**Sepsis Six Pathway**



**Use this form if PARS ≥ 3 or clinical evidence of infection**

Are any 2 of the following present?

* Temperature less than 36˚C or more than 38˚C
* Respiratory rate more than 20/min
* Acutely altered mental state
* HR more than 90
* WCC >12 or WCC <4

# Name of person completing form:

**Date:**

Yes

Consider:

* + Respiratory tract
  + Urinary tract
  + Joint infection
  + Endocarditis
  + Line infection
  + Travel in last 3 months

# Signature:

***Patient sticker***

Measure Lactate

**Result:**

**Time taken:**

**Look for:**

* **Systolic BP less than 90**
* **MAP less than 65**
* **Lactate greater than 2**
* **Other evidence of organ dysfunction**

**(Creat > 177, Bili > 34, Plt < 100, INR > 1.5,**

**urine output < 0.5mL/kg/hr, SpO2 < 90%)**

**Sepsis.**

**No Investigate, treat and monitor closely.**

**Restart assessment if patient deteriorates.**

Yes

**Time severe sepsis identified: Complete tasks below**

**SEVERE SEPSIS - Inform senior Doctor IN 1 HOUR**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | **Time done** | **Reason not done** |
| **1** | **100% oxygen** | **Give 15L/min via facemask with reservoir bag unless oxygen restriction necessary.** |  |  |
| **2** | **IV fluid bolus** | **Give 1000ml bolus of crystolloid rapidly (<30mins), if fluid overload 250-500ml boluses.** |  |  |
| **3** | **Blood cultures** | **Culture other sites as clinically indicated e.g. sputum, wound swabs.** |  |  |
| **4** | **IV antibiotics** | **Use Trust antibiotic guidelines. Ensure to inform nursing staﬀ of stat dose written on the front of the drug chart.** |  |  |
| **5** | **Lactate + bloods** | **Lactate on venous or arterial sample. Request FBC, U&Es, LFT, clotting screen and glucose.** |  |  |
| **6** | **Monitor urine output** | **Consider catheter.**  **Monitor output hourly using fluid balance chart.**  **Dip urine and send MSU.** |  |  |
| **Repeat Lactate. Ensure urgent review by senior Doctor.** | | |  |  |

**Baseline results:**