

## Adult ED Sepsis Alert Worksheet (\*in addition to use of sepsis narrator, age $\geq$ 18)

- ☐ If patient fires SIRS BPA (meets 2 out of 4 SIRS criteria), inform ED provider and draw a lactate (or discuss decision to withhold lactate with ED provider):
- Temp  $< 96.8$  or  $> 100.4$  F
  - HR  $> 90$
  - RR  $> 20$  or  $\text{pCO}_2 < 32$
  - WBC  $< 4$  or  $> 12$  or  $> 10\%$  bands
- ☐ Overhead page SEPSIS ALERT for pts w/ suspected infection exhibiting any of the following:
- ☐ Lactate  $> 2.00$  (result: \_\_\_\_\_) \_\_\_\_\_ AM/PM
  - ☐ SBP  $< 90$  or MAP  $< 65$
  - ☐ Altered mental status AND 2 out of 4 SIRS criteria
  - ☐ Clinical discretion (e.g., 2/4 SIRS criteria + other sign of organ dysfunction\*\*)
- \*\*Alternate criteria for end-organ damage: New Cr  $> 2.0$  (or  $\uparrow$  Cr  $> 0.5$  above baseline); T bili  $> 2$ , ptt  $< 100$ , INR  $> 1.5$  or aPTT  $> 60$ , acute resp failure requiring intubation/Bipap/CPAP
- ☐ Huddle at bedside with attending \_\_\_\_\_ AM/PM
- ☐ Start Sepsis Narrator and document a huddle accordingly \_\_\_\_\_ AM/PM
- ☐ On protocol, **\*\*place patient on monitor, upgrade to ESI level 2\*\***
  - ☐ Not on protocol (Attending should document reasoning in Epic; no need to complete rest of worksheet)
- ☐ Ensure initial lactate collected (if not already done, result: \_\_\_\_\_) \_\_\_\_\_ AM/PM
- ☐ Blood Cultures x 2 from two sites. Document collection time in Epic **before** antibiotics. Set #1 \_\_\_\_\_ AM/PM
- ☐ Broad Spectrum Antibiotics **< 60 minutes**. Documented **after** cultures, with **first** antibiotic Set #2 \_\_\_\_\_ AM/PM
- from the following list:
- ☐ Cefepime OR Zosyn OR Ceftriaxone OR Meropenem OR Unasyn \_\_\_\_\_ AM/PM
  - ☐ Second line (if severe PCN allergy): Aztreonam followed by Vancomycin w/in 2 hrs
- ☐ If lactate  $\geq 4$  or SBP  $< 90$  at any time: **Initiate 30 cc/kg fluid bolus** (provider may use IBW if BMI  $> 30$ ) \_\_\_\_\_ AM/PM
- Document fluid end-time in MAR. **Check vitals every 15 mins x 3 sets within 1 hour after 30 cc/kg fluid completed.** VS q15min x 3 sets: ☐ ☐ ☐
  - When 30 cc/kg bolus complete, notify provider so they can complete perfusion reassessment note (e.g., "I have reassessed the patient's hemodynamic status."): ☐
  - If persistent hypotension, notify providers to initiate vasopressor: ☐
- ☐ If initial lactate  $> 2.00$ : **Repeat VBG lactate** within 3 hours of initial lactate or prior to ED departure (result: \_\_\_\_\_) \_\_\_\_\_ AM/PM
- If lactate uptrending, continue to check repeat lactates q3hrs
- ☐ If patient started on sepsis protocol, final co-review of checklist with Attending and Primary RN:

\_\_\_\_\_  
Attending signature

\_\_\_\_\_  
Primary RN signature

**All highlighted items (unless patient not on protocol) must be completed prior to ED departure.** Please return forms to Charge Nurse.