

SEPSIS SCREENING TOOL FOR ADULTS

THIS FORM DOES NOT REPLACE CLINICAL JUDGEMENT

Any Healthcare Professional (HCP) should start this tool if **CONFIRMED** or **SUSPECTED INFECTION** present PLUS presence of ≥1 of the triggers listed below

- | | |
|--|---|
| ☐ Patient looks sick | ☐ Patient/Family/Carer/Clinician Concern |
| ☐ Emergency Dept. Manchester Triage Category 2 | ☐ GP/ Ambulance personnel queries sepsis |
| ☐ Elevated EMEWS or INEWS (INEWS ≥ 4 or ≥5 if on O ₂) | Score: <input type="text"/> |

YES

*Time Zero:

 : : :

Name _____ Grade _____

*When the patient 1st triggers for sepsis screen

NMBI/MCRN _____ DATE: ____/____/____

REQUEST MEDICAL REVIEW AS PER ESCALATION AND RESPONSE PROTOCOLS TO RISK ASSESS PATIENT USING ISBAR

Is any **ONE RED FLAG** present? 

Signs of Shock

- ☐ Systolic Blood Pressure < 90mmHg (or drop of > 40mmHg below normal +/- Point of care lactate > 2mmols/L)

OR

Risk of Neutropenia

- ☐ Recent chemotherapy/radiotherapy

OR

Evidence of New Organ Dysfunction

(any one of the following)

- ☐ New Acutely altered Mental Status
- ☐ Respiratory Rate > 30 bpm
- ☐ Heart rate > 130 bpm
- ☐ Not passed urine in 12 hours or urine output < 0.5mls/kg/hr
- ☐ Non blanching rash
- ☐ New or increased need for O₂ to achieve SpO₂ >90%
- ☐ Pallor/mottling with central CRT > 3 seconds
- ☐ Other organ dysfunction

YES

PROBABLE SEPSIS
IMMEDIATE ACTION IS REQUIRED

YES

SITE OF INFECTION (IF KNOWN) _____

START SEPSIS 6 NOW

INFORM SENIOR DECISION MAKER

See overleaf

NO RED FLAGS - CHECK FOR AMBER FLAGS

≥ 2 Systemic Inflammatory Responses (SIRS) that are sustained PLUS ≥ 1 Comorbidity.

SIRS (check for 2 or more listed below)

- ☐ Respiratory rate ≥ 20 bpm
- ☐ Heart rate 91- 130 bpm
- ☐ Temperature < 36 or > 38.3 °C
- ☐ Blood glucose level > 7.7 mmol/l (in absence of diabetes mellitus)
- ☐ WCC < 4 or > 12 x 10⁹ /L

AND

≥ 1 Comorbidity (listed below)

- ☐ Aged ≥ 75 years
- ☐ Frailty
- ☐ Diabetes Mellitus
- ☐ COPD
- ☐ Cancer
- ☐ Chronic Renal Disease
- ☐ Chronic Liver Disease
- ☐ Recent Surgery /Trauma (past 6 weeks)
- ☐ Immunosuppression (due to medication or disease)

YES

NO

POSSIBLE SEPSIS

YES

NEGATIVE SCREEN SEPSIS UNLIKELY AT THIS TIME

EXIT PATHWAY

Sign _____

MCRN / NMBI (ANP)

Treat as per diagnosis and continue to monitor. Rescreen if deteriorates

Is there an End-of-Life Pathway in place? Yes ☐ No ☐ Is escalation clinically appropriate? Yes ☐ No ☐

If Sepsis 6 is not clinically appropriate, exit the sepsis pathway.

Doctor Signature _____ MCRN _____

SEPSIS TREATMENT PROTOCOL FOR ADULTS (NON MATERNITY) ≥16 YRS

SEPSIS 6 BUNDLE

- COMPLETE WITHIN 1 HOUR

Addressograph

TAKE 3	1 TAKE BLOOD CULTURES 2 sets of peripheral blood cultures (aseptic technique) prior to giving antimicrobials unless this leads to a delay >45mins. If patient has CVAD, take line cultures at the same time. Other cultures as indicated by history and examination.	Time Taken: □□:□□
	2 TAKE BLOOD TESTS FBC, Renal and Liver profile, point of care lactate , CRP +/- coagulation screen. If initial lactate elevated > 2mmols/L, repeat lactate after sepsis 6 bundle to assess response.	Time Taken: □□:□□
	3 URINARY OUTPUT ASSESSMENT Assess urinary output as part of volume/perfusion status assessment. For patients with sepsis/septic shock start fluid balance charts. Catheterisation and hourly measurements may be required.	Time: □□:□□ Fluid balance chart commenced ☐
GIVE 3	4 IV ANTIMICROBIALS (if appropriate), THINK SOURCE CONTROL. Consider Microbiology review	
	Red Flags (PROBABLE SEPSIS)  IV Antimicrobials within 1 HOUR	Amber Flags (POSSIBLE SEPSIS)  Review test results to identify infectious vs non-infectious causes of acute illness. If infection confirmed, administer IV antimicrobials within 3 HOURS . Note: If infection with new onset organ dysfunction present (e.g. AKI, thrombocytopenia or hyperlactatemia etc.) administer antimicrobials immediately.
	TIME GIVEN □□:□□ ☐ Patient already on appropriate antimicrobials ☐ This patient does not require antimicrobials at this time	TIME GIVEN □□:□□
	5 GIVE IV FLUID BOLUS IF REQUIRED For patients with hypotension or hypoperfusion give a 250 - 500mls IV fluid bolus of balanced crystalloid. Administer a total volume of fluid resuscitation up to 30ml/kg within the first 3 hours unless fluid intolerant or the patients clinical condition requires earlier referral to critical care for consideration of inotropes/ vasopressors, Reassess response to fluid resuscitation frequently. Refer to fluid resuscitation algorithm.	
	6 GIVE OXYGEN IF REQUIRED Titrate supplementary oxygen to maintain oxygen saturations 94-96% (88-92% for patients with chronic lung disease).	Time Given: □□:□□ or N/A ☐

Reassess vital signs at least every 30 minutes.
IF CONDITION WORSENING / NOT IMPROVING, ESCALATE TO CONSULTANT.
Consider SEPTIC SHOCK if MAP less than 65mmHg DESPITE FLUID RESUSCITATION and escalate to critical care.

- ☐ Sepsis **UNLIKELY** at this time, treat as per working diagnosis, continue to monitor. Rescreen if deteriorates
- ☐ This is likely to be **SEPSIS** at this time
- ☐ Senior Clinician informed

Signature _____ MCRN / NMBI (ANP) _____

Print _____ Date: ____/____/____ Time □□:□□