Appendix 1

Adult Sepsis Screening and Immediate Action Tool

Complete and file in medical record

Name:

Date of Birth:

Hospital Number:

Affix Hospital Label if available

Caring at its best

1. At least one of the following present?

TICK BOX

- [ ] Early Warning Score 3 or more OR
- [ ] Patient looks unwell OR
- [ ] Concern regarding acute change in mental state

N (TICK BOX) → Low Risk of SEPSIS

Y ↓

2. Is the clinical picture suggestive of an infection?

YES [ ]

If there is a high probability of a non-infective explanation for clinical features (eg AMI, PE, liver failure, pancreatitis or stroke) then manage as low risk of sepsis

- [ ] Chest
- [ ] Urinary Tract
- [ ] Cellulitis, necrotizing fasciitis
- [ ] Abdominal
- [ ] Bone or joint
- [ ] Meningitis
- [ ] Device related (eg catheter, line)
- [ ] Other, state:
- [ ] Yes, but source unclear

N (TICK BOX) → Low Risk of SEPSIS

Y ↓

Perform rapid ABCDE assessment

3. At least one red flag present?

- Assessment MUST allow for patients usual chronic baseline
- Obstetric patients: use corresponding red MEOWS triggers

TICK BOX

- A [ ] Respiratory rate 25/min or more
- B [ ] New need for >40% O_2 to keep saturations over 91% (saturations > 87% in COPD)
- [ ] Systolic BP < 91mmHg or fall of 40 from normal
- C [ ] HR >130/min
- [ ] No urine output for 16hrs or UO<10ml/hr
- D [ ] New onset delirium
- [ ] Responds only to voice or pain / unresponsive
- E [ ] Non-blanching rash/ mottled / ashen / cyanotic
- [ ] Neutropenia or chemotherapy within last 6 weeks

N (TICK BOX) → Moderate Risk of SEPSIS

Y (TICK BOX) → HIGH Risk of SEPSIS

Low Risk of SEPSIS

Treat to local protocols, review if patient deteriorates. Consider other diagnoses. TICK BOX [ ]

Moderate Risk of SEPSIS

Sepsis Likely / Present

TICK BOX [ ]

- Inform responsible clinician
- Consider Sepsis Six interventions (see overleaf)
- Begin at least hourly observations
- Act on early warning score triggers
- Send appropriate microbiological samples (including blood culture)
- Send blood samples for FBC, CRP, U&E, LFT coagulation, Blood gas (venous or arterial) Glucose, ensure **results are reviewed**
- Source specific antimicrobial prescribing based on local policy (e.g. 4hr CAP bundle)

If EWS 4 or more **AND** Lactate ≥ 2 or AKI ≥ 2
If YES Then treat as RED FLAG SEPSIS TICK BOX [ ]
Time zero = Time of abnormal blood results availability

HIGH Risk of SEPSIS

Red Flag Sepsis

TICK BOX [ ]

This is a time critical condition, immediate action is required!

TICK BOX **Start Sepsis 6 bundle NOW** (see overleaf)

- [ ] Inform resident senior doctor
- [ ] Inform outreach team (ward patients): BLEEP LRI 5293 / GH 2808 / LGH 3457
- [ ] Inform Sepsis Team (ED): CALL # 6826

Time Zero: ______ (ED, time of admission. Ward, time of first red flag)

Target Time: ______ (Time when sepsis six to be complete. Time zero plus 1 hr)

Delivery of Sepsis Six by junior staff must not be delayed. Resident senior doctor review can stop the process on the following grounds:

TICK BOX

- [ ] Patient is End of Life
- [ ] Patient low suspicion of infection
- [ ] Red Flag due to chronic disease

STOP

SURNAME & GRADE	SIGNATURE	DATE & TIME

PRINT NAME:	Title:	Date:	Time:

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Sepsis Six Bundle

Complete in one hour.

Actions should be carried out simultaneously.

Use sepsis box / pack to support delivery of sepsis six

THE UK SEPSIS TRUST

Supporting Resources

Sepsis
Frequently Asked Questions

How to:
Take a blood culture
Draw up meropenem
Use a sepsis box

	Action	Time	Name	Reason
1	**Administer supplementary oxygen (if required)** • Aim to keep saturations > 94% COPD: Adjust target saturations to 88-92%	Time Started	Name	Reason not administered
2	**Blood Culture & Source Management** • Take blood cultures (before IV antibiotic) • Think source confirmation and control! • Consider also sputum, urine, CSF, line culture/removal • involve appropriate surgical team / radiologist as indicated • For Community Acquired Pneumonia start 4 hr CAP Bundle	Time Taken	Name	Reason not taken
3	**Give IV antibiotics** PRESCRIBE STAT (TIMED). GIVE YOURSELF OR MAKE SURE SOMEONE DOES • Red Flag Sepsis: Meropenem IV 1g stat (+/- second dose at 8hrs) and review at first inpatient consultant assessment (microbiology advice may be needed at this stage) • Sepsis: According to local antimicrobial policy	Time Given	Name	Reason for departure from prescribing guidance
4	**Give a fluid challenge** Check and monitor response If SBP <90mmHg or Lactate >2 • Give 500mls Hartmann's or 0.9% NaCl over 15 mins, repeat once if necessary • Senior resident doctor review to exclude other causes of shock before giving up to 30 ml/kg If SBP >90mmHg and Lactate <2 consider IV fluids	Time Given	Name	Reason not given
5	**Measure lactate** • Obtain blood gas - venous or arterial • If lactate >4mmol/L refer to critical care • Ensure samples are sent for FBC, CRP, U+E, LFT, coag screen • Repeat lactate after fluid challenge	Time Taken	Name	Reason not done
6	**Measure urine output** • Ensure hourly fluid balance chart commenced • Catheterise if AKI / SBP <90 / Lactate >2 • Monitor Vital Signs at 15-30mins intervals until EWS below 3	Time Started	Name	Reason not started
Escalation	**Critical Care Medical Team** refer if patient: • SBP <90 and lactate >2 after fluid resuscitation • Has Red Flag Sepsis and lactate >4 • Has Red Flag Sepsis and requires >50% O_2 • Has Red Flag Sepsis and significant respiratory/ cardiovascular/ CNS or renal dysfunction.	Time Referred	Name of Referrer Name of ICU Doctor	Reason NOT Referred:

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NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents

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