## Severe Sepsis

**Start the clock:** Date / / ___:____:___h

<table>
<thead>
<tr>
<th>Time</th>
<th>Initial</th>
<th>Reason not done</th>
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### A. Inform Nurse in Charge

### B. Discuss with Senior Dr or Consultant- use SBAR

1. **Oxygen:** High flow 15L/min via non rebreathe mask
   Target saturations > 94% (unless otherwise stated in medical notes)

2. **Blood cultures:** Take at least one set plus all relevant blood tests. (Consider also sputum, urine, CSF, pus samples)

3. **IV antibiotics:** As per Trust Guidelines
   *Prescribe first dose as Stat dose*

4. **Fluid resuscitate:** If hypotensive give 250 mls sodium chloride 0.9% / colloid given over 10 minutes, assess response. Further fluid boluses up to 40 ml/kg.
   *NB. PGD trained nurses can give up to 500 mls in total*

5. **Serum arterial lactate and Hb:** (ABG analyser: ED, ITU)
   *Ensure Hb > 70g/l. Cross match if Hb < 70 g/l*

6. **Catheterise and commence fluid balance:**
   *If fully mobile allow to self void but record balance*

### PLUS

**C. If organ dysfunction persists despite above interventions or lactate >4, discuss with Critical Care holder Bleep 4716**

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One hour time check: all steps done? Yes☐ No☐

Name: __________________________ (print) __________________________ (sign)

Designation: ______ Bleep/Ext no: ______