ADDRESSOGRAPH

NHS
County Durham and Darlington
NHS Foundation Trust

Nurse Led Sepsis Pathway Emergency Department

This Pathway can only be used by RGN working in the Emergency Department who has completed the relevant training programme and competencies.

Exclusion Criteria:
Pregnancy
Age under 18 years
Penicillin Allergy
Neutropenic Patient
Known MRSA, VRE, ESBL, CPE, MRO colonisation.
Tazocin resistant (or intermediate) organisms in blood cultures, sputum and urine during the previous 3 months

Those who fit into the exclusion criteria MUST be escalated to a medical Dr for urgent review.

Inclusion Criteria:
Sepsis of Unknown Origin.
If source of Sepsis is known, the senior clinician must be informed so the appropriate antibiotics can be prescribed and administered urgently.

Identified as Septic by the Trust Infection and Sepsis Screening Tool

Pathway Commenced:

Date: .....

Time: .....

Current Blood Sugar:

Current NEWS Score:

Do you suspect infection? ☐ **YES** ☐ **NO, If no follow standard protocols**
(Consider signs and symptoms of infection, such as temperature ≥38°C or <36°C

- ☐ Pneumonia / Respiratory tract infection
- ☐ Intraperitoneal infection
- ☐ Bone or joint infection
- ☐ Endocarditis
- ☐ Foreign body / implanted device infection
- ☐ Skin or soft tissue infection *(incl. wound)*
- ☐ Unknown source / other _____
- ☐ Urinary tract infection
- ☐ Biliary tract infection
- ☐ ENT / maxillofacial infection
- ☐ CNS infection
- ☐ Intravascular catheter infection
- ☐ Female reproductive tract infection

Ensure the patient has been examined as part of an ABCDE assessment (they should be in a gown) and obtain a clinical history.

Any 2 of the below Sepsis Risk Criteria:

- ☐ Respiratory rate ≥ **22 breaths/minute**
- ☐ **Altered Mental Status** (new or deteriorating if chronic confusion)
- ☐ Systolic Blood Pressure ≤**100 mmHg**

NO

Sepsis still suspected or high risk patient

- ☐ History of chemotherapy (6 weeks)
- ☐ Bone marrow transplant within last year
- ☐ Any other immunosuppression risk factor
- ☐ Recent truama/surgery/intervention (6 weeks)
- ☐ Non blanching rash or mottled/ashen skin
- ☐ Lactate > 2mmol/L
- ☐ Acute Kidney Injury
- ☐ Other _____
- ☐ **If non of the above, follow standard protocols**

PATIENT HAS SEPSIS

Diagnosis Time (Time Zero) ___:___ Initials _____*

Start **SEPSIS MANAGEMENT** (see over)

Does your patient need to be moved to another area for closer observation?
Consider using Monitoring or Resus depending on availability.
Inform Nurse in Charge that you have commenced the Nurse Led Sepsis Pathway

If not already completed:

Secure IV Access ☐

Take the following bloods:

- LFT's ☐
- U&E's ☐
- Lactate ☐
- Glucose ☐
- FBC ☐
- Clotting ☐

Take Blood Cultures ☐

Date Bloods Taken:

.....

Time Bloods Taken:

.....

Taken By (if not taken by the person completing this pathway):

.....

Current Sp02: Start **Oxygen** if below 94% (or 88% in hypercapnic patient) ☐

Commence via venture face mask and titrate until level is between 94-98%. If the patient is severely unwell, deteriorating then seek urgent medical support and consider High Flow oxygen via a non-rebreathe until help arrives.

Consider whether an ABG is required?

Amount of Oxygen Delivered:

.....

Oxygen Delivery Device:

.....

MICROBIOLOGY REVIEW

Check i-soft for **infection control** ' flags' (i.e. MRSA, CPE, VRE, MRO).

In addition check for any **tazocin** resistant or intermediate organisms **in sputum, blood or urine in the last 3 months**.

If either of the above **are true** please refer to the Dr for advice & do not administer **tazocin, if needed** the Dr will need to seek further advice from the microbiology team.

Time IV Abx given:

.....

CHECK ALLERGY STATUS OF PATIENT -
STOP PATHWAY IF PATIENT IS PENICILLIN ALLERGY

Give IV Tazocin 4.5g as per PGD as soon as possible ☐
(Mix with 20mls of sterile water to dissolve and then add to 100ml 0.9% Saline)

Give over 30 minutes.

Current Blood Pressure:

.....

Lactate:

.....

Monitor Patient's Vital Signs every 30 minutes from commencement of Pathway ☐

Commence Fluid Balance Chart and record input / output hourly, consider the need for catheterisation ☐

Is the Patient hypotensive? BP below 100mmhg or 40mmhg drop in usual baseline BP

Give 250mls balanced crystalloid as per PGD ☐

A further 250mls can be administered following reassessment ☐

SEEK MEDICAL SUPPORT IF THE PATIENT REMAINS HYPOTENSIVE

Are Blood Tests Back? Document results here:

WCC	CRP	Lactate	Urea	Creatinine	K+	HB	Bilirubin

Is imaging required? (CXR / AXR / USS / CT) This will need discussion and can be completed during Senior review.

Is further culture required? (e.g. Wound Swab, Urine Culture, Sputum) Document any swabs taken here:

Following delivery of IV abx and IV fluids complete a VBG to ensure a rapid lactate:

REPEAT LACTATE LEVEL: **LATEST NEWS SCORE:**

Ensure a Senior Review within 30 minutes of completion of this Pathway. This must be ST3 or Above.
Ensure all treatment and test results are available to the Clinician at the time of review.

Time of Senior Review: .....

Signature of Staff Completing this Pathway: .....