Belfast Health and Social Care Trust

Integrated Care Pathway for the Management of Oncology/Haematology Adult Patients *(18 yrs and over)* with Suspected Neutropenic Sepsis

Patient
Name: ……

Ward: …….... DOB: .....

Hosp No: …… H&C No: ….... *(or affix label)*

Date: ..... Time of initial assessment: ..... Location of 1st Assessment: .....

Oncology/Haematology Consultant: ..... Oncology/Haematology diagnosis: .....

Systemic Anti-Cancer Therapy: ..... Last start date: .....

Clinical trial patient: Yes ☐ No ☐ History of bone marrow transplant: Yes ☐ No ☐

Unit attended: ..... Weight: ..... kg

Allergies **Yes ☐ No ☐**

Initials: ..... Date: ..... Time: .....

Patient Information

This Integrated Care Pathway is a document detailing the management of adult patients who have presented with suspected Neutropenic Sepsis. It has been agreed and documented as the most common pathway that this care may follow. As an individual your health requirements may vary from those laid out in this pathway, in which case the health professionals will use their judgement to adapt that care accordingly. Any variations from the pathway will be explained to you. If you do not have a clear understanding of what is going to happen, please ask a member of staff to explain.

Staff Information

This Integrated Care Pathway **MUST** be commenced for:

- Adult cancer patients (18 yrs and over) receiving chemotherapy or having received it within the last 6 weeks who are unwell or febrile.
- Adult patients (18 yrs and over) with neutropenia secondary to known bone marrow failure (e.g. due to a primary haematological disorder) who are unwell or febrile.
- Assume Neturopenic Sepsis until proven otherwise.

The goal is a "door to needle" time of 60 minutes for administration of IV antibiotics.

It replaces all other documentation. ***However if an adult patient remains an inpatient for longer than 24 hours this pathway should be discontinued, filed in the patient's notes and details of care/treatment should be continued in the patient's notes.***

When the adult patient is admitted to the ward Nurses MUST complete the inpatient nursing assessment documentation in conjunction with this pathway.

Initialling the Care Pathway

You should use the initials column to confirm that an intervention has been carried out or an outcome achieved.

Variances: "what is a variance"?

A variance is any non-completion of a planned intervention, e.g. "Consent form ***not*** completed correctly" or an outcome ***not*** achieved, e.g. "Fasting regime ***not*** adhered to". In the event of a variance occurring, enter a 'V' in the initials column and then complete the variance section. When documenting variances include reasons for variations as well as action taken. Variances take into account patient individuality and professional judgement.

Signature Register

Since you are only required to initial parts of the Care Pathway itself, this page serves as a record of your full signature and thus satisfies medico-legal requirements. Accordingly, all staff using this Pathway ***MUST*** complete their details below.

Name *(block capitals)*	Designation	Professional Registration Number	Initials	Full signature

Abbreviations

ANC	Absolute Neutrophil Count	IV	Intravenous
AVPU	Alert, Verbal, Pain, Unresponsive	MSSU	Mid-Stream Specimen of Urine
BD	Twice Daily	NEWS	National Early Warning Score
BP	Blood Pressure	OD	Once Daily
BM	Blood Monitoring	Onc	Oncology
CO_2	Carbon Dioxide	PICC	Peripherally Inserted Central Catheter
CRP	C-reactive protein	QID	Four Times Daily
CXR	Chest X-ray	RR	Respiratory Rate
ED	Emergency Department	SpO_2	Oxygen Saturation
FBP	Full Blood Picture	Temp	Temperature
Hb	Haemoglobin	TID	Three Times Daily
Haem	Haematology	WCC	White Cell Count

Triage/Initial Assessment *(Immediately commence National Early Warning Score chart)*

AVPU: ..... BM: ..... Weight: .....

Temp: ..... RR: ..... SpO_2: ..... Pulse: ..... BP: ..... NEWS: .....

If any signs of sepsis are present (tick below):

Temperature >38 or <36 ☐ Pulse >90 ☐ RR>20 ☐

Commence ABCD action checklist.

Do not wait for laboratory confirmation of neutropenia before giving first dose antibiotics.

If no signs of sepsis reassess diagnosis.
Care should be taken if neutropenic and low grade pyrexia as patient may deteriorate.

If any additional signs of SEVERE sepsis are present (tick below):

Altered mental state ☐ Hypoxia (SpO_2 sats <94%) ☐ Shock (sys BP ≤90mmHg) ☐

Add Gentamicin also. Early senior input from oncology/haematology registrar and consider HDU/ICU input.

Action Checklist

Patient
Name: ……

Ward: .....

Hosp No: …… H&C No: ..... *(or affix label)*

Actions Date action list commenced:		**Target time**	**Performed by**	**Time performed**
A – Airway	Oxygen if sats <94% For CO_2 retainers target sats 88-92%	< 1 hour		
B – Bloods and Blood cultures	Following bloods required all sent urgently: FBP Oncology profile or **U+E, LFTs and Bone profile** CRP Venous lactate	< 1 hour		
	Peripheral blood cultures If PICC/Hickman line present cultures from each lumen	< 1 hour		
C – Circulation	Give IV fluids Monitor urine output hourly Commence fluid balance chart	< 1 hour		
D – Don't ever forget Antibiotics	**Stat doses of IV ANTIBIOTICS within SIXTY MINUTES**	< 1 hour		

Variances: If any action is not performed, document reason why:

Chosen Antibiotic regimen		**Given by**	**Time given**
1a)	**Preferred regimen:** Piperacillian 4g/Tazobactam 500mg IV QID		
1b)	**Severe sepsis:** Add Gentamicin 5mg/kg slow IV OD		
2	**Penicillin Allergy Regimen:** Ciprofloxacin 600mg slow IV BD		
	Gentamicin 5mg/kg slow IV OD		
	Tecicoplainin 10mg/kg slow IV (BD for 3 doses then OD)		
3	**Penicillin Allergy regimen for patients who have received prophylactic ciprofloxacin:** Aztreonam 2g IV TID		
	Gentamicin 5mg/kg slow IV OD		
	Telcoplainin 10mg/kg slow IV (BD for 3 doses then OD)		

Further Assessment

Multidisciplinary notes:

Medical review: (History and Examination) Document any symptoms or signs which suggest a focus of infection.

Blood results (Neutropenia is an ANC <1)

Hb: ..... WCC: ..... ANC: ..... Platelets: .....

Biochemistry:

Investigations: Document and sign when the following have been taken. Urinalysis +/- MSSU, sputum, swabs of throat/skin lesions, CXR if clinically indicated.

Diagnosis:

Plan:

Oncology/Haematology registrar contacted (if patient is in ED contact through central switchboard):

Name: ..... Date: ..... Time: .....

Advice given:

Onc/Haem Sprs will give advice re: treatment intent and discontinuing systemic anti-cancer therapy.
The full guideline for management of neutropenic sepsis within the first hour and first 48 hours is available on the Trust intranet.

Assessing Doctor's initials: ..... Grade: ..... Contact/bleep: .....