
- Heart rate:  $\geq 130$  beats per minute
- Systolic BP  $\leq 90$  mmHg
- Non-blanching rash, mottled, ashen or cyanotic
- Lactate  $\geq 2$  mmol/l

**YES** → **High Risk of Sepsis**  
**Start Sepsis Six path way**

**If 1 or more above give IV antibiotics immediately and start IV fluids!**

Time of Sepsis recognition \_\_\_\_\_ Signature \_\_\_\_\_  
Antibiotics given at \_\_\_\_\_ Printed Name \_\_\_\_\_

Complete Sepsis 6 Sticker and place it on clinical form

**Think Sepsis!! Don't Delay!!**

If they have **1** Sepsis Red Flag Criteria **Think B.U.F.A.L.O!**



Administer antibiotics within 60 minutes and Deliver the rest of the 'Sepsis 6' Pathway.



| Action (Complete ALL within 1 hour)  | Time Complete | Initials | Reason Not Done / Variance |
|--|---------------|----------|----------------------------|
| <b>1 Administer Oxygen</b><br>Only if needed to keep saturations $>94\%$ ( $88-92\%$ if at risk of $CO_2$ retention e.g. COPD)   |               |          |                            |
| <b>2 Take blood cultures</b><br>Take a set peripherally. Consider sending specimens e.g. Sputum, urine, CSF. Request CRX and Urinalysis for all adults. Think source control e.g. drainable infection - Call surgeon / radiologist if needed.                          |               |          |                            |
| <b>3 Give IV antibiotics (within 60 minutes)</b><br>According to Trust protocol - see note below / overleaf. Consider allergies prior to prescription and administration. <b>DO NOT DELAY ADMINISTRATION.</b> Antibiotics must be reviewed in $<24$ hrs by consultant. |               |          |                            |
| <b>4 Give IV fluids</b><br>If hypotensive or lactate $>2$ mmol/l give up to 30ml/kg of Crystalloid. Give 500ml stat if not hypotensive and lactate normal. Use caution if patient has chronic renal failure or chronic heart failure.                                  |               |          |                            |
| <b>5 Check Venous Blood Gas Lactates</b><br>If high Venous Blood Gas Lactate then confirm with an arterial sample. If lactate $>2$ mmol/l, recheck lactate after each 10ml/kg fluid challenge and consider referral to Critical Care Complex for Medical Review.       |               |          |                            |
| <b>6 Measure urine output</b><br>May require a urinary catheter (caution if suspected neurotrauma). If there is a catheter in-situ, record hourly urine volumes. Ensure fluid balance chart commenced and completed hourly.  |               |          |                            |

If you are certain of the source of the sepsis follow the antibiotic prescribing guidelines (see overleaf); otherwise, give Piperacillin/Tazobactam for penicillin non-allergic patients or Teicoplanin and Ciprofloxacin for penicillin allergic patients (included in Sepsis Emergency Kit).

Make a treatment escalation plan and decide on resuscitation status. Consultant informed? (tick) ☐

Name \_\_\_\_\_ Signature \_\_\_\_\_ Designation \_\_\_\_\_ Date \_\_\_\_\_